CASE MANAGER SUPERVISOR CERTICATION
~~TARGETED CASE MANAGEMENT~~
~~FOR CHILDREN AT RISK OF ABUSE AND NEGLECT~~

Case Manager Supervisor: _____

Provider Agency Name: _____

Provider Agency Address: _____

_____

Provider Phone Number: ( ) Florida Medicaid Provider Number: _____

Is hereby certified as having met the requirements for the supervision of, or the provision of, Targeted Case Management for Children at Risk of Abuse and Neglect services. This individual case manager supervisor meets all the following criteria:

(1) ~~a.~~ Is employed by or under contract with a provider ~~an~~ agency that has been certified by a ~~the~~ children's services council or local government entity as qualified to provide supervision for case management services to the target population. ~~;and~~

(2) ~~b.~~ Has a minimum of one of the following:
   a) Bachelor's degree in a human services field and two years of professional experience working with children who have been or are at risk of being abused, neglected, or abandoned.
   b) Bachelor's degree and five years of professional experience working with children who have been or are at risk of being abused, neglected, or abandoned.
   c) Master's degree in a human services field and one year of professional experience working with children who have been or are at risk of being abused, neglected, or abandoned.

(3) ~~c.~~ Agrees ~~Has agreed~~ to complete all required training and any other training including periodic retraining. ~~training~~;

(4) ~~d.~~ Has completed the mandated reporter training that addresses abuse and neglect.

(5) ~~e.~~ Will be enrolled, prior to providing ~~provider~~ supervision, as a ~~Florida~~ Medicaid approved social worker/case manager.

(6) ~~f.~~ Is knowledgeable of the resources, specific to the identified service area, ~~Specific to the identified service area, has knowledge of the resources~~ that are available for children who are abused, neglected, or abandoned or are at risk for abuse, neglect, or abandonment.

(7) ~~g.~~ Is knowledgeable of and in compliance ~~comply~~ with the state and federal statutes, rules, and policies that pertain to this service and target population. ~~and;~~

(8) ~~h.~~ Is hereby certified by the certified provider agency as meeting these requirements.

_____

Agency Administrator: Date:

_____

Authorized Representative of the Date:
Children's Services Council or Local Government Entity ~~Authorized Representative~~

_____

County:

~~Florida Medicaid Area #~~ _____

AHCA Form 5000-3536, Revised (APR 2024) ~~MAY 2014~~ (incorporated by reference in Rule 59G-1.060, F.A.C.)