Oklahoma Department of Mental Health

And Substance Abuse Services

Support Services Provider Verification Form

**Support Services Provider**- an individual age eighteen (18) or older with a high school diploma or equivalent *[Per 450:1-1-1.1.]*

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ confirm that I meet the requirements for the Print Name

Oklahoma Department of Mental Health and Substance Abuse Services Support Services Provider as defined above, and maintain documentation supporting these requirements in my personnel record at my place of employment. I agree to submit supporting documentation to the Oklahoma Health Care Authority upon request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date