Behavioral Health Services

Attach written verification that your agency has a contract with MassHealth or a MassHealth behavioral health contractor. *(If you do not have such a contract, your agency is not eligible to apply for a contract for these services)**

* = required field

I. Service Capacity

A. Identify which of the three qualification categories applies to your provision of services:*

- ☐ Community Mental Health Center (CMHC) that contracts with MassHealth
- ☐ Hospital outpatient behavioral health center under contract to MassHealth
- ☐ Provider under contract to one of the MassHealth agency's behavioral health MCOs

B. Indicate which of the following your organization provides:*

- ☐ Diagnostic Services
- ☐ Individual Therapy
- ☐ Couple/Family Therapy
- ☐ Group Therapy
- ☐ Case Consultation
- ☐ Emergency Services
- ☐ Re-evaluation

C. Describe your capacity to provide behavioral health services to older adults, including whether your organization employs clinicians with experience in geriatrics.*

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D. Describe your experience in counseling at-risk individuals, including those who self-neglect and/or are victims of abuse.*

_____

E. Describe your experience in coordinating care and services with community-based organizations.*

_____

F. Describe your capacity to provide counseling services in the consumer's home and any limitations thereto.*

_____

G. Describe your ability to serve consumers who have limited English speaking ability.*

_____

II. Staff Qualifications

A. Describe your process to ensure that services, including development of mental health plans of care, are provided by qualified individuals in accordance with MassHealth regulations or MassHealth behavioral health contractor rules.*

_____

B. Describe your capacity to provide services in accordance with the protocols included in EOEA PI 08-08 and in compliance with 101 CMR 305. *

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III. Training and In-Service Education

A. Describe your policy for professional development, in-service education, and mandated reporter and confidentiality/privacy training.*

_____

IV. Supervision

A. Describe your procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors.*

_____

V. Billing

A. Describe your billing arrangement with the ASAP to obtain co-payments if the consumer has other insurance and the preference is to third party bill.*

_____

Provider employee who completed this form*

Name: _____ Date: _____