

WASATCH MENTAL HEALTH SERVICES
SPECIAL SERVICE DISTRICT

**INTAKE, TREATMENT/RECOVERY PLANNING & DISCHARGE
SERVICES FOR MEDICAID CLIENTS BY OUTSIDE CONTRACTED
PROVIDERS– C – 4.31**

Purpose:

To ensure Wasatch Mental Health's (WMH) outside contracted providers provide its Medicaid Enrollees quality services, including (1) timely access to intake and treatment (2) an individualized treatment/recovery plan designed to provide a proper diagnosis, age-appropriate growth and development (3) the ability to attain, maintain, or regain the client's functional capacity, and (4) to ensure that, when possible, clients are discharged appropriately from services.

Definitions:

Medically Necessary: Any mental health service that is necessary to diagnose, correct or ameliorate a mental illness or condition, or prevent deterioration of that mental illness or condition or development of additional health problems and there is no other equally effective course of treatment available or suitable that is more conservative or substantially less costly.

Contract Manager: WMH's Associate Director is responsible for oversight of all outside contractor operations. These duties include obtaining contracts, contractor provider certification and recertification, contractor contract application reviews, and Actions and Appeals processes

Outside Provider Program Manager (Manager): WMH's Outside Provider Manager or his or her designee shall be responsible for all service authorization requests including prior and continuing authorizations for Enrollee treatment, contractor contract compliance reviews, records auditing, and certification of claims for payment. The Outside Provider Program Manager or designee in this policy is personified in the terms program manager or manager.

Service Authorization: The request for services from an outside contracted provider when WMH is unable to supply an Enrollee with a qualified in-house clinician to provide the medically necessary service(s). The Manager shall be responsible for all service authorization requests.

Policy:

- A. Wasatch Mental Health (WMH) shall provide timely access (See Policy 3.06 – Access Performance Standards) and mental health evaluation services to all Pre-paid Mental Health Plan (PMHP) Medicaid Enrollees who request treatment services to an outside contracted provider. Enrollees requiring medically necessary, services with an outside contracted provider shall be offered appropriate, individualized mental health treatment.

Medicaid Enrollees shall not be refused treatment services for any reason other than failure to meet medical necessity criteria or due to the requested service not being a service covered by the PMHP contract.

- B. When WMH is unable to supply the Enrollee with a qualified in-house clinician to provide the medically necessary service(s) it shall refer the client to a contracted, qualified, outside provider. WMH may elect to allow an Enrollee to be treated by an outside contracted provider under other circumstances, but is not required to do so by the PMHP Medicaid contract between Medicaid and WMH when it has a qualified in-house provider.
- C. An Enrollee, who requests and is refused an outside contracted provider as a result of WMH having a qualified in-house provider, may grieve WMH's decision orally or in writing. (See Policy C – 3.08, Medicaid Enrollee Actions and Grievance System).
- D. An Enrollee requesting an outside contracted provider shall be screened by an in-house intake clinician through a face-to-face evaluation to determine any special circumstances of medical necessity, or required clinical expertise that would preclude the use of an in-house provider prior to being referred to a outside contracted provider. Should an outside contracted provider be necessary, the manager shall make all necessary arrangements, including an attempt to contract an Enrollee requested non-contracted provider, and shall provide initial and continuing authorizations for treatment as needed.
- E. It is a violation of this policy for WMH to refuse to allow an Enrollee access to an available, qualified, outside contracted provider when WMH has no in-house provider with the required expertise and when the Enrollee qualifies for treatment services. The refusal constitutes a denial of services and is defined as an Action by the PMHP Medicaid Contract. WMH shall upon initiating an Action immediately notify the Enrollee and all affected parties, in writing, of its decision and provide the parties with all necessary information regarding their appeal rights. (See Policy C - 3.08, Medicaid Enrollee Actions and Grievance System).
- F. The WMH approved outside contracted provider and his/her Medicaid Enrollee client, staying within WMH's prior-authorization of services parameters, shall collaboratively develop a mutually agreed upon Individualized treatment/recovery plan designed to address treatment, discharge planning, and the Enrollee's cultural competency issues. The treatment/recovery plan shall be considered a living document, and as such shall be updated as needed. All prescribed services shall be included in the plan and prescribed prior to implementation.
- G. The outside contract provider's treatment services shall be provided as promptly and continuously as is consistent with generally accepted standards of medical/mental health practice and contract requirements. All treatment/recovery plans and clinical treatment shall be documented in the client's medical record. Treatment notes of all services provided shall be written and placed in the clinical record.
- H. All authorized medically necessary services in terms of amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished shall be provided. Covered services shall be provided by qualified staff in accordance with the scope of services identified in the WMH's Provider Agreement (see attached Agreement), Utah Medicaid Mental Health Centers Providers Manual, and the Utah State Division of Substance Abuse and Mental Health's Preferred Practice Guidelines where guidelines have been identified and approved. (See WMH Policy C - 5.01 Preferred Practice Guidelines and its website www.wasatch.org for the guidelines).

- I. WMH shall ensure that utilization management activities are not structured in such a way as to provide incentives to any individual or entity to deny, limit, or discontinue medically necessary mental health services to any Enrollee.
- J. Should WMH deny payment to an outside contracted provider, and/or reduce, suspend or terminate a Medicaid client's previously authorized services it shall notify the provider and client in writing, and provide them information regarding the Enrollee's appeal rights to WMH's Action. The notification shall contain all the necessary information required regarding the appeal process, including the right to receive assistance if needed. (The Enrollee's rights and a brief description of the process are contained in the Enrollee's Medicaid Handbook. The full particulars are contained in WMH's Policy C – 3.08, Medicaid Enrollee Actions and Grievance System).
- K. Clients shall be discharged from services with mutual agreement between WMH, the outside contracted provider, and the client whenever possible. When a client drops out without mutual agreement, the outside contracted provider shall attempt to contact the client, and when appropriate, encourage him/her to continue treatment to mutual termination.
- L. WMH shall provide technical assistance training on WMH's Provider Agreement (See attachment Agreement) to the outside contracted provider when requested. It is expected that the provider shall be knowledgeable of all agreement obligations and shall faithfully act in accordance with them. Failure of the provider to do so could result in denial of payment for services rendered.
- M. WMH Outside Providers shall not be prohibited from advising or advocating on behalf of the client for the following:
 - i. The client's health status, medical care, or treatment options—including any alternative treatments that may be self-administered.
 - ii. Any information the client needs in order to decide among all relevant treatment options.
 - iii. The risks, benefits, and consequences of treatment or non-treatment.
 - iv. The client's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.
- N.

Procedure:

Service Authorization Procedures:

1. Each client, WMH intake clinician, outside contracted provider, and family member(s), where appropriate, shall collaboratively develop a mutually agreed upon Individualized treatment/recovery plan designed to address treatment, discharge planning, and their cultural competency issues. The treatment/recovery plan shall be considered a living document, and as such shall be updated as clients needs indicate, The outside provider is responsible to conduct reassessments/treatment plan reviews with the client as clinically indicated to ensure the client's treatment plan is current and accurately reflects the client's rehabilitative goals and needed behavioral health services. All prescribed services shall be included in the treatment/recovery plan and prescribed prior to implementation.

2. Treatment services shall be provided as promptly and continuously as is consistent with generally accepted standards of medical/mental health practice and PMHP Medicaid contract requirements. All treatment/recovery plans and clinical treatment shall be documented in the client's clinical record including any family or significant others involvement. Treatment notes shall be written and placed in the clinical record immediately following services whenever possible.
4. All appropriate medically necessary contract covered services in terms of amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished shall be provided.
3. When an Enrollee requests at intake to see a non-contracted outside provider or an outside contracted provider, the intake staff person shall notify the manager of the request and inform the Enrollee that the manager shall review the Enrollee's request with the Enrollee. When the selected provider is contracted with WMH, the manager shall follow the Service Authorization Request Review procedures. When a selected provider is not contracted with WMH, The manager shall follow the Outside Provider Contract Process in this policy. The manager shall notify the Enrollee of the decision within 14 calendar days of their request. The manager may under certain circumstances, described below, request up to an additional 14-day extension. (See flow chart page 1 Standard Service Authorization Request Action #1: Denial or Limited Authorization Requested Service and related policy C-3.08 Medicaid Enrollee Actions and Grievance System).
5. When an Enrollee's selected provider initiates a request for the Enrollee to be treated by the selected provider, the program manager shall make a decision and provide notice to the selected provider and Enrollee as expeditiously as the Enrollee's health condition requires, but no later than 14 calendar days from receipt of the outside providers request for a service authorization. The manager shall also consult, as appropriate, with the requesting provider.
6. WMH shall inform the Enrollee that they will need to complete WMH's intake process. When the selected provider is contracted with WMH, the manager shall follow Service Authorization Request Review procedures pg. 5. When a selected provider is not contracted with WMH, The manager shall follow the Outside Provider Contract Process in this policy.
7. When an Enrollee/ or the Enrollee's selected provider indicates that adhering to the 14 day standard time frame could seriously jeopardize the Enrollee's life, or health, or ability to attain, maintain, or regain maximum function, the manager shall make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires. The program manager must make an expedited decision no later than 3 working days after receipt of the request for Service Authorization. (See flow chart page 2 Expedited Service Authorization Request Action #1: Denial or Limited Authorization Requested Service and related policy C-3.08 Medicaid Enrollee Grievance, Action, and Appeal).
8. When the manager denies a service authorization request from an outside contracted provider, or authorizes a service in an amount, duration, or scope that is less than requested by the outside contracted provider, including the type or level of service, this constitutes an Action unless the Enrollee agrees with the services offered. When an Action is constituted, the manager shall notify the Associate Director. The Associate Director shall:

- a. Notify the requesting provider verbally or in writing, and give the Enrollee written notice of Action that includes his /her right to Appeal, and the right to receive reasonable assistance with the appeal process (See form 7.59b-N2a Notice of Action and Appeal Rights).
 - b. Notify the Manager who shall monitor service authorization requests and report any Actions to the Associate Director.
 - c. Forward verbal and/or written notice information to the Associate Director designee who shall log the Action information, as per PMHP Medicaid Contract requirements, in the Enrollee Grievance/Action/Appeal database.
9. Should the Enrollee or other affected parties, decide to appeal an Action, WMH's Associate Director shall follow the policy and procedures in Policy C-3.08 Medicaid Enrollee Grievance, Action, and Appeal.

NOTE: While it is highly unlikely WMH would ever refuse to continue authorizations to an Enrollee's current provider, WMH's Medicaid contract specifies in Article X, B., 1., b. that this decision does not constitute an Action.

10. When the manager fails to reach a decision on a standard or expedited service authorization request within the required time frames, this constitutes an Action. The manager shall notify the Associate Director. The Associate Director shall:
- a. Notify the requesting outside contracting provider verbally or in writing, and give the Enrollee written notice of Action, that includes his /her right to Appeal, and the right to receive reasonable assistance with the appeal process (See form 7.59b-N2a Notice of Action and Appeal Rights, by or on the date the applicable time frame for making the decision expires.
 - b. Forward verbal and/or written notice information to the designee who shall log the Action information, as per PMHP Medicaid Contract requirements, in the Enrollee Grievance/Action/Appeal database.

Extensions for EXPEDITED Service Authorization Requests:

- 1. The manager may extend the 3 working day time period by up to a total of 14 calendar days if:
 - a) The Enrollee requests an extension; or
 - b) The manager needs an extension for additional information, the extension is in the Enrollee's interest, and the manager can justify his/her reason to the Utah State Department of Health upon their request.
- 2. Should the manager extend the time frame to make an expedited service authorization decision, the manager shall, within the allocated time period, make a decision and provide notice to the Enrollee and all affected parties.
- 3. The designee shall log information, as per PMHP Medicaid Contract requirements, in the Enrollee Grievance/Action/Appeal database and maintain documentation of Request for Extension.

Extensions for STANDARD Service Authorization Requests:

- 1. When the manager extends the time frame for making a standard service authorization decision, the manager shall:

- a) Give the Enrollee/provider written notice of the reason for the decision to extend the time frame (See form 7.59a-N1a Notice of Extension for Service Authorization Request).
 - b) Inform the Enrollee of his/her right to file a Grievance, and how to do so, if the Enrollee disagrees with the decision to extend the time frame (See Policy C-3.08 Medicaid Enrollee Actions and Grievance System).
 - c) Issue and carry out the determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.
11. When an Enrollee seeks services from an outside contracted provider, and WMH authorizes the request, the date and time of 30-minute follow-up screenings for emergencies shall not be documented.

Service Authorization Request Review:

1. When the manager establishes medical necessity for treatment and the Enrollee's needs can be met in house, the Enrollee shall be offered appropriate service within WMH.
2. When there is medical necessity and the Enrollee's needs cannot be met within WMH, the manager shall contact an appropriate outside contracted provider to meet the clinical needs of the Enrollee.
3. When the Enrollee becomes eligible for Medicaid and has an established relationship with a provider outside WMH and is involved in treatment, the manager shall attempt to contract with the treating outside provider if they meet the Medicaid guidelines (See Outside Provider Contracting Process).
4. The manager shall make a decision and provide notice to the Enrollee/provider as expeditiously as the Enrollee's health condition requires, but no later than 14 calendar days from receipt of the request for service authorization.
5. The manager shall monitor service authorization requests and report to the Associate Director.
6. The Associate Director or designee shall log information, as per PMHP Medicaid Contract requirements, in the Enrollee Grievance/Action/Appeal database and maintain documentation of notice or decision.
7. When the request is in favor of the Enrollee, the manager shall submit the Service Authorization request to WMH's Contracted Provider Records Coordinator (CPRC). The CPRC shall develop and send a treatment authorization to the Enrollee/provider.
8. Should the manager deny the Enrollee's request to see an outside contracted provider when WMH has no in-house qualified provider for the needed services and/or refuses continuation of services when WMH has no qualified provider, the manager notify the Associate Director who shall follow Notice of Action procedures in policy C-3.08 Medicaid Enrollee Actions and Grievance System.
9. Should the client be refused a requested outside contracted provider and WMH has a qualified in-house provider who can provide the service the Enrollee may grieve the decision by asking orally or in writing that it be reviewed. WMH's decision, following a review by the Grievance Review Committee, is final.

10. Should the Enrollee or other affected parties, decide to appeal an Action, WMH's Associate Director shall follow the policy and procedures in Policy C-3.08 Medicaid Enrollee Actions and Grievance System, Appeal Process.

Outside Provider Contracting Process:

1. When an outside provider is not contracted with WMH, the manager shall submit a request for contracted (outside) provider to the Associate Director. The Associate Director or his/her designee shall send the outside provider a Contracted Provider Application (See attachments 1-10). The outside provider must complete the application and submit back to the Associate Director. The Associate Director shall complete a Contracted Provider Contract (See attachment Agreement). The contract shall be submitted to WMH's Executive Committee and WMH's attorney for review. The contract shall be approved or rejected by WMH's Authority Board.
2. For Termination of a Contracted Provider see policy C – 3.14.

WMH Intake Staff Responsibilities:

All intake/crisis staff shall:

1. Provide supportive intake services designed to encourage client follow through from telephone contact to treatment. Intake staff shall be responsive to barriers to accessing treatment such as cultural competency issues, and transportation problems.
2. Respond as quickly as possible to minimize the length of time between screening, intake, and first appointment with the outside contracted provider.
3. Allow Enrollees to choose their mental health provider to the extent possible and appropriate.
4. Ensure Enrollees are aware of how to access outpatient emergency crisis services if needed prior to their intake, and/or emergency hospitalization services if needed.

Outside Contract Provider Responsibilities:

Outside contracted providers shall be knowledgeable of WMH's Contracted Provider Agreement provisions including:

1. All laws, regulations, or actions applicable to the services provided therein.
2. All terms and conditions applicable to licensed mental health providers contained in "Mental Health Center Provider Manual" – Utah State Division of Health Care Financing.
3. The Enrollee grievance system and client rights contained in WMH's Medicaid Member Handbook.
4. "Best Practice Guidelines" found on WMH's website (www.wasatch.org) Providers agreement to abide by and cooperate with WMH's Quality Utilization and Performance Improvement (QAPI) policies and procedures as they apply to private providers located on the www.wasatch.org website. Conduct a monthly review of its agency staff through the Inspector General (HHS - OIG) list of excluded individuals and entities (LEIE) and the System for Award Management (SAM) databases <http://exclusions.oig.hhs.gov/> and <https://www.sam.gov/sam/>
5. Obtain a National Provider Identifier number (NPI).
<https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart>

Identifying Members of the “Treatment/Recovery” Plan:

At the time of the client’s first treatment session, clients who shall be receiving their mental health treatment services from an outside contracted provider shall conjointly develop a treatment/recovery plan with their outside contracted provider and identify any treatment/recovery team members necessary. The outside contracted provider shall, in conjunction with the client, be responsible for initiating, maintaining, and updating the client’s treatment/recovery plan as required in the outside contracted provider agreement with WMH.

Sharing of Protected Health Information for Treatment Among Treatment Team Members:

The outside contracted provider shall abide by and follow The Health Insurance Portability and Accountability Act (HIPAA) and all local, state, and federal regulations pertaining to Protected Health Information (PHI).

Establishment and Continuation of the Treatment/Recovery Plan:

- A. The treatment/recovery plan shall be written within twenty (10) working days of the initial appointment and include a DSM, five axis diagnosis. Individualized plan, which contains measurable treatment goals related to problems identified through diagnostic intake interview(s) that include addressing any cultural competency issues. The treatment/recovery plan shall be designed to improve and/or stabilize the client’s condition.
- B. Per the Utah Medicaid Mental Health Centers Providers Manual, the treatment/recovery plan shall include the following:
 1. Measurable treatment/recovery goals.

If the treatment plan contains individual skills training and development or psychosocial rehabilitative services as treatment methods, there must be measurable goals specific to all skills issues being addressed with these treatment methods. Actual treatment goals may be developed by qualified providers identified in the ‘Who’ section in Chapter 2 -10, Individuals Skills Training and Development, and Chapter 2-11, Psychosocial Rehabilitative Services, and they may be documented in an addendum to the treatment plan;
 2. The treatment/recovery regimen – The specific treatment/recovery methods that shall be used to meet the measurable treatment goals
 3. A projected schedule for service delivery, including the expected frequency and duration of each treatment/recovery method.
 4. The licensure or credentials of individuals who shall furnish the prescribed services.
- C. The outside contracted provider shall request continuing treatment authorizations in writing at least 10 business days prior to the expiration of the current authorization.
- D. The outside contracted provider shall collect continuing outcome and client satisfaction data using instruments provided by WMH. Measures must be collected monthly unless alternative arrangements have been made.
- E. The outside contracted provider shall be responsible for verifying the Enrollee’s continuing Medicaid eligibility each month.

Documentation of Therapy:

Outside Contracted Provider shall:

1. Maintain sufficient written documentation for each medical or remedial therapy, service, or session for which billing is made using the documentation requirements associated with each service as identified in Utah Medicaid Provider Manual, Chapter 2, Scope of Services.
2. The clinical record shall be kept on file for the GRAMA legally required time, and made available for State and Federal review, upon request. An adult record may be destroyed, with the exception of the last discharge summary, 10 years following the client's last discharge from service. A youth record may be destroyed, with the exception of the last discharge summary, 10 years following the client's 25th birthday, or 10 years following the Enrollee's last treatment episode whichever is later.

Termination From Services:

1. Should WMH decide to reduce, suspend or terminate a Medicaid client's previously authorized services WMH shall notify the client, and inform him/her of their right to appeal the Center's Action. The notification shall contain all the necessary information required regarding the appeal process, including the right to receive assistance if needed. (See Policy C – 3.08b, Medicaid Actions and Appeals, Action 2 Reducing, Suspending, or Terminating Previously Authorized Services).
2. Clients shall be terminated with mutual agreement between WMH, contracted outside provider, and client. A Discharge Summary shall be completed by the outside contracted provider and placed in the client's record.
3. When a client drops out of treatment without mutual consent, the outside contracted provider shall, when appropriate, initiate a follow-up contact to encourage the client to return to treatment.

Provider Selection, Credentialing and Re-credentialing:

Outside contracted provider shall follow the procedures outlined in WMH policy A – 1.10 Provider Selection and Retention.

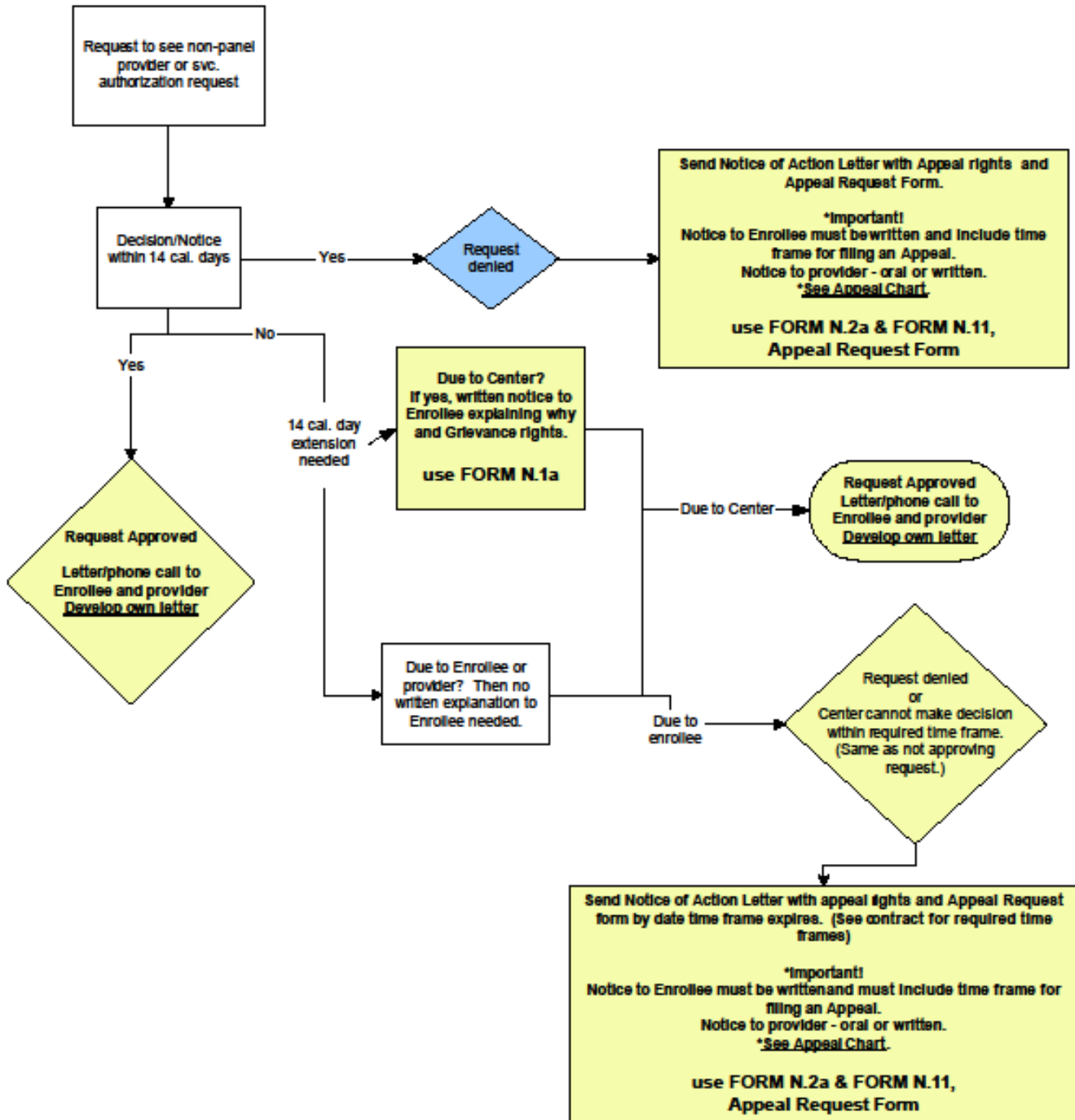
Outside Provider Auditing:

All WMH clients' currently in services with contracted outside providers shall have their clinical record and billing documentation audited by the Outside Provider Contract Program Manager or his/her designee annually. (See policy C-3.12 Peer and Electronic Record Review).

Right to Change and/or Terminate Policy:

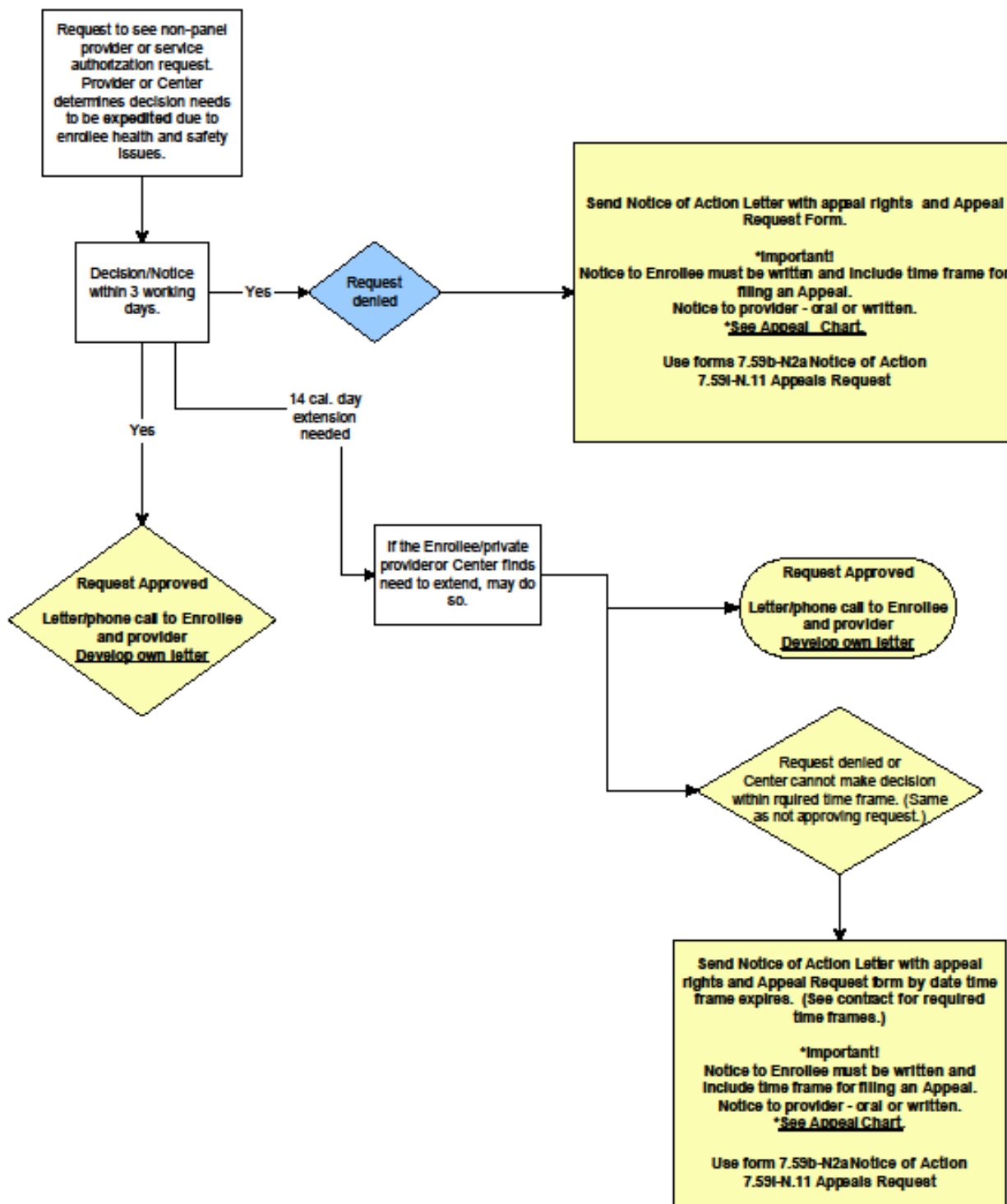
Reasonable efforts shall be made to keep employees informed of any changes in the policy; however, WMH reserves the right, in its sole discretion, to amend, replace, and/or terminate this policy at any time.

Flowchart 1
Action 1
Standard Service Authorization
Denial or Limited Authorization of Requested Service



10/16/12

Flowchart 2
Action 1
Expedited Service Authorization Request
Denial or Limited Authorization of Requested Service



10/16/12

7.59a-N1a Notice of Extension for Service Authorization Request

If you need this letter in Spanish, call the Wasatch Mental Health customer service representative at (801) 373-4760. Si usted necesita esta carta en español, llame a un representante de Wasatch Mental Health al (801) 373-4760.

Delete all information in Red before sending letter to client...

"[Click here and type date]"

"[Click here and type recipient's name]"

"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]" ,

*On "[Click here and type date]" you asked for approval to get **(name of service)** from **(name of therapist)** or **(name of therapist)** asked for approval to provide **(name of service)** to you. We are supposed to make a **decision in 14 days. If we cannot make a decision in that time, we can take up to 14 more days.** We are letting you know that we need more time to make a decision.

We need more time because **(explain reason for the delay *and why it'll help them in the long run, including type of information needed and from whom, if applicable)**

*If you are unhappy that we need more time, you may file a grievance with us.

You, your legally authorized representative or your provider may file your grievance. If you need help filing your grievance, call the Wasatch Mental Health customer services representative at (801) 373-4760. If you need an interpreter to help you file your grievance, call Wasatch Mental Health customer services representative at (801) 373-4760. Outside of Utah County call 866-366-7987.

To file a grievance:

You may file your grievance by calling us, talking to a center staff member in person or by giving it to us in writing. If you want to mail it, please mail it to:

Wasatch Mental Health
c/o Care Management Department
750 North Freedom Blvd (200 West), Suite 300
Provo, UT 84601

Once we get the grievance, we will give you a decision within **45 calendar days.** We will either talk to you about our decision, or we will send you a letter.

Sincerely,

[Click **here** and type your name]

Cc: Private provider (if applicable)
Affected Parties (if applicable)

**Wasatch Mental Health
7.59b-N2a Notice of Action**

If you need this letter in Spanish, call the Wasatch Mental Health customer service representative at (801) 373-4760. Si usted necesita esta carta en español, llame a un representante de Wasatch Mental Health al (801) 373-4760.

Delete all info in red (The notice of action shall clearly indicate the action that has been taken and provide a clear statement of the basis for the action. The notice must be individualized to the enrollee's case and medical and legal terms must be explained if the terms cannot be simplified. The notice shall also be written in easily understood language and format. See policy C-3.10 Readability of Documents for testing procedures)

"[Click here and type date]"

"[Click here and type recipient's name]"
"[Click here and type recipient's address]"

Dear "[Click here and type recipient's name]" ,

On "[Click here and type date]" Wasatch Mental Health took the following action;

We denied or limited approval of your requested service/provider.

(Explain why services were limited or denied. If limited, explain the details of the request and the limited approval. Limited approvals may include: a. provider asked for certain number of sessions, you approve less with no chance for approval of the remaining sessions requested; or b). provider asks for certain number of sessions and services and you do not end up approving the original amount requested.)

We denied payment for services you received that you may have to pay for.

(Explain what led to the action, individualized to the enrollee. Refer to your handbook section on payment liability and provide information to the enrollee as to which reason fits their situation.)

We did not offer your first appointment within the required amount of time, and you were unhappy with this.

(Explain what led to the action, individualized to the enrollee)

We did not make a decision about your request service within the required amount of time (28 days for a standard request or 17 days for an expedited (quick) request).

(Summarize request and explain why you were not able to make a decision within the required time frame and when you plan to make decision by- may reduce likelihood they'll appeal.)

We did not make a decision about your Grievance within the required amount of time (45 days.)

(Explain why you were not able to make a decision within the required time frame and when you plan to make decision by- may reduce likelihood they'll appeal.)

If you are unhappy with this action, you have the right to appeal. The rest of this letter explains how to file an Appeal.

You must file your Appeal within 90 calendar days from the date on this letter.

You, your legally authorized representative or your provider may file your appeal. If you need help filing your appeal, call the Wasatch Mental Health customer services representative at (801) 373-4760. If you need an interpreter to help you file your appeal, call the Wasatch Mental Health customer services representative at (801) 373-4760.

Outside of Utah County call 866-366-7987.

Sample Form

To file an Appeal:

1. You may file your Appeal/Review by calling us at (801) 373-4760 and asking for the Wasatch Mental Health customer service representative. You may also send us your appeal/action using the enclosed written appeal form.
2. If you call us to file your appeal, you or your authorized representative will have 90 days from the Notice of Action to request and Appeal/Review of a WMH Action.
4. If your provider files your Appeal, the Appeal must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed written appeal request form or by sending us a separate note. This is important. If we do not receive your written permission, your provider may not appeal the Action.
5. Send the complete written appeal to:

Example Form

Wasatch Mental Health
Care Management Department
1750 North Freedom Blvd. (200 West), Suite 300
Provo, UT 84601

We plan to make a decision within **30 calendar days** from the date you requested an Appeal/Review.

Sometimes we'll need more time to make a decision, or you may ask us to take more time. If so, we may take an additional 14 calendar days to make our decision. If we need to take extra time, we will send you a letter telling you that.

EXPEDITED (QUICK) APPEALS)

If you or your provider believes taking this amount of time could place your life or health in danger, or that you might have a permanent setback, you may ask for an expedited (quick) Appeal.

To file an expedited appeal:

1. You may ask for an expedited appeal by calling the Wasatch Mental Health customer services

representative at (801) 373-4760. You do not also have to send your Appeal in writing.

2. If you do not want to call first, check the “expedited Appeal” box on the enclosed Appeal form and send it to us.
3. If your provider files your appeal, the appeal must include your written permission. You may give your written permission by completing and signing the bottom of the enclosed written appeal request form or by sending us a separate note. This is important. If we do not receive your written permission, your provider may not appeal the action.

If we agree the decision needs to be made quickly, we will make a decision in **3 working days**. If you or we need more time to make the decision, we can take up to another **14 calendar days**. If we need more time, we will send you a letter telling you why.

Again if you have any questions please contact the Wasatch Mental Health customer services representative at (801) 373-4760.

Sincerely,

[Click **here** and type your name]

Sample Form

Cc: **Private provider (if applicable)**
Affected Parties (if applicable)

Enclosure: Appeal Request Form

**Wasatch Mental Health
APPEAL REQUEST FORM**

1. Is the client or a provider requesting this **Appeal**? Client? Or Provider? (Circle)

2. Name of Client: _____
Client's Address: _____

3. Name of Provider Involved: _____
Provider's Address: _____

4. The reason you are requesting the Appeal: _____

5. You may ask for an expedited (quick) decision on your Appeal if you believe taking the regular amount of time could place your life or health in danger, or that you might have a permanent setback.

___ Check here if you want an expedited Appeal.

6. If the Appeal is about decreasing or ending services, do you want the services continued during the Appeal process? Please remember if the Appeal decision is not in your favor, you may have to pay for these services.

___ Check here if you want services continued.

7. If you need help filling out this form, an interpreter, or have any questions about the Appeal process please call (name or title) at (phone number).

Sample Form

Provider Permission Statement

If your provider is filing the Appeal for you, you must give your written permission.

I _____ (your name) give my permission for
_____ (provider's name) to file this Appeal for me.

Client's Signature

Date

Form # 7.59I-N11

Attachment 1

Cover Letter (print on letterhead)

Date

Name

Company

Address

CSZ

Sample Form

Dear ,

Thank you for your interest in becoming a Contracted Provider with Wasatch Mental Health Services. **NAME OF CONTRACT MANAGER** has requested that I send you our Credentialing Application packet. I will be in charge of getting your application and contract processed and completed. Because so many entities are involved, this process can take anywhere from 5 to 12 weeks to complete.

- Please complete the application and attach any necessary documentation required (see page 3). Also enclosed is a W-9 IRS form and a BCI form that will need to be filled out. The application, BCI and W-9 forms will need to be returned by mail to the attention of . A Reimbursement Rate Sheet has also been enclosed.
- When I have received the application along with copies of all the required documents, I will review it for completeness then submit it to the Contract Program Manager for review. If approved, two contracts will be generated and submitted to the Executive Committee for approval.
- Upon approval from the Executive Committee, the contracts are then given to the County Attorney for review and then to the Authority Board for a final approval and signatures. When approved, the two signed contracts will be sent to you, one of which is to be signed by you and sent back to me. The other contract is to be kept for your records.
- As you can see, this process does take quite a bit of time to complete. Therefore, if you can fill out the Credentialing Application and the other required forms and return them as soon as possible, I can get the contracts on their way through this lengthy process.

If, at any time, you have any questions, please do not hesitate to call me at **NUMBER**. Thank you again for your interest in working with Wasatch Mental Health Services Special Services District.

Sincerely,

NAME OF STAFF

Outside Provider Records/Contract Coordinator

Enclosures: Contracted Provider Application
BCI Application / W-9 Form / Rate Sheet

**Cover Letter - Supervisee
(print on letterhead)**

Date

Name

Company

Address

CSZ

Dear ,

Thank you for expressing interest in your colleague becoming a Contracted Provider for Wasatch Mental Health Services. Dr. Geri Alldredge has requested that I send you our Credentialing Application packet. I will be in charge of getting your application and contract processed and completed. Because so many entities are involved, this process can take anywhere from 5 to 12 weeks to complete.

- Please have this application filled out and all other required documentation (see page 3). Also enclosed is a W-9 IRS form and a BCI form that will need to be filled out. The application, BCI and W-9 forms will need to be returned by mail to the Attention of **NAME OF STAFF**. A Reimbursement Statement also been enclosed.
- When I have received the application along with copies of all the required documents, I will review it for completeness then submit it to the Associate Director for review. If approved, two contracts will be generated and submitted to the Executive Committee for approval.
- Upon approval from the Executive Committee, the contracts are then given to the County Attorney for review and then to the Authority Board for a final approval and signatures. When approved, two signed contracts will be sent to you, one of which is to be signed by you and sent back to me. The other contract is to be kept for your records.
- As you can see, this process does take quite a bit of time to complete. Therefore, if you can fill out the Credentialing Application and the other required forms and return them as soon as possible, I can get the contracts on their way through this lengthy process.

If, at any time, you have any questions, please do not hesitate to call me at **NUMBER**. Thank you again for your interest in working with Wasatch Mental Health Services Special Services District.

Sincerely,

Staff Name

Outside Provider Records/Contract Coordinator

Enclosures: Contracted Provider Application
BCI Application / I-9 Form

Attachment 2
**CONTRACTED PROVIDER APPLICATION
MEDICAID PREPAID CAPITATED PLAN
WASATCH MENTAL HEALTH**

Application Profile

Last Name	First Name	MI
Degree	License Type	SS#

Office Address

Practice Information

Street	Suite	Type of Practice (Solo, Group, Other)
City	State	ZIP
Office Telephone Number		Corporate or Group Name (if applicable)
Office Manager or Contact Person		Billing Tax ID Number (if different from SS#)
Office Manager or Contact Person		After Business Hours Availability

How do you handle 7 day/week, 24-hour backup and crisis Coverage?

Licensing Information

Sample Form

Type of Utah License	Utah License Number
Date of First Issue	Expiration Date
Other Licensure or Certification	NPI #

Psychiatrists/Physicians

Board Certified	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____
Board Eligible	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date: _____

DBA #	Medicaid #	Medicare#
-------	------------	-----------

Clinical Expertise and Practice

Please summarize the major characteristics of your current practice (age, gender, diagnosis, etc).

Identify areas of clinical expertise and summarize your style of practice and clinical orientation.

Identify any specialized skills you use in your practice (languages, cultural competency, etc).

Professional Liability Information

Carrier	Expiration Date
Per incident amount	Per aggregated amount

Please respond to each of the following questions. If you answer YES to any of these questions, please explain on a separate sheet.

1. Has your clinical license been revoked, suspended, limited or is any action pending?	Yes	No
2. Within the past five years, have you been denied hospital privileges?	Yes	No
3. Has your narcotics license ever been revoked, suspended or limited?	Yes	No
4. Have you had liability insurance denied or canceled?	Yes	No
5. Have you been party to malpractice suits, which resulted in payment to the plaintiff?	Yes	No
6. Do you presently have any malpractice suits pending against you?	Yes	No
7. Have you resigned from a professional group because of problems with credentials?	Yes	No
8. Within the past five years, have you been convicted of or pleaded guilty to a felony?	Yes	No
9. Do you suffer from any physical or mental condition, which impairs you ability to practice?	Yes	No
10. Has Medicaid or Medicare ever denied you provider status?	Yes	No

Sample Form

Instructions

Please attach the following documentation to this application:

1. Photocopy of State Professional License and DEA certificate (if applicable) with expiration date visible.
2. Photocopy of current city/county business license.
3. Proof of professional liability coverage indicating coverage limits and expiration date.
4. Proof of general liability insurance covering accident or other mishap at your office.
5. Background Criminal Investigation Clearance required by State of Utah. (Application Form Enclosed)
6. A curriculum vitae (resume) which includes education, post graduate training, professional experience, credential, professional memberships and three references.

Please return this information to: Credentialing Office
c/o **NAME OF CONTRACT MANAGER**
Wasatch Mental Health
750 North Freedom Blvd. (200 West), Suite 300
Provo, UT 84601

Certification

I certify that the information contained herein and attached to this application is correct and complete to the best of my knowledge and belief. I understand that misrepresentations or omissions from the application constitute cause for denial or dismissal from provider status in the Wasatch Mental Health Medicaid Prepaid Capitated Plan.

By applying to be a provider in the Wasatch Mental Health Medicaid Prepaid Capitated Plan, I hereby authorize WMH and its representatives to consult with individual, institutions, and professional organizations with which I have been associated, who may have information bearing on my professional competence.

Signature of Applicant

Date

Sample Form

Attachment 3

BCI Cover Letter

Date

Dear Applicant:

Attached is a Background Criminal Investigation (BCI) application form. This is a document Wasatch Mental Health is required by the State to have completed for all clinical employees, both in-house and outside contracted providers, in order to provide treatment for adolescents and children.

In order to expedite this process as quickly as possible with the State, please follow the steps outlined below:

- 1) Complete and sign the attached BCI Background Screening Application form.
We will need the original form with your original signature - NOT A COPY

- 2) Attach to the BCI Application form a very clear copy of your driver's license with the expiration date clearly visible. Your license must have a current expiration date/not expired. *If your license has been renewed and the expiration date is on the back, please make a copy of both the front and back of your driver's license.*
(ENLARGING THE PICTURE & LIGHTENING IT, MAKES IT CLEARER)

- 2) DO NOT FAX THIS PAPERWORK. Please mail the BCI and the copy of your ID to:
Wasatch Mental Health
Attn: Outside Provider Coordinator
750 North Freedom Blvd. (200 West), Suite 300
Provo, UT 84601

Please return the BCI as soon as possible. Wasatch Mental Health cannot authorize children or adolescents to be seen by anyone not having a BCI clearance from the State. If you have any questions, please feel free to contact me at 801-852-1422.

Sincerely,

Staff Name
Contract Coordinator

Sample Form

Enclosure: BCI Application

Attachment 4
Background Screening (BCI) Application

Utah-DHS-OL

July 2004

Utah Department of Human Services Office of Licensing
120 North 200 West, #303 Salt Lake City, Utah 84103
BACKGROUND SCREENING APPLICATION

PURPOSE: The purpose of the background screening as part of the licensing process is to protect children and vulnerable adults in licensed programs, by determining if applicants have been convicted of certain crimes or have supported/substantiated child/adult abuse records.

******* APPLICANT REQUEST AND RELEASE*******

I hereby authorize the Utah Department of Human Services Office of Licensing to investigate my past and present child and adult abuse, law enforcement, drivers license and any and all information which may be pertinent to my application according to Utah Code 82A-2-120, 121. The release of any and all information is authorized whether the same is of record or not. I do hereby release all persons, firms, agencies, companies, groups, or installations, whomsoever, from any damages of, or resulting from, furnishing such information to the Department of Human Services.

Incomplete/illegible applications or applications without copies of photo ID will be returned.
Completion of the form in any color of ink other than black is helpful (but not required).

Please answer the following questions:

1. Have you ever been convicted of a crime? Yes No
If yes, please state type of conviction, date of conviction and in which court you were convicted (attach another paper if needed).
Or attach court docket.
2. Have you lived in another U.S. state (besides Utah) in the last five years? Where and dates? Yes No
If yes, you must submit *two* completed fingerprint cards with this form and a money order, cashiers check or company check for \$24.00 payable to *Department of Public Safety* for each applicant.
3. Have you lived in another country other than the U.S.? Yes No
If yes and you were a citizen or resident of that country, a current background check from that country must be submitted with this form.

Full First Name _____ Full Middle Name _____ Last Name _____

All Maiden/Alias /Previous Married Names: _____

Current Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Social Security Number: ____-____-____

I certify that my answers contain no misrepresentation or falsification, and that the information is true and complete to the best of my knowledge. I understand that providing false or inaccurate information or failing to provide information may result in my background screening being denied.

Applicant Signature: _____

******* LICENSED PROGRAM REQUEST AND RELEASE*******

This section to be completed by the Foster Care Licensor, or the authorized representative for the DHS Licensed program.

Complete all fields. Incomplete or illegible applications will be returned.

Name of Licensed Organization, or DHS Licensor: Wasatch Mental Health Phone number: (801) 373-4760

Address: 750 North 200 West Suite 300 City: Provo State: UT Zip Code: 84601

Type of clients served under this license (check applicable boxes): Children and Youth (Up to age 18) Vulnerable Adults (including age 65 and over)
Does the applicant provide foster/proctor care services? Yes No

I certify that I have read and understand this form and that my answers to the questions contain no misrepresentation or falsification and that the information is true and complete to the best of my knowledge. The licensee releases the Department from any damages of, or resulting from, furnishing this information for licensing purposes. I understand this form and its contents may not be shared in any way with any other organization, company, or provider or given to the above named applicant.

Signature of Authorized Program Representative or DHS Licensor

Judy Guilbert, HR Assistant
Printed Name of Authorized Program Representative or DHS Licensor

This Area for CBS Use Only

Attachment 5

Expired BCI Application Cover Letter

Date

Name

Company

Address

City, State Zip

Dear Name,

Your Background Criminal Investigation (BCI) application has expired and needs to be updated in order to be in compliance with your Wasatch Mental Health Contract Agreement. Therefore, in order to expedite this process as quickly as possible with the State, please follow the steps outlined below:

- 1) Complete and sign the attached BCI Application request and Release form and return it to my attention. We need the original form with your original signature – (NOT A COPY).
- 2) Attach to the BCI Application a very clear copy of your driver's license with the expiration date clearly visible. Your license must be current/not expired. ; *If your license has been renewed and the expiration date is on the back, please make a copy of both the front and back of your driver's license. (ENLARGING THE PICTURE & LIGHTENING IT, MAKES IT CLEARER).*
- 3) DO NOT FAX THIS PAPERWORK. Please mail the BCI and copy of your ID to:

Wasatch Mental Health
750 North Freedom Blvd. (200 West), Suite 300
Provo, Utah 84601
Attn: *Name, Coordinator*

Please return the BCI as soon as possible. Wasatch Mental Health cannot authorize clients to be seen by anyone not having a BCI clearance from the State of Utah. If you have any questions please contact Name at 801-852-1422.

Sincerely,

Name

Title

Enclosure: BCI Application

Sample Form

Attachment 6
Expired Document Notice

Date

Name
Company
Address
City, State Zip

Dear Name,

Our records show that one or more of the documents listed below has or will expire shortly. In order to keep your Contract Agreement current through the end of the contract period, Please fax or mail to my attention a copy of the indicated item(s) as soon as possible.

<u>Document</u>	<u>Expiration Date</u>
___Professional License	_____
___DEA Controlled Substance Cert	_____
___Business License	_____
___General Liability	_____
___Professional Liability)	_____
___BCI Clearance	_____

(BCI information must be mailed – PLEASE DO NOT FAX)

Some of the above mentioned documents may not be due yet. Therefore, please mail or fax a copy of these documents as soon as they are received. My fax number is 852-1468.

If you have any question, please feel free to contact me at 852-1422. Thank you for your willingness to work with us and your prompt attention to this matter.

Sincerely,

Name
Title

Sample Form

Credentialing Expired Document 2nd Notice

Date

2nd Notice

Name

Company

Address

City, State Zip

Dear Name,

Our records show that one or more of the documents listed below has or will expire shortly.

In order to keep your Contract Agreement current through the end of the contract period, please fax or mail to my attention a copy of the indicated item(s) as soon as possible.

<u>Document</u>	<u>Expiration Date</u>
<input type="checkbox"/> Professional License	_____
<input type="checkbox"/> DEA Controlled Substance Cert	_____
<input type="checkbox"/> Business License	_____
<input type="checkbox"/> General Liability	_____
<input type="checkbox"/> Professional Liability)	_____
<input type="checkbox"/> BCI Clearance	_____

(BCI information must be mailed – PLEASE DO NOT FAX)

Some of the above mentioned documents may not be due yet. Therefore, please mail or fax a copy of those documents as soon as they are received. My fax number is 852-1468. If you have any questions, please feel free to call me at **NUMBER**.

Thank you for your help and willingness to work with us.

Sincerely,

Name

Title

Sample Form

Attachment 8
Expired Document Notice FINAL

Date

Final Notice

Name
Company
Address
City, State Zip

Dear Name,

In order to keep your Contract Agreement with Wasatch Mental Health current, the enclosed expired document form was previously sent to you asking that a current copy of the indicated Document(s) be sent as soon as possible.

To keep your contract active and any current Treatment Authorization in effect, your expired or expiring documents must be received within ten (10) days from the date of this letter unless other arrangements have been made. You can contact me at 852-1422 if other arrangements are necessary.

Sincerely,

Name
Title

Enclosure

Sample Form

Attachment 9

GROUP PROVIDER ATTESTATIONS

Copies of current **Professional Licensure** and **Controlled Substance Certificate** *(if applicable)* for all contractors, sub-contractors and/or employees of the CONTRACTOR providing services under this agreement shall be held by CONTRACTOR – in lieu of being attached – during the term of this agreement and are subject to audit by Wasatch Mental Health at it's discretion.

Signature

Date

Title

Copies of current, state required, **Background Criminal Investigation (BCI)** clearances for all contractors, sub-contractors and/or employees of the CONTRACTOR providing services under this agreement shall be held by CONTRACTOR – in lieu of being attached – during the term of this agreement and are subject to audit by Wasatch Mental Health at it's discretion.

Signature

Date

Title

Sample Form

Attachment 10

Application Deficit Letter

date

name
company
address
csz

Dear

Your Credentialing Contract Application Packet was received in my office on _____. However, in going thru the packet, I found there are some pertinent documents that are missing or are expired, making the packet incomplete. I have indicated in the list below what documents are still needed to complete your Application.

- _____ Copy of current Professional License
- _____ Copy of current DEA Drug License (*if applicable*)
- _____ Copy of current Business License
- _____ Copy of current Professional Liability Insurance
- _____ Copy of current Accident/Fire Insurance for Treatment Facility
- _____ Completed BCI Consent and Release Form
- _____ Copy of Photo ID for BCI

We can begin to process your Application as soon as these documents are received. Please mail or fax them to 852-1422 as soon as possible. If you have questions or concerns regarding the above mentioned items, please feel free to call me at **NUMBER** or **CONTRACT MANAGER** at **NUMBER**.

Sincerely,

STAFF NAME
PP Records Coordinator

Sample Form

AGREEMENT

- I. **CONTRACTING PARTIES:** This Agreement is between Wasatch Mental Health Services Special Service District, hereinafter referred to as “WASATCH”, and **NAME, ADDRESS, Federal Tax ID No, and National Provider Identification #** , hereinafter referred to as “CONTRACTOR”.
- II. **GENERAL PURPOSE OF AGREEMENT:** The general purpose of this Agreement is to provide preauthorized and approved mental health services to Medicaid Enrollees of WASATCH under its prepaid capitation plan.
- III. **AGREEMENT TERM:** This Agreement shall be effective on 7/1/2016 and shall terminate on 6/30/2017, unless it is otherwise extended or terminated according to the terms and conditions of this Agreement.
- IV. **AGREEMENT COMPENSATION:** CONTRACTOR shall collect all monies available to it, as compensation for services rendered to its WASATCH Medicaid Enrollees where WASATCH is not the primary payer including, but not limited to private health insurance carriers, employment related health insurance carriers, and medical support of absent parents, prior to requesting payment from WASATCH. (See Attachment B for specific payment requirements) Payments made to CONTRACTOR by WASATCH shall not exceed the rate shown in Attachment D herein, less all payments collected from all third-party payers.
- V. **SCOPE OF DOCUMENT:** This Agreement supersedes any and all previous agreements between the parties.
- VI. **PROVIDER DOCUMENTS THAT MUST BE INCLUDED WITH THIS AGREEMENT:**
Proof of Contractor’s Insurance: 1) General Liability; 2) Professional Liability
Copy of Contractor’s Professional Licensure
Copy of Contractor’s Business License
State Required Background Criminal Investigation (BCI) Clearances
- VII. **ATTACHMENTS INCLUDED AS PART OF THIS AGREEMENT:**
Attachment A: Standard Terms and Conditions
Attachment B: Additional Agreement Stipulations
Attachment C: Clinical Record Standards
Attachment D: Reimbursement Rates
- VIII. **DOCUMENTS INCORPORATED INTO THIS AGREEMENT BY REFERENCE BUT NOT ATTACHED:**
 - A. All laws, regulations, or actions applicable to services provided herein.
 - B. All terms and conditions applicable to licensed mental health providers contained in “Mental Health Center Provider Manual” located on the Division of Health Care Financing Internet website. www.health.state.ut.us/medicaid/mentalhealth.pdf
 - C. WASATCH’S Medicaid Member Handbook and Privacy Rights located on WASATCH’S Internet web site. (www.wasatch.org) Contracted Providers dropdown menu.
 - D. “Best Practice Guidelines” located on WASATCH’S Internet web site. (www.wasatch.org)
The following WASATCH policies and procedures located on WASATCH’S Internet web site. (www.wasatch.org) Contracted Providers dropdown menu.
 - C-3.05 Client Rights
 - C-3.06 Access Performance Standards
 - C-3.07 Quality Assessment and Performance Improvement Program (QAPI)
 - C-3.08 Medicaid Enrollee Actions and Grievance System.
 - A-1.10 Provider Selection and Retention
 - C – 3.12 Peer and Electronic Record Review
 - C-3.13 WMH Fraud and Abuse Deficit Reduction Act

- C-4.31 Intake, Recovery Planning, and Discharge Services for Medicaid Clients-Outside Providers
- C-5.01 Preferred Practice Guidelines
- C-5.06 Advance Directives
- F-1.07 Action to Deny Claim Payment
- Wasatch Mental Health's Notice of Privacy Practices (English/Spanish)
- Wasatch Mental Health's Medicaid Member Handbook (English/Spanish)

IX. SCREENING for EXCLUDED PROVIDERS:

The CONTRACTOR shall have procedures for reviewing public records for any adverse actions, including sanctioning and Federal exclusions. For Federal exclusions, the CONTRACTOR may use the HHS-OIG's List of Excluded Individuals and Entities (LEIE) database and the System for Award Management (SAM) database. These databases are accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and other Federal health care programs. The LEIE website is located at <http://www.oig.hhs.gov/fraud/exclusions.asp>. The SAM database is located at <https://www.sam.gov/sam/>

The CONTRACTOR shall utilize the Inspector General HHS-OIG's List of Excluded Individuals and Entities (LEIE) database and the System for Award Management (SAM) database to ensure that they do not employ any individual who is under a current federal debarment, suspension, sanction or exclusion from participation in Medicare Medicaid, and other Federal health care programs.

The CONTRACTOR shall search the (LEIE) and (SAM) databases to capture exclusions and reinstatements that have occurred since the last search. The CONTRACTOR shall maintain documentation of the searches.

By signing this contract, CONTRACTOR agrees to provide services and abide by the terms outlined in the policies and documents above.

IN WITNESS WHEREOF, the parties have executed this Agreement on the dates listed below:

DATED this ___ day of _____, 20____.

WASATCH MENTAL HEALTH SERVICES
SPECIAL SERVICE DISTRICT

By: _____

Larry A. Ellertson, Governing Authority Chair
Wasatch Mental Health Services Special Service District

ATTEST:

By: _____
Secretary of Governing Authority Board

APPROVED AS TO FORM:
Jeffrey R. Buhman
Utah County Attorney

By: _____
Deputy County Attorney

DATED this _____ day of _____ 20_____.

By: _____

PRESCRIBER

STANDARD TERMS AND CONDITIONS

1. **CONTRACTOR, AN INDEPENDENT CONTRACTOR:** CONTRACTOR is an independent contractor, and as such, shall have no authorization, express or implied, to bind WASATCH to any agreements, settlements, liability, or understanding whatsoever, and agrees not to perform any acts as agent for WASATCH, except as herein expressly set forth. Compensation provided for herein shall be the total compensation payable hereunder by WASATCH.
2. **RENEGOTIATIONS OR MODIFICATIONS:** This Agreement may be amended, modified or supplemented only by written amendment to the Agreement, executed by the parties hereto, and attached to the original signed copy of this Agreement. WASATCH shall not allow any claim for services furnished by the CONTRACTOR not specifically authorized by this Agreement.
3. **TERMINATION:** This Agreement may be terminated, without cause, prior to the specified expiration date, by either party upon 30 days prior written notice being given to the other party. This Agreement may be terminated immediately, for cause, upon written notice being given to the other party. Upon termination of this Agreement all accounts and payments shall be processed according to financial arrangements set forth herein for services rendered to the date of termination.
4. **AGREEMENT JURISDICTION:** The laws of the State of Utah shall govern the provisions of this Agreement.
5. **SEVERABILITY CLAUSE:** The declaration by any court or other binding legal source that any provision of this Agreement is illegal and void shall not affect the legality and enforceability of any other provision of this Agreement unless said provision(s) are mutually dependent.
6. **NONAVAILABILITY OF FUNDS:** Financial obligations of WASATCH for the current fiscal year are contingent upon funds for that purpose being budgeted, appropriated or otherwise made available. If funds are not available to continue the payments, CONTRACTOR shall be notified immediately. WASATCH shall only be responsible for payment for services rendered to the date of official notification of non-availability of funds. The financial obligation of WASATCH for subsequent fiscal years is subject to an approved agreement between WASATCH and CONTRACTOR effective at the beginning of the subsequent fiscal year.
7. **INDEMNITY CLAUSE:**
CONTRACTOR agrees to indemnify, hold harmless, and release WASATCH and its officers, agents, and employees from and against any and all losses, damages, injuries, liabilities, suits and proceedings arising out of the performance of this Agreement by CONTRACTOR, in the event the insurance provided, pursuant to paragraph 8 hereof, is found to be insufficient to cover said claims.
8. **INSURANCE COVERAGE:** CONTRACTOR shall maintain adequate liability coverage for the entire term of this Agreement and agrees to provide proof of this insurance prior to the expiration date of coverage.

Minimum coverage amounts include:

Accident/Fire Liability: \$1,000,000/3,000,000

Professional Liability: \$1,000,000/3,000,000

9. **BANKRUPTCY:** Should CONTRACTOR become insolvent or bankrupt, Enrollees shall not be liable for the debts of CONTRACTOR, and if WASATCH does not pay the CONTRACTOR, that the CONTRACTOR will not seek reimbursement from the Enrollee or the Department of Health.

ATTACHMENT A (Continued)

STANDARD TERMS AND CONDITIONS

10. **WORKERS' COMPENSATION INSURANCE:** CONTRACTOR must provide evidence of Workers' Compensation Insurance coverage to WASATCH.

ATTACHMENT B
ADDITIONAL AGREEMENT STIPULATION

1. WASATCH'S Outside Provider Contract Program Manager shall not pay CONTRACTOR for Medicaid Enrollee services provided by Contractor prior to a contract being in force without a prior written preauthorization. Except for emergency treatment, CONTRACTOR shall only be paid for services that are preauthorized. WASATCH'S Outside Provider Contract Program Manager shall make all pre-authorizations and referrals for treatment in written form using WASATCH'S Treatment Authorization form to the CONTRACTOR or Contractor's designated representative. Enrollees shall be evaluated by WASATCH prior to referral unless specific alternative arrangements have been made. Enrollees will be given a Medicaid handbook at their evaluation/intake.
2. CONTRACTOR shall complete a treatment plan that is in accordance with Attachment C (2) within ten (10) working days of the initial appointment. The treatment plan shall require a current five (5) Axis DSM *and/or* ICD diagnosis. CONTRACTOR shall make changes to working diagnoses in the Enrollee's treatment plan as the changes occur. WASATCH shall provide training to CONTRACTOR on these tasks upon request. Training to complete these tasks is available, upon request.
3. Services by CONTRACTOR shall be limited to a specified number of preauthorized sessions and require collection of outcome and Enrollee satisfaction data. Exceptions to these limitations must be approved in advance. Requests for additional treatment must be made by the treatment provider, in writing, and be received by WASATCH'S Outside Provider Contract Program Manager no less than 10 business days prior to the expiration of the current treatment authorization date. The WASATCH Outside Provider Contract Program Manager will review the Enrollee's progress with CONTRACTOR at the time CONTRACTOR requests continuing authorization, and at other mutually identified times as determined by WASATCH, to evaluate the type, frequency, and validity of additional treatment.
4. Only Utah State licensed mental health providers may provide reimbursable Medicaid services.

CONTRACTOR shall have a written policy in place that describes how the CONTRACTOR shall ensure that:

- a. All employees and/or sub-contractors providing treatment services, as defined in this Agreement, are properly licensed for the services provided, and in good standing with the Utah State Department of Professional Licensing (DOPL).
- b. None of its employees and/or sub-contractors are listed on the following websites <http://exclusions.oig.hhs.gov>, <https://www.sam.gov/sam> indicating they are under federal debarment, suspension, sanction or exclusion from participating in federal health care programs.
- c. CONTRACTOR shall not willingly have a relationship of the type described in "d" below with any of the following:
 - 1) an individual who is debarred, suspended or otherwise excluded from participation in procurement activities under the Federal Acquisition Regulations or under Executive Orders Nos. 12549 & 12649.
 - 2) an individual who is an affiliate, as defined in the Federal Acquisition Regulations, of a person described in "a" above.
- d. CONTRACTOR shall not knowingly have a relationship of the following types with individuals identified in "a & b" above:
 - 1) a director, officer or partner of the CONTRACTOR
 - 2) a person with beneficial ownership of five percent or more of the CONTRACTOR's equity;
 - 3) a person with an employment, consulting or other arrangement with CONTRACTOR for the
 - 4) provision of items or services that are significant and material to the CONTRACTOR's obligations under this Agreement.
- e. CONTRACTOR shall notify WASATCH, who shall notify the appropriate agencies, of any person or entity that has five percent or more ownership or controlling interest in the entity, or of any business transaction, as required under 42 CFR 455 Subpart B.

ATTACHMENT B (Continued)

ADDITIONAL AGREEMENT STIPULATION

- f. WASATCH and CONTRACTOR shall ensure that they have and adhere to procedures for notifying licensing and disciplinary bodies or other appropriate entities when suspensions or terminations of providers occur because of reportable quality-of-care deficiencies.
5. It shall be the responsibility of the CONTRACTOR to verify continued Medicaid eligibility at the beginning of each month by requesting the Enrollee show a current Medicaid card or by contacting WASATCH to verify the Enrollee's current eligibility. WASATCH'S reimbursement responsibility covers only those periods during which the Enrollee is Medicaid eligible and for which preauthorization has been obtained.
6. The CONTRACTOR shall administer to, or complete in behalf of, all Enrollees treated by the CONTRACTOR for whom WASATCH is providing Medicaid reimbursement a WASATCH specified outcome measure once/month unless alternative arrangements have been made. CONTRACTOR agrees to use forms provided by WASATCH and shall return the completed forms to WASATCH via mail for scoring.
7. CONTRACTOR shall submit claims, on the most current **HCFA 1500 form**, for approved services to Wasatch Mental Health's Outside Provider Contract Dept, 750 No. 200 West, Suite 300 Provo, UT 84601 within six (6) months of service date, using the most current CMS1500 claim forms, to receive payment. WASATCH shall have no obligation to pay for services except through this billing process. Incomplete claim forms shall be treated as denials and returned to CONTRACTOR for completion prior to processing for payment.
8. WASATCH shall pay approved claims within twenty (20) working days following approval. CONTRACTOR shall be responsible for billing and collecting fees from all other carriers and sources of payment before billing WASATCH. Evidence of payment or denial from other carriers (i.e. Explanation of Benefits (EOB) - including denial codes, when applicable) must be included with billing for reimbursement. Billings submitted without EOBs shall be returned. CONTRACTOR shall retain other carrier payments, and report and deduct said payments on a CMS1500 billing form. It is the responsibility of the CONTRACTOR to notify WASATCH if insurance or Medicare coverage begins or changes while the WASATCH Treatment Authorization is valid.
9. When a WASATCH Medicaid Enrollee has a primary insurance carrier and WASATCH'S Medicaid is secondary:
 - a. WASATCH shall pay only a co-pay equal to the difference of what the primary carrier paid, and WASATCH'S current rate as a primary insurance carrier with the exception of Medicare (See Article IV, page 1).
 - b. When the CONTRACTOR is not an impaneled provider for the Enrollee's primary insurance carrier, WASATCH shall pay a \$15 co-pay as the secondary insurance carrier.
 - c. WASATCH may require a face-to-face assessment of the Medicaid Enrollee prior to authorizing and paying for treatment authorizations as the new primary insurance carrier, when the previous primary insurance carrier's benefits have been maximized, and/or the previous primary carrier refuses to continue treatment authorizations.
10. WASATCH shall pay for emergency services to Medicaid Enrollees. Emergency services include outpatient or inpatient services furnished by a qualified provider, that are necessary to evaluate or stabilize a psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
 - a. Placing the health or safety of the Medicaid Enrollee (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
 - b. Placing the health or safety of other individuals in serious jeopardy.
 - c. Serious impairment of bodily functions; or serious dysfunction of any bodily organ or part. When a clinician delivers an outpatient service it must be provided by a licensed physician or licensed mental health therapist. Reimbursement for emergency services shall be at the rates contained in this Agreement. (Attachment D)

ATTACHMENT B (Continued)

ADDITIONAL AGREEMENT STIPULATION

11. CONTRACTOR shall not charge Medicaid Enrollees any co-payment for services reimbursed by WASATCH under this Agreement. Any attempt by the CONTRACTOR to bill or collect from Medicaid Enrollees shall void this Agreement in its entirety without notice.
12. CONTRACTOR understands that Medicaid Enrollees classified as “Foster Care” are excluded from the terms of this Agreement for all covered mental health services, except inpatient services.
13. CONTRACTOR shall maintain a single clinical record on each of its WASATCH Enrollees, wherein any and all treatment activities will be recorded. Minimum standards for the clinical record are included in Attachment C.
14. WASATCH shall provide technical assistance and/or training regarding the clinical record forms and format used in maintaining clinical information to CONTRACTOR, upon request. WASATCH'S Outside Provider Program Manager shall also, upon CONTRACTOR request, perform reviews of CONTRACTOR record-keeping procedures prior to formal WASATCH audits.
15. WASATCH'S Outside Provider Program Manager shall arrange with the CONTRACTOR for periodic peer reviews of Enrollee medical records as specified in WASATCH'S Peer Review Policy (A-1.02) to review Enrollee progress and to assess the quality of service. Treatment plans, progress notes, and financial records for each billed session shall be available for review during WASATCH peer reviews. Treatment plans and progress notes shall meet or exceed Medicaid standards for content, accuracy and legibility. CONTRACTOR shall pay back any funds paid for services that are disallowed due to: (1) lack of documentation, or (2) inconsistencies with treatment plans or goals.
16. CONTRACTOR will collaborate with WASATCH, as it pertains to this Agreement, with WASATCH'S Medicaid Quality Utilization and Performance Improvement Plan. This would include periodic peer chart reviews for quality assessment and documentation reflecting that treatment services are not being over or under utilized, staff trained in Enrollee cultural competency, following Utah State Division of Substance Abuse and Mental Health Practice Guidelines, etc. (See www.wasatch.org for WASATCH QAPI Policy and Procedures).
17. CONTRACTOR shall maintain each adult Medicaid record for ten years following final contact with the Enrollee. CONTRACTOR must maintain the record of a child until the Enrollee reaches the age of twenty-five or for ten years following final contact, whichever is later. Following these periods, a record can be destroyed provided a discharge summary is maintained. It is the responsibility of each CONTRACTOR to arrange for such records maintenance. WASATCH shall provide archive arrangements for such records during the ten-year period and shall store the discharge summary following destruction of the record at the discretion of the CONTRACTOR.
18. CONTRACTOR shall not prohibit its health care professionals, when acting within the lawful scope of their practice, from advising or advocating on behalf of a Medicaid Enrollee for the following:
 - a. The Enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered.
 - b. Any information the Enrollee needs in order to decide among all relevant treatment options.
 - c. The risks, benefits, and consequences of treatment or non-treatment; and
 - d. The Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
19. CONTRACTOR'S chosen method(s) of treatment for WASATCH Medicaid Enrollees shall reflect the generally accepted standard of care for the diagnoses. Non-traditional, experimental or creative methods are not covered mental health services, unless reviewed and preauthorized. According to Medicaid, the use of “coercive techniques” other than for the protection of the child - where the therapist or others under the direction of the therapist use physical restraint, noxious stimulations, and/or interference with body functions, such as vision, breathing, and movement during the session to evoke an emotional response in the child such as rage or to cause the child to undergo a rebirth experience are not covered services under Medicaid and a provider may not bill Medicaid for these services. These coercive interventions are sometimes also referred to as “holding therapy”, “rage therapy”, “rage reduction therapy”, “attachment therapy”, or “rebirthing therapy”. This also includes services wherein the therapist instructs and directs parents or others in the use of coercive techniques that are used with the child in the home or other setting outside the therapy session.

ATTACHMENT B (Continued)

ADDITIONAL AGREEMENT STIPULATION

- i. Enrollees referred by WASATCH to a CONTRACTOR who subsequently applies for and obtains Medicare insurance may continue to be treated by the CONTRACTOR, if the CONTRACTOR is Medicare approved. If the CONTRACTOR is not Medicare approved, WASATCH must be notified and the Enrollee must be referred to WASATCH or another Medicare provider.
21. CONTRACTOR shall be knowledgeable of all Enrollee rights, including the right to file grievances and to appeal actions, associated with their enrollment and participation in the Medicaid Insurance Prepaid Mental Health Plan as explained in the Medicaid Member Handbook located on the WASATCH Internet website www.wasatch.org. WASATCH shall provide CONTRACTOR training on the Handbook and particularly on Enrollees' rights including his/her right to file grievances and appeals. CONTRACTOR acknowledges the Enrollee's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment. (See Article VII, page 1.) CONTRACTOR agrees to take Enrollee rights into account when furnishing covered services and acknowledges that Enrollees are free to exercise these rights and that the exercise of these rights will not adversely affect the way the CONTRACTOR treats the Enrollee. By signing this contract, CONTRACTOR agrees to provide services in accordance with Enrollee rights.
22. CONTRACTOR agrees and understands that this agreement may be terminated or other sanctions may be imposed for inadequate performance.
23. CONTRACTOR must enroll as either a Medicaid fee-for-service provider or as a "limited enrollment provider."
24. The CONTRACTOR shall not hold an Enrollee liable for the following:
 - a. The debts of WASATCH should it become insolvent;
 - b. Payment for Covered Services provided to the Enrollee for which WASATCH does not pay the CONTRACTOR that furnishes the Covered Services under a contractual, referral or other arrangement with WASATCH; or
 - c. The payments for Covered Services under a contract, referral or other arrangement with WASATCH, to the extent that those payments are in excess of the amount that normally would be paid by the Enrollee if the service had been received directly from WASATCH.
25. CONTRACTOR agrees to comply with all applicable Local, State, Federal, and all HIPAA regulations.

ATTACHMENT C
CLINICAL RECORD STANDARDS

CONTRACTOR may reference the following Medicaid website for complete documentation regulations.
www.health.state.ut.us/medicaid/mentalhealth.pdf

CONTRACTOR shall maintain the clinical record. Each record must meet the requirements below:

1. Each record must contain a written clinical assessment that evaluates the presenting complaints and mental health needs. If this assessment has been completed by WASATCH, WASATCH shall provide it to the CONTRACTOR at the point of referral. If WASATCH has not completed the assessment, it shall be the responsibility of the CONTRACTOR to insure that the assessment meets Medicaid standards.
2. Each record must contain a written individualized treatment plan or plan of care developed by a licensed mental health therapist. The treatment plan must include the following:
 - a. Current five (5) axis DSM *and/or* ICD diagnosis. *Any change in the working diagnosis before the next treatment plan review must be documented with a treatment note.
 - b. Identification of the desired change stated in behavioral terms.
 - c. The treatment regimen: Specific therapeutic services provided to accomplish the stated behavioral changes.
 - d. The projected schedule of service delivery, including frequency and duration.
 - e. Identity and credentials of the individual(s) providing the service.
 - f. Reasonable measures to evaluate whether objectives are met. Objectives and measures should be developed in conjunction with the Enrollee.
 - g. A projected schedule for reevaluation and update of the treatment plan (maximum interval six (6) months).
 - h. Enrollee signature is required on all treatment plans and revisions.
 - i. Treatment plans shall include a projected termination date of Enrollee.
3. CONTRACTOR must document each therapeutic contact in a clinical note. Each note must be maintained within the clinical record. Each clinical note must include the following:
 - a. The date the service was provided.
 - b. The time of day the service was provided in 24-hour clock time.
 - c. The duration of the service.
 - d. The specific service rendered.
 - e. The setting in which the services were rendered.
 - f. Relationship of the services provided and the progress noted to the specific treatment goals described in the treatment plan.
 - g. Description of the Enrollee's progress toward objectives identified in the treatment plan.
 - h. A signature of the individual who rendered the service, including full name and license. If the service provider is non-licensed, the supervising professional must also sign.

ATTACHMENT C (continued)
CLINICAL RECORD STANDARDS

- i Legible hand written notes are acceptable.
4. A termination or discharge summary when treatment is completed. This summary must include the following:
- a. Date of admission.
 - b. Admission problems.
 - c. Summary of services including modalities, frequency of treatment, response to treatment and medication at discharge.
 - d. Condition upon discharge relative to treatment goals.
 - e. Discharge recommendations and referral.
 - f. Qualification at discharge as seriously and persistently mentally ill.
 - g. Global Assessment of Functioning (GAF) at discharge.
 - h. Five (5)-axis discharge diagnosis.
 - i. Name, address and telephone of next of kin, guardian or responsible person.
 - j. Date of discharge.
 - k. The signature of treating professional preparing the summary.

**ATTACHMENT D
REIMBURSEMENT RATES - PSYCIATRISTS**

OUTPATIENT

CPT Codes	Description	MD/DO
90792	Psychiatric Diagnostic Evaluation with Medical Services per 15 minutes up to 1.5 hours	\$31.25
99213	Pharmacologic Management (outpatient face to face w/ client)	\$75.00
99214	Pharmacologic Management (outpatient face to face w/ client)	\$80.00
99215	Pharmacologic Management (outpatient face to face w/ client)	\$85.00

ATTACHMENT E

QUALIFICATION OF PRE-LICENSURE THERAPISTS

As a Licensed Mental Health Therapist and CONTRACTOR with WASATCH, it may be possible for you to bill WASATCH for preauthorized Medicaid services provided by a supervisee. If it is your intention to do so, you shall be required to identify any supervisee and provide documentation of their qualifications to WASATCH prior to any services being provided. Pre-licensure "trainees" fall into two categories for qualification and reimbursement and must be on course for licensure. Following you will find a listing of each category of "trainee" and the required documentation that must be provided. Please submit any requests for approval and documentation to Geri Alldredge, Ph.D. at WASATCH.

Category One: Pre-doctoral Psychology Interns, Post Internship Doctoral Candidates or Post Doctoral Psychology Residents

Requirements:

1. Completion of courses, comprehensive exams, and certified by Doctoral program as "internship ready".
2. Enrollment in or completion of an APPIC or APA approved Pre-doctoral internship program.
3. An awarded Doctoral Degree or on course to graduate with Doctorate.
4. Conformity with all applicable State Licensure Laws and Rules.

Documentation:

1. WASATCH Contracted Provider Application, including specified documentation.
2. Copy of Doctoral Degree if awarded; or
3. Certificate of internship completion if available; or
4. A letter from the internship site documenting enrollment and status if applicable; and
5. A letter from the Doctoral program or Professional School documenting status; and
6. A statement from the supervisor that supervision is provided according to State Licensure Law and Rules; and
7. A statement verifying that the non-licensed provider is covered with liability insurance.

Category Two: Psychology Externs

Requirements:

1. Matriculated as a student in an accredited Psychology Doctoral program.
2. Enrolled for externship credit at the University or Professional School.
3. Certification by Clinical Director of the Doctoral program as "at least Master's level".
4. Supervision by a licensed Psychologist with two years of post licensure experience.
5. Conformity with all applicable State Licensure Laws and Rules.

Documentation:

1. Wasatch Contracted Provider Application, including specified documentation.
2. A letter from the Clinical Director certifying that the Extern is enrolled for credit at the University or Professional School, on course for completion and "at least Master's Level"; and
3. A statement from the supervisor that supervision is provided according to State Licensure Laws and Rules; and
4. A statement verifying that the non-licensed provider is covered with liability insurance.

Category Two: Certified Social Workers, Marriage and Family Therapists, Pre-Licensure Professional Counselors

Requirements:

1. Completion of requisite Master's or Doctor's Degree.
2. Approval by the Utah State Department of Professional Licensing of supervision arrangement.

Documentation:

1. Wasatch Contracted Provider Application, including specified documentation.
2. A copy of the Diploma; and
3. A statement from the supervisor that supervision is provided according to State Licensure Laws and Rules; and
4. A statement verifying that the non-licensed provider is covered with liability insurance.

Sample Form

GROUP PROVIDER ATTESTATIONS

Copies of current **Professional Licensure** and **Controlled Substance Certificate** *(if applicable)* for all contractors, sub-contractors and/or employees of the CONTRACTOR providing services under this agreement shall be held by CONTRACTOR – in lieu of being attached – during the term of this agreement and are subject to audit by Wasatch Mental Health at its discretion.

Signature

Date

Title

Copies of current, state required, **Background Criminal Investigation (BCI)** clearances for all contractors, sub-contractors and/or employees of the CONTRACTOR providing services under this agreement shall be held by CONTRACTOR – in lieu of being attached – during the term of this agreement and are subject to audit by Wasatch Mental Health at its discretion.

Signature

Date

Title

Sample Form

**Wasatch Mental Health
Attestation of Compliance
Fraud and Abuse Prevention and Reporting**

Pursuant to your organization's contract agreement with Wasatch Mental Health, and as required by Utah Code, Title 26, Chapter 20 False Claims Act and United States Code 3729 – 3733, your organization is required to complete a fraud, waste and abuse prevention and reporting training to ensure your organization does not engage in fraudulent and/or abusive practices, or wrongdoing in its administrative, clinical and billing procedures.

Topics that should be addressed in a fraud, waste and abuse training program include, but are not limited to the following:

- Definitions of fraud, waste and abuse,
- Overview of laws and regulations related to fraud, waste and abuse, including a brief description of main requirements and criminal and civil penalties related to Federal and State False Claims Act,
- Entities/individuals excluded from doing business with the Federal Government (LEIE and SAM exclusion lists),
- Obligations to have appropriate policies and procedures to address fraud, waste and abuse,
- Process for reporting suspected fraud, waste and abuse,
- Protections for employees who report suspected fraud, waste and abuse.

Please indicate which of the following fraud, waste and abuse training programs have been completed by your organization.

- Wasatch Mental Health's Fraud, Waste and Abuse Prevention and Reporting Policies and Procedures.
- Your Organization's Fraud, Waste and Abuse Training Program.
- Other _____ (Name of Training Program).

I, the undersigned, attest that I am an authorized representative with signature authority for the organization listed below and that all employees that provide services for Medicaid members have completed Fraud and Abuse Prevention and Reporting training.

Facility/Provider Name: _____

Authorized Representative: _____ Title: _____

My signature certifies that the information I provided is true and correct. I understand that Wasatch Mental Health and/or the Utah Department of Health (Medicaid) may request additional information to substantiate our Attestation.

Signature: _____ Date: _____