

Application for School-Based Mental Health Service Providers

Each school district and prospective mental health partner must complete this application in its entirety in order to be considered for the School-Based Mental Health Network. This application will precede the school district application to Arkansas Medicaid. Medicaid will not approve a provider number to a school district without a letter of approval from the Arkansas Department of Education. This application must be submitted to the ADE regardless of the school district's intention to bill for Medicaid-related school-based mental health services.

The application serves a dual purpose. Section I is information for the district/educational service cooperative to submit as a Provider. Section II is to be completed for each individual practitioner working in the program. Consideration will not be given to incomplete applications and each must include original signature and dates.

Section I

1. Identifying Information

A. District/Education Services Cooperative

Name: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

B. LEA Supervisor

Name: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

C. Mental Health Licensed Practitioner (*If more than one, list all on a separate sheet with the requested information and attach to application.*)

Name: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

D. Contact Person for Program (If not the LEA Supervisor)

Name: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

2. Signed Statement of Assurances/Agreement

(Copy Attached)

3. Description of Caseload to be Served: **(Include description of district and community and specific issues/problems identified)**

4. Service Delivery Plan to include:

- A. Location for services to be provided
- B. Anticipated frequency of service (hours of service delivery)
- C. Provision for emergency service consistent with Medicaid Manual, Section 202.110 (24 hours, 7 days, 12 months)
- D. Responsible party for billing SBMH Medicaid-related services.

**Job Description for School Based Mental Health Services Practitioner
(Provide for each position – therapist, case manager)**

Position Title: _____

Responsible to: _____

Qualifications:

Specific Tasks:

Evaluation:

STATEMENT OF ASSURANCES

The undersigned RSPMI provider or School District/Education Services Cooperative (ESC), as a provider of School-based Mental Health Services (SBMHS) approved to receive Medicaid reimbursement for services provided to the under age 21 Medicaid population, agrees to the following assurances in order to ensure quality and continuity of care:

PROVIDER STAFF OR CONTRACTED PROFESSIONALS: Employees or contractors engaged as Licensed School-based Mental Health Practitioners will meet specific qualification for their services. Further, such practitioners will provide services only in those areas in which they are licensed or credentialed.

SERVICES: As a provider of SBMHS, the School District/ESC, agrees to provide, either through employees or contractors, mental health services in a manner consistent with Section 202.110 of the Arkansas Medicaid Manual for SBMHS.

LIABILITY INSURANCE: Each practitioner will be covered by liability insurance.

CONTINUITY OF CARE/SERVICES: As a public education agency or RSPMI provider, we agree to work cooperatively with other providers of services to children and youth. We further agree to work collaboratively to coordinate delivery of mental health services with other sources of similar services and care. We will make appropriate disclosure consistent with privacy and confidentiality rights of the treatment plan to all parties involved.

NON REFUSAL REQUIREMENT: As a provider of SBMHS, we will not refuse services to a Medicaid eligible recipient under age 21 in a school setting unless, based upon the primary mental health diagnosis, the provider does not possess the services or program to adequately treat the recipient's mental health needs.

PHYSICIAN REFERRAL: Recipients of services will be referred verbally or in writing for School-based Mental Health Services by a Medicaid enrolled physician. It is understood that the referral must establish that services are medically necessary.

COMPREHENSIVE ASSESSMENT: Recipients of SBMHS will receive a documented comprehensive assessment before services are begun.

TREATMENT PLAN: Recipients of SBMHS will have an individualized, written treatment plan to be included in the recipient's medical record.

PLACE OF SERVICE: School-based Mental Health Services will be provided in a school setting, to include an area on or off site based on accessibility for the child, or at the home of the child when it is the educational setting for a child enrolled in the public schools.

RECORD KEEPING: All medical records which support the provision of medical services billed to Medicaid will be completed promptly, filed and retained by the School District/ESC in which the child attends school, and will be made available for audit.

CONFIDENTIALITY: All aspects of the SBMHS will comply with regulations regarding client privacy and confidentiality. Space for the delivery of personal client services will be guaranteed privacy and confidentiality. Records of all SBMHS clients will be maintained in locked files and access will be regulated in accordance with confidentiality requirements.

DOCUMENTATION: The School District/ESC will properly maintain prescribed written records for each child receiving SBMHS.

RECIPIENT APPEAL PROCESS: Upon receipt of an adverse decision, the recipient may request a fair hearing of the denial decision.

School District/ESC Chief Administrative Official

Date

Practitioner of School-based Mental Health Services
(Agency Director or Independent Provider)

Date

LEA Supervisor/EC Coordinator

Date

Practitioner Checklist

Section II

Note: This is to be completed by the licensed Mental Health Practitioner (Therapist and Case Managers)

The following items must be submitted in order to complete the Application to become a school based mental health practitioner. Please return all of these documents with the Provider Application.

- Current Resume of Practitioner** – must include month and year. Any lapse in continuous employment for work history since graduation from your graduate degree program must be fully explained on a separate sheet.
- Copy of Practitioner’s Current State License/Certification (showing expiration date)**
- Practitioner’s Board Certifications** (If applicable)
- Copy of Practitioner’s Diploma**
- If Applicable, Current Professional Liability Face sheet** (must indicate applicant as the insured, policy period and coverage amounts with minimum limits of \$1,000,000.)
- Practitioner Profile**
- Explanation of any malpractice suits or licensing boards actions

Practitioner Profile

Name: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

NOTE: If “YES” is checked, please explain fully on a separate sheet. Documentation is required if you have malpractice claims pending or settled in the past five (5) years (include any settlements/adjudications, original complaint and final disposition).

1. **Health Status:** Do you currently have any physical, mental, or emotional conditions which may impair your ability to render the professional services which are the subject of this application? YES NO
 - a. Do you currently use illegal drugs or abuse drugs or alcohol? YES NO

2. **Insurance Coverage:** Have you ever been denied professional liability insurance or initially refused upon application? YES NO

3. **License/Certification:** Has your professional license/certification in any state ever been revoked, suspended, placed on probation, conditional status, or limited? YES NO
 - a. Have you ever voluntarily surrendered your license/certification? YES NO
 - b. Are formal charges pending against you at this time? YES NO

4. **If Applicable: Hospital Privileges:** Has any hospital ever dismissed you from its staff? YES NO
 - a. Has any hospital ever revoked, suspended, or limited your privileges? YES
NO
 - b. Has any hospital initiated either type of aforementioned action by formal notice to you? YES NO
 - c. Has any hospital refused or denied you privileges? YES NO

- d. Have you ever voluntarily surrendered your hospital privileges?
YES NO
5. **If Applicable: Hospital Sanctions:** Have you ever surrendered your clinical privileges upon threat of censure, restriction, suspension or revocation of such privileges? YES
NO
6. **Professional Membership(s):** Has your membership in any professional society or association ever been canceled, revoked, or censured? YES NO
7. **Medicare/Medicaid:** Have you ever been fined, had an arrangement suspended, been expelled from participation or had criminal charges brought against you by Medicare or Medicaid? YES NO
8. **Criminal Offences:** Have you ever been convicted of a felony or involved in charges relating to moral or ethical turpitude? YES NO
- a. Have you ever been named as a defendant in any criminal proceedings?
YES NO
9. **Board Discipline:** Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board, certification board, county, local school board, state or national professional society, hospital medical or clinical staff)? YES NO
10. **Malpractice Action:** Has any malpractice action against you been brought or settled in the past 5 years or has there been any unfavorable judgement(s) against you in a malpractice action? YES NO
- a. To your knowledge, is any malpractice action against you currently pending?
YES NO
- b. Have you ever been a defendant in any lawsuit involving your practice where there has been an award or payment of \$50,000 or more? YES NO

Attestation/Participation Statement

I fully understand that if any matter stated in this application is or becomes false, _____(district) will be entitled to terminate my employment as a School Based Mental Health Practitioner. All information that is being submitted by me in this application is warranted to be true, correct and complete.

I authorize _____(district) to consult with the State licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, hospitals, professional references from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character, and moral and ethical qualifications, and I also authorize all of them to release such information to _____(district). I release _____(district) and its employees and agents and all those whom _____(district) contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application to provide school based mental health services.

Signature

Date

Name (Please Print)

***For assistance with Individual Practitioner
Application contact:***

Ruth Fissel, LCSW
415 N. McKinley Suite 1060
Little Rock, AR. 72205
Phone: 501-537-2200
Fax: 501-537-2202
E-mail: ruthfissel@aristotle.net

***For assistance with District Provider
Application contact:***

Tony Boaz, LCSW
2402 Wildwood
Wildwood Centre, Suite 170
Sherwood, AR. 72120
Phone: 501-835-2093
Fax: 501-833-8412
E-mail: tboaz@arkedu.k12.ar.us

Please mail completed application to:

***Tony Boaz, LCSW
Lead Consultant
Medicaid In The Schools (MITS)
Arkansas Department of Education,
Special Education
2402 Wildwood
Wildwood Centre, Suite 170
Sherwood, AR. 72120***