# PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

## (Louisiana Medicaid Program)

# Mental Health Rehabilitation Agency (MHR)

**(Enrollment packet is subject to change without notice.)**

# Mental Health Rehabilitation Agency (MHR)

## REQUIRED DOCUMENTS FOR ENROLLMENT

**The following checklist shows all required documents that MUST be submitted to enroll with Fee For Service (FFS) Louisiana Medicaid. Please make certain to complete each required form in its entirety to avoid processing delays.**

**NOTE: Mental Health Rehabilitation Agencies (PT-77) may only enroll in Louisiana Medicaid (Fee-For-Service) for Medicare Cross-Over and QMB claims.**
**The provider MUST be enrolled with Medicare prior to requesting enrollment in Louisiana Medicaid (Fee-For-Service).**

*Forms are included in the **Basic Enrollment Packet for Entities/Businesses**.
**Forms are included here.

| Completed | Document Name |
|---|---|
| ☐ * | 1. Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form. |
| ☐ * | 2. PE-50 Addendum – Provider Agreement Form. (Three pages) |
| ☐ * | 3. Medicaid Direct Deposit (EFT) Authorization Agreement Form. |
| ☐ * | 4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. |
| ☐ * | 5. **(If submitting claims electronically)** Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form **and** Power of Attorney Form (if applicable). |
| ☐ | 6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited **(deposit slips are not accepted**). |
| ☐ | 7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records (**W-9 forms are not accepted**). |
| ☐ | 8. Copy of the **Behavioral Health Service Provider (BHSP)** License issued by the Health Standards section from Louisiana Department of Health (LDH).<br><br>The license must include one or more of the following treatment programs:<br>-Psychosocial Rehabilitation Services Program (PSR);<br>-Crisis Intervention Program (CI); or<br>-Community Psychiatric Supports and Treatment Program (CPST) |
| ☐ | 9. **Providers with a BHSP license for CPST and/or PSR shall provide:**<br>Verification of full or preliminary accreditation issued by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).<br><br>**Providers with a BHSP license for CI shall provide:**<br>- Verification of full accreditation issued by CARF, COA or JCAHO; **or**<br>- Verification the accreditation application was submitted and the application fee was paid. |
| ☐ ** | 10. MHR Agency Provider Attestation |
| ☐ ** | 11. Medical Director Attestation |
| ☐ | 12. Copy of the **Medical Director's** current medical license from the governing license board of their profession as one of the following:<br>- Physician;<br>- Advanced Practice Registered Nurse; or<br>- Medical Psychologist |

| | |
|---|---|
| ☐ ** | 13. Clinical Supervisor Attestation |
| ☐ | 14. Copy of the **Clinical Supervisor's** current medical license from the governing license board of their profession as one of the following:<br>- Medical Psychologist;<br>- Licensed Psychologist;<br>- Licensed Clinical Social Worker (LCSW);<br>- Licensed Professional Counselor (LPC);<br>- Licensed Addiction Counselor (LAC);<br>- Licensed Marriage And Family Therapist (LMFT); or<br>- Advanced Practice Registered Nurse (APRN) |
| ☐ ** | 15. Mental Health Supervisor Attestation<br>Note: Only required for providers with an BHSP license issued by the Health Standards Section from LDH for CPST and or PSR |
| ☐ | 16. Copy of the **Mental Health Supervisor's** current medical license from the governing license board of their profession as one of the following:<br>- Medical Psychologist;<br>- Licensed Psychologist;<br>- Licensed Clinical Social Worker (LCSW);<br>- Licensed Professional Counselor (LPC);<br>- Licensed Marriage And Family Therapist (LMFT); or<br>- Advanced Practice Registered Nurse (APRN)<br><br>NOTE: Only required if the Mental Health Supervisor Attestation is submitted. |
| ☐ | 17. On **Section A** of the PE-50 Form, in the **Specialty Code** space write in **'78'** (Mental Health Rehab) and leave the **Subspecialty Code** space **'blank'.** |
| ☐ | 18. On **Section D** of the PE-50 Form, in the **Provider Type Description** space write in '**Mental Health Rehab'** and in the **Provider Type Code** space write in **'77'.** |

**TO LINK INDIVIDUAL PROFESSIONALS**

| | |
|---|---|
| ☐ ** | 1. Link/Unlink and Working Relationship Form for currently enrolled professional individuals needing to link to this Mental Health Rehab Agency.<br><br>The following individuals may link to a Mental Health Clinic – if their Specialty is Psychiatric: Physicians (PT-20), Nurse Practitioner (PT-78), Psychologist or Medical Psychologist (PT-31) and Social Worker (PT-73).<br><br>If any individual is not enrolled or active in Medicaid, then a full Individual Enrollment Application is required, in addition to the Group Link/Unlink form.<br><br>**NOTE: All provider MUST be enrolled with Medicare prior to requesting linkage to the agency in Louisiana Medicaid (Fee-For-Service).** |

**Original Signatures Required – Please Do NOT Use Black Ink**

Please submit all required documentation to:
**Gainwell Provider Enrollment Unit**
**PO Box 80159**
**Baton Rouge, LA 70898-0159**
**225-216-6370**

# Louisiana Medicaid Link/Unlink and Working Relationship Form

Copy this form for additional space as needed.

***PURPOSE***

This form allows one individual to link to and/or unlink from two (2) separate entities/businesses.
This form also serves as documentation that a working relationship exists between an Individual and an Entity.

| | | | |
|---|---|---|---|
| Individual Provider Name: | | | |
| Individual Provider Number | LA Medicaid Provider # | National Provider Identifier (NPI) | |
| Entity Name: | | | |
| Entity Provider Number | LA Medicaid Provider # | National Provider Identifier (NPI) | |
| LINK ☐ | Effective Date: | UNLINK ☐ | Termination Date: |
| Approximate Number of Hours Working at this Entity Per Week (required) | | | |
| Entity Name: | | | |
| Entity Provider Number | LA Medicaid Provider # | National Provider Identifier (NPI) | |
| LINK ☐ | Effective Date: | UNLINK ☐ | Termination Date: |
| Approximate Number of Hours Working at this Entity Per Week (required) | | | |
| Contact Person for questions regarding this form: | | | |
| Contact Person Phone Number: | | | |

**Working Relationship Agreement**

I am a medical professional who has a contractual agreement to see patients for the above-identified entity(s). I recorded the approximate number of hours working per week for the entity(s) identified above.
I understand that upon request I must provide LDH a copy of the written contractual agreement.

| _____ | _____ | _____ |
|---|---|---|
| **Print Individual Provider's Name** | **Individual Provider's Signature** | **Date of Signature** |

**Original Signatures Required – Please Do NOT Use Black Ink**

Please submit all required documentation to:
**Gainwell Provider Enrollment Unit**
**PO Box 80159**
**Baton Rouge, LA 70898-0159**
**225-216-6370**

# Provider Attestation for
# Mental Health Rehabilitation (MHR) Agency

***PURPOSE***

This form confirms that the below-named Mental Health Rehabilitation (MHR) agency attests to meeting the qualifications and requirements in accordance with the Mental Health Rehabilitation Services section of the LA Medicaid Behavioral Health Services Manual.

| | |
|---|---|
| **National Provider Identifier (NPI):** | |
| **MHR Name:** | |
| **MHR Physical Address:** | |
| **Contact person for questions regarding this form:** | |
| **Contact Person Phone Number:** | (  )  -  **EXT:** |

I hereby affirm under oath that all statements made on this application and the attachments thereto are:

- True and correct; and
- That the denial, loss of, or any negative change in accreditation status will be reported in writing immediately upon notification to Louisiana Department of Health (LDH) or its designee;
- That all services are delivered in accordance with federal and state laws and regulations, the provider manual and other notices or directives;
- That all non-licensed persons employed by the organization complete and document training in a recognized Crisis Intervention curriculum prior to handling or managing crisis calls which shall be updated annually;
- That non-licensed staff complete a basic clinical competency training program approved by the Office of Behavioral Health (OBH) prior to providing the service;
- That criminal background checks, including sexual offender registry checks, will be arranged no more than 90 days prior to employment (or contracting, volunteering, or as required by law) and documentation will be maintained to show that individuals have pass background checks in accordance with any applicable state and federal law;
- That the Department of Health and Human Services' Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the LDH State Adverse Actions website are reviewed prior to hiring or contracting any employee or contractor that performs services that are compensated with Medicaid/Medicare funds. Once employed, the lists must be checked once a month thereafter to determine if there is a finding that an employee or contractor has abused, neglected or extorted any individual or if they have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General. **Results are to be maintained that checks have been completed**. The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, anyone who has a negative finding placed on the Louisiana State Adverse Action List, or who have been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid or the Department of Health and Human Services' Office of Inspector General;
- Written policies and procedures are in place inclusive of drug testing staff to ensure an alcohol and drug-free workplace and a workforce free of substance use has been established and maintained;
- Documentation has been maintained to verify that all direct care staff, who are required to complete First Aid, cardiopulmonary resuscitation (CPR) and seizure assessment training, complete American Heart Association (AHA) recognized training within 90 days of hire and is reviewed within a time period recommended by the American Heart Association (AHA).;
- The NPI number of direct care staff rendering services on the agencies behalf is included on all claims for Medicaid reimbursement;
- A crisis mitigation plan is in place as defined in LAC 48:I.Chapter 56;
- That the above named Provider will comply with all agency and direct care staff qualifications and requirements for services provided, as defined in the LDH BH Services Provider Manual;

- That the above named Provider abides by the minimum core staffing requirements as defined in the Behavioral Mental Health Rehabilitation Services section of the LA Medicaid Behavioral Health Services Manual;
- That the above named Provider complies with the responsibilities of a Mental Health Rehabilitation (MHR) Agency as detailed in the Mental Health Rehabilitation Services section of the LA Medicaid Behavioral Health Services provider manual; and
- I further affirm on behalf of the above named Provider that documentation supporting compliance with all the requirements identified above will be maintained; and upon request will be provided to the Louisiana Department or its designee.
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

_____

Print Name of Authorized Representative

_____ _____

Signature of Authorized Representative Date of Signature

*Signature and date stamps, or the signature of anyone other than the provider or a person legally authorized to sign on behalf of a legal entity, are not acceptable*

**Complete this form in its entirety. Original Signatures Required – Please Do NOT Use Black Ink**

Please submit all required documentation to:
**Gainwell Provider Enrollment Unit**
**PO Box 80159**
**Baton Rouge, LA 70898-0159**
**225-216-6370**

# Mental Health Rehabilitation (MHR)
# Medical Director Attestation

***PURPOSE***

This form confirms that I serve as the active Medical Director of the below-named Mental Health Rehabilitation (MHR) agency, and attest to meeting the qualifications of the Medical Director according to the Mental Health Rehabilitation Services section of the LA Medicaid Behavioral Health Services Manual.

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Individual Provider Name:** | | | | | | | | | | | | | | | | | | |
| **Individual Provider Number** | **LA Medicaid Provider Number:** | | | | | | | | **National Provider Identifier (NPI):** | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **MHR Name:** | | | | | | | | | | | | | | | | | | |
| **MHR Physical Address:** | | | | | | | | | | | | | | | | | | |
| **Contact person for questions regarding this form:** | | | | | | | | | | | | | | | | | | |
| **Contact Person Phone Number:** | (  )  -  **EXT:** | | | | | | | | | | | | | | | | | |

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are:

- True and correct; and
- That I further certify that I comply with the responsibilities of an MHR Medical Director as detailed in the Mental Health Rehabilitation Services section of the LA Medicaid Behavioral Health Services Manual including but not limited to:
  - Ensuring that necessary medical services are provided that meet the needs of the clients;
  - Directing the specific course of medical treatment for all clients;
  - Reviewing reports of all medically related accidents/incidents occurring on the premises; and
  - Periodically reviewing the delivery of services to ensure care meets the current standards of practice.

In addition, as the Medical Director I have the following responsibilities or have designated these duties to a qualified practitioner who is also linked to the above named Provider:

- Writes the admission and discharge orders.
- Writes and approves all prescription medication orders.
- Develops, implements and provides education regarding the protocols for administering prescription and non-prescription medications on-site.
- Provides consultative and on-call coverage to ensure the health and safety of clients; and
- Collaborates with the client's primary care physician as needed for continuity of the client's care.

| _____ | _____ | _____ |
|---|---|---|
| Print Name of Medical Director | Signature of Medical Director | Date of Signature |

| _____ | _____ |
|---|---|
| Print Name of Authorized Representative | Title of Authorized Representative |
| _____ | _____ |
| Signature of Authorized Representative | Date of Signature |

*Signature and date stamps, or the signature of anyone other than the provider or a person legally authorized to sign on behalf of a legal entity, are not acceptable*

**Complete this form in its entirety. Original Signatures Required – Please Do NOT Use Black Ink**

Please submit all required documentation to:
**Gainwell Provider Enrollment Unit**
**PO Box 80159**
**Baton Rouge, LA 70898-0159**
**225-216-6370**

# Mental Health Rehabilitation (MHR)
# Clinical Supervisor Attestation

***PURPOSE***

This form confirms that I serve as the active Clinical Supervisor of the below-named MHR agency, and attest to meeting the qualifications of the Clinical Supervisor according to the Mental Health Rehabilitation Services section of the LA Medicaid Behavioral Health Services Manual.

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Individual Provider Name:** | | | | | | | | | | | | | | | | | | |
| **Individual Provider Number** | **LA Medicaid Provider Number:** | | | | | | | | **National Provider Identifier (NPI):** | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **MHR Name:** | | | | | | | | | | | | | | | | | | |
| **MHR Physical Address:** | | | | | | | | | | | | | | | | | | |
| **Contact person for questions regarding this form:** | | | | | | | | | | | | | | | | | | |
| **Contact Person Phone Number:** | (  )  -  **EXT:** | | | | | | | | | | | | | | | | | |

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are:

- True and correct; and
- That I further certify that I comply with the responsibilities of a MHR Clinical Supervisor as detailed in the Mental Health Rehabilitation Services section of the LA Medicaid Behavioral Health Services Manual including but not limited to:
  - Providing supervision utilizing evidence-based techniques related to the practice of behavioral health counseling;
  - Serving as a resource person for other professionals counseling or providing direct services to clients with behavioral health disorders;
  - Attending and participating in treatment planning activities and discharge planning;
  - Serving as a client advocate in treatment decisions;
  - Ensuring the above named Provider adhere to rules and regulations regarding all behavioral health treatment, such as group size, caseload and referrals; and
  - Assisting the Medical Director with the development and implementation of policies and procedures.

_____ _____ _____

Print Name of Clinical Supervisor | Signature of Clinical Supervisor | Date of Signature

_____ _____

Print Name of Authorized Representative | Title of Authorized Representative

_____ _____

Signature of Authorized Representative | Date of Signature

*Signature and date stamps, or the signature of anyone other than the provider or a person legally authorized to sign on behalf of a legal entity, are not acceptable*

**Complete this form in its entirety. Original Signatures Required – Please Do NOT Use Black Ink**

Please submit all required documentation to:
**Gainwell Provider Enrollment Unit**
**PO Box 80159**
**Baton Rouge, LA 70898-0159**
**225-216-6370**

# Mental Health Rehabilitation (MHR)
# Mental Health Supervisor Attestation

***PURPOSE***

This form confirms that I serve as the active Mental Health Supervisor of the below-named MHR agency, and attest to meeting the qualifications of the Mental Health Supervisor pursuant to La. R.S. 40:2162 and according to the Mental Health Rehabilitation Services section of the LA Medicaid Behavioral Health Services Manual.

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Individual Provider Name:** | | | | | | | | | | | | | | | | | | |
| **Individual Provider Number** | **LA Medicaid Provider Number:** | | | | | | | | **National Provider Identifier (NPI):** | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **MHR Name:** | | | | | | | | | | | | | | | | | | |
| **MHR Physical Address:** | | | | | | | | | | | | | | | | | | |
| **Contact person for questions regarding this form:** | | | | | | | | | | | | | | | | | | |
| **Contact Person Phone Number:** | ( ) - **EXT:** | | | | | | | | | | | | | | | | | |

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are:

- True and correct; and
- That I further certify that I comply with the responsibilities of a Mental Health Supervisor for MHRs as detailed in the Mental Health Rehabilitation Services section of the LA Medicaid Behavioral Health Services Manual including but not limited to:
    - Having a current license that is in good standing in the state of Louisiana to practice within the scope of all applicable state laws, practice acts, and the individual's professional license, as one of the following:
        - Licensed Physician;
        - Licensed Psychologist;
        - Licensed Clinical Social Worker (LCSW);
        - Licensed Professional Counselor (LPC);
        - Licensed Marriage and Family Therapist (LMFT); or
        - Licensed Advanced Practice Registered Nurse (APRN) in adult psychiatric and mental health, or family psychiatric and mental health, or a certified nurse specialists in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health, or child-adolescent mental health.
    - Being employed by the above named Provider for at least 35 (thirty-five) hours per week; and
    - Assisting in the design and evaluation of treatment plans for PSR and CPST services.

_____ _____ _____

Print Name of Mental Health Supervisor | Signature of Mental Health Supervisor | Date of Signature

_____ _____

Print Name of Authorized Representative | Title of Authorized Representative

_____ _____

Signature of Authorized Representative | Date of Signature

*Signature and date stamps, or the signature of anyone other than the provider or a person legally authorized to sign on behalf of a legal entity, are not acceptable*

**Complete this form in its entirety. Original Signatures Required – Please Do NOT Use Black Ink**

Please submit all required documentation to:
**Gainwell Provider Enrollment Unit**
**PO Box 80159**
**Baton Rouge, LA 70898-0159**
**225-216-6370**