The Georgia Collaborative ASO

GEORGIA COLLABORATIVE ASO
Behavioral Health Application for Existing Providers

Note: Information must be typed with all fields completed. If a field does not apply, indicate "NA". Handwritten applications will NOT be accepted.

Please return the following checklist and applicable documents to:
Georgia Collaborative Enrollment
P.O. Box 56324
Atlanta, GA 30343
OR
Email to: GA_Enrollment@beaconhealthoptions.com

Existing Provider Application Checklist:

- ☐ Complete Application Form
- ☐ Completed Service Location Addendum(s)
- ☐ Staffing Form for each service and site
- ☐ Current Resume of each staff listed on each Staffing Form
- ☐ Copy of each individual practitioner's state license/certificate as required based upon services requested
- ☐ Employment Attestations
- ☐ Evidence of two (2) most recent GA Collaborative Quality Assessment Report and/or ERO audit scores (score must be 80% and above to qualify)
- ☐ Copy of "DBA" or trade name Registration *(if applicable)*
- ☐ Copy of the Current Georgia Secretary of State Registration
- ☐ Copy of County/City Business license or permit for each site or documentation from municipality stating a Business license or permit is not required
- ☐ Copy of current Commercial General Liability or Comprehensive General Liability insurance certificate
- ☐ Accreditation Certificate/Award Letter
- ☐ Current Organizational Chart
- ☐ Drug Abuse Treatment and Education Program (DATEP) License *(Core Benefit Package & Substance Abuse applicants only)*
- ☐ Narcotics Treatment Program License *(Medication Assisted Treatment (MAT) applicants only)*
- ☐ DEA Controlled Substance Registration Certificate *(Medication Assisted Treatment (MAT) applicants only)*
- ☐ SAMSHA Opioid Treatment Provider Certification Letter *(Medication Assisted Treatment (MAT) applicants only)*
- ☐ ACT Narrative *(New ACT applicants only)*

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Details for Application Requirements	
Commercial General Liability Insurance	DBHDD requires providers to submit a certificate of insurance demonstrating the following types of insurance coverage: A. **Commercial General Liability Policy**: The Commercial General Liability Policy shall have dollar limits of $1,000,000 per incident and an annual aggregate limit of $3,000,000.00. B. **Business Auto Policy:** The Business Auto Policy shall include but not be limited to liability coverage on any owned, non-owned and hired vehicle used by Provider or Provider's personnel in the performance of services approved by DBHDD. C. **Workers Compensation Insurance:** The Workers Compensation Policy shall include coverage in the amounts of the statutory limits established by the General Assembly of the State of Georgia O.C.G.A. Section 33-9-40.1. D. **Commercial Umbrella Policy**: The Commercial Umbrella Policy must provide the same or broader coverage than those provided for in the above Commercial General Liability and Business Auto Policies. Each service location must be listed on the certificate. The certificate holder listed on the insurance certificate must be: **The State of Georgia** **Department of Behavioral Health & Developmental Disabilities** **Office of Provider Enrollment** **2 Peachtree Street NW, Suite 23-247** **Atlanta, GA 30303**
Staffing Form(s) *(Attachment A)*	Complete the appropriate Staffing Form(s) for the services and locations in this application. Staffing forms are located in Attachment A.
Current Organizational Chart	Provide a current Organizational Chart for the organization's Georgia Operations. The Organizational Chart must be labeled with the agency's name and demonstrate the minimum required staff as defined by each service definition. Additionally, the Organizational chart should clearly demonstrate a distinction of all services provided and clearly identify the lines of authority.
Copy of Professional License/Certificate	Provide a copy of Professional License/Certificate for all applicable staff. A copy of the actual license/certificate is required. **The Licensee Details page from the Secretary of State's website will not be accepted.**
Current Resume	Provide a current resume for each staff listed on the Staffing Form. Resumes should indicate current employment with the applicant agency.
Employment Attestation (*Attachment B)*	Provide an Employment Attestation form signed by each staff listed on the Staffing Form. Employment attestation forms are located in Attachment B.
ACT Narrative *(Attachment C)*	**Required for ACT Applicants ONLY**: Complete the ACT Narrative found in Attachment C.

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Select the description(s) from the following list that best describes this request.

☐ Current DBHDD Behavioral Health Provider applying for New Service at a New Site

☐ Current DBHDD Behavioral Health Provider applying for New Service at a Currently Established Site

I. GENERAL INFORMATION

A. Georgia Agency Information:

Agency Legal Name: _____

DBA/Trade Name: _____

Address: _____

City: _____ County: _____ State: _____ Zip Code (9 Digits): _____

Phone #: (___)_____ TAX ID#: _____

Mailing Address (if different): _____

City: _____ County: _____ State: _____ Zip Code (9 Digits): _____

Person completing this application / Title: _____

Phone: _____ Email: _____

B. Executive Leadership/Management

Chief Executive Officer: _____

Phone: _____ E-mail: _____

Behavioral Health Clinical Director *(Core Benefit Package Applicants)*: _____

Phone: _____ E-mail: _____

Agency Contact Name: _____ Title: _____

Phone: _____ E-mail: _____

C. Corporate Information

Please complete if agency is part of a corporate system:
Corporate Name: _____

Corporate Address: _____

City: _____ County: _____ State: _____ Zip Code (9 Digits): _____

Mailing Address *(if different)*: _____

City: _____ County: _____ State: _____ Zip Code (9 Digits): _____

D. Business Classification
Please Check only one box for Ownership and only one box for Status.

1. Ownership: ☐ Private ☐ Public ☐ Government Program

2. Status: ☐ For-Profit ☐ Not-for-Profit

E. Accreditation
This organization is accredited by one or more of the following:

☐ The Joint Commission (TJC)

Certificate No. _____ Effective Date:_____ Expiration Date:_____

☐ Commission on Accreditation of Rehabilitation Facilities (CARF)

Certificate No. _____ Effective Date:_____ Expiration Date:_____

☐ Council On Accreditation (COA)

Certificate No. _____ Effective Date:_____ Expiration Date:_____

☐ Council on Quality and Leadership (CQL)

Certificate No. _____Effective Date:_____ Expiration Date:_____

II. PROVIDER PROFILE QUESTIONS

PLEASE ATTACH A DETAILED EXPLANATION FOR ANY QUESTIONS BELOW THAT WERE ANSWERED "YES"

A. Please answer the following questions regarding your organization's **programs:**

1. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had its professional liability or malpractice insurance refused, revoked, declined or accepted on special terms in the past five (5) years? ◯ Yes ◯ No

2. Has any government agency suspended, revoked, or taken other action against the organization's license to practice or to conduct business in the past five years, or taken such an action in the past five years against any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee? (To include Medicaid /Medicare) ◯ Yes ◯ No

3. Have any accreditations or memberships in professional organizations been revoked, reduced, denied, or suspended by others or voluntarily given up by the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, in the past five years, or are any actions now under way which may lead to such sanctions? ◯ Yes ◯ No

4. Has any Owner, Managing Employee, officer, or shareholder of the organization **ever** been convicted of a crime, excluding minor traffic misdemeanors? ◯ Yes ◯ No

5. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, **ever** been previously denied acceptance into, disenrolled from, or withdrawn from GA DBHDD or GA Collaborative ASO network participation? ◯ Yes ◯ No

6. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had any settled claims or judgments relating to sexual misconduct or civil rights violations in the past five years? If **Yes**, enter the total number: _____ ◯ Yes ◯ No

7. In the past five years, has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had any settled claims or judgments relating to any other matter not disclosed in the response to Question 6 above? If **Yes**, enter the total number: _____ ◯ Yes ◯ No

8. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, been a defendant in five (5) or more lawsuits within the **past five (5) years?** If **Yes**, enter the total number: _____ ◯ Yes ◯ No

9. Does the organization hire, continue to employ, or contract with individuals listed on the Office of Inspector General's List of Excluded Individuals/Entities (to include owners, officers, employees, subcontractors, and others identified in §1128)? ◯ Yes ◯ No

10. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, filed for Bankruptcy in the past five years? ◯ Yes ◯ No

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III. SERVICE LOCATION ADDENDUM
Complete one page per service location.

A. Service Location:

Site Name:_____

Address Line 1: _____

Address Line 2: _____

City, State, ZIP (9 Digit): _____

Phone Number: _____

B. Billing Address:
(Please confer with your Billing Dept.)

Address Line 1: _____

Address Line 2: _____

City, State, Zip (9 Digit): _____

Phone Number: _____

Community Behavioral Health Rehabilitation Service (CBHRS)/Medicaid Rehab Option (MRO) Number (list only the numeric not the alpha part of the number):

_____

C. Counties Requested:
Counties requested must be within a 50 mile radius of the service location. Only counties that are approved are eligible for service.

D. Accessibility:
This service location is:

☐ Yes ☐ No - Accessible by Public Transportation

☐ Yes ☐ No - Americans with Disabilities Act Compliant

E. Healthcare Facility Regulation (HFR) Permits/Licenses:
This site is licensed by Healthcare Facility Regulation (HFR) as a (include a copy of the license:)

☐ Drug Abuse Treatment and Education Program (DATEP) License:

Permit No. _____ Effective Date: _____ Expiration Date: _____

☐ Narcotics Treatment Program (NTP) License:

Permit No. _____ Effective Date: _____ Expiration Date: _____

☐ Not Required

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F. Services Requested Grid
Select the services and applicable age group being requested.

SERVICES REQUESTED AT LOCATION *(PLEASE SELECT APPLICABLE AGE GROUP)*	CHILD & ADOL (4-17)	ADULT (18+)
CORE BENEFIT PACKAGE		
SUBSTANCE ABUSE INTENSIVE OUTPATIENT (SAIOP)		
AMBULATORY SUBSTANCE ABUSE DETOXIFICATION		
ASSERTIVE COMMUNITY TREATMENT (ACT)		
COMMUNITY SUPPORT TEAM (CST)		
INTENSIVE CASE MANAGEMENT (ICM) *(Must be an approved Adult Core Benefit Package provider)*		
INTENSIVE CUSTOMIZED CARE COORDINATION (IC3) *[Must be deemed a Care Management Entity via Community Based Alternatives for Youth (CBAY) and Children's Health Insurance Program Reauthorization Act (CHIPRA)]*		
INTENSIVE FAMILY INTERVENTION (IFI)		
MEDICATION ASSISTED TREATMENT (MAT)		
MENTAL HEALTH PEER SUPPORT PROGRAM		
ADDICTIVE DISEASES PEER SUPPORT PROGRAM		
PEER SUPPORT WHOLE HEALTH AND WELLNESS *(Groups and Individual)*		
PARENT PEER SUPPORT *(Group and Individual)* *(Must be a* Tier I, Tier II+, or has *3 or more years providing Parent/Youth Peer support through a Medicaid mechanism (e.g. CBAY etc.)*		
YOUTH PEER SUPPORT *(Group and Individual)* *(Must be a* Tier I, Tier II+, or has *3 or more years providing Parent/Youth Peer support through a Medicaid mechanism (e.g. CBAY etc.)*		
PSYCHOSOCIAL REHABILITATION PROGRAM		
TASK ORIENTED REHABILITATION SERVICES (TORS) *(Must be state funded Supported Employment provider)*		

Attestation Statement:
My signature below indicates that all of the information provided above, and in any attachments to this application document, is complete and correct to the best of my knowledge.

Name: _____ Title: _____

Signature: _____ Date: _____

IV. PARTICIPATION STATEMENT

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) requires that services be provided according to the service guidelines and that the agency will operate in accordance with applicable standards, rules and regulations and policies.

By signing below, I hereby certify and attest that my staff, agents, contractors, subcontractors, billing agent(s) and I have reviewed and agree to comply with the terms and conditions set forth in the applicable DBHDD and Department of Community Health (DCH)/ Medicaid Provider manuals.

I understand and acknowledge that the policies and procedures manuals are amended (generally on a quarterly basis) when either Department finds it necessary or appropriate to do so, and that it is my responsibility to check periodically for any revisions pertaining to the delivery of or reimbursement for services rendered to eligible individuals.

I further understand that failure to abide by either Department's (DBHDD or DCH) policies and procedures will result in adverse actions including, but not limited to the denial of claims, monetary recoupment, termination, suspension of payments, and reduction of reimbursement.

I certify and attest that I have reviewed the entire contents of the completed application and that the information provided is accurate and complete. I understand that inaccurate, incomplete or omitted data may lead to sanctions against me.

Under applicable state and federal laws, I do hereby affirm that I am the authorized agent to complete this document and that the information contained herein this document is complete, true, and correct to the best of my knowledge. I understand that material misrepresentation and/or falsification of any information contained herein shall result in the immediate removal of further consideration for participation.

_____
Agency Name

_____ Date (mm/dd/yy): _____/_____/_____
Authorized Signature

_____
Name (Please Print)

_____
Title

IV. Application Attachments

This section contains additional documents required to submit the application. Review each attachment and submit all applicable documentation.

Attachment A: **Staffing Forms**

Attachment B: **Employment Attestation Form**

Attachment C: **ACT Narrative** *(ACT Applicants Only)*

Attachment A:

Behavioral Health Services
STAFFING FORM

Complete the appropriate Staffing Form(s) for each service and location.

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STAFFING FORM: ADULT CORE BENEFIT PACKAGE

Complete an Adult Core Staffing Form for each Adult Core location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		**County:**		**State:**		**Zip:**	
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
AM							
PM							
By Appt.							

NOTE: Positions indicated with an asterisk (*) below are the minimum staffing requirements for this service. All positions listed with an asterisk must have staff names in addition to the applicable licenses or certificates. "To Be Hired" (TBH) and any other notation which shows a failure to properly staff ready and qualified personnel will not be accepted. Include a copy of all applicable licenses or certificates, a current resume and list the number of hours worked per week in this service for each staff member listed.

Position Title	Name	License/Certificate Type, Number and Expiration Date	Number of Hours Per Week
Clinical Director* *(Minimum one per agency) Must be fulltime position*			
Physician* *Must be on site to provide direct services a minimum of 10 hours weekly per site.*			
Physician's Assistant; Advanced Practice RN; Clinical Nurse Specialist; or Nurse Practitioner			
Psychologist			
Registered Nurse (RN)* *Must be on site to provide direct services a minimum of 10 hours weekly per site.*			
Licensed Professional Nurse (LPN)			
Licensed Clinicians* *(LCSW, LPC, LMFT) May be part-time or full-time position*			
Associate Licensed Clinicians *(LMSW, LAPC, LAMFT)*			
Addiction Practitioner* *(MAC, CACII, CADC, CCADC, GCADC II, GCADC III)May be part-time or full-time*			
Certified Peer Specialists* *Minimum 2 Full Time Equivalent (FTE) agency-wide*			
Paraprofessional(s)* *May be part-time or full-time position*			

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STAFFING FORM: C&A CORE BENEFIT PACKAGE

Complete a C&A Core Staffing Form for each C&A Core location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		**County:**		**State:**		**Zip:**	

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
AM							
PM							
By Appt.							

NOTE: Positions indicated with an asterisk (*) below are the minimum staffing requirements for this service. All positions listed with an asterisk must have staff names in addition to the applicable licenses or certificates. "To Be Hired" (TBH), and any other notation which shows a failure to properly staff ready and qualified personnel will not be accepted. Include a copy of all applicable licenses or certificates, a current resume and list the number of hours worked per week in this service for each staff member listed.

Position Title	**Name**	**License / Certificate Type, Number and Expiration Date**	**Number of Hours Per Week**
Clinical Director* *(Minimum one per agency) Must be full time position*			
Physician* *Must be on site to provide direct services a minimum of 10 hours weekly per site.*			
Physician's Assistant; Advanced Practice RN; Clinical Nurse Specialist; or Nurse Practitioner			
Psychologist			
Registered Nurse (RN)* *Must be on site to provide direct services a minimum of 10 hours weekly per site.*			
Licensed Professional Nurse (LPN)			
Licensed Clinicians* *(LCSW, LPC, LMFT) May be part-time or full-time position*			
Associate Licensed Clinicians *(LMSW, LAPC, LAMFT)*			
Addiction Practitioner * *(MAC, CACII, CADC, CCADC, GCADC II, III) May be part-time or full-time position*			
Paraprofessional(s)* *May be part-time or full-time position*			

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STAFFING FORM: SUBSTANCE ABUSE INTENSIVE OUTPATIENT (SAIOP) SERVICES

Complete a SAIOP Staffing Form for each SAIOP location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		**County:**		**State:**		**Zip:**	
Population:		☐ **Adult**		☐ **Child & Adolescent**			

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
PM							
By Appt.							

NOTE: Positions indicated with an asterisk (*) below are the minimum staffing requirements for this service. All positions listed with an asterisk must have staff names in addition to the applicable licenses or certificates. "To Be Hired" (TBH), and any other notation which shows a failure to properly staff ready and qualified personnel will not be accepted. Include a copy of all applicable licenses or certificates, a current resume and list the number of hours worked per week in this service for each staff member listed.

Position title	Name	License / Certificate Type, Number and Expiration Date	Number of Hours Per Week
Clinical Supervisor*			
Physician, Registered Nurse (RN), or LPN with Supervision*			
Physician's Assistant; Advanced Practice RN; Clinical Nurse Specialist; or Nurse Practitioner			
Psychologist			
Licensed Professional Nurse (LPN)			
Licensed Clinicians*[1] *(LCSW, LPC, LMFT, CACII, GCADC-II, MAC)*			
Associate Clinicians*[1] *(LMSW, LAPC, LAMFT, CACI with BS, CADC, CPS-AD with BS, ACT with supervision)*			
Paraprofessional(s)[1] *(CACI without BS, CPS-AD without BS)*			

1-Service must be provided by Licensed Clinicians, Associate Clinicians OR Paraprofessionals with supervision. Applicants are not required to have all three types of staff.

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STAFFING FORM: AMBULATORY SUBSTANCE ABUSE DETOXIFICATION

Complete an Ambulatory Substance Abuse Detoxification Staffing Form for each Ambulatory Substance Abuse Detoxification location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Please note that this service is also covered by Drug Abuse Treatment Programs Rule 290-4-2. Reflect all the required staff on the above form. Please refer to the DBHDD Provider Manual Service Guidelines for Staffing Requirements.

Site Address:							
City:		**County:**		**State:**		**Zip:**	
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
AM							
PM							
By Appt.							

NOTE: Positions indicated with an asterisk (*) below are the minimum staffing requirements for this service. All positions listed with an asterisk must have staff names in addition to the applicable licenses or certificates. "To Be Hired" (TBH), and any other notation which shows a failure to properly staff ready and qualified personnel will not be accepted. Include a copy of all applicable licenses or certificates and a current resume, and list the number of hours worked per week in this service, for each staff member listed.

Position Title	**Name**	**License / Certificate Type, Number and Expiration Date**	**Number of Hours Per Week**
Medical Doctor /Psychiatrist*			
On-call Physician			
Physician's Assistant			
Nursing Staff: **Clinical Nurse Specialist*** **Registered Nurse (RN)*** **Licensed Practical Nurse (LPN)***			
Other			

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STAFFING FORM: ASSERTIVE COMMUNITY TREATMENT (ACT)

Complete an ACT Staffing Form for each ACT location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		**County:**		**State:**		**Zip:**	
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
AM							
PM							
By Appt.							

NOTE: Positions indicated with an asterisk (*) below are the minimum staffing requirements for this service. All positions listed with an asterisk must have staff names in addition to the applicable licenses or certificates. "To Be Hired" (TBH), and any other notation which shows a failure to properly staff ready and qualified personnel will not be accepted. Include a copy of all applicable licenses or certificates and a current resume, and list the specific days and hours worked in this service, for each staff member listed.

Position Title	Name	License / Certificate Type, Number and Expiration Date	Number of Hours Per Week
Team Leader * *Must be a full time employee (Physician, Psychologist, Physicians' Assistant, APRN, RN with 4 year BSN, LCSW, LPC, LMFT, LMSW, LAPC, LAMFT)*[1]			
Psychiatrist*			
Registered Nurse (RN)*			
Licensed Clinicians* *(LCSW, LPC, LMFT)*			
Associate Clinicians* *(LMSW, LAPC, LAMFT)*			
Addiction Practitioner* *(CACI, MAC, CACII, CADC, CCADC, GCADC II, GCADC III)*			
Certified Peer Specialist*			
Vocational Rehabilitation Specialist*			
Paraprofessional(s)*			
Other			

1- *If the team lead is not independently licensed, then clinical supervision duties should be delegated appropriately with expectations set forth in O.C.G.A. Practice Acts.*

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STAFFING FORM: COMMUNITY SUPPORT TEAM (CST)

Complete a CST Staffing Form for each CST location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		**County:**		**State:**		**Zip:**	

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
PM							
By Appt.							

NOTE: Positions indicated with an asterisk (*) below are the minimum staffing requirements for this service. All positions listed with an asterisk must have staff names in addition to the applicable licenses or certificates. "To Be Hired" (TBH), and any other notation which shows a failure to properly staff ready and qualified personnel will not be accepted. Include a copy of all applicable licenses or certificates and a current resume, and list the number of hours worked per week in this service, for each staff member listed.

Position Title	Name	License / Certificate Type, Number and Expiration Date	Number of Hours Per Week
Team Leader * *Must be full time and dedicated to one team*			
Psychiatrist			
Registered Nurse (RN)*			
Licensed Clinicians *(LCSW, LPC, LMFT)*			
Associate Clinicians *(LMSW, LAPC, LAMFT)*			
Addiction Practitioner *(CACI, MAC, CACII, CADC, CCADC, GCADC II, GCADC III)*			
Certified Peer Specialist*			
Paraprofessional(s)*			
Other			

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STAFFING FORM: INTENSIVE CASE MANAGEMENT (ICM) SERVICES

Complete an ICM Staffing Form for each ICM location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		County:		State:		Zip:	
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
PM							
By Appt.							

NOTE: Positions indicated with an asterisk (*) below are the minimum staffing requirements for this service. All positions listed with an asterisk must have staff names in addition to the applicable licenses or certificates. "To Be Hired" (TBH), and any other notation which shows a failure to properly staff ready and qualified personnel will not be accepted. Include a copy of all applicable licenses or certificates and a current resume, and list the number of hours worked per week in this service, for each staff member listed.

Position Title	Name	License / Certificate Type, Number and Expiration Date	Number of Hours Per Week
Licensed Supervisor *			
Case Manager*			
Case Manager*			
Case Manager*			
Case Manager*			
Case Manager*			
Case Manager*			
Case Manager*			
Case Manager*			
Case Manager*			
Case Manager*			
Case Manager*			
Other			

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STAFFING FORM: INTENSIVE CUSTOMIZED CARE COORDINATION (IC3)

Complete an ICM Staffing Form for each ICM location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		**County:**		**State:**		**Zip:**	
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
AM							
PM							
By Appt.							

NOTE: Positions indicated with an asterisk (*) below are the minimum staffing requirements for this service. All positions listed with an asterisk must have staff names in addition to the applicable licenses or certificates. "To Be Hired" (TBH), and any other notation which shows a failure to properly staff ready and qualified personnel will not be accepted. Include a copy of all applicable licenses or certificates and a current resume, and list the number of hours worked per week in this service, for each staff member listed.

Position Title	**Name**	**License / Certificate Type, Number and Expiration Date**	**Number of Hours Per Week**
Program Director*			
Licensed Clinician* *(LPC, LMFT, LCSW)*			
Wraparound Supervisor* *(1 PER 6 Care Coordinators)* ☐ Licensed *(LPC, LMFT, LCSW)* ☐ Unlicensed			
Care Coordinators* ☐ Licensed *(LPC, LMFT, LCSW)* ☐ Unlicensed			
Certified Peer Specialist – Parent *(CPS-P)*			
Other			

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STAFFING FORM: INTENSIVE FAMILY INTERVENTION

Complete an IFI Staffing Form for each IFI location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		**County:**		**State:**		**Zip:**	
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
AM							
PM							
By Appt.							

NOTE: Positions indicated with an asterisk (*) below are the minimum staffing requirements for this service. All positions listed with an asterisk must have staff names in addition to the applicable licenses or certificates. "To Be Hired" (TBH), and any other notation which shows a failure to properly staff ready and qualified personnel will not be accepted. Include a copy of all applicable licenses or certificates and a current resume, and list the number of hours worked per week in this service, for each staff member listed.

Position Title	**Name**	**License / Certificate Type, Number and Expiration Date**	**Number of Hours Per Week**
TEAM NUMBER:	#:_____		
Team Leader* Licensed Clinician *(LCSW, LPC, LMFT)*			
Paraprofessional*			
Paraprofessional*			
Paraprofessional			

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STAFFING FORM: MEDICATION ASSISTED TREATMENT (MAT)

Complete a Medication Assisted Treatment (MAT) Staffing Form for each Medication Assisted Treatment (MAT) location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Include a copy of the following for each site:

- Opioid Treatment Program Certificate issued by SAMSHA
- Controlled Substance Registration Certificate issued by DEA

Site Address:							
City:		**County:**		**State:**		**Zip:**	

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
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By Appt.							

NOTE: Positions indicated with an asterisk (*) below are the minimum staffing requirements for this service. All positions listed with an asterisk must have staff names in addition to the applicable licenses or certificates. "To Be Hired" (TBH), and any other notation which shows a failure to properly staff ready and qualified personnel will not be accepted. Include a copy of all applicable licenses or certificates, a current resume list the number of hours worked per week in this service for each staff member listed.

Position Title	**Name**	**License / Certificate Type, Number and Expiration Date**	**Number of Hours Per Week**
Program Physician*			
Clinical Director* *(CACII, CADCII, MAC, LPC, LCSW, LMFT, CAS with Bachelor's degree)*			
Physician's Assistant; Advanced Practice RN;			
Psychologist			
Nurse* **Registered Nurse (RN) or** **Licensed Professional Nurse (LPN)**			
Licensed/ Certified Practitioner* *(LPC, LCSW, LMFT, CACII, CACI, CADCII, CADCI, MAC, CAS with Bachelor's degree)*			
Associate Licensed Clinicians *(LMSW, LAPC, LAMFT)*			
Addiction Practitioner(s) *(CACII, CADCII, CCADCI, CAS)*			
Paraprofessional(s)			

GEORGIA COLLABORATIVE ASO
Behavioral Health Application for Existing Providers

STAFFING FORM: MENTAL HEALTH PEER SUPPORT PROGRAM

Complete a Peer Support Mental Health Services Staffing Form for each Peer Support Mental Health Services location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		**County:**		**State:**		**Zip:**	
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
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By Appt.							

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Position Title	**Name**	**License / Certificate Type, Number and Expiration Date**	**Number of Hours Per Week**
Program Leader *			
Certified Peer Specialist*			
Certified Peer Specialist*			
Certified Psychiatric Rehabilitation Professional (CPRP)			
Licensed Clinicians *(LCSW, LPC, LMFT)*			
Associate Clinicians *(LMSW, LAPC, LAMFT)*			
Other			

GEORGIA COLLABORATIVE ASO
Behavioral Health Application for Existing Providers

STAFFING FORM: ADDICTIVE DISEASES PEER SUPPORT PROGRAM

Complete an Addictive Diseases Peer Support Services Staffing Form for each Addictive Diseases Peer Support Services location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		**County:**		**State:**		**Zip:**	
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
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By Appt.							

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Position Title	**Name**	**License / Certificate Type, Number and Expiration Date**	**Number of Hours Per Week**
Supervisor* *(LPC, LMFT, LCSW, MAC, CACII, GCADCII,III)*			
Program Leader * *Certified Peer Specialist - AD (CPS-AD)*			
Certified Peer Specialist *Certified Peer Specialist - AD (CPS-AD)*			
Certified Psychiatric Rehabilitation Professional (CPRP)			
Certified Peer Specialist (CPS)			
Addiction Practitioner *(CACI, MAC, CACII, CADC, GCADC, GCADC II, GCADC III)*			
Other			

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Behavioral Health Application for Existing Providers

STAFFING FORM: PEER SUPPORT – WHOLE HEALTH AND WELLNESS

i. Peer Support – Whole Health and Wellness - Groups

ii. Peer Support - Whole Health and Wellness - Individuals

Complete a Peer Support – Whole Health and Wellness Services Staffing Form for each Peer Support Whole Health and Wellness Services location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		**County:**		**State:**		**Zip:**	
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
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Position Title	**Name**	**License / Certificate Type, Number and Expiration Date**	**Number of Hours Per Week**
Whole Health and Wellness Coach* *(CPS Whole Health Action Management (WHAM) Certified)* (CPS -WH)			
Whole Health and Wellness Coach *(CPS Whole Health Action Management (WHAM) Certified)* (CPS -WH)			
Registered Nurse (RN)*			
Licensed Clinician *(LCSW, LPC, LMFT)*			
Certified Peer Specialist *Whole Health Action Management (WHAM) Certified* (CPS -WH)			
Other			

GEORGIA COLLABORATIVE ASO
Behavioral Health Application for Existing Providers

STAFFING FORM: YOUTH PEER SUPPORT

i. Youth Peer Support - Groups
ii. Youth Peer Support - Individual

Complete a Youth Peer Support Staffing Form for each Youth Peer Support location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is also your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		**County:**		**State:**		**Zip:**	
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
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Position Title	**Name**	**License / Certificate Type, Number and Expiration Date**	**Number of Hours Per Week**
Certified Peer Specialist-Youth* *(CPS-Y)*			
Supervising Licensed Clinician* *(LCSW, LPC, LMFT)*			
Associate Clinicians *(LMSW, LAPC, LAMFT)*			
Other (*List Title)***:**			

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Behavioral Health Application for Existing Providers

STAFFING FORM: PARENT PEER SUPPORT

i. Parent Peer Support - Groups

ii. Parent Peer Support - Individual

Complete a Parent Peer Support Staffing Form for each Parent Peer Support location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is also your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		**County:**		**State:**		**Zip:**	
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
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By Appt.							

NOTE: Positions indicated with an asterisk (*) below are the minimum staffing requirements for this service. All positions listed with an asterisk must have staff names in addition to the applicable licenses or certificates. "To Be Hired" (TBH), and any other notation which shows a failure to properly staff ready and qualified personnel will not be accepted. Include a copy of all applicable licenses or certificates and a current resume, and list the number of hours worked per week in this service, for each staff member listed.

Position Title	**Name**	**License / Certificate Type, Number and Expiration Date**	**Number of Hours Per Week**
Certified Peer Specialist-Parent* *(CPS-P)*			
Supervising Licensed Clinician* *(LCSW, LPC, LMFT)*			
Associate Clinicians *(LMSW, LAPC, LAMFT)*			
Other			

GEORGIA COLLABORATIVE ASO
Behavioral Health Application for Existing Providers

STAFFING FORM: PSYCHOSOCIAL REHABILITATION (PSR) Program

Complete a Psychosocial Rehabilitation Services Staffing Form for each Psychosocial Rehabilitation Services location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		**County:**		**State:**		**Zip:**	
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
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By Appt.							

NOTE: Positions indicated with an asterisk (*) below are the minimum staffing requirements for this service. All positions listed with an asterisk must have staff names in addition to the applicable licenses or certificates. "To Be Hired" (TBH), and any other notation which shows a failure to properly staff ready and qualified personnel will not be accepted. Include a copy of all applicable licenses or certificates and a current resume, and list the number of hours worked per week in this service, for each staff member listed.

Position Title	**Name**	**License / Certificate Type, Number and Expiration Date**	**Number of Hours Per Week**
Program Supervisor* Certified Psychiatric Rehabilitation Practitioner (CPRP)			
Clinical Supervisor* *(LCSW, LPC, LMFT)*			
Certified Psychiatric Rehabilitation Practitioner*			
Licensed Clinicians *(LCSW, LPC, LMFT)*			
Associate Licensed Clinicians *(LMSW, LAPC, LAMFT)*			
Certified Peer Specialist			
Addiction Practitioner *(CACI, MAC, CACII, CADC, CCADC, GCADC II, GCADC III)*			
Other			

GEORGIA COLLABORATIVE ASO
Behavioral Health Application for Existing Providers

STAFFING FORM: TASK ORIENTED REHABILITATION SERVICES (TORS)

Complete a Task Oriented Rehabilitation Services Staffing Form for each Task Oriented Rehabilitation Services location. Duplicate as needed. It is your duty to read the DBHDD Provider Manual Service Guidelines for Staffing Requirements. It is your responsibility and duty to fully adhere to the requirements of the DBHDD Provider Manual Service Guidelines.

Site Address:							
City:		**County:**		**State:**		**Zip:**	
	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
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NOTE: Positions indicated with an asterisk (*) below are the minimum staffing requirements for this service. All positions listed with an asterisk must have staff names in addition to the applicable licenses or certificates. "To Be Hired" (TBH), and any other notation which shows a failure to properly staff ready and qualified personnel will not be accepted. Include a copy of all applicable licenses or certificates and a current resume, and list the number of hours worked per week in this service, for each staff member listed.

Position Title	**Name**	**License / Certificate Type, Number and Expiration Date**	**Number of Hours Per Week**
Program Supervisor* *(LPC, LCSW, LMFT, Physician, Psychologist or CPRP)*			
Employment Specialist*			
Certified Psychiatric Rehabilitation Practitioner			
Licensed Clinicians *(LCSW, LPC, LMFT)*			
Associate Licensed Clinicians *(LMSW, LAPC, LAMFT)*			
Certified Peer Specialist			
Paraprofessional			
Other			

Attachment B:

Behavioral Health Employment Attestation

Each staff member listed on the Staffing form must complete an Employment Attestation.

Name			
Phone		**Email**	
License Number *(if applicable)*		**Expiration Date**	
Certificate number *(if applicable)*		**Expiration Date**	
Hire Date			
Position		**Service**	
Service location			

Select one:

☐ I have a written contract with the agency and work the following number of hours per week in this position.

☐ I am an employee of the agency and work the following number of hours per week in this position.

Indicate specific hours worked in this position in the grid below.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
PM							
By Appt.							

I, hereby attest that I am employed in the position listed above.

Signature: _____ **Date:** _____

GEORGIA COLLABORATIVE ASO
Behavioral Health Application for Existing Providers

Attachment C:

Assertive Community Treatment (ACT) Narrative

(ACT Applicants Only)

In addition to the required application, the following narratives must be submitted. These elements will assist the GA Collaborative ASO and DBHDD staff with understanding the agency's service philosophy and practice. It will provide insight and assist in tailoring technical support to your agency.

1. Narrative that describes the agency's philosophical approach for providing services to behavioral health consumers. The narrative will, at a minimum, enumerate: **(Limit 5 pages**)
    a. The evidenced based practices that the agency utilizes in the provision of behavioral health services.
    b. The agency's mission statement, vision, and values.
    c. A description of the strategies used to treat ACT consumers with co-occurring disorders.
    d. A description on how the team measures readiness for treatment.
    e. The types of treatment offered and frequency of each treatment offered.

2. A plan that illustrates how ACT service delivery and crisis intervention services are available 24 hours a day, 365 days a year for ACT consumers. **(Limit 1 page)**

3. A description of: **(Limit 5 pages)**
    a. The characteristics of the target population for ACT services.
    b. Barriers to engagement.
    c. How the agency plans to effectively address each barrier.
    d. Identify past accomplishments that illustrates effective management of these barriers.

4. A description of the agency's methodology for determining when an ACT consumer is ready for discharge and how the agency effectively transitions consumers to a lesser intensive service. **(Limit 2 pages)**

5. A description of the model for delivering ACT services for the following five populations, those who have: **(Limit 5 pages)**
    a. Long term hospitalization(s) in a state psychiatric facility
    b. Frequent hospitalization (3 or more times) in the last twelve months in a state psychiatric facility
    c. Chronic homelessness and SPMI;
    d. Chronic incarceration due to the effects of their mental illness; and
    e. Frequent utilization of emergency rooms for psychiatric treatment.

6. A plan to manage medical needs for those with co-morbidities, including primary care, dental needs, co-occurring mental illness and substance use disorder. **(Limit 2 pages)**

7. A copy of the agency's Quality Improvement Plan which includes, at a minimum the following elements:
    a. Policies and procedures for consumer complaints, grievances and appeals.
    b. Utilization management and review;
    c. A description on how the agency measures and analyzes consumer outcomes, which must include number of hospitalizations, incarcerations, episodes of homelessness, and employment.
    d. The frequency of data collection, data analysis techniques utilized and evaluation results are distributed and shared with consumers and other stakeholders.

8. A description of the agency's Management Information System (MIS) to include HIPAA compliance and authorization process (batch filing or ERO website). **(Limit 5 pages)**

9. If the agency utilizes an Electronic Health Record (EHR), please describe it. **(Limit 3 pages**)

In order to bill ACT services the ACT team must be fully staffed.