COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
BUREAU OF CHILDREN'S BEHAVIORAL HEALTH SERVICES

## Verification of Responsibilities

I understand that when I provide Behavioral Health Rehabilitation Services (BHRS) I must comply with both the Pennsylvania Board of Psychology's licensing requirements and the requirements that govern participation in the Pennsylvania Medical Assistance Program and provision of BHRS. I also understand that I am fully responsible for any services billed under my Medical Assistance provider number. By signing the attached service description, I accept responsibility for the following services to be billed using my Medical Assistance provider number:

- ☐ Evaluations
- ☐ MT
- ☐ BSC
- ☐ TSS

_____
Psychologist Signature

_____
Psychologist Printed Name

_____
Date

_____
Psychologist License Number