

Requirements for Provider Type 11 – Mental Health/Substance Abuse Services

Specialty Code

Please choose from the following for specialty and code:

- 076 Peer Support Services (see Addendum information on page 3)
- 113 Partial Psychiatric Hospitalization (Children)
- 114 Partial Psychiatric Hospitalization (Adults)
- 115 Family Based Mental Health Services
- 118 Mental Health Crisis Intervention
- 421 Autism Social Worker
- 422 Autism Marriage and Family Therapist
- 423 Autism Professional Counselor
- 424 Autism Counseling Agency
- 442 Partial Psychiatric Hospitalization Children Therapeutic Staff Support
- 443 Partial Psychiatric Hospitalization Children Mobile Therapy
- 444 Partial Psychiatric Hospitalization Children Behavioral Specialist Consultant
- 445 Partial Psychiatric Hospitalization Children Summer Therapeutic Activity Program
- 446 Partial Psychiatric Hospitalization Adult Therapeutic Staff Support
- 447 Partial Psychiatric Hospitalization Adult Mobile Therapy
- 448 Partial Psychiatric Hospitalization Adult Behavioral Specialist Consultant
- 449 Partial Psychiatric Hospitalization Adult Summer Therapeutic Activity Program
- 450 Family Based Mental Health Therapeutic Staff Support
- 451 Family Based Mental Health Mobile Therapy
- 452 Family Based Mental Health Behavioral Specialist Consultant
- 453 Family Based Mental Health Summer Therapeutic Activity Program
- 548 Therapeutic Staff Support
- 549 Mobile Therapy
- 558 Behavior Specialist for Children with Autism
- 559 Behavioral Specialist Consultant
- 561 Entity BSC - ASD
- 562 Entity TSS

Provider Eligibility Program (PEP)

- Fee-for-Service
- Adult Autism Waiver

Required Documents for Provider Type 11:

The following documents and supporting information are required by the Bureau of Fee-For-Service Programs to enroll as a provider (please ensure all documents are legible):

- Completed application for the enrollment of a Facility/Agency—application must include:
 - Signed Outpatient Provider Agreement with original signature of an authorized representative; and
 - Copy of Ownership or Control Interest Disclosure form
- Copy of DHS Certificate of Compliance
- Documentation generated by the IRS showing both the Provider's legal name and FEIN—documentation must come from the IRS; this Department does not accept W-9s
- If Provider is tax-exempt, submit IRS 501 (c)(3) letter confirming this status
- If application is for an Out-of-State Provider, submit proof of current home state Medicaid participation

- Copy of Corporation papers issued by Department of State Corporation Bureau or business partnership agreement
- If Provider operates under a fictitious name, submit copy of D/B/A filing with Department of State Corporation Bureau

Partial Hospitalization (113/114) providers must submit a statement signed by the Medical Director indicating its affiliation with the facility. The Medical Director must be a physician currently participating with Pennsylvania Medicaid and a copy of DOS license must accompany letter.

Family Based Mental Health Services (115) and Mental Health Crisis Intervention (118) must submit a letter from County denoting its intent to support the program under county funding and/or MA Fee-for-Service funding.

Specialties 421 through 424 must also submit a copy of the provider's SPeCTRUM training certificate and a copy of the applicable Title 49 license.

Specialties 442 through 559 and 561/562 must submit a service description which has been approved by the Bureau of Children's Behavioral Health Services in OMHSAS. For further information, contact the Bureau at (717)705-8289.

Mental Health/Substance Abuse Services Providers (11) are encouraged to apply online via our Electronic Provider Portal at <https://provider.enrollment.dpw.state.pa.us>. If circumstances do not allow online submission, send application and documents to:

**DHS Provider Enrollment
PO Box 8045
Harrisburg, PA 17105-8045
Fax: (717) 265-8284
E-mail: RA-ProvApp@pa.gov**

ADDENDUM – PEER SUPPORT SERVICES (Specialty 076)

In addition to all the above-listed requirements, providers requesting peer support services must submit their application to the OMHSAS Field Office along with:

- Copy of the Certificate of Compliance (as applicable)
- Copy of the peer support service description
- Signed supplemental provider agreement for peer support services
- Copy of the subcontract agreement (for subcontracted providers only)

Submit the information to the appropriate OMHSAS Field Office:

OMHSAS - Scranton Field Office
Scranton State Office Bldg
100 Lackawanna Avenue, Room 321
Scranton PA 18503-1939

OMHSAS - Pittsburgh Field Office
301 5th Avenue, Suite 480
Pittsburgh PA 15222

OMHSAS – Southeast Field Office
Norristown State Hospital
1001 Sterigere Street, Bldg. #48
2nd Floor Room 208
Norristown PA 19401

OMHSAS – Harrisburg Field Office
Commonwealth Tower – 12th Floor
PO Box 2675
Harrisburg PA 17105-2675

**PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
SUPPLEMENTAL PROVIDER AGREEMENT FOR THE
DELIVERY OF PEER SUPPORT SERVICES**

This Supplemental Provider Agreement sets forth the responsibilities of the peer support services provider (Provider), which are in addition to those set forth in the Medical Assistance Outpatient Provider Agreement and addendums to that agreement, and the Provider handbooks and supplements.

The Provider agrees to deliver services in accordance with the service description approved by the Office of Mental Health and Substance Abuse Services (OMHSAS) and the revised Peer Support Standards found in the provider handbook.

The Provider agrees to deliver services to individuals who meet all eligibility criteria including, age requirements, presence or history of serious mental illness (SMI) or serious emotional disturbance (SED) that results in a functional impairment, a written recommendation from a licensed practitioner of the healing arts (LPHA), and chooses to receive Peer Support.

I hereby agree to comply with the terms of the Peer Support Services Bulletin, the Medical Assistance Provider Handbook, and all requirements that govern participation in the Medical Assistance Program:

Provider Name (please type or print)

Provider signature

Date

Provider Address (please type or print)