Banner Plan Administration

Instructions on Submitting Behavioral Health Program Questionnaire

Dear Behavioral Health Provider:
Many Members contact Banner and request specific types of outpatient behavioral health services. The more information you submit to Banner about the services you provide, the better we can determine if there is a network need for your services.

Check the populations and programs your clinic currently offers in the form below. Attach a detailed description of each program that you checked and include any Evidenced Based Practice(s) utilized. Include in the description the types of therapy utilized in the program, the license type of practitioners providing the services, and the typical length of program.

Additionally, Banner expects that every interested behavioral health provider has read and understands the Banner - University Family Care Provider Manual – Appendix Behavioral Health Specific and other applicable manuals located on our website at https://www.banneruhp.com/materials-and-services/provider-manuals-and-directories.

Behavioral Health Residential Facility (BHRF) Provider:
Please submit the program of scheduled activities, experience of staff that provide these activities, mission and goals, and the overall philosophy of how residents are oriented to the facility's programs and expected lengths of stay.

Describe respite services, if offered, for those who admit for an overnight stay and those who admit for non-overnight stay. Briefly describe program activities and staff ratios. Include the education and skill set of staff responsible for Members receiving respite services.

If you are unsure of the requirements of Behavioral Health Residential Facilities, please refer to the Arizona Administrative Code 10, Article 7: Behavioral Health Residential Facilities and the licensing requirements R9-10-701 through R9-10-722.

Behavioral Health Program Questionnaire

Provider Name: _____

Tax ID#: _____ **Site NPI#:** _____

Geographic Area: _____

Address: _____ **City, State Zip:** _____

Website: _____ **Email:** _____

AHCCCS Medicaid Behavioral Health Services: For Providers that provide Medicaid behavioral health services, the codes and service definitions can be found in the AHCCCS Behavioral Health Covered Services Guide. Providers are responsible for ensuring that the services checked below meet the AHCCCS definition and the accompanying codes, billing limitations, and staff qualifications

*For all sections below, check **only** the boxes that apply.*

Population Served:	**Types of Population**	
Serious Mental Illness (SMI)	☐ Males	☐ Females
General Mental Health/Substance Use (GMH/SU)	☐ Males	☐ Females
Arizona Long Term Care Services (ALTCS)	☐ Males	☐ Females
Transitional Age Youth	☐ Males	☐ Females
Children /Adolescents	☐ Males	☐ Females
0-5 Children	☐ Males	☐ Females

Languages Offered (*specific to programming*):

English Services. ☐ Yes ☐ No

List services offered in English: _____

Spanish Services ☐ Yes ☐ No

List services offered in Spanish: _____

Other Languages, please list: _____

List services offered in other languages: _____

_____

Licensed Practitioners:

☐ Licensed Clinical Social Workers (Provider Type 85)	☐ Medicare Certified
☐ Licensed Professional Counselor (Provider Type 87)	☐ Medicare Certified
☐ Licensed Marriage/Family Therapist (Provider Type 86)	☐ Medicare Certified
☐ Licensed Independent Substance Abuse Counselor (Provider Type A4)	☐ Medicare Certified
☐ Licensed Behavioral Analyst	N/A
☐ Licensed Psychologist	☐ Medicare Certified
☐ Psychiatrists	☐ Medicare Certified
☐ Nurse Practitioner	☐ Medicare Certified

Medicare

Medicare Number (PTAN – Provider Transaction Access Number): _____

Medicare Services offered: _____

_____

Screening and Assessment Tools ***(****Check all screening and assessment tools utilized****):***

☐ PHQ-9: Patient Health Questionnaire-9
☐ Biopsychosocial
☐ ASAM: American Society of Addiction Medicine
☐ GAD-7: Generalized Anxiety Disorder-7
☐ CALOCUS: Child and Adolescent Level of Care Utilization System
☐ LOCUS: Level of Care Utilization System for Psychiatric and Addiction Services
☐ PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences
☐ Other (please specify): _____

_____

Treatment & Assessment Services

☐ Autism Assessment	☐ Office	☐ Home	☐ Telemedicine
☐ Adult ☐Child	☐ Provides Diagnosis	☐ Provides Programming	☐ Provides Both
☐ Mental Health Assessments	☐ Office	☐ Home	☐ Telemedicine
☐ Psychiatric Evaluations	☐ Office	☐ Home	☐ Telemedicine
☐ Psychological Testing	☐ Office	☐ Home	☐ Telemedicine
☐ Individual Counseling / Therapy	☐ Office	☐ Home	☐ Telemedicine
☐ Hypnotherapy	☐ Office	☐ Home	
☐ Family Counseling / Therapy	☐ Office	☐ Home	☐ Telemedicine
☐ Group Counseling / Therapy	☐ Office	☐ Home	☐ Telemedicine

Medical Services for Behavioral Health Conditions

☐ Medication Services
☐ Laboratory, Radiology and Medical Imaging for Behavioral Health Conditions
☐ Medication Management
☐ Long Acting Injectables
☐ RN Services
☐ LPN Services
☐ Electroconvulsive Therapy (Outpatient)
☐ Ketamine Treatment

Facility Services: *(Must include a detailed Program Description, Behavioral Health Facility Questionnaire and AzAHP Practitioner Roster along with AzAHP Facility Application for applicable facility).*

- ☐ Behavioral Health Outpatient Clinic (77)
- ☐ Community Service Agency (A3)
- ☐ Counseling Only Facility (CF)
- ☐ Clinic (05)
- ☐ Integrated Clinic (IC)
- ☐ Sub-Acute/Detox (B5, B6)
- ☐ Inpatient Services-Level 1 Psychiatric (71)
- ☐ Behavioral Health Inpatient Services (B1, B2 or B3)
- ☐ Behavioral Health Residential Facility (B8)
- ☐ Behavioral Health Day Treatment (27)
- ☐ Supervised Behavioral Health Day Treatment (27)
- ☐ Substance Abuse Transitional Facility Services (A6)
- ☐ Adult Therapeutic Foster Care Services (A5)
- ☐ Supervising Agency- One site or multiple sites that are considered to be a ***Supervising Agency as licensed by ADHS*** *and have capacity to accept, treat and follow statutory requirements for members placed on Court Ordered Treatment for GMH/SU Adults.*

Behavioral Health Residential Facility (BHRF) Section *(if group is licensed to provide BHRF services, please complete this section – additional information see Behavioral Health Residential Facility (BHRF) Provider:):*

Does BHRF have any exclusionary criteria: ☐Yes ☐ No

If yes, please describe exclusionary criteria: _____

_____

Is BHRF licensed to provide respite services: ☐Yes ☐ No

If yes, please describe respite services offered: _____

_____

Is BHRF licensed to provide personal care services: ☐Yes ☐ No

If yes, please describe personal care services offered: _____

_____

BHRF Staff Ratios: _____

Program activities description: _____

_____

_____

Employment Services

Work related support programs: ☐Yes ☐ No

If yes, please describe work related support program services offered: _____

_____

Specialty Services/ Programs *(For any specialty population selected below, you must provide a detailed description of specialty programming in the Program Overview section)*:

☐ First Episode Psychosis Program	☐ Adult	☐ Child
☐ Transition to Independence (TIP) Model	☐ Adult	☐ Child
☐ Case Management	☐ Adult	☐ Child
☐ High needs case management/FOCUS/Wraparound	☐ Adult	☐ Child
☐ Treatment of maladaptive sexual behavioral behaviors and sex offenders	☐ Adult	☐ Child
☐ Trauma/Post Traumatic Stress Disorder/Abuse/Victims of Sex Trafficking	☐ Adult	☐ Child
☐ Transmagnetic Stimulation (TMS)	☐ Adult	☐ Child
☐ Eye movement Desensitization and Reprocessing (EMDR)	☐ Adult	☐ Child
☐ Eating Disorders	☐ Adult	☐ Child
☐ Traumatic Brain Injury/Cognitive Rehabilitation	☐ Adult	☐ Child
☐ Intellectual Disabilities	☐ Adult	☐ Child
☐ Domestic Violence Programs for Offenders	☐ Adult	☐ Child
☐ Programs/Services for Anxiety Disorders/Phobias	☐ Adult	☐ Child
☐ LGBTQIA2S Programs/Groups	☐ Adult	☐ Child
☐ Programs/Services for Veterans	☐ Adult	☐ Child
☐ Programs for members with co-morbid physical conditions/disabilities	☐ Adult	☐ Child
☐ Faith-Based Programs	☐ Adult	☐ Child
☐ Cognitive Behavioral Therapy	☐ Adult	☐ Child
☐ Dialectical Behavioral Therapy	☐ Adult	☐ Child
☐ Equine Therapy	☐ Adult	☐ Child
☐ Wellness Programs/ Health Promotion	☐ Adult	☐ Child
☐ Grief/Bereavement Counseling	☐ Adult	☐ Child
☐ Services for members with Autism	☐ Adult	☐ Child

☐ Birth through five/infant toddler interventions:

Modality Used:

- ☐ Dyadic/relational therapies
- ☐ Specialists endorsed by the Infant Toddler Mental Health Coalition of Az. (ITMHCA) or other endorsing program under the Alliance for the Advancement of Infant Mental Health

☐ Multisystemic therapy for juveniles

☐ Self Help/Peer Support Services

☐ Credentialed (*specify credentialing source*): _____

☐ Unskilled Respite Services

☐ Transportation

☐ Crisis Services in Emergency Department for evaluation and management of a patient

(Note: Mobile, telephonic and crisis stabilization services are excluded from this contract.)

☐ Programs/Services specific to cultures and populations *(Not listed above).*

☐ American Indian/Alaskan Native ☐ BIPOC ☐ Immigrants and Refugees ☐ Indigenous and Tribal Community

Please describe: _____

_____

☐ Other: Please list all other additional programs/services: _____

_____

Specialty Services and Programming

Description of specialty services and programming for specialty populations (required for any specialty population checked above):

_____

_____

_____

Substance Abuse Service Providers/Programs:

☐ Alcohol and Drug Services
☐ Opioid Dependence/Suboxone
☐ Methadone Programs
  ☐ Administration ☐ Maintenance
☐ Gender Specific Programs
☐ Pregnant Substance Dependent Women Programs
☐ Outpatient Programs
☐ Intensive Outpatient Programs
  ☐ Psychiatric ☐ Substance Use Disorder
☐ Detoxification Services
☐ DUI Program
☐ Acupuncture
☐ Transitional Substance Abuse Facility
☐ Peer led Substance Use Programs

Substance Programs for Children/Adolescents

Modality used:

☐ Adolescent Community Reinforcement Approach (A-CRA)
☐ Assertive Community Care (ACC)
☐ Global Appraisal of Individual Needs (GAIN)
☐ Other, please describe: _____

_____

Program Overview *(Please provide detailed descriptions for the following)*:

Involvement with Evidence-Based Models

Group participation/facilitate Adult Recovery Team (ART)? ☐ Yes ☐ No

If yes, please describe: _____

Group participation/facilitate Child and Family Team (CFT)? ☐ Yes ☐ No

If yes, please describe: _____

Social Determinants of Health (SDOH)

Do you assess for Social Determinants of Health (SDOH)? ☐ Yes ☐ No

Do you connect members to SDOH resources? ☐ Yes ☐ No

If yes, please describe process: _____

Coordination of Care

Description of coordination of care process: _____

_____

Discharge Planning

Description of discharge planning process: _____

_____

School Coordination

Coordination with schools: _____

_____

Services provided within school settings: _____

_____

Outpatient/Clinic or Individual Provider Accessibility of Services:

- ☐ Open access scheduling for outpatient services
- ☐ Open access Psychiatric/Medication Services
- ☐ Accept Walk Ins
- ☐ Extended Business Hours: ***(****Please list hours and location****)***

Hours: _____ Location: _____

Hours: _____ Location: _____

Hours: _____ Location: _____

Behavioral Health Provider Attestation

I _____(Owner/Administrator) attest to the following requirements below in order to have my request to join the network reviewed for a possible contract with Banner.

Check all that apply:

☐ The Owner/Administrator and clinical staff, if applicable, have read and understood the Banner University Health Plan Manual – Appendix Behavioral Health Specific

☐ ***For Behavioral Health Residential Facilities (BHRF) only*** - The Owner/Administrator understands that the per diem rate includes all requirements as outlined in the Arizona Administrative Code Arizona Administrative Code 10, Article 7 including counseling for residents. Residents are not to receive counseling services outside of the BHRF unless a prior authorization has been submitted to Banner Behavioral Health Medical Management with a justification as to why the BHRF is unable to provide counseling for the member during their residential stay. (*For example, the member may require a specialty type of counseling for trauma-related conditions for which the BHRF does not have expertise. The BHRF is permitted to subcontract with outside vendors; however, they must be AHCCCS-registered providers and must not bill Banner for their services. Their contract is with the BHRF provider and not Banner).*

_____
Printed Name

_____
Signature (Owner/Administrator)

Date of Signature _____

Behavioral Health Facility Questionnaire

(To be completed if your facility utilizes Behavioral Health Technicians and/or Paraprofessionals)

Does your facility utilize Behavioral Health Technicians and Paraprofessionals? ☐Yes ☐ No

If yes, please submit an explanation on your process for the supervision of BHT's or your policy and procedure explaining the process of supervision:

_____

_____

_____

Please explain your process for supervision/clinical oversight by a licensed professional and how it is documented in the health plan member's record or treatment plan:

_____

_____

_____

_____
Printed Name and Title

_____
Signature (Owner/Administrator)

Date of Signature _____