MENTAL HEALTH ADDENDUM
TO THE BEHAVIORAL HEALTH VOUCHER PROGRAM SERVICES AGREEMENT

For Services Provided by Independent Mental Health Providers

This document serves as a formal addendum to the Behavioral Health Voucher Program Agreement and allows your participation as a direct medical assistance provider. Providers must meet all of the following requirements:

1) The mental health provider must be any one of the following with active licensure in good standing to practice in the State of South Dakota: psychologist, psychiatrist, mental health advanced practice nurse, physician's assistant, licensed professional counselor - mental health, licensed professional counselor working toward a mental health designation, clinical nurse specialist, certified social worker-PIP, certified social worker - PIP candidate, or a licensed marriage and family therapist.
2) The mental health provider must make a good faith attempt to contact voucher recipients within two (2) business days (defined as Monday-Friday) of voucher issuance to schedule an initial appointment.
3) The mental health provider must confirm recipients' financial eligibility for services and realign to other payers if/as applicable.
4) The mental health provider must prepare a diagnostic assessment and treatment plan according to ARSD 67:16:41:04 and 67:16:41:06.
5) The mental health provider provides treatment directly to the recipient.
6) Delivery of services is limited to individual or family therapy or psychiatric evaluation and medication management.
7) The treatment is documented in the recipient's clinical record according to ARSD 67:16:41:08.
8) The treatment is medically necessary according to ARSD 67:16:01:06.02.

Failure to meet all of the above requirements will be cause for the Department of Social Services to determine that the mental health services provided are non-covered services.

SAMPLE - DO NOT SIGN

TO BE COMPLETED BY THE PROVIDER

I declare and affirm under the penalties of perjury that this Addendum has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. I further declare and affirm under the penalties of perjury that any claim to be submitted pursuant to this Addendum will be examined by me, and to the best of my knowledge and belief, will be in all things true and correct.

Provider Name: ______________________________

Legal Name of Individual Provider

By: ______________________________

Authorized Signature of Provider

Name/Title: ______________________________

Printed Name of Signatory

Date: ______________________________