

## Facility/Program Credentialing Location and Services Form

### Facility Checklist (2 pages)

To ensure timely processing of your application, please return the following:

- ☐ Completed Service Location Addendum(s) - One per Service Location (Attached please copy as needed)
- ☐ Copies of all applicable state or agency licenses
- ☐ National Provider Identification (NPI)
- ☐ Staff Roster if applicable **(Required for WA state DCRs)**  
<https://providerportal.carelonbehavioralhealth.com>  
**(Credentialing/Facility Roster)**

### Accreditation certificate(s):

- ☐ Accreditation Association for Ambulatory Health Care (AAAHC)
- ☐ American Osteopathic Association (AOA)
- ☐ Council on Accreditation of Rehabilitation Facilities (CARF)
- ☐ Community Health Accreditation Program (CHAP)
- ☐ Council On Accreditation (COA)
- ☐ Det Norske Veritas (DNV)
- ☐ Healthcare Facilities Accreditation Program (HFAP)
- ☐ The Joint Commission (TJC)
- ☐ Current CMS/State Site Visit/Survey (If not Accredited) (Not required if deemed rural) [Find a Health Center \(hrsa.gov\)](#)

### Certification(s):

- ☐ Other state licensure reports (i.e., Dept. of Human Services, Dept. of Mental Health and Mental Retardation)  
Please specify: \_\_\_\_\_
- ☐ Substance Abuse and Mental Health Services Administration (SAMHSA)
- ☐ NDA Approval Letter - Department of Health and Human Services Spravato (esketamine)  
**(include copy of letter)**
- ☐ Clinical Laboratory Improvement Amendments (CLIA), if applicable
- ☐ Medicaid
- ☐ Medicare
- ☐ Quality Assurance Policies and Procedures (QA P&P)
- ☐ Hiring Policies (Employment and Background Policies)

### Credentialing Contact information

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: \_\_\_\_\_



**Instructions:** Please complete this form for each site location associated with the facility and indicate **all** services for the location. If there are more than 15 locations that provide the **same** services, please complete one (1) form and submit a roster in PDF format of all other locations providing the **same** services.

If any locations provide **different/additional** services, you must complete a form for the location(s) providing different/additional services (photocopy as needed). **Any locations or programs not identified will not be credentialed.**

Service Location \_\_\_\_ of \_\_\_\_

Billing Address: (Please confer with your billing dept.)

Site NPI

Tax ID Number

Site Name

Billing Address Line 1

Service Address Line 1

Billing Address Line 2

Service Address Line 2

City State Zip

City State Zip

Phone Number

Phone Number

OASAS PRU ID (NY specific)

Medicare Number

Medicaid Number

Facility Type

Programs Offered At Location (National)	# Of Units	Age 0-12	Age 13-17	Age 18-64	Age 65+	Program Code(s)
23-Hour Observation	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.HOB
ABA	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.ABA
Ambulatory Detox/Outpatient – medically supervised withdrawal	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.OC
Crisis Intervention	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.CRI
Crisis Stabilization	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.CR
Day Treatment (Psychiatric)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.DP
Day Treatment (Substance Use Disorder)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.DC
Day Treatment Dual Diagnosis	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.DX
Day Treatment Eating Disorder	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.DE
Employee Assistance Program (EAP)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.EAP
Halfway House	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.HWH
Home Health	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.HOM
Inpatient (Acute) Detoxification		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.AD
Inpatient Dual Diagnosis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.AX
Inpatient Eating Disorder		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.AE
Inpatient Psychiatric (190-Day Lifetime Limit)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.190
Inpatient Psychiatric		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.AP

Programs Offered At Location (National)		# Of Units	Age 0-12	Age 13-17	Age 18-64	Age 65+	Program Code(s)	
Inpatient Substance Use Disorder Rehab			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.AC	
Intensive Outpatient (Psychiatric)		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.IP	
Intensive Outpatient (Substance Use Disorder)		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.IC	
Intensive Outpatient Dual Diagnosis		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.IX	
Intensive Outpatient Eating Disorder		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.IE	
Mobile Crisis		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.CRM P.MOB	
Outpatient Clinic (Psychiatric)		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.CP P.OPP	
Outpatient Clinic (Substance Use Disorder)		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.CC P.OPR	
Outpatient Clinic Dual Diagnosis		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.CX	
Partial Hospital Dual Diagnosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.PX	
Partial Hospital Eating Disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.PE	
Partial Hospitalization (Psychiatric)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.PP	
Partial Hospitalization (Substance Use Disorder)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.PC	
Peer-Delivered		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.PDS	
Peer Support		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.PES	
Residential Rehabilitation – Medicaid Only			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.RRE	
Residential Reintegration – Medicaid Only			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.RRI	
Residential Stabilization – Medicaid Only			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.RST	
Residential Treatment (Psychiatric)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.RP	
Residential Treatment (Substance Use Disorder)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.RC	
Residential Treatment Eating Disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.RE	
Residential Treatment Dual Diagnosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.RX	
Treatment Group Home		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.GPH	
Telehealth Services (Psychiatric)		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.THM P.TPS	
Telehealth Services (Substance Use Disorder)		N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.THD	
MAT Services (National)		# Of Units	Age 0-12	Age 13-17	Age 18-64	Age 65+	SAMHSA Certified	Program Code
Esketamine (REMS Certification)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		F.ESK
Opioid Treatment Program (OTP) (SAMHSA certification Required)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		F.NRO
Opioid Treatment – Methadone Maintenance Therapy *Indicate # Of Days Per Week In # Of Units Column		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A		P.MM P.OMM
Opioid Treatment - Suboxone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A		P.SXN
Opioid Treatment - Vivitrol		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A		P.VVT
Medicaid Services (Illinois-Specific)		# Of Units	Age 0-12	Age 13-17	Age 18-64	Age 65+		Program Code
Integrated Assessment and Treatment Plan			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		P.IAT
Family Support Program Services			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		P.FSP
Developmental Screening			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		P.DVS
Violence Prevention Team			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		P.VPT

ASAM Services	# Of Units	Age 0-12	Age 13-17	Age 18-64	Age 65+	Program Code
ASAM 3.1 - Alcohol and/or Other Drug Treatment Program, Per Diem		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.AS1
ASAM 3.2wm - Alcohol and/or Drug Services, Acute Detoxification		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.A2W
ASAM 3.3 - Alcohol and/or Other Drug Treatment Program, Per Diem		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.AS3
ASAM 3.5 - Alcohol and/or Other Drug Treatment Program, Per Diem		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.A5S
ASAM 3.7 - Alcohol and/or Other Drug Treatment Program, Per Diem		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.AS7
ASAM 3.7wm - Alcohol and/or Drug Services, Acute Detoxification		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.A7W
Block Grant Services (Kansas-Specific)	# Of Units	Age 0-12	Age 13-17	Age 18-64	Age 65+	Program Code
Acute Detoxification Treatment Modality		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.AD
Inpatient Treatment Modality (Hospital-Based Residential)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.RC
Intermediate Treatment Modality (Residential)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.IT
Reintegration Treatment Modality (Residential)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.RR
Alcohol and Drug Assessment and Referral Program (KCPC Assessment)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.AST
Intensive Outpatient Treatment Modality	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.IT
Case Management Services	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.CM
Outpatient Treatment Modality– Individual Counseling	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.I1
Outpatient Treatment Modality – Group Counseling	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.G1
Peer Support (Please Provide Certification)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.PES
Kansas Problem Gambling	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.GMB
29-I Voluntary Foster Care Services (New York-Specific)	# Of Units	Age 0-12	Age 13-17	Age 18-64	Age 65+	Program Code
Foster Care – Alcohol and Drug Testing		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.ALC
Foster Care – Developmental Testing		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.DTA
Foster Care – Neuropsych Testing/Eval Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.NET
Foster Care – Office Visit/Psychotropic Medication Treatment		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.NOF
Foster Care – Psychiatric Diagnostic Exam		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.DIA
Foster Care – Psychotherapy (Individual and Family)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.PTH
Foster Care – Psychotherapy Group		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.GTH
Foster Care – Screening-Developmental/Emotional/Behavioral		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.DES
Foster Care – Smoking Cessation Treatment		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.SMO
Adult HARP and HCBS Services (New York-Specific)	# Of Units	Age 0-12	Age 13-17	Age 18-64	Age 65+	Program Code
Education Support Services	N/A	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>	P.ESS
Habilitation/Residential Support Services	N/A	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>	P.HRS
Intensive Supported Employment	N/A	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>	P.ISE
Mobile Crisis Intervention	N/A	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>	P.MCI
Ongoing Supported Employment	N/A	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>	P.OSE
Prevocational Services	N/A	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>	P.PVS
Provider Travel Supplement	N/A	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>	F.TRV
Transitional Employment	N/A	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>	P.TRE

<b>Core Services (New York-Specific)</b>	<b># Of Units</b>	<b>Age 0-12</b>	<b>Age 13-17</b>	<b>Age 18-64</b>	<b>Age 65+</b>	<b>Program Code</b>
Community Psychiatric Support & Treatment (CORE)	N/A	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>	P.CPD
Peer Supports – Empowerment Services (CORE)	N/A	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>	P.PPD
Family Support and Treatment (CORE)	N/A	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>	P.FSC
Psychosocial Rehabilitation (CORE)	N/A	N/A	N/A	<input type="checkbox"/>	<input type="checkbox"/>	P.PSD
<b>Children’s HCBS Services (New York-Specific)</b>	<b># Of Units</b>	<b>Age 0-20</b>	<b>Age 13-17</b>	<b>Age 18-64</b>	<b>Age 65+</b>	<b>Program Code</b>
Caregiver Family Supports and Services	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CFI
Caregiver Family Supports and Services – Group Of 2	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CFG
Caregiver Family Supports and Services – Group Of 3	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CFG
Community HCBS Habilitation Individual	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.HCH
Community HCBS Habilitation Group Of 2	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.HCH
Community HCBS Habilitation Group Of 3	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.HCH
Community Self-Advocacy and Support – Group 2	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CAG
Community Self-Advocacy and Support – Group Of 3	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CAG
Community Self-Advocacy and Support Individual	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CSI
Crisis Respite – Less Than 4 Hours	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CRT
Crisis Respite – More Than 12 Hours, Less Than 24 Hours	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CRT
Crisis Respite – More Than 4 Hours, Less Than 12 Hours	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CRT
Day HCBS Habilitation Individual	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.HDH
Day HCBS Habilitation Group Of 2	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.HDH
Day HCBS Habilitation Group Of 3	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.HDH
Palliative Care Expressive Therapy	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.PET
Palliative Care Massage Therapy	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.PMT
Planned Respite – Individual Per Diem	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.PPR
Planned Respite – Individual (Under 4 Hours)	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.PPR
Planned Respite – Group Less Than 4 Hours	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.PPG
Prevocational Services - Individual	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.PVI
Prevocational Services – Group Of 2	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.PVG
Prevocational Services – Group Of 3	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.PVG
Supported Employment	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.SUP
<b>Children’s CTFSS Services (New York-Specific)</b>	<b># Of Units</b>	<b>Age 0-20</b>	<b>Age 13-17</b>	<b>Age 18-64</b>	<b>Age 65+</b>	<b>Program Code</b>
Children’s Mobile Crisis Intervention-2 LP 90-180 Minutes	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CM1
Children’s Mobile Crisis Intervention-2 LP Over 3hr	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CM2
Children’s Mobile Crisis Intervention-1 LP F2f Follow Up	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CM3
Children’s Mobile Crisis Intervention-1 Peer F2f Follow Up	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CM4
Children’s Mobile Crisis Intervention-1 LP 1 Peer F2f Follow Up	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CM5
Children’s Mobile Crisis Intervention-1 LP Telephonic Follow Up	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CM6
Children’s Mobile Crisis Intervention-1 Peer Telephonic Follow Up	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CM7
CPST Service Professional (Onsite)	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CSP
CPST Service Professional (Offsite)	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.COI
CPST Service Professional Group (Onsite)	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CSG
CPST Service Professional Group (Offsite)	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.COG
Crisis Intervention – 1 Licensed Practitioner	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CLP
Crisis Intervention – 1 LP And Peer Support	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.CPE

Crisis Intervention – 2 Clinicians 1 LP	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.C90
<b>Children's CTFSS Services (New York-Specific)</b>	<b># Of Units</b>	<b>Age 0-20</b>	<b>Age 13-17</b>	<b>Age 18-64</b>	<b>Age 65+</b>	<b>Program Code</b>
Crisis Intervention – 2 LPs	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.C2P
Family Peer Support Service (FPSS) Professional	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.FSP
Family Peer Support Service (FPSS) Group	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.FSG
FPSS/YPSS (Offsite)	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.FOI F.YOI
FPSS/YPST Group (Offsite)	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.FOG
OLP Counseling Individual	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.OCI
OLP Crisis	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.OLC
OLP Crisis Complex Care	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.OCC
OLP Crisis Triage	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.OCT
OLP Family Counseling	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.OLF
OLP Group	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.OCG
Other Licensed Professional - OLP Licensed Evaluation	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.OLE
PSR Service Professional (Onsite)	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.PSP
PSR Service Professional (Offsite)	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.OPP
PSR Service Professional Group (Onsite)	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.PSG
PSR Service Professional Group (Offsite)	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.OPS
Youth Peer Support and Training (YPSS) - Individual	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.YSP
Youth Peer Support and Training (YPSS) - Group (YPSS)	N/A	<input type="checkbox"/>	N/A	N/A	N/A	F.YSG
<b>Medicaid Advantage Plus (New York-Specific)</b>	<b># Of Capacity</b>	<b>Age 0-12</b>	<b>Age 13-17</b>	<b>Age 18-64</b>	<b>Age 65+</b>	<b>Program Code</b>
Assertive Community Treatment (ACT)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.ACT
Adult Intensive Care Residence	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.NCR
Adult Residential Crisis Support	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.NCS
Children's Crisis Residence	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.NCC
Community Integration Counseling	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.COM
Continuing Day Treatment		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.CDT
Intensive Crisis Residence (ICR) 18-20 Years	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.NIC
Intensive Psychiatric Rehabilitation Treatment	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.IPR
Mobile Crisis	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.CRM P.MOB
Mobile Crisis Intervention Services – Telephonic Crisis	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.CPT
Mobile Crisis Intervention Services – Follow Up	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.MCF
Mobile Mental Health Treatment	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.MMH
NYS OMH Licensed Community Residences	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.NYS
Partial Hospitalization – Collateral	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.PHC
Partial Hospitalization –Crisis	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.PCR
Partial Hospitalization – Group Collateral	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.PHG
Partial Hospitalization – Regular	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.PHR
Peer Mentoring	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.PEM
Personalized Recovery Oriented Services (PROS)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.PRO
Positive Behavioral Intervention Supports (PBIS)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.PBI
Residential Crisis Support 18-20 Years	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.NRC
Structured Day Program	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.SDP

Pennsylvania	# Of Units	Age 0-20	Age 13-17	Age 18-64	Age 65+	Program Code
Acute Partial Hospitalization	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.AHO
Adolescent Diversion and Stabilization Unit	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.DAS
Adult Family-Focused Solutions-Based Services - Individual	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.FFA
Assertive Community TX Team/ Community TX Teams	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.CTT
Behavioral Health Hotline Service (Telephone Crisis)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.CPT
BSU Diagnostic Assessment, By Non-Physician (MH Diagnostic Assessment)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.BSU
Clozapine Support	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.ZPE
Community Mental Health/Other (Mobile Meds)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.MDM
Crisis Intervention Service (Mobile Crisis)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.CRM
Crisis Intervention Service (Walk-In Crisis)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.CRW
Crisis Intervention Service, MH Services (Crisis Residential)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.CRH
Dual Diagnosis Treatment Team	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.DTT
Eating Disorder Treatment	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.OED
Extended Acute Care - Inpatient	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.EAC
Family-Based Services	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.FBS
Federally Qualified Health Clinic	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.QHC
Individual Therapy - Parent-Child Interaction Therapy(PCIT)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.PCT
Intensive Behavioral Health Services	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.IBH
Laboratory	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.LAB
Long-Term Rehab 3.5 H Highest Intensity	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.NLR
Long-Term Structured Residential	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.LTR
Multi-Systemic Therapy	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.MST
Psych Rehab Clubhouse	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.PSC
Resource Coordination Substance Use Disorder; Case Management (SUD RC)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.RCO
Single County Authority (SCA) Service Plan Assessment	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.SCA
Smoking and Tobacco Use Cessation	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.SMC
Substance Use Disorder Case Coordination	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.DAC
Substance Use Disorder ICM Substance Use Disorder Services; Case Management (SUD ICM)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.GC
Substance Use Disorder Op IN An Alternative Setting - Individual	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.ALT
Substance Use Disorder Recovery Specialist	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.DAR
Targeted Case Management (Blended Case Management)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.BCM
Trauma-Focused Services	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.TFS
Withdrawal Management 3.7	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.RDA F.RDL
Specialty Services (National)	# Of Units	Age 0-12	Age 13-17	Age 18-64	Age 65+	Program Code
CPEP		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.CPE
Crisis/Evaluation INER		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.CRE
ECT		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.ECT
Harm Reduction		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.HRC
SDE (State-Designated Entity)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F.SDE
Special Connections Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	





Specialty Services (National)	# Of Units	Age 0-12	Age 13-17	Age 18-64	Age 65+	Program Code
Transportation Services		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	P.TET
Other Psych, Sub Use Service: _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If you indicated the facility is providing services for Inpatient Detox and/or Inpatient Substance Use Disorder Rehab, answer the below questions.

- 1) Inpatient Detox: Does the facility provide emergency medical services on-site to treat severe, unstable conditions related to withdrawal? ☐ Yes ☐ No
- 2) Inpatient Substance Use Disorder Rehab: Does the facility provide emergency psychiatric/medical services on-site or by contract? ☐ Yes ☐ No

**If your site has multiple NPI numbers, please complete the following box to provide us with all NPIs that apply to your facility/clinic:**

Additional NPIs	Additional Medicaid IDs	Level of Care

### Attestation Statement:

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

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Location effective date (only for new locations being added):** \_\_\_\_\_

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