

**AMERIHEALTH CARITAS FAMILY OF COMPANIES  
POLICY AND PROCEDURE**

**Subject:** Credentialing/Recredentialing of Providers, Organizational Providers and Non-Traditional Long Term Services and Supports (LTSS) Contractors/Providers

**Policy No:** CP [Confidential information redacted]

**Department:** Enterprise Operations Management

**Current Effective Date:** 12/12/2019

**Last Review Date:** 12/4/2020

**Original Effective Date:** 8/29/2019

**Next Review Date:** 12/4/2021

**Related Departments:** Provider Network Management, Provider Network Operations, Provider Database Maintenance, Quality Management

**Lines of Business:** North Carolina

**Products:** Medicaid and Health Choice

**Policy:**

AmeriHealth Caritas North Carolina is a member of the AmeriHealth Caritas Family of Companies. AmeriHealth Caritas North Carolina, also known as the Prepaid Health Plan “PHP,” adheres to the North Carolina Department of Health and Human Services’ (the “Department”) Medicaid managed care program streamlined approach for the credentialing and recredentialing of providers. AmeriHealth Caritas North Carolina will rely on a provider’s presence on the Medicaid Provider Enrollment File (NCTracks extended version) for credentialing/recredentialing purposes. Per the direction of the Department in the email ‘NOTIFICATION: Medicaid Credentialed Provider File – Termination’ on December 12, 2019 (Attachment E), a provider’s presence on the NCTracks extended version replaces the quality determination to be performed by AmeriHealth Caritas North Carolina in accordance with Section V.D.2.b of the RFP. Through this standardized credentialing/recredentialing approach, AmeriHealth Caritas North Carolina will not outreach to in-state, bordering (i.e., providers that reside within forty (40) miles of the North Carolina state line), or out of state providers about credentialing/recredentialing in accordance with the direction from the Department in Section V.D.2.g of the RFP. North Carolina state law and the RFP requires PHPs to negotiate in good faith with, and include in the network, all qualified willing providers, except when the PHP is unable to negotiate rates.

Provider/Contactor/Organizational Providers who are not enrolled with the Department as North Carolina Medicaid Providers, consistent with the provider disclosure, screening, and enrollment requirements, will not be contracted with AmeriHealth Caritas North Carolina. AmeriHealth Caritas North Carolina will partner with the Department on a long term model for credentialing to meet NCQA compliance.

This policy and procedure will be presented for review and approval on at least an annual basis to both the Department and AmeriHealth Caritas North Carolina's Quality Assessment Performance Improvement Committee (QAPIC). AmeriHealth Caritas North Carolina will submit any significant policy changes to the Department for review and approval at least sixty (60) calendar days prior to implementation.

AmeriHealth Caritas North Carolina is prohibited from employing or contracting with providers excluded from participation in federal health care programs under the Social Security Act.

AmeriHealth Caritas North Carolina credentialing staff abide by policies and procedures for the collection, use, transmission, storage, access to and disclosure of Confidential Information in order to protect the privacy and confidentiality rights of AmeriHealth Caritas North Carolina's Members and Providers and to ensure the appropriate and legitimate use of the information. AmeriHealth Caritas North Carolina is prohibited from using, disclosing or sharing provider credentialing information for any purpose other than use in Medicaid Managed Care without the express, written consent of the provider and the Department.

## **Procedure:**

### **Initial Credentialing**

AmeriHealth Caritas North Carolina will rely on the enrollment/credentialing of the Department for initial credentialing and will not have its own independent credentialing process in accordance with guidance from the Department in the email 'NOTIFICATION: Medicaid Credentialed Provider File – Termination' on December 12, 2019 (Attachment E). AmeriHealth Caritas North Carolina will accept the NCTracks extended version as the source for provider eligibility and credentialing status purposes. AmeriHealth Caritas North Carolina matches the provider to the active Medicaid/North Carolina Health Choice (NCHC) provider record by using the NPI, location code, effective date methodology provided by the Department.

### **Recredentialing**

1. Providers/Contractors/Organizational Providers are recredentialled no less frequently than every 5 years by the Department during the Provider Credentialing Transition period.
2. AmeriHealth Caritas North Carolina will suspend claims payments to any non-compliant provider for dates of services after the effective date provided by the Department. Claims payment suspension will occur within one (1) business day of receipt of notice from the Department that Provider payment has been suspended for failing to submit re-credentialing documentation to the Department, or for otherwise failing to meet Department requirements.
3. AmeriHealth Caritas North Carolina will reinstate provider payments upon notice of compliance from the Department.
4. If the provider remains non-compliant more than fifty (50) days after suspension, the Department and AmeriHealth Caritas North Carolina will terminate the provider and AmeriHealth Caritas North Carolina will likewise terminate the provider from its network.

NOTE: The PHP will not be liable for interest or penalties for payment suspension at recredentialing.

**Note:** Any provider found to be excluded from Medicare or Medicaid will be terminated immediately from the PHP.

### **Quality Assessment Performance Improvement Committee (QAPIC)**

1. The QAPIC is staffed with participating providers with the goal of representing the range of North Carolina licensed primary care, specialty and Allied Health Practitioners furnishing care to AmeriHealth Caritas North Carolina members. The AmeriHealth Caritas North Carolina Market Chief Medical Officer or physician designee is Chairman of the QAPIC and is licensed in the state of North Carolina.
2. The primary responsibilities of the QAPIC are described more fully in the [Confidential information redacted] (reviewed and approved by the Department). Those responsibilities pertinent to credentialing/re-credentialing include:
  - Review and revise Credentialing/Rec credentialing policies and procedures at least annually and modify them as necessary.
  - Help ensure that AmeriHealth Caritas North Carolina's Credentialing / Recredentialing policies and procedures are consistently followed and aligned with state policies and procedures.
  - Monitor the credentialing processes to ensure implementation is in accordance with federal, state and NCQA standards.
  - Compare provider performance against quality data, including quality of care and quality of service concerns, and review provider performance at least as often as the NC DHHS rec credentialing cycle. Any severity levels reached as outlined in the [Confidential information redacted] will be presented to the QAPIC for review, discussion, and determination.
3. Any provider terminated for reasons of suspected fraud, waste, or abuse are reviewed pursuant to the requirements under the Department Contract.

**NOTE:** This process is based on the AmeriHealth Caritas North Carolina authorizing legislation that provides AmeriHealth Caritas North Carolina must include all willing providers in their network, except when AmeriHealth Caritas North Carolina is unable to negotiate rates.

### **Confidentiality**

1. The Plan-wide policy [Confidential information redacted], addresses the overall procedure for confidentiality. On an annual basis all associates must read and sign the policies Associate Confidentiality, Privacy, and Security Agreement. In addition, [Confidential information redacted], addresses the specific procedures with regard to the confidentiality of information obtained in the Credentialing/Rec credentialing process. All new hires must sign the Affirmation Statement Form in the New Hire Orientation.

## **On-going Monitoring**

1. Through the uniform credentialing process, the Department will screen and enroll, and revalidate, all providers as participating and non-sanctioned Medicaid Providers.
2. AmeriHealth Caritas North Carolina will reconfirm providers' Medicaid eligibility upon receipt of every NCTracks extended file.
3. AmeriHealth Caritas North Carolina will monitor provider performance against Quality data on an ongoing basis, as outlined in the Quality Improvement Program Description.

## **Provider Network Composition**

1. The AmeriHealth Caritas North Carolina Provider Network Management (PNM) team establishes a network of providers necessary to furnish Covered Services, specific to the North Carolina plan that meets network adequacy requirements to help ensure access for enrollees, including those with limited English proficiency or physical or mental disabilities. The AmeriHealth Caritas North Carolina PNM team is responsible for validating female enrollees have direct access to women's health specialists to provide women's routine and preventive health services.
2. The provider network includes, but is not limited to, hospitals, providers (specialists and primary care), nurse midwives, nurse practitioners, family planning providers, federally qualified health centers, medical specialists, dentists, allied health professionals, ancillary providers, DME providers, home health providers, behavioral health providers, transportation providers, nursing facilities and supportive living facilities, and Long Term Services and Supports, such as adult day programs, home delivered meals and environmental modification services.
3. The AmeriHealth Caritas North Carolina network of contracted, credentialed providers includes adequate numbers of Providers with the training, experience, and skills necessary to furnish quality care to Members in a manner that is accessible and culturally competent.
4. If the provider network is unable to provide necessary services or the need for a second opinion, AmeriHealth Caritas North Carolina will support the arrangement of such services at no cost to the member.

**NOTE:** Refer to Policy [Confidential information redacted]

## **Contract Execution**

1. The AmeriHealth Caritas North Carolina contract network management team meets with providers interested in joining the AmeriHealth Caritas North Carolina provider network (potential providers) and supplies a copy of the contracting packet including the data intake form. The data intake forms request additional information from the potential providers including but not limited to office hours, ADA compliance information, and provider type. (Attachments A through D – AmeriHealth Caritas North Carolina Provider Data Intake forms)
2. If the contract negotiation process proceeds to conclusion and completed contract packets are received, the information from the data intake form is shared with appropriate AmeriHealth Caritas North Carolina departments. The data will be validated against the NC Tracks Extended file for participation.

3. AmeriHealth Caritas North Carolina may execute a network provider contract, pending the outcome of the Department screening, enrollment, and revalidation, of up to one hundred twenty days (120), but must terminate a network provider immediately upon notification from the Department that the network provider cannot be enrolled.

### **Provider Directories**

1. Directories that list credentialed and participating providers/contractors/organizational providers are made available upon request to the Members. A real time provider directory is also available through the AmeriHealth Caritas North Carolina website.
2. The information populated in the provider directory outlines the Provider's professional qualifications that are gathered from the provider's initial intake form and the NC Tracks Extended file.
3. Members are informed through the member newsletter and website that they may request the following information on any AmeriHealth Caritas North Carolina primary and/or specialty care provider's professional qualifications:
  - Medical school attended;
  - Residency completed; and ○ Board certification status (also included in the Provider Directory)

### **Oversight**

1. AmeriHealth Caritas North Carolina will meet with the Department, or designated Department vendor, quarterly and as requested regarding the credentialing process and network contracting process.
2. AmeriHealth Caritas North Carolina will publish all previous versions of this policy on the AmeriHealth Caritas North Carolina website including the policy effective date.

### **Related Policies and Procedures:**

1. [Confidential information redacted]
2. [Confidential information redacted]
3. [Confidential information redacted]
4. [Confidential information redacted]

### **Attachments:**

1. Attachment A – NC DHHS Email: NOTIFICATION: Medicaid Credentialed Provider File – Termination
2. Attachment B – Sample AmeriHealth Caritas North Carolina Provider Data Intake Forms
  - **Provider Data Intake**
  - **Behavioral Health Data Intake**
  - **Facility Data Intake**
  - **Ancillary Data Intake**

### **Approved By:**

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

Date: 12-17-20

[Confidential information redacted]

**Attachment A – NC DHHS Email: NOTIFICATION: Medicaid Credentialed Provider File – Termination**

Subject:FW: NOTIFICATION: Medicaid Credentialed Provider File - Termination

From: [Confidential Information Redacted]  
Sent: Thursday, December 12, 2019 2:59 PM  
To: [Confidential Information Redacted]  
Subject: NOTIFICATION: Medicaid Credentialed Provider File - Termination

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WARNING: This email originated outside of the company.  
DO NOT CLICK links or attachments unless you recognize the sender and are expecting the email.  
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Plans,

Due to suspending the roll out of Managed Care the Department has decided to terminate the daily Medicaid Credentialed Provider File, effective immediately.

The Plans will rely on the enrollment/credentialing of GDIT, as indicated on the Medicaid Provider Enrollment File (vs the Medicaid Credentialed Provider File), to replace individual Plan Quality Determinations during the transition period.

The plans will:

- a. ingest the Medicaid Provider Enrollment File (extended version) and when a Medicaid/NCHC enrolled provider is active in the Medicaid program you may contract with them using our enrollment effective date
- b. update procedures to reflect this change and resubmit to the Department for approval

We will work on the long term model of the PDM/CVO to work toward NCQA compliance.

Please let me know if you have any questions or concerns.

Christina Bunch, CPMSM, CPCS  
Associate Director, Provider Operations  
NC Medicaid  
Division of Health Benefits  
[NC Department of Health and Human Services](#)

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**Attachment B** – Sample AmeriHealth Caritas North Carolina Provider Data Intake Forms

**Section 1 instructions:** Please complete all fields below for the Provider.

Entity name (as written on W9):				Category: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> FQHC <input type="checkbox"/> RHC <input type="checkbox"/> Behavioral health <input type="checkbox"/> Urgent care			
IPA name (if applicable):				Billing type: <input type="checkbox"/> UB-04/Institutional <input type="checkbox"/> CMS-1500/Professional			
Name doing business as (if applicable):				Group/Facility TIN/EIN # (nine characters):		NCTracks Provider ID:	
Primary contact name:		Primary contact email:			Primary contact phone:		
Pay to: Street address:		Building or suite number:	City, state, ZIP:			Phone number:	
Recoveries address (if different from pay to above):				Building or suite number:		City, state, ZIP:	
Organization website:							

**Section 2 instructions:** Please complete each section below for all locations including applicable NPI or Atypical ID information. (Make additional copies if needed.)

Location	Group name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Group or Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Main Practice Location 1								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 1 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	AM/PM
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									



Location	Group name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Group or Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Practice Location 2								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 2 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

Location	Group name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Group or Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Practice Location 3								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 3 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									



Location	Group name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Group or Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Practice Location 4								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 4 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

Location	Group name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Group or Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Practice Location 5								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 5 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									



Location	Group name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Group or Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Practice Location 6								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 6 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	AM/PM
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

**Section 3 instructions:** Please indicate ADA compliance for each location, as appropriate.

ADA Compliance	Facility Locations						
Compliant Access Service Location	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Compliant Access Rest Rooms	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Compliant Access Examination Rooms	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Handicap Accessible Medical Equipment	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Blind/Visually Impaired	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Cognitively Disabled	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Deaf or Hard of Hearing	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6



**Section 4 instructions:** Please complete all fields below by selecting which service(s) are provided at each location and ages served.

Services	Age Range		Locations
Adult Care Homes	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Ambulance Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Anesthesia Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Assertive Community Treatment (ACT)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Assisted Living	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Behavioral Health Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Behavior Support Consultation	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Behavioral Health Professional and Substance Abuse Services, Evaluations, Testing, Assessments, Med Management and/or Therapies	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Cardiovascular Rehabilitation	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Chemotherapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Childbirth Education	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Chiropractic Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Clinically Managed Low-Intensity Residential Treatment Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Community Transition Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Diagnostic Imaging	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Dialysis	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Durable Medical Equipment/Supplies	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
End-Stage Renal Disease Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Facility-Based Crisis Service for Adults		From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Services	Age Range		Locations
Facility-Based Crisis Service for Children and Adolescents		From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Family Care Homes	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Family Planning and Reproductive Health Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Family Support (Behavioral Health)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Habilitative and Rehabilitative Services — Occupational Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Habilitative and Rehabilitative Services — Physical Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Habilitative and Rehabilitative Services — Speech Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Health and Behavior Intervention	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Health Department Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Hearing Aids and Related Evaluations	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Health Aide	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Health Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Infusion Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Modifications	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Visit for Newborn Care and Assessment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Visit for Postnatal Assessment and Follow-up Care	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Hospice Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Inpatient Behavioral Health Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Intermediate Care Facilities for Individuals with Intellectual Disabilities	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Services	Age Range		Locations
IV Outpatient Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Laboratory Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Mammography Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Maternal Care Skilled Nurse Home Visit	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Medical Supplies	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Medication Assisted Treatment for Opioid Dependence	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Midwife Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Nursing Equipment and Supplies	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Nursing Facility Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Nutritional Evaluations and Counseling — Dietary Evaluation and Counseling as Medical	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Nutritional Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
OB/GYN Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Ophthalmology	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Optical Services — Optometry	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Organ and Tissue Transplants	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Outpatient Behavioral Health Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Outpatient Opioid Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Outpatient Specialized Therapy Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Partial Hospitalization	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Personal Care Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Physical Rehabilitation Equipment and Supplies	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Services	Age Range		Locations
Podiatry Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Private Duty Nursing, <b>over</b> age 21			<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Private Duty Nursing, <b>under</b> age 21			<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Prosthetics and Orthotics	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Psychiatric Residential Treatment Facilities for Children under age 21			<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under 21 Population			<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Pulmonary Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Radiation Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Radiology Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Reconstructive Surgery	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Recovery Services (Behavioral Health)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Rehabilitation Services Providers	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Reproductive Health Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Residential Treatment Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Respiratory Equipment and Supplies	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Respiratory Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Respite	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
School-Based Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Services for Individuals with Intellectual and Developmental Disabilities and Mental Health or Substance Abuse	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Skilled Nursing Facility	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Sleep Studies	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Services	Age Range		Locations
Telemedicine, Primary Care	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Telemedicine, Medical	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Telemedicine, Psychiatric	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Transportation	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Ultrasound Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6

**ASAM Levels of Care**

Services	Age Range		Locations
ASAM Level OTS Outpatient Opioid Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 1 Outpatient Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 1-WM Ambulatory Detoxification	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 2.1 Substance Abuse Intensive Outpatient Program (SAIOP)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 2.5 Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 3.7-WM Non-Hospital Medical Detoxification	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 3.9-WM (NC) Medically Supervised or ADATC Detoxification Crisis Stabilization	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 4 Inpatient Hospital Substance Abuse Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Please add any unlisted services below and indicate age range and location.

Services	Age Range		Locations
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6

Additional Notes:



**Section 5 instructions:** Please complete all fields below. Please include practitioner licensure(s), i.e., MLADC, APRN etc., and indicate practice location numbers for each practitioner.

Category	First name	Last name	MI	Degree/License	Gender	Specialty	Accepting new patients?	Practitioner NPI/Atypical ID	Practice Location number for practitioner
						Taxonomy code	Age Range	Affiliated Hospital with Admitting Privileges	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
	Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege						

**Provider Training/Experience:**

Blindness or Visual Impairment  
  Child Welfare  
  Chronic Illness  
  Cognitively Disabled  
  Co-occurring Disorders  
  Deafness or Hard of Hearing  
  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**  Yes  No

<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
	Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege						

**Provider Training/Experience:**

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 Physical Disability  
 Serious Mental Illness  
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 Trauma

**Cultural Competency Training Completed?**  Yes  No

<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
	Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege						

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 Trauma

**Cultural Competency Training Completed?**  Yes  No



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						Taxonomy code	Age Range	Affiliated Hospital with Admitting Privileges	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

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						Taxonomy:	Age Range	Affiliated Hospital with Admit Privilege	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

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						Taxonomy:	Age Range	Affiliated Hospital with Admit Privilege	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

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 Trauma

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Category	First name	Last name	MI	Degree/License	Gender	Specialty	Accepting new patients?	Practitioner NPI/Atypical ID	Practice Location number for practitioner
						Taxonomy code	Age Range	Affiliated Hospital with Admitting Privileges	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

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 Physical Disability  
 Serious Mental Illness  
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**Cultural Competency Training Completed?**    Yes    No

<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

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  HIV/AIDS  
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 Physical Disability  
 Serious Mental Illness  
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 Trauma

**Cultural Competency Training Completed?**    Yes    No

<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

Blindness or Visual Impairment  
  Child Welfare  
  Chronic Illness  
  Cognitively Disabled  
  Co-occurring Disorders  
  Deafness or Hard of Hearing  
  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**    Yes    No

**Section 1 instructions:** Please complete all fields below for the Provider.

Entity name (as written on W9):				Category: <input type="checkbox"/> Behavioral health provider/group <input type="checkbox"/> Behavioral health hospital <input type="checkbox"/> Behavioral health facility			
IPA name (if applicable):				Billing type: <input type="checkbox"/> UB-04/Institutional <input type="checkbox"/> CMS-1500/Professional			
Name doing business as (if applicable):				Group/Facility TIN/EIN # (nine characters):		NCTracks Provider ID:	
Primary contact name:			Primary contact email:			Primary contact phone:	
Pay to: Street address:		Building or suite number:	City, state, ZIP:			Phone number:	
Recoveries address (if different from pay to above):				Building or suite number:		City, state, ZIP:	
Organization website:							

**Section 2 instructions:** Please complete each section below for all locations including applicable NPI or Atypical ID information. (Make additional copies if needed.)  
If statewide coverage, please attach spreadsheet or document listing coverage areas.

Location	Group name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Group or Facility NPI/Atypical ID	Telephone with Area Code
								Taxonomy Code	
Main Practice Location 1								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 1 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	AM/PM
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									



Location	Group name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Group or Facility NPI/Atypical ID	Telephone with Area Code
								Taxonomy Code	
Practice Location 2								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 2 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

Location	Group name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Group or Facility NPI/Atypical ID	Telephone with Area Code
								Taxonomy Code	
Practice Location 3								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 3 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									



Location	Group name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Group or Facility NPI/Atypical ID	Telephone with Area Code
								Taxonomy Code	
Practice Location 4								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 4 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

Location	Group name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Group or Facility NPI/Atypical ID	Telephone with Area Code
								Taxonomy Code	
Practice Location 5								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 5 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									



Location	Group name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Group or Facility NPI/Atypical ID	Telephone with Area Code
								Taxonomy Code	
Practice Location 6								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 6 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	AM/PM
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

**Section 3 instructions:** Please indicate ADA compliance for each location, as appropriate.

ADA Compliance	Facility Locations						
Compliant Access Service Location	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Compliant Access Rest Rooms	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Compliant Access Examination Rooms	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Handicap Accessible Medical Equipment	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Blind/Visually Impaired	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Cognitively Disabled	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Deaf or Hard of Hearing	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6



**Section 4 instructions:** Please complete all fields below by selecting which service(s) are provided at each location and ages served.

Services	Age Range		Locations
Advanced Practice Registered Nurse	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Alcohol or Drug Acute Detox	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Alcohol or Drug Assessment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Alcohol or Drug Case Management	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Alcohol or Drug Intensive Outpatient Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Alcohol or Drug Methadone or Equivalent Administration	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Alcohol or Drug Services Group Counseling by Clinician	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Alcohol or Drug Subacute Detox	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Alcohol or drug treatment in an ambulatory setting for any of the following: A. Crisis Intervention; B. Detoxification; or C. Medical or Somatic Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Alcohol or Drug Treatment Medication Training and Support	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Behavioral Health (BH) or Substance Use Disorder (SUD) Comprehensive Community Support Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Behavioral Health Counseling and Therapy, or Screening to Determine Eligibility for Admission to a Treatment Program	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Behavioral Health Crisis Treatment Center	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Behavioral Health Short Term Residential	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
BH or SUD Comprehensive Medication Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Buprenorphine Prescribers (Suboxone)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Clinically Managed Low-Intensity Residential Treatment Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Community Mental Health Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Continuous Recovery Monitoring	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Facility-Based Crisis Service for Adults		From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Services	Age Range		Locations
Crisis Intervention	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Designated Receiving Facilities	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Early and Periodic Screening, Diagnostic and Treatment Services Including Applied Behavioral Analysis Coverage	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Evaluations to determine the existence and severity of the SUD and appropriate level of care	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Facility-Based Crisis Service for Adults	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Facility-Based Crisis Service for Children and Adolescents	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Family Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
General Psychiatric Care on an Inpatient Basis	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Group Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Individual or Group Counseling for Mental Health (MH) or SUD	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Individual/Group MLADCs	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Inpatient Hospital	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Inpatient Psychiatric Facility Services Under Age Twenty-One (21)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Inpatient Psychiatric Treatment in an Institution for Mental Disease	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Intensive Outpatient SUD Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Medically Managed Withdrawal in an Acute Care Setting	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Medically Monitored Outpatient Withdrawal Management (WM)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Medically Monitored Residential Withdrawal Management (WM)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Non-Emergent Medical Transportation	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Non-Peer Recovery Support	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Services	Age Range		Locations
Opioid Treatment Programs (OTPS)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Opioid Treatment Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Outpatient Behavioral Health Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Outpatient, Individual Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Partial Hospitalization Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Peer Recovery Support	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Prescribed Drugs	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Psychiatric Diagnostic Evaluation with Medical Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Psychiatric Residential Treatment Facilities for Children under age 21			<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under 21 Population			<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Psychology	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Psychosocial Rehabilitation	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Recovery Services (Behavioral Health)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Rehabilitative Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Rehabilitative Services Post Hospital Discharge	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Residential Substance Use Disorder (SUD) Treatment Programs	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Screening and Assessment Services for MH or SUD	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Services for Individuals with Intellectual and Developmental Disabilities and Mental Health or Substance Abuse	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
SUD Screening	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Services	Age Range		Locations
Telemedicine, Primary Care	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Telemedicine, Medical	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Telemedicine, Psychiatric	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Therapeutic behavioral services provided in segments defined by number of minutes or on a per diem basis	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6

**ASAM Levels of Care**

Services	Age Range		Locations
ASAM Level OTS Outpatient Opioid Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 1 Outpatient Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 1-WM Ambulatory Detoxification	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 2.1 Substance Abuse Intensive Outpatient Program (SAIOP)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 2.5 Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 3.7-WM Non-Hospital Medical Detoxification	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 3.9-WM (NC) Medically Supervised or ADATC Detoxification Crisis Stabilization	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 4 Inpatient Hospital Substance Abuse Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Please add any unlisted services below and indicate age range and location.

Services	Age Range		Locations
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6

Additional Notes:



**Section 5 instructions:** Please complete all fields below. Please include practitioner licensure(s), i.e., MLADC, APRN etc., and indicate practice location numbers for each practitioner.

Category	First name	Last name	MI	Degree/License	Gender	Specialty	Accepting new patients?	Practitioner NPI/Atypical ID	Practice Location number for practitioner
						Taxonomy code	Age Range	Affiliated Hospital with Admitting Privileges	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

Blindness or Visual Impairment  
  Child Welfare  
  Chronic Illness  
  Cognitively Disabled  
  Co-occurring Disorders  
  Deafness or Hard of Hearing  
  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**    Yes    No

<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

Blindness or Visual Impairment  
  Child Welfare  
  Chronic Illness  
  Cognitively Disabled  
  Co-occurring Disorders  
  Deafness or Hard of Hearing  
  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**    Yes    No

<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

Blindness or Visual Impairment  
  Child Welfare  
  Chronic Illness  
  Cognitively Disabled  
  Co-occurring Disorders  
  Deafness or Hard of Hearing  
  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**    Yes    No



Category	First name	Last name	MI	Degree/License	Gender	Specialty	Accepting new patients?	Practitioner NPI/Atypical ID	Practice Location number for practitioner
						Taxonomy code	Age Range	Affiliated Hospital with Admitting Privileges	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

- Blindness or Visual Impairment  
  Child Welfare  
  Chronic Illness  
  Cognitively Disabled  
  Co-occurring Disorders  
  Deafness or Hard of Hearing  
  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**    Yes    No

<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

- Blindness or Visual Impairment  
  Child Welfare  
  Chronic Illness  
  Cognitively Disabled  
  Co-occurring Disorders  
  Deafness or Hard of Hearing  
  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**    Yes    No

<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

- Blindness or Visual Impairment  
  Child Welfare  
  Chronic Illness  
  Cognitively Disabled  
  Co-occurring Disorders  
  Deafness or Hard of Hearing  
  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**    Yes    No



Category	First name	Last name	MI	Degree/License	Gender	Specialty	Accepting new patients?	Practitioner NPI/Atypical ID	Practice Location number for practitioner
						Taxonomy code	Age Range	Affiliated Hospital with Admitting Privileges	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

Blindness or Visual Impairment  
  Child Welfare  
  Chronic Illness  
  Cognitively Disabled  
  Co-occurring Disorders  
  Deafness or Hard of Hearing  
  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**    Yes    No

<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

Blindness or Visual Impairment  
  Child Welfare  
  Chronic Illness  
  Cognitively Disabled  
  Co-occurring Disorders  
  Deafness or Hard of Hearing  
  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**    Yes    No

<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

Blindness or Visual Impairment  
  Child Welfare  
  Chronic Illness  
  Cognitively Disabled  
  Co-occurring Disorders  
  Deafness or Hard of Hearing  
  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**    Yes    No

**Section 1 instructions:** Please complete all fields below for the Provider.

Entity name (as written on W9):		Category: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> FQHC <input type="checkbox"/> RHC <input type="checkbox"/> Behavioral health <input type="checkbox"/> Urgent care			
IPA name (if applicable):		Billing type: <input type="checkbox"/> UB-04/Institutional <input type="checkbox"/> CMS-1500/Professional			
Name doing business as (if applicable):		Group/Facility TIN/EIN # (nine characters):		NCTracks Provider ID:	
Primary contact name:		Primary contact email:		Primary contact phone:	
Pay to: Street address:		Building or suite number:	City, state, ZIP:		Phone number:
Recoveries address (if different from pay to above):			Building or suite number:	City, state, ZIP:	
Organization website:					

**Section 2 instructions:** Please complete each section below for all locations including applicable NPI or Atypical ID information. (Make additional copies if needed.)

Location	Facility name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Facility NPI/Atypical ID	Phone with Area Code
								Taxonomy Code	
Location 1								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 1 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

# AmeriHealth Caritas North Carolina Facility Data Intake Form



Location	Facility name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Location 2								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 2 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	AM/PM
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

Location	Facility name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Location 3								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 3 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	AM/PM
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

# AmeriHealth Caritas North Carolina Facility Data Intake Form



Location	Facility name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Location 4								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 4 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	AM/PM
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

Location	Facility name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Location 5								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 5 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	AM/PM
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									



Location	Facility name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Location 6								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 6 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	AM/PM
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

**Section 3 instructions:** Please indicate ADA compliance for each location, as appropriate.

ADA Compliance	Facility Locations						
Compliant Access Service Location	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Compliant Access Rest Rooms	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Compliant Access Examination Rooms	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Handicap Accessible Medical Equipment	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Blind/Visually Impaired	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Cognitively Disabled	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Deaf or Hard of Hearing	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6



**Section 4 instructions:** Please complete all fields below by selecting which service(s) are provided at each location and ages served.

Services	Age Range		Locations
Adult Care Homes	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Ambulance Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Anesthesia Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Assertive Community Treatment (ACT)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Assisted Living	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Behavioral Health Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Behavior Support Consultation	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Behavioral Health Professional and Substance Abuse Services, Evaluations, Testing, Assessments, Med Management and/or Therapies	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Cardiovascular Rehabilitation	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Chemotherapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Childbirth Education	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Chiropractic Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Clinically Managed Low-Intensity Residential Treatment Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Community Transition Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Diagnostic Imaging	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Dialysis	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Durable Medical Equipment/Supplies	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
End-Stage Renal Disease Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Facility-Based Crisis Service for Adults		From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Services	Age Range		Locations
Facility-Based Crisis Service for Children and Adolescents		From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Family Care Homes	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Family Planning and Reproductive Health Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Family Support (Behavioral Health)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Habilitative and Rehabilitative Services — Occupational Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Habilitative and Rehabilitative Services — Physical Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Habilitative and Rehabilitative Services — Speech Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Health and Behavior Intervention	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Health Department Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Hearing Aids and Related Evaluations	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Hemophilia Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Delivery Meals	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Health Aide	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Health Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Infusion Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Modifications	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Visit for Newborn Care and Assessment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Visit for Postnatal Assessment and Follow-up Care	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Hospice Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Inpatient Behavioral Health Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Intermediate Care Facilities for Individuals with Intellectual Disabilities	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Services	Age Range		Locations
IV Outpatient Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Laboratory Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Mammography Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Maternal Care Skilled Nurse Home Visit	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Medical Supplies	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Medication Assisted Treatment for Opioid Dependence	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Midwife Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Nursing Equipment and Supplies	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Nursing Facility Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Nutritional Evaluations and Counseling — Dietary Evaluation and Counseling as Medical	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Nutritional Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
OB/GYN Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Ophthalmology	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Optical Services — Optometry	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Organ and Tissue Transplants	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Outpatient Behavioral Health Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Outpatient Opioid Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Outpatient Specialized Therapy Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Partial Hospitalization	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Personal Care Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Physical Rehabilitation Equipment and Supplies	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Services	Age Range		Locations
Podiatry Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Private Duty Nursing, <b>over</b> age 21			<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Private Duty Nursing, <b>under</b> age 21			<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Prosthetics and Orthotics	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Psychiatric Residential Treatment Facilities for Children under age 21			<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Psychological Services in Health Departments and School-Based Health Centers Sponsored by Health Departments to the under 21 Population			<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Pulmonary Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Radiation Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Radiology Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Reconstructive Surgery	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Recovery Services (Behavioral Health)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Rehabilitation Services Providers	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Reproductive Health Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Residential Treatment Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Respiratory Equipment and Supplies	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Respiratory Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Respite	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
School-Based Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Services for Individuals with Intellectual and Developmental Disabilities and Mental Health or Substance Abuse	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Skilled Nursing Facility	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Sleep Studies	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Services	Age Range		Locations
Telemedicine, Primary Care	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Telemedicine, Medical	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Telemedicine, Psychiatric	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Transportation	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Ultrasound Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6

**ASAM Levels of Care**

Services	Age Range		Locations
ASAM Level OTS Outpatient Opioid Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 1 Outpatient Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 1-WM Ambulatory Detoxification	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 2.1 Substance Abuse Intensive Outpatient Program (SAIOP)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 2.5 Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 3.7-WM Non-Hospital Medical Detoxification	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 3.9-WM (NC) Medically Supervised or ADATC Detoxification Crisis Stabilization	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 4 Inpatient Hospital Substance Abuse Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Please add any unlisted services below and indicate age range and location.

Services	Age Range		Locations
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6

Additional Notes:



**Section 5 instructions:** Please complete all fields below. Please include practitioner licensure(s), i.e., MLADC, APRN etc., and indicate practice location #s for each practitioner.

Category	First name	Last name	MI	Degree/License	Gender	Specialty	Accepting new patients?	Practitioner NPI/Atypical ID	Practice Location number for practitioner
						Taxonomy code	Age Range	Affiliated Hospital with Admitting Privileges	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

Blindness or Visual Impairment  
  Child Welfare  
  Chronic Illness  
  Cognitively Disabled  
  Co-occurring Disorders  
  Deafness or Hard of Hearing  
  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**  Yes  No

<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

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 Physical Disability  
 Serious Mental Illness  
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 Trauma

**Cultural Competency Training Completed?**  Yes  No

<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

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 Physical Disability  
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						Taxonomy code	Age Range	Affiliated Hospital with Admitting Privileges	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

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						Taxonomy:	Age Range	Affiliated Hospital with Admit Privilege	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

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						Taxonomy:	Age Range	Affiliated Hospital with Admit Privilege	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

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						Taxonomy code	Age Range	Affiliated Hospital with Admitting Privileges	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

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**Cultural Competency Training Completed?**    Yes    No

Category	First name	Last name	MI	Degree/License	Gender	Specialty	Accepting New Patients?	NPI/Atypical ID	Practice Location number for practitioner
						Taxonomy:	Age Range	Affiliated Hospital with Admit Privilege	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

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**Cultural Competency Training Completed?**    Yes    No

Category	First name	Last name	MI	Degree/License	Gender	Specialty	Accepting New Patients?	NPI/Atypical ID	Practice Location number for practitioner
						Taxonomy:	Age Range	Affiliated Hospital with Admit Privilege	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

Blindness or Visual Impairment  
  Child Welfare  
  Chronic Illness  
  Cognitively Disabled  
  Co-occurring Disorders  
  Deafness or Hard of Hearing  
  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**    Yes    No

**Section 1 instructions:** Please complete all fields below for the Provider.

Entity name (as written on W9):				Category: <input type="checkbox"/> Ancillary <input type="checkbox"/> Behavioral health <input type="checkbox"/> Urgent care			
IPA name (if applicable):				Billing type: <input type="checkbox"/> UB-04/Institutional <input type="checkbox"/> CMS-1500/Professional			
Name doing business as (if applicable):				Group/Facility TIN/EIN # (nine characters):		NCTracks Provider ID:	
Primary contact name:			Primary contact email:			Primary contact phone:	
Pay to: Street address:		Building or suite number:		City, state, ZIP:			Phone number:
Recoveries address (if different from pay to above):				Building or suite number:		City, state, ZIP:	
Organization website:							

**Section 2 instructions:** Please complete each section below for all locations including applicable NPI or Atypical ID information. (Make additional copies if needed.)

Location	Facility name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Facility NPI/Atypical ID		Phone with Area Code
								Taxonomy Code		
<b>Location 1</b>								NPI/Atypical ID:		
								Taxonomy Code:		

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 1 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

# AmeriHealth Caritas North Carolina Ancillary Data Intake Form



Location	Facility name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Location 2								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 2 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

Location	Facility name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Location 3								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 3 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

# AmeriHealth Caritas North Carolina Ancillary Data Intake Form



Location	Facility name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Location 4								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 4 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

Location	Facility name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Location 5								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 5 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									



Location	Facility name (as it will appear in provider directory)	Street address	Building or suite number	City	State	ZIP + 4 Digits	County	Facility NPI/ Atypical ID	Telephone with Area Code
								Taxonomy Code	
Location 6								NPI/Atypical ID:	
								Taxonomy Code:	

**Languages Spoken:**  English  Spanish  Chinese  Vietnamese  Korean  French  Arabic  ASL  Other (please list):

Location 6 — Office Hours									
Day	Start	AM/PM	End	AM/PM	Start	AM/PM	End	AM/PM	AM/PM
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

**Section 3 instructions:** Please indicate ADA compliance for each location, as appropriate.

ADA Compliance	Facility Locations						
Compliant Access Service Location	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Compliant Access Rest Rooms	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Compliant Access Examination Rooms	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Handicap Accessible Medical Equipment	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Blind/Visually Impaired	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Cognitively Disabled	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Deaf or Hard of Hearing	<input type="checkbox"/> All	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6



**Section 4 instructions:** Please complete all fields below by selecting which service(s) are provided at each location and ages served.

Services	Age Range		Locations
Adult Medical Day Care	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Ambulance Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Ambulatory Surgery Center	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Assisted Living Facility	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Audiology	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Behavioral Health	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Birthing Centers	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Cardiac Rehabilitation	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Cardiac Testing	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Care Management	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Certified Nurse Midwife	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Certified Registered Nurse Anesthetist (CRNA)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Chiropractic Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Clinical Psychologist	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Community Residential Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Diabetes Education	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Diabetes Self-Management	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Diagnostic Imaging/X-Ray	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Diagnostic Therapeutic Custodial	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Dietitian	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Services	Age Range		Locations
Durable Medical Equipment (DME)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Facility-Based Crisis Service for Adults	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Facility-Based Crisis Service for Children and Adolescents	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Freestanding Birth Centers	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Furnished Medical Supplies & Durable Medical Equipment (DME)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Genetic Testing	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home And Vehicle Modifications	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Delivered Meals	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Health	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Infusion	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Home Visiting Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Hospice Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Imaging Centers	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Infusion Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Kidney Dialysis	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Laboratory	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Mammography Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Medical Nutrition	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Medical Services Clinic (e.g., Opioid Treatment Program)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Medical Weight Loss Clinic	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Mental Health And Addiction Services — Please Specify:	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Services	Age Range		Locations
Non-Emergency Medical Transportation	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Nursing Home Care	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Nutrition Education	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Inpatient Behavioral Health	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Outpatient Behavioral Health	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Occupational Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Partial Hospitalization	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Personal Care Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Personal Emergency Response Systems	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Pharmacy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Physical Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Plasma Donation Centers	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Podiatry	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Private Duty Nursing, over age 21			<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Private Duty Nursing, under age 21			<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Psychiatric Rehabilitation	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Psychosocial Rehabilitation	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Pulmonary Testing	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Radiology	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Rehabilitation Hospital	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Rehabilitative Services Post Hospital Discharge	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Services	Age Range		Locations
Residential Care	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Residential Treatment Facility	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Respite	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Skilled Nursing Facility	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Sleep Lab	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Social Worker	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Speech Therapy	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Substance Abuse Rehabilitation Facility	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Telemedicine, Primary Care	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Telemedicine, Medical	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Telemedicine, Psychiatric	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Therapist (i.e., Marriage, Family, etc.). Please Specify:	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Transitional Housing Program Services and Community Residential Services with Wrap-Around Services and Supports	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Transportation	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Ultrasound Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Urgent Care Facilities	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Weight Management	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
Wheelchair Van	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



**ASAM Levels of Care**

Services	Age Range		Locations
ASAM Level OTS Outpatient Opioid Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 1 Outpatient Services	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 1-WM Ambulatory Detoxification	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 2.1 Substance Abuse Intensive Outpatient Program (SAIOP)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 2.5 Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 3.7-WM Non-Hospital Medical Detoxification	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 3.9-WM (NC) Medically Supervised or ADATC Detoxification Crisis Stabilization	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
ASAM Level 4 Inpatient Hospital Substance Abuse Treatment	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6



Please add any unlisted services below and indicate age range and location.

Services	Age Range		Locations
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
	<input type="checkbox"/> All Ages	From Age ____ to ____	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6

Additional Notes:



**Section 5 instructions:** Please complete all fields below. Please include practitioner licensure(s), i.e., MLADC, APRN etc., and indicate practice location number for each practitioner.

Category	First name	Last name	MI	Degree/License	Gender	Specialty	Accepting new patients?	Practitioner NPI/Atypical ID	Practice Location number for practitioner
						Taxonomy code	Age Range	Affiliated Hospital with Admitting Privileges	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

Blindness or Visual Impairment  
  Child Welfare  
  Chronic Illness  
  Cognitively Disabled  
  Co-occurring Disorders  
  Deafness or Hard of Hearing  
  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**    Yes    No

<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

**Provider Training/Experience:**

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  HIV/AIDS  
  Homelessness  
 Physical Disability  
 Serious Mental Illness  
 Substance Abuse  
 Trauma

**Cultural Competency Training Completed?**    Yes    No

<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
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 Physical Disability  
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 Trauma

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						Taxonomy code	Age Range	Affiliated Hospital with Admitting Privileges	
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Hospital Based					<input type="checkbox"/> M <input type="checkbox"/> F	Specialty:	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	NPI/Atypical ID	<input type="checkbox"/> All <input type="checkbox"/> 1 <input type="checkbox"/> 4 <input type="checkbox"/> 2 <input type="checkbox"/> 5 <input type="checkbox"/> 3 <input type="checkbox"/> 6
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						Taxonomy:	From Ages ____ to ____ <input type="checkbox"/> All Ages	Affiliated Hospital with Admit Privilege	

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