



CHAPTER 503 LICENSED BEHAVIORAL HEALTH CENTER (LBHC) SERVICES

Chapter 503

Licensed Behavioral Health Center (LBHC) Services

Appendix 503H

Application for Mobile Crisis Team Services

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DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.

APPLICATION FOR MOBILE CRISIS TEAM SERVICES

Please complete the following identifying information for your agency.

Name of Provider/Agency operating Mobile Crisis at site listed below: Provider/Agency Address: _____ Organization Type: CCBHC CFQHC CBHC CBHC NPI Number: CEO/Executive Director Name: _____ CEO/Executive Director Telephone and extension: _____ CEO/Executive Director Email: Clinical Director: Clinical Director Telephone and extension: Clinical Director Email: Is the above provider currently enrolled in West Virginia Medicaid Program: Y N Requested Start Date of Program: _____ Name & Title of Individual Completing Application: Email Address: Telephone Number and Extension: _____ Fax Number: BMS Provider Manual Page 2

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□Barbour	Crisis team (check all counties	□ Preston
□Berkeley		🗆 Putnam
□Boone	□ Lincoln	🗆 Raleigh
□ Braxton	🗆 Logan	🗆 Randolph
□ Brooke	□ Marion	□ Ritchie
□ Cabell	□ Marshall	🗆 Roane
□ Calhoun	□ Mason	□ Summers
□ Clay	□ McDowell	□ Taylor
Doddridge	□ Mercer	□ Tucker
□ Fayette	Mineral	□ Tyler
□ Gilmer	Mingo	🗆 Upshur
Grant	🗆 Monongalia	🗆 Wayne
Greenbrier		□ Webster
□ Hampshire	🗆 Morgan	□ Wetzel
□ Hancock	□ Nicholas	□ Wirt
□ Hardy		\Box Wood
□ Harrison	□ Pendleton	□ Wyoming
□ Jackson	□ Pleasants	
□ Jefferson	□ Pocahontas	
I		l

Counties served by Mobile Crisis team (check all counties that will be served):

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PROGRAM DESCRIPTION

Α.	This application is	for (please	circle all that	apply):
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Initial or New Certification

Change of Service Area

Β.	Types of	population(s)	to be served:	(circle one)
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Adults

Adolescents

C. Attestation from CEO/Executive Director:

I attest that the Mobile Crisis Team that is approved through this application will operate 24 hours a day, 7 days a week, 365 days of the calendar year. I understand that if we cannot operate within these guidelines, we will notify BMS immediately of our inability to meet this requirement and may lose our certification as a Mobile Crisis Team as a result of this.

CEO/Executive Director Signature: _____ Date: _____

Send Completed Application to:

West Virginia Department of Human Services Bureau for Medical Services Attention: Behavioral Health & Long- Term Care Unit 350 Capitol Street, Room 251 Charleston, West Virginia 25301

BMS USE ONLY:

Utilization Contractor Approval:

Signature:	Date:
BMS Approval:	
Signature:	Date:
Effective Date of Program:	
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