Chapter 503

Licensed Behavioral Health Center (LBHC) Services

Appendix 503H

Application for Mobile Crisis Team Services

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 ☐FQHC ☐LBHC ☐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: _____

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

☐Barbour	☐ Kanawha	☐ Preston
☐Berkeley	☐ Lewis	☐ 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	☐ Monroe	☐ Webster
☐ Hampshire	☐ Morgan	☐ Wetzel
☐ Hancock	☐ Nicholas	☐ Wirt
☐ Hardy	☐ Ohio	☐ Wood
☐ Harrison	☐ Pendleton	☐ Wyoming
☐ Jackson	☐ Pleasants	
☐ Jefferson	☐ Pocahontas	

PROGRAM DESCRIPTION

A. This application is for (please circle all that apply):

Initial or New Certification Change of Service Area

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

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: _____