MID-VALLEY BEHAVIORAL CARE NETWORK

OUT OF AREA AGENCY AGREEMENT FOR MENTAL HEALTH SERVICES

Agreement for services for youth residing in Behavioral Rehabilitation Service facilities whose Oregon Health Plan membership is with Mid-Valley Behavioral Care Network.

This agreement makes the Service Organization eligible for payment when mental health services to a specific child are authorized by one of the MVBCN Counties (Linn, Marion, Polk, Tillamook, Yamhill).

This agreement is between the Mid-Valley Behavioral Care Network, and the mental health agency named below:

Service Organization: _____

Address: _____

City, State & Zip Code: _____

Phone: _____Fax: _____

Tax ID: _____DMAP Vendor#: _____

NPI#: _____Taxonomy Code: _____

Credentialing

Organization currently holds a Certificate of Approval for Mental Health Services

☐ If certified in multiple counties, submit certificates for all

☐ Maintains professional liability insurance

Clinical Documentation

Service Organization Representative Initials: _____. We (Service organization named above) agree to maintain clinical records consistent with OAR 410-141-0180, Oregon Health Plan Prepaid Health Plan Recordkeeping, and with all applicable DHS Rules in OAR chapter 309.

Confidentiality Statement

Service Organization Representative Initials: _____. We (Service organization named above) understand that we are to maintain full confidentiality of private client information and protected health information in accordance with federal HIPAA standards (P.L 104-191, 45 CFR Parts 160, 161, and 164), Oregon laws (ORS 179.505), and applicable Oregon Administrative Rules. We will not discuss or give out information about clients served or his/her family without written authorization from the client or family unless specifically allowed by law to

do so. HIPAA and Oregon statutes allow exchange of information necessary to authorize services and process claims without a Release of Information from the agency which holds custody of the youth.

Payment Schedule

Service Organization Representative Initials: _____. We (Service organization named above) agree that payment for authorized services will be made in accordance with existing rates for services established by the Local Mental Health Authority in the County of legal jurisdiction of the youth. We agree to accept payment rates established by each County as full payment of services rendered.

Billing

Service Organization Representative Initials: _____. We (Service organization named above) will submit a *CMS 1500 for 08/05* claim form for all authorized services rendered, as described in the *AUTHORIZATION PROCESS FOR MVBCN MEMBERS PLACED IN BRS PROGRAMS OUTSIDE OF OUR REGION.*

Mandatory Abuse Reporting

Service Organization Representative Initials: _____. We (Service organization named above) understand that under state law we are a mandatory reporter of abuse and must promptly report any suspected abuse or neglect to local child welfare or law enforcement personnel.

Critical Incident Reporting

Service Organization Representative Initials: _____. We (Service organization named above) will notify Mid-Valley Behavioral Care Network if any clients for whom we are authorized to provide services are involved in a Critical Incident while we are working with the client. (See MVBCN Critical Incident definitions on page 4 of this agreement)

Responding to Grievances

Service Organization Representative Initials: _____. We (Service organization named above) will respond to grievances concerning MVBCN-funded services from MVBCN members or their representatives as set forth in OAR 309-032-1560. Copies of grievances and written responses to the member will be sent to MVBCN, Attention Complaints Representative.

Criminal Background and Medicaid Exclusion Checks

Service Organization Representative Initials: _____. We (Service organization named above) certify that we follow the Department of Human

Services guidelines for criminal history background checks for all service delivery staff. We determine that professional staff are not excluded from Medicaid participation. Verification of both of these checks for staff working with MVBCN clients are available upon request.

Conditions of Agreement

By signing this document, We (Service organization named above) agree to assume all risks and responsibilities that are applicable. This agreement may be modified or cancelled by either party at any time for any reason with or without prior notice. Any modification of this agreement must include the date and signature of all parties in order for the revisions to be in force.

Service Organization Representative_____
Signature

Date: _____

MVBCN Representative: _____
Signature

Date: _____

Please Attach:

- € Copy of applicable Certificate of Approval
- € Copy of professional liability insurance endorsement

Return this Agreement to:

Kathy Savicki, Clinical Director
Mid-Valley Behavioral Care Network
1660 Oak St. SE, Suite 203
Salem, OR 97301

MVBCN Critical Incident Definitions

The following Critical Incidents **involving MVBCN Capitated Members** should be reported to the MVBCN via a phone call to Kathy Savicki, Clinical Director (503-585-4985): We will provide consultation on whether the incident is reportable and assistance with the reporting and review process. Note that all such events happening in the BRS residential setting may not be reportable by a provider of outpatient mental health services. 'Provider' as used below, refers to the outpatient mental health provider agency.

Client, as used in the following definitions, includes any person currently enrolled or within 3 months of discharge, or those having had recent contact with MVBCN providers (to the extent that information is available to the provider agency):

1.0 **Client Suicide**

2.0 **Attempted Client Suicide:** A serious action that would likely have resulted in death without intervention.

3.0 **Client Death:** Deaths which are violent, unexplained, or related to behavioral health disorders or treatment.

4.0 **Allegation of Client Abuse or Neglect:** Includes any allegation of physical or emotional abuse involving Provider Staff and/or Provider Contractors, and any client to client abuse occurring at the site of mental health services.

4.1 Physical aggression between clients is a Critical Incident when it requires outside medical treatment beyond first aid)

4.2 ***Note that OAR's prescribe other mandatory abuse reporting responsibilities for vulnerable populations.***

5.0 **Danger to Health and Safety:** Includes any client-related violence; client injuries occurring on the mental health services site; client-to-client threats that interfere with access to services, or unsafe conditions that have resulted in risk of imminent harm to clients or others.

5.1 Violence or injuries to staff or clients which require outside medical treatment beyond first aid qualify as Critical Incidents.

6.0 **Alleged homicide of or by client:** The organization will conduct or contribute to an incident review.

7.0 **Police intervention:** Involvement by law enforcement personnel in response to a crisis call from the mental health agency, to control disruptive client behavior at the site of contracted service.