

Nursing Facility / Mental Health Service Provision Agreement

**Resident Name or
Initials and MCD #**

Covered Dates

Payer Source

	NA	Issue being addressed	Intervention	Is this service a Level II requirement?	Service Schedule (example 1x week for 60 minutes) Initiated w/in BHO required	Service Provider (clinician, social worker, case manager, therapist)	Services Currently Provided in Inpatient Setting
Specialized Services Mental Health Dual-Diagnosis							
Specialized Services Mental Health Dual-Diagnosis							
Transition Readiness							
Specialized Rehabilitative Program - Nursing Facility							
Specialized Rehabilitative Program - Nursing Facility							
Behavioral Plan							
Service Effectiveness Review							
Continuity of Care Plan							

Specialized Services Provider

Signature

Date

Specialized Rehabilitative Program Provider

Signature

Date

Revised May 24, 2012

Nursing Facility / Mental Health Service Effectiveness Report

**Resident Name or
Initials and MCD #**

Covered Dates

	Issue being addressed	Intervention	Expected outcome for this time period (measurable objective)	Was this outcome met?		If No, why not?	If No, how will the intervention be modified?	If Yes, what is the next intervention/outcome?
				Yes	No			
Specialized Services Mental Health Dual-Diagnosis								
Specialized Services Mental Health Dual-Diagnosis								
Transition Readiness								
Specialized Rehabilitative Program - Nursing Facility								
Specialized Rehabilitative Program - Nursing Facility								
Specialized Rehabilitative Program - Nursing Facility								

Specialized Services Provider

Signature

Specialized Rehabilitative Program Provider

Signature
