Washington State Department of
CHILDREN, YOUTH & FAMILIES

SECTION I: TO BE COMPLETED BY THE ADOPTIVE PARENT(S) (PLEASE PRINT)		
LEGAL NAME OF CHILD (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER	DATE OF BIRTH
PARENT(S) NAME	PREFERRED TELEPHONE NUMBER	

ADDRESS   CITY   STATE   ZIP CODE

TYPE OF SERVICE REQUESTED ☐ **Counseling** ☐ **Evaluation**	PROVIDER'S NAME

Does child have medical insurance? ☐ Yes ☐ No

COMPANY NAME	POLICY NUMBER	

Will family insurance cover the above requested service? ☐ Yes ☐ No   If yes, how much: _____

I am requesting service per above for my (our) child.

ADOPTIVE PARENT'S SIGNATURE	DATE	ADOPTIVE PARENT'S SIGNATURE	DATE

SECTION II: TO BE COMPLETED BY THE PROVIDER

The above named child is seeking service from you for:

☐ Counseling (please attach copy of the child's current treatment plan)
☐ Psychological Evaluation
☐ Neuropsychological Evaluation

SERVICE BEGIN DATE	SERVICE END DATE	Service will be a total of _____ sessions. **OR** The total fee for the service is $_____

BILLING INSTRUCTIONS:
Bills should be submitted monthly using the Adoption Support Monthly Counseling Billing form (DCYF 06-160). If the child's private insurance has been billed, please indicate on the billing form the amount the company reimbursed and attach a copy of the Explanation of Benefit document. The Adoption Support Program will pay the difference up to the maximum allowable adoption support rates. All bills will be paid by DCYF by the 30th day after receipt. Bills received more than 90 days out may not receive payment. Providers will submit all adoption support pre-authorized counseling billings by **EMAIL** to ASProfessionalsvcs@dcyf.wa.gov.

PROVIDER'S SIGNATURE	CREDENTIALS	
PROVIDER'S PRINTED NAME	PROVIDER'S TELEPHONE NUMBER	PROVIDER'S TAX IDENTIFICATION

ADDRESS   CITY   STATE   ZIP CODE

ROUTE ALL COPIES OF COMPLETED FORM TO ADOPTION SUPPORT PROGRAM (ASP)
ASP WILL RETURN A COPY TO PROVIDER AND TO ADOPTIVE FAMILY

SECTION III: TO BE COMPLETED BY THE PROGRAM CONSULTANT

Requested service approved: ☐ Yes ☐ No

COMMENTS

PROGRAM CONSULTANT'S SIGNATURE	SERVICE END DATE

Adoption Support Counseling/Evaluation/Billing Protocol

Counseling

The Adoption Support Program directly pays for a child's outpatient counseling or mental health services, when the following conditions apply: the adoptive parent must obtain written authorization from the department's adoption support program before the service is rendered; the adoptive parent must explain why these services are not available through the Medicaid provider network or through private insurance; the adoptive parents' primary health care coverage must be billed prior to billing the department's adoption support program; the department will pay the adoption support program's preauthorized rate minus any payment made by the primary (and other) insurer; the department may grant verbal authorization for no more than three counseling sessions prior to providing the required written authorization; and the child's therapist or other treatment provider must submit a written treatment plan prior to authorization for continued treatment. The treatment plan should include: begin date of service and anticipated end date, diagnosis of the problem and areas of identified need, and the plan for addressing the child's needs. The adoptive family can be included in sessions as well. The provider must provide services to the client (child/adoptive family) face-to-face, i.e., in the same room except where face-to-face services are not reasonably accessible to the child.

The Adoption Support Program may authorize counseling as follows: up to six hours of outpatient counseling per month for up to twelve months; up to a total of twenty hours per quarter when critical need warrants; for only one provider at a time unless a second provider is required for a different service; or evidence based programs contracted by the department to help stabilize the child in the adoptive home if those programs are pertinent to the needs of the child and family.

The Adoption Support Program may extend the authorization for counseling (beyond the initial time period authorized) upon receipt of an updated treatment plan, documentation supporting the need for additional treatment from the treatment provider, and a parent's request for continuing counseling.

The treatment provider must receive a signed and approved Pre-Authorization for Services (DCYF 10-214), from the Adoption Support Program Consultant, prior to providing a fourth hour of treatment. The provider must be licensed and credentialed in the state in which they are practicing with a minimum of a Master's Degree.

Evaluations

Adoption Support may pay for up to one pre-authorized evaluation per year. The pre-authorization must be approved prior to the evaluation occurring, and the written evaluation must be received prior to payment being made. If available, the adoptive family's private insurance or Medicaid should be billed first. All payments must be made directly to the provider.

> **REIMBURSEMENT RATES**
> - Master's level counseling……………………………………not to exceed $55.00/hr.
> - Psychologist level counseling………………………………not to exceed $70.00/hr.
> - Psychiatrist level counseling…………………………………not to exceed $75.00/hr.
> - Psychological/Psychiatric Evaluation…………………..not to exceed $380.00
> - Neuropsychological Evaluation...……………….……not to exceed $800.00

Billing

Providers will submit all adoption support pre-authorized counseling billings by **EMAIL** to ASProfessionalsvcs@dcyf.wa.gov. Bills should be submitted monthly using the Adoption Support Monthly Counseling Billing form (DCYF 06-160). If the child's private insurance has been billed, please indicate on the billing form the amount the company reimbursed and attach a copy of the Explanation of Benefit document. The Adoption Support Program will pay the difference up to the maximum allowable adoption support rates. All bills will be paid by DCYF by the 30th day after receipt. Bills received more than 90 days out may not receive payment.