New Jersey Department of Children and Families (DCF)
Division of Child Behavioral Health Services (DCBHS)

Item-by-Item Instructions for Completing the CONFIDENTIAL Intensive In-Community Service Delivery Encounter Documentation Form

February 22, 2006

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Introduction

The CONFIDENTIAL Intensive In-Community Service Delivery Encounter Documentation Form is designed to collect auditable documentation of every service delivery encounter occurring between a provider of Intensive In-Community (IIC) or Behavioral Assistance (BA) Services and the individual child who has been authorized to receive the services or for whom the services were provided on behalf of and to whose Medicaid/NJ FamilyCare or insurance number the treatment services will be billed. The services authorized and billed to Medicaid/NJ FamilyCare must be in direct support of the child, consistent with the plan of care.

At service providers' request, the form is designed to collect information on up to six service delivery encounters between a provider and the same service recipient.

Audits of Completed Forms

Information on the CONFIDENTIAL Intensive In-Community Service Delivery Encounter Documentation Form, as well as all other provider-produced records consistent with the regulation covering IIC and BA services, is subject to audit by the New Jersey Department of Human Services and any other Federal or State-designated entity. The form may be used to:

1. Verify that services were delivered as actually reported on the form;
2. Verify consistency between the service recipient's clinical needs and the services delivered;
3. Verify consistency between the service recipient's treatment plan and the services delivered;
4. Verify consistency between the services authorized and services delivered; and
5. Verify consistency between the services delivered and the services billed.

Submission of Completed forms

The CONFIDENTIAL Intensive In-Community Service Delivery Encounter Documentation Form must be completed accurately and completely and submitted within 30 days of the date of the earliest service delivery listed on the form.

The submission site of completed forms varies depending on the agency requesting the service delivery and the Medicaid/NJ FamilyCare eligibility of the authorized service recipient.

a. **Forms Completed to Document Services Delivered to Medicaid/NJ FamilyCare Eligible Service Recipients**

   A hard-copy of the accurately completed form must be retained on the service recipient's file or chart for future auditing.

b. Forms Completed to Document Services Delivered to Non - Medicaid/NJ FamilyCare Eligible Service Recipients, that is those youth whose Eligibility Identification numbers start with 3560 and those youth with no eligibility identification number.

   The original of the accurately completed form must be submitted to the agency requesting the delivery of services to the authorized service recipient together with a completed CMS1500. "Service Requestor's" include:

   - The Youth Case Management Agency (YCM)
   - The Care Management Organization (CMO)

- The Mobile Response and Stabilization Services Agency (MRSS)
- The Contracted Services Administrator (CSA)

Maintaining Completed Forms on Individual Child and/or Family Charts

Since completed Service Delivery Encounter Documentation Forms may be used by Federal or State-designated auditors, the Department of Human Services and the Division of Child Behavioral Health Services expect that copies of completed documentation forms will be maintained by service providers on the individual records they maintain for the children and families served.

Deadline for the Submission of Completed Forms

The CONFIDENTIAL Intensive In-Community Service Delivery Encounter Documentation Form must be completed accurately and completely and submitted within 30 days of the earliest date of service delivery.

Completeness and Accuracy of Submitted Forms

Incomplete and/or inaccurate forms received may be returned to submitters for correction and completion.

Confidentiality of Completed Forms

The CONFIDENTIAL Intensive In-Community Service Delivery Encounter Documentation Form collects information that is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) and should be completed, handled and transmitted as HIPAA-protected information.

Signatures of Children over the Age of Fourteen and their Parents, Legal Guardians or Responsible Parties

Consistent with State statute and the regulations at N.J.A.C. 10:37, "Community Mental Health Services Act," children aged fourteen and above may certify the receipt of services by signing the Service Delivery Encounter Documentation Form independently of and without corroborating certifying signatures from their parents, legal guardians or responsible parties.

However, DCBHS advises service providers that DCBHS holds that best practice with regard to obtaining the certification of minors between the ages of fourteen and 18 is that providers attempt to obtain the certifying signatures of the parent, legal guardian and/or responsible party for all minors regardless of the age of the minor.

Completing the Form Electronically

In response to service provider's requests, the Service Delivery Encounter Documentation Form has been designed as a form in Microsoft Word 2002 and may be completed electronically by any person operating that program. However all completed and submitted forms must bear actual certifying signatures.

To complete the form electronically, operators should use the tab key to navigate the cursor to the form's data entry fields (highlighted in yellow on the electronic form). The tab key will move the cursor to fields in the order that the fields are listed in these instructions.

NOTE: the Intensive In-Community Service Delivery Encounter Documentation Form has been designed as a data entry form that may be converted electronically into standard database readable format for programs like Access, SPSS or SASS. Form users seeking to utilize this

function should consult the manual for the database software to be used in order to convert the form correctly.

Definition of Terms and Abbreviations Used in the Form

1. A "Service Delivery Encounter" is the period of time a provider of Intensive In-Community and/or Behavioral Assistance treatment services spends in direct face-to-face contact with the child or family member who is the recipient or beneficiary of the service(s).
2. The "Service Recipient" is the individual child receiving the Intensive In-Community and/or Behavioral Assistance treatment services. In the case of family therapy (i.e. therapy provided to more than one member of a family at one time), the "Service Recipient" is the individual child who has been authorized to receive the services and to whose Medicaid/NJ FamilyCare or insurance number the treatment services will be billed. The services authorized and billed to Medicaid/NJ FamilyCare must be in direct support of the child, consistent with the plan of care.
3. "DOB" is an abbreviation for "Date of Birth."
4. "Mo." is an abbreviation for "Month."
5. "Yr." is an abbreviation for "Year."
6. "M.I." is an abbreviation for "Middle Initial."
7. "IIC" is an abbreviation for "Intensive In-Community services as defined at N.J.A.C. 10:77.
8. "IIC – Bachelors" means Intensive In-Community support services delivered by at a minimum a Bachelors-level practitioner as defined at N.J.A.C. 10:77.
9. "IIC – Masters" means Intensive In-Community services delivered by, at a minimum, a Masters-level practitioner as defined at N.J.A.C. 10:77.
10. "IIC – Licensed" means Intensive In-Community Clinical Services delivered by a clinically licensed practitioner as defined at N.J.A.C. 10:77.
11. "BA" is an abbreviation for "Behavioral Assistance" services as defined at N.J.A.C. 10:77.
12. "Authorized" means assigned an authorization number by the Contracted Systems Administrator (CSA).
13. "CSA" means Contracted Systems Administrator
14. "Units" means units of service. A unit of service is one 15-minute period time in face-to-face contact with the service recipient who has been authorized to receive services.
15. "Responsible Party" means a person aged 18 or older who, in the absence of the child's parent or legal guardian, can certify the delivery of services to a child under the age of fourteen.
16. "Signatory" and "Authorized Signatory" means the official employed by a provider agency who is authorized as an official representative of the agency to sign binding certifications on behalf of the agency.

Important Notes on Certifications

Signed certification statements on the Intensive In-Community Service Delivery Documentation Form attest to:

a. truth and accuracy of the information submitted on the completed form and

b. certification of the certifier's credentials

Providers are reminded that as a recipient of both federal and state dollars, all of the services provided under BA and IIC, must meet all the requirements set forth in the Medicaid/NJ FamilyCare regulations and the policies issued by DCBHS, whether the claims have been reimbursed through Unisys, the Medicaid fiscal agent, or through the DCBHS broker agencies.

Submitting claims for reimbursement and receiving funds for services which do not meet all of the requirements can be construed to be fraud and abuse, depending on the scope and circumstances of the inappropriate billings. If found upon audit by federal, state, or other governmental entities, the provider may be subject to fines and penalties, as well as the recovery of the identified inappropriately reimbursed funds. Providers may also be subject to federal and/or state criminal charges, as well as suspension, termination, or debarment from the program.

Form Approval by Service Providers

The Intensive In-Community Service Delivery Encounter Documentation Form was reviewed and approved for use by a panel of representatives of the IIC and BA provider community on Monday January 30, 2006.

Charles Brown, Executive Director
Camden County Partnership for Children

Alan DeStefano, Executive Director
Cape/Atlantic Integrated Network for Kids

George Forman, YES Coordinator/CIACC/CART
Community Planning & Advocacy Council (CPAC)

Chuck Goldstein, Executive Director
C/G/S Family Partnership, Inc.

David Hoffman
TheraCare

Debbie Riddle, LCSW
Director, Total Family Solutions

Directions for Completing Side 1 of the Form

Item label: 1. Service Recipient's Name ↓

Purpose of item: To document the name of the child who directly received the services or for whom the services were provided on behalf of consistent with the approved plan of care, on the completed In-Community Service Delivery Encounter Documentation Form.

Instructions for completing the item:

a. In the yellow shaded box labeled "Last Name," enter as many characters as will fit of the last name of the child who directly received the services or for whom the services were provided on behalf of, consistent with the approved plan of care, to be documented on the completed In-Community Service Delivery Encounter Documentation Form.

b. In the yellow shaded box labeled "First Name" enter as many characters as will fit of the first name of the child who directly received the services or for whom the services were provided on behalf of, consistent with the approved plan of care to be documented on the completed In-Community Service Delivery Encounter Documentation Form.

c. In the yellow shaded box labeled "Middle Initial" enter the middle initial of the child who directly received the services of for whom the services were provided on behalf of, consistent with the approved plan of care, to be documented on the completed In-Community Service Delivery Encounter Documentation Form.

   Note that the "Middle Initial" box is of particular importance because it is used to help establish the unique identity of service recipient's who have the same or similar first and last names.

Item label: 2. Recipient DOB ↓

Purpose of item: To record the date of birth (DOB) of the child who directly received the services or for whom the services were provided on behalf of, consistent with the approved plan of care, on the completed In-Community Service Delivery Encounter Form.

The "Recipient DOB" item is important because it is used to:

- Determine the age of the service recipient at the time the services were received;
- Help establish the unique identity of service recipients who have the same or similar names; and
- Eliminate duplicate records.

Instructions for completing the item:

a. In the yellow shaded box labeled "Mo." enter the month of the service recipient's date of birth in two-digit numerical format (e.g. January = 01 and November = 11).

b. In the yellow shaded box labeled "Day" enter the day of the month of the service recipient's date of birth in two-digit numerical format (e.g. the first of the month = 01 and the thirtieth of the month = 30).

c. In the yellow shaded box labeled "Yr." enter the year of the service recipient's date of birth in two-digit numerical format (e.g. 1965 = 65 and 2001 = 01).

Therefore, correctly completed date boxes for the date January 1, 2005 would be 01- 01 - 05.

Item label: 3. Recipient Gender ↓

Purpose of item: To record the gender of the child who directly received the services or for whom the services were provided on behalf of, consistent with the approved plan of care, on the completed In-Community Service Delivery Encounter Form.

The "Recipient Gender" item is important because it is used to:

- Help establish the unique identity of service recipients who have the same or similar names and birth dates;
- Eliminate duplicate records; and
- Document the gender of the service recipient in situations in which the service recipient's gender is of clinical and/or critical importance.

Instructions for completing the item:

Use the mouse to point to the box to the left of the correct gender selection. Left click on the box. An "X" will appear in the box to indicate that it has been selected. Please ensure that only one box is selected (i.e. only the box labeled "Male" has an "X" in it or the box labeled "Female" has an "X" in it.) Selecting both genders will cause confusion requiring the form to be returned to the submitter for corrections.

Item label: 4. Recipient ABSolute Number ↓

Purpose of item: To record the ABSolute Number of the child who directly received the services or for whom the services were provided on behalf of, consistent with the approved plan of care, documented on the completed In-Community Service Delivery Encounter Documentation Form.

The Recipient ABSolute Number is of particular importance because it is used to cross reference the Intensive In-Community Service Delivery Encounter Documentation Form with the child who directly received the services or for whom the services were provided on behalf of Individualized Service Plan and authorization(s) for services.

Instructions for completing the item:

In the yellow shaded box labeled "4. Recipient ABSolute Number ↓," enter the ABSolute Number of the service recipient.

Item label: 5. Recipient Medicaid/NJ FamilyCare Number ↓

Purpose of item: To record the Medicaid/NJ FamilyCare Number of the child who directly received the services or for whom the services were provided on behalf of, consistent with the plan of care.
The Recipient Medicaid/NJ FamilyCare Number is important because it is used to cross reference the Intensive In-Community Service Delivery Encounter Documentation Form with the service recipient's Medicaid/NJ FamilyCare claims and billing record.

NOTE: Not all authorized service recipients will have Medicaid/NJ FamilyCare numbers. However, it is important that the Medicaid/NJ FamilyCare numbers of service recipients who are Medicaid/NJ FamilyCare beneficiaries be recorded on the form.

Instructions for completing the item:

a. For authorized Service Recipients who are Medicaid/NJ FamilyCare beneficiaries:

In the yellow shaded box labeled "5. Recipient Medicaid/NJ FamilyCare Number ↓," enter the 12-digit Medicaid/NJ FamilyCare number of the child who has been authorized to receive services or for whom the services were provided on behalf of and to whose Medicaid/NJ FamilyCare account the services will be billed. (Medicaid/NJ FamilyCare identification numbers do not include an identification number that starts with "3560".)

b. For authorized Service Recipients who are not Medicaid/NJ FamilyCare beneficiaries:

In the yellow shaded box labeled "5. Recipient Medicaid/NJ FamilyCare Number ↓" enter the words: "No Medicaid/NJ FamilyCare".

Item label: 6. Recipient Home Address ↓

Purpose of item: To record the home address of the child who directly received the services or for whom the services were provided on behalf of, consistent with the plan of care. If the child is in an out of home treatment setting, please record the home address of the child's family. The address where the child is currently residing would then be recorded in the Service Delivery address, if appropriate.

The Recipient Home Address is important because it is used to regionally track the utilization of services.

Instructions for completing the item:

a. In the yellow shaded box labeled "Street," enter the street address of the service recipient's family's home address. Include in this box an apartment or unit number number where appropriate.

b. In the yellow shaded box labeled "City," enter name of the town in which the service recipient's home is located.

c. In the yellow shaded box labeled "State," enter the two character abbreviation of the state in which the service recipient's home is located.

d. In the yellow shaded box labeled "Zip," enter the zip code of the city in which the service recipient's home is located.

Item label: 7. Recipient Telephone No. & Area Code ↓

Purpose of item: To record the home telephone number of the child who directly received the services or for whom the services were provided on behalf of, consistent wit the plan of care. If the child is in an out of home treatment setting, record the telephone number of the child's family/caregiver.

The home telephone number and area code are important in case the need arises to contact the service recipient.

Instructions for completing the item:

a. In the yellow shaded box labeled "Area Code," enter the three-digit area code for the service recipient's telephone number.

b. In the yellow shaded box to the right of the box labeled "Area Code" enter the three-digit exchange of the service recipient's telephone number.

c. In the yellow shaded box two boxes to right of the box labeled "Area Code" enter the last four-digits of the telephone number.

Item label: 8. Service(s) ↓

Purpose of item: Items 8, 10, 11, and 12 were added to the Intensive In-Community Service Delivery Encounter Form at the request of service providers who pre-viewed the form prior to publication. The purpose of these four items is to record the basic authorization information needed by providers when delivering either Behavioral Assistance or the three levels of Intensive In-Community services that may be provided to an authorized recipient.

The four services that may be documented on the form include:

1. Behavioral Assistance, as defined at N.J.A.C. 10:75-4.6.
2. Intensive In-Community (IIC) supportive services, as defined at N.J.A.c. 10:77-5.7(b) provided by a, at a minimum, a Bachelors-level practitioner, labeled as "IIC-Bachelors," , as defined at N.J.A.C. 10:77-5.7.
3. IIC professional services, as defined at N.J.A.C. 10:77-5.7(c) provided by, at a minimum, a Masters-level practitioner, labeled as "IIC-Masters."

4. IIC clinical services, as defined at N.J.A.C. 10:77-5.7(d), provided by a Licensed clinical practitioner, labeled as "IIC-Licensed."

Instructions for completing the item:

In each of the three rows, select the service delivered to be documented on that row. The service is selected by using the mouse to point the screen arrow to the small box to the left of the service to be selected then left clicking once. An "X" will appear in the selected box. To avoid confusion, please be sure to select only one service in each of the five rows. If you inadvertently select the wrong box, simply left click on it again and the "X" will disappear, then left click on the correct box.

Item label: 9. Authorization No. ↓

Purpose of item: To record the authorization number(s) of the services selected in the box to the left on the same row

Recording the authorization number corresponding to the service selected in the box to the left on the same row is of particular importance since it will be used to verify that the service has been authorized by the Contracted Systems Administrator (CSA) for delivery.

Instructions for completing the item:

In the yellow shaded box beneath the label "9. Authorization Number" and on each row in which a service has been selected in the column to the left, please enter the ten-digit Authorization Number for the selected service as issued by the Contracted Systems Administrator (CSA). If multiple services are listed, please be sure that the Authorization Number entered is the one corresponding to the service selected in the column to the left on the row.

Item label: 10. Start Date ↓

Purpose of item: This item was added to the form at the request of service providers to record the start date of the authorization period for the authorization number indicated in item,, during which authorized services may be delivered to the service recipient.

Recording the start date of the authorized service delivery period is of particular importance since it will be compared to the actual service delivery date to ensure that services were delivered during the authorized service delivery period identified by the authorization number in item 9.

Instructions for completing the item:

a. In the yellow shaded box labeled "Mo." enter in two-digit numerical format (e.g. January = 01 and November = 11) the month of the start date of the period during which authorized services may be delivered.

b. In the yellow shaded box labeled "Day" enter in two-digit numerical format (e.g. the first of the month = 01 and the thirtieth = 30) the day of the month of the start date of the period during which authorized services may be delivered.

c. In the yellow shaded box labeled "Yr." enter in two digit numerical format (e.g. 2006 = 06 and 2007 = 07) the year of the start date of the period during which authorized services may be delivered.

Item label: 11. End Date ↓

Purpose of item: This item was added to the form at the request of service providers to record the end date of the authorization period for the authorization number identified in item 9, during which authorized services may be delivered to the service recipient.

Recording the end date of the authorized service delivery period for the identified authorization number is of particular importance since it will be compared to the actual service delivery date to ensure that services were delivered during the authorized service delivery period.

Instructions for completing the item:

a. In the yellow shaded box labeled "Mo." enter in two-digit numerical format (e.g. January = 01 and November = 11) the month of the end date of the period during which authorized services may be delivered.

b. In the yellow shaded box labeled "Day" enter in two-digit numerical format (e.g. the first of the month = 01 and the thirtieth = 30) the day of the month of the end date of the period during which authorized services may be delivered.

c. In the yellow shaded box labeled "Yr." enter in two digit numerical format (e.g. 2006 = 06 and 2007 = 07) the year of the end date of the period during which authorized services may be delivered.

Item label: 12. Units Authorized ↓

Purpose of item: This item was added to the form at the request of service providers to record the total number of units of a particular service authorized by the CSA for delivery to an individual service recipient during the authorization period identified by the authorization number in 9.

Instructions for completing the item:

In the yellow shaded boxes in the column labeled "12. Units Authorized ↓" enter the total number of units of service authorized by the CSA for delivery of the service selected on the same row in the column labeled "8. Service(s) ↓", under the authorization number entered in the column labeled "9. Authorization No. ↓" and during the period identified in the columns labeled "10. Start Date ↓" and "11. End Date ↓".

Item label: 13. For Provider Use

Purpose of item: This item was added to the form at the request of service providers to be used to make notations of their own directly on the form.

Instructions for completing the item:

Providers may type notes directly in the box. Note that all notations are considered to be part of the certified document and the provider's billing records. This information should be treated as such for documentation purposes.

Item label: 14. Behavioral Assistance Certification ↓

Purpose of item: Items 14a. through 14f. are to identify and obtain certification of the delivery of services from the individual person who actually provided the face-to-face Behavioral Assistance Services documented on the form.

These items are to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance Services. If no Behavioral Assistance Services are being documented on the form, this section should be left blank.

Item label: 14a. Name and Medicaid/NJ FamilyCare Provider Number ↓

Purpose of item: To record the name of the person directly providing the services and the Medicaid/NJ FamilyCare provider number of the agency employing the person who actually delivered the face-to-face Behavioral Assistance Services documented on the form. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

Instructions for completing the item:

For purposes of this section, if an individual is providing the services as a sole practitioner, then they are considered to be considered employed by their own agency, and should enter the provider number of their sole practitioner agency.

a. In the yellow shaded box labeled "Last Name" enter as many characters as will fit of the last name of the person who actually delivered the face-to-face Behavioral Assistance Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

b. In the yellow shaded box labeled "First Name" enter as many characters as will fit of the first name of the person who actually delivered the face-to-face Behavioral Assistance Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

c. In the yellow shaded box labeled "M.I." enter the middle initial of the person who actually delivered the face-to-face Behavioral Assistance Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. The inclusion of the Middle Initial of the provider's name is of particular importance as it is used to help establish the unique identity of direct service providers with the same or similar names. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

d. In the yellow shaded box labeled "Medicaid/NJ FamilyCare Provider Number" enter the seven-digit Medicaid/NJ FamilyCare Provider number of the agency who employed the person who actually delivered the face-to-face Behavioral Assistance Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

Item label: 14b. Business Address ↓

Purpose of item: To record the business address of the agency employing the person who actually delivered the face-to-face Behavioral Assistance Services documented on the form. If no Behavioral Assistance Services are documented on the form, this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Street," enter the street address of the business address of the person who actually delivered the face-to-face Behavioral Assistance Services documented on the form. Include in this box an apartment, unit, or suite number where appropriate. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

b. In the yellow shaded box labeled "City," enter the name of the city of the business address of the person who actually delivered the face-to-face Behavioral Assistance Services documented on the form. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

c. In the yellow shaded box labeled "State" enter the state of the business address of the person who actually delivered the face-to-face Behavioral Assistance Services documented on the form. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

d. In the yellow shaded box labeled "Zip" enter the zip code of the business address of the person who actually delivered the face-to-face Behavioral Assistance Services documented on the form. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

Item label: 14c. Business Phone ↓

Purpose of item: To record the business telephone number of the person who actually delivered the face-to-face Behavioral Assistance Services documented on the form. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Area Code" ender the three-digit area code of the business telephone number of the person who actually delivered the face-to-face Behavioral Assistance Services documented on the form. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

b. In the yellow shaded box one box to the right of the yellow shaded box labeled "Area Code" enter the three-digit exchange of the business telephone number of the person who actually delivered the face-to-face Behavioral Assistance Services documented on the form. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

c. In the yellow shaded box two boxes to the right of the yellow shaded box labeled "Area Code" enter the last four-digits of the business telephone number of the person who actually delivered the face-to-face Behavioral Assistance Services documented on the form. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

Item label: 14d. Clinical Supervisor's Name and License Number ↓

Purpose of item: To record the name and license number of the Clinical Supervisor of the person who actually delivered the face-to-face Behavioral Assistance Services documented on the form. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Name" enter the first name, middle initial and last name of the Clinical Supervisor of the person who actually delivered the face-to-face Behavioral Assistance Services documented on the form. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

b. In the yellow shaded box labeled "License Number" enter the license number of the Clinical Supervisor of the person who actually delivered the face-to-face Behavioral Assistance Services documented on the form. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

Item label: 14e. Progress Notes on file? ↓

Purpose of item: This item was added to the form at the request of service providers. The purpose of this item is to indicate whether or not the required progress notes on the delivered services documented on the form are maintained on file in the service provider's office. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

Instructions for completing the item:

To complete this item, use the mouse to move the screen arrow to the box next to the correct response. Left click on the box and an "X" will appear in the box. Please be sure to select only one box. If you inadvertently select the wrong box, simply left click on it again and the "X" will disappear, then left click on the correct box. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

Item label: 14f. Behavioral Assistant Certification ↓

Purpose of item: To document with a signature the certification of the person who actually delivered the face-to-face Behavioral Assistance; that he or she possesses the minimum qualifications required for providers of the service; and that the services were rendered exactly as documented on the completed form.

The minimum credentials required to provide Behavioral Assistance services are published at N.J.A.C. 10:77-4.9(e)-(g) as follows:

> (e) All direct care staff shall, at a minimum, have a high school diploma or equivalent, be 21 years old and have a minimum of one year relevant experience in a comparable environment and shall be supervised by appropriate clinical staff in accordance with this subchapter.
>
> (f) All employees shall have a valid driver's license if his or her job functions include the operation of a vehicle used in the transportation of the children/youth or young adults. Transportation is not a covered behavioral assistance service.
>
> (g) All employees having direct contact with and/or rendering behavioral assistance services directly to the beneficiaries shall be required to successfully complete criminal background checks.

Note that signed certification statements on the Intensive In-Community Service Delivery Documentation attest to:

a. truth and accuracy of the information submitted on the completed form and
b. certification of the certifier's credentials.

Providers are reminded that as a recipient of both federal and state dollars, all of the services provided under BA and IIC, must meet all the requirements set forth in the Medicaid/NJ FamilyCare regulations and the policies issued by DCBHS, whether the claims have been reimbursed through Unisys, the Medicaid fiscal agent, or through the DCBHS broker agencies.

Submitting claims for reimbursement and receiving funds for services which do not meet all of the requirements can be construed to be Medicaid fraud and abuse, depending on the scope and circumstances of the inappropriate billings. If found upon audit by federal, state, or other governmental entities the provider may be subject to fines and penalties, as well as the recovery of the identified inappropriately reimbursed funds. Providers may also be subject to federal and/or state criminal charges, as well as suspension, termination, or debarment from the program.

Instructions for completing the item:

a. The service provider who actually delivered the face-to-face Behavioral Assistance Services should read the certification statement, ensure that it is true, and then sign the form on the signature line. If no Behavioral Assistance Services are being documented on the form, this item should be left blank.

Item label: 15. IIC – Bachelors Level Certification ↓

Purpose of item: Items 15a. through 15f. are to identify, document, and obtain certification of the delivery of services from the individual person who actually provided the face-to-face IIC support level of services provided, at a minimum, by a Bachelors Level practitioner.

These items are to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of IIC supportive level of services, provided at a minimum, by a bachelor's level practitioner. If no IIC - Bachelors Level Services are being documented on the form; this section should be left blank.

Item label: 15a. Name and Medicaid/NJ FamilyCare Provider Number ↓

Purpose of item: To record the name and Medicaid provider number of the person who actually delivered the face-to-face IIC-Bachelors Level Services documented on the form. If no IIC - Bachelors Level Services are being documented on the form; this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Last Name" enter as many characters as will fit of the last name of the person who actually delivered the face-to-face IIC-Bachelors Level Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. If no IIC - Bachelors Level Services are being documented on the form; this item should be left blank.

b. In the yellow shaded box labeled "First Name" enter as many characters as will fit of the first name of the person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

c. In the yellow shaded box labeled "M.I." enter the middle initial of the person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. The inclusion of the Middle Initial of the provider's name is of particular importance as it is used to help determine the unique identity of direct service providers with the same or similar names. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

d. In the yellow shaded box labeled "Medicaid/NJ FamilyCare Provider Number" enter the seven-digit Medicaid/NJ FamilyCare Provider number of the agency who employed the

person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

Item label: 15b. Business Address ↓

Purpose of item: To record the business address of the Medicaid/NJ FamilyCare provider agency that employed the person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the form. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Street," enter the street address of the business address of the Medicaid/NJ FamilyCare provider who employed the person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the form. Include in this box an apartment, unit, or suite number where applicable. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

b. In the yellow shaded box labeled "City," enter the name of the city of the business address of the Medicaid/NJ FamilyCare provider who employed the person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the form. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

c. In the yellow shaded box labeled "State" enter the state of the business address of the Medicaid/NJ FamilyCare provider who employed the person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the form. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

d. In the yellow shaded box labeled "Zip" enter the zip code of the business address of the Medicaid/NJ FamilyCare provider who employed the person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the form. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

Item label: 15c. Business Phone ↓

Purpose of item: To record the business telephone number of the person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the form. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Area Code" ender the three-digit area code of the business telephone number of the person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the form. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

b. In the yellow shaded box one box to the right of the yellow shaded box labeled "Area Code" enter the three-digit exchange of the business telephone number of the person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the form. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

c. In the yellow shaded box two boxes to the right of the yellow shaded box labeled "Area Code" enter the last four digits of the business telephone number of the person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the form. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

Item label: 15d. Clinical Supervisor's Name and License Number ↓

Purpose of item: To record the name and license number of the Clinical Supervisor of the person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the form. If no IIC - Bachelors Level Services are being documented on the form; this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Name" enter the first name, middle initial and last name of the Clinical Supervisor of the person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the form. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

b. In the yellow shaded box labeled "License Number" enter the license number of the Clinical Supervisor of the person who actually delivered the face-to-face IIC - Bachelors Level Services documented on the form. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

Item label: 15e. Progress Notes on file? ↓

Purpose of item: This item was added to the Intensive In-Community Service Delivery Encounter Documentation Form at the request of service providers. The purpose of this item is to indicate whether or not the required progress notes on the delivered services documented on the form are maintained on file in the service provider's office. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

Instructions for completing the item:

To complete this item, use the mouse to move the screen arrow to the box next to the correct response. Left click on the box and an "X" will appear in the box. Please be sure to select only one box. If you inadvertently select the wrong box, simply left click on it again and the "X" will disappear, then left click on the correct box. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

Item label: 15f. IIC – Bachelors Level Certification ↓

Purpose of item: To document with a signature the certification of the person who actually delivered the face-to-face IIC - Bachelors Level Services, that he or she possesses the minimum qualifications required for providers of the service and that services were rendered exactly as documented on the completed form.

The minimum credentials required to provide Bachelors Level IIC

services are published at N.J.A.C. 10:77-5.7(a) 1. and (b) as follows:

> 1. Supportive services (intensive in-community services that can be delivered by a Bachelors level direct care provider);…
>
> (b) Supportive services shall be delivered by individuals with a minimum of a Bachelors degree in a related field, including, but not limited to, social work, psychology, counseling or nursing and one year of relevant experience working with children and families with mental health needs. Supportive services shall be provided under the direct clinical supervision of a licensed behavioral health care practitioner, who within the scope of his or her practice, is licensed to provide, or supervise the provision of, services. The direct service provider shall receive a minimum of one hour of direct clinical supervision for every 40 hours of work. For those direct service providers who work less than 40 hours a month, one hour of face-to-face clinical supervision shall be provided a minimum of once a month.

Note that signed certification statements on the Intensive In-Community Service Delivery Documentation Form attest to:

c. truth and accuracy of the information submitted on the completed form and
d. certification of the certifier's credentials.

Providers are reminded that as a recipient of both federal and state dollars, all of the services provided under BA and IIC, must meet all the requirements set forth in the Medicaid/NJ FamilyCare regulations and the policies issued by DCBHS, whether the claims have been reimbursed through Unisys, the Medicaid fiscal agent, or through the DCBHS broker agencies.

Submitting claims for reimbursement and receiving funds for services which do not meet all of the requirements can be construed to be fraud and abuse, depending on the scope and circumstances of the inappropriate billings. If found upon audit by federal, state, or other governmental entities the provider may be subject to fines and penalties, as well as the recovery of the identified inappropriately reimbursed funds. Providers may also be subject to federal and/or state criminal charges, as well as suspension, termination, or debarment from the program.

Instructions for completing the item:

The service provider who actually delivered the face-to-face IIC - Bachelors Level Services should read the certification statement, ensure that it is true, and then sign the form on the signature line. If no IIC - Bachelors Level Services are being documented on the form, this item should be left blank.

Item label: 16. IIC – Masters Level Certification ↓

Purpose of item: Items 16a. through 16f. are to identify and obtain certification of the delivery of services from the individual person who actually delivered the face-to-face IIC professional level services documented on the form.

These items are to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of IIC - Masters Level Services, provided by at a minimum, by a Masters Level practitioner, as defined at N.J.A.C. 10:77.,. If no IIC - Masters Level Services are being documented on the form, this section should be left blank.

Item label: 16a. Name and Medicaid/NJ FamilyCare Provider Number ↓

Purpose of item: To record the name of the person who delivered the services and the Medicaid/NJ FamilyCare provider number of the agency who employed the person who actually delivered the face-to-face IIC-Masters Services documented on the form. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled “Last Name” enter as many characters as will fit of the last name of the person who actually delivered the face-to-face IIC-Masters Level Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

b. In the yellow shaded box labeled “First Name” enter as many characters as will fit of the first name of the person who actually delivered the face-to-face IIC - Masters Level Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

c. In the yellow shaded box labeled “M.I.” enter the middle initial of the person who actually delivered the face-to-face IIC - Masters Level Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. The inclusion of the Middle Initial of the provider’s name is of particular importance as it is used to help determine the unique identity of direct service providers with the same or similar names. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

d. In the yellow shaded box labeled “Medicaid/NJ FamilyCare Provider Number” enter the seven-digit Medicaid/NJ FamilyCare Provider number of the who actually delivered the face-to-face IIC - Masters Level Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. If the person who actually delivered the face-to-face services did so as an employee of a provider agency under whose Medicaid/NJ FamilyCare provider number the services were delivered, then the agency’s Medicaid/NJ

FamilyCare Provider number should be entered in the box. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

Item label: 16b. Business Address ↓

Purpose of item: To record the business address of the Medicaid/NJ FamilyCare agency that employed the person who actually delivered the face-to-face IIC - Masters Level Services documented on the form. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Street," enter the street address of the business address of the Medicaid/NJ FamilyCare agency that employed the person who actually delivered the face-to-face IIC - Masters Level Services documented on the form. Include in this box an apartment, unit, or suite number where applicable. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

b. In the yellow shaded box labeled "City," enter the name of the city of the business address of the Medicaid/NJ FamilyCare agency that employed the person who actually delivered the face-to-face IIC - Masters Level Services documented on the form. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

c. In the yellow shaded box labeled "State" enter the state of the business address of the Medicaid/NJ FamilyCare agency who employed the person who actually delivered the face-to-face IIC - Masters Level Services documented on the form. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

d. In the yellow shaded box labeled "Zip" enter the zip code of the business address of the Medicaid/NJ FamilyCare agency that employed the person who actually delivered the face-to-face IIC - Masters Level Services documented on the form. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

Item label: 16c. Business Phone ↓

Purpose of item: To record the business telephone number of the person who actually delivered the face-to-face IIC - Masters Level Services documented on the form. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Area Code" ender the three-digit area code of the business telephone number of the person who actually delivered the face-to-face IIC - Masters Level Services documented on the form. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

b. In the yellow shaded box one box to the right of the yellow shaded box labeled "Area Code" enter the three-digit exchange of the business telephone number of the person who actually delivered the face-to-face IIC - Masters Level Services documented on the form. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

c. In the yellow shaded box two boxes to the right of the yellow shaded box labeled "Area Code" enter the last four digits of the business telephone number of the person who actually

delivered the face-to-face IIC - Masters Level Services documented on the form. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

Item label: 16d. Clinical Supervisor's Name and License Number ↓

Purpose of item: To record the name and license number of the Clinical Supervisor who actually delivered the face-to-face IIC - Masters Level Services documented on the form. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Name" enter the first name, middle initial and last name of the Clinical Supervisor who actually delivered the face-to-face IIC - Masters Level Services documented on the form. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

b. In the yellow shaded box labeled "License Number" enter the license number of the Clinical Supervisor who actually delivered the face-to-face IIC - Masters Level Services documented on the form. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

Item label: 16e. Progress Notes on file? ↓

Purpose of item: This item was added to the Intensive In-Community Service Delivery Encounter Documentation Form at the request of service providers. The purpose of this item is to indicate whether or not the required progress notes on the delivered services documented on the form are maintained on file in the service provider's office. If no IIC - Masters Level Services are being documented on the form; this item should be left blank.

Instructions for completing the item:

To complete this item, use the mouse to move the screen arrow to the box next to the correct response. Left click on the box and an "X" will appear in the box. Please be sure to select only one box. If you inadvertently select the wrong box, simply left click on it again and the "X" will disappear, then left click on the correct box. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

Item label: 16f. IIC- Masters Level Certification ↓

Purpose of item: To document with a signature the certification of the person who actually delivered the face-to-face IIC – Masters Level Services; that he or she possesses the minimum qualifications required for providers of the service; and that the services were rendered exactly as documented on the completed form.

The minimum credentials required to provide Masters Level IIC services are published at N.J.A.C. 10:77-5.7(a) 2. and (c) as follows:

> 2. Professional services (intensive in-community services delivered by a master's level direct care provider);…
>
> (c) Professional services shall be delivered by individuals with a minimum of a master's degree in related field including, but not limited to, social work, psychology, counseling or nursing and one year of relevant experience working with children and families with mental health needs. Professional services shall be provided under the direct clinical supervision of a licensed behavioral health care practitioner, who, within the scope of his or her practice, is licensed to provide, or supervise the provision of, services. The direct service provider shall receive a minimum of one hour of clinical supervision for every 40 hours of work. For those direct service providers who work less than 40 hours a month, one hour of face-to-face clinical supervision shall be provided a minimum of once a month.

Note that signed certification statements on the Intensive In-Community Service Delivery Documentation Form attest to:

a. truth and accuracy of the information submitted on the completed form and

b. certification of the certifier's credentials.

Providers are reminded that as a recipient of both federal and state dollars, all of the services provided under BA and IIC, must meet all the requirements set forth in the Medicaid/NJ FamilyCare regulations and the policies issued by DCBHS, whether the claims have been reimbursed through Unisys, the Medicaid fiscal agent, or through the DCBHS broker agencies.

Submitting claims for reimbursement and receiving funds for services which do not meet all of the requirements can be construed to be fraud and abuse, depending on the scope and circumstances of the inappropriate billings. If found upon audit by federal, state, or other governmental entities the provider may be subject to fines and penalties, as well as the recovery of the identified inappropriately reimbursed funds. Providers may also be subject to federal and/or state criminal charges, as well as suspension, termination, or debarment from the program.

Instructions for completing the item:

a. The service provider who actually delivered the face-to-face IIC - Masters Level Services should read the certification statement, ensure that it is true, and then sign the form on the signature line. If no IIC - Masters Level Services are being documented on the form, this item should be left blank.

Item label: 17. IIC – Licensed Clinical Certification ↓

Purpose of item: Items 17a. through 17f. are to identify and obtain certification of the delivery of services from the individual person who actually

provided the face-to-face IIC – Licensed Clinical Services documented on the form.

These items are to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of IIC Licensed Clinical Services. If no IIC – Licensed Services are being documented on the form, this section should be left blank.

Item label: 17a. Name and Medicaid/NJ FamilyCare Provider Number ↓

Purpose of item: To record the name and Medicaid/NJ FamilyCare provider number of the person who actually delivered the face-to-face IIC-Licensed Clinical Services documented on the form. If no IIC - Licensed Services are being documented on the form; this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Last Name" enter as many characters as will fit of the last name of the person who actually delivered the face-to-face IIC-Licensed Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. If no IIC – Licensed Services are being documented on the form, this item should be left blank.

b. In the yellow shaded box labeled "First Name" enter as many characters as will fit of the first name of the person who actually delivered the face-to-face IIC – Licensed Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. If no IIC - Licensed Services are being documented on the form, this item should be left blank.

c. In the yellow shaded box labeled "M.I." enter the middle initial of the person who actually delivered the face-to-face IIC - Licensed Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. The inclusion of the Middle Initial of the provider's name is of particular importance as it is used to help determine the unique identity of direct service providers with the same or similar names. If no IIC - Licensed Services are being documented on the form, this item should be left blank.

d. In the yellow shaded box labeled "Medicaid/NJ FamilyCare Provider Number" enter the seven-digit Medicaid/NJ FamilyCare Provider number of the person who actually delivered the face-to-face IIC - Licensed Services documented on the Intensive In-Community Service Delivery Encounter Documentation Form. If the person who actually delivered the face-to-face services did so as an employee of a provider agency under whose Medicaid/NJ FamilyCare provider number the services were delivered, then the agency's Medicaid/NJ FamilyCare Provider number should be entered in the box. If no IIC - Licensed Services are being documented on the form, this item should be left blank.

Item label: 17b. Business Address ↓

Purpose of item: To record the business address of the provider agency that employed the person who actually delivered the face-to-face IIC - Licensed Services documented on the form. If no IIC - Licensed

Services are being documented on the form; this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Street," enter the street address of the business address of the provider agency that employed the person who actually delivered the face-to-face IIC - Licensed Services documented on the form. Include in this box an apartment, unit, or suite number where applicable. If no IIC - Licensed Services are being documented on the form, this item should be left blank.

b. In the yellow shaded box labeled "City," enter the name of the city of the business address of the provider agency that employed the person who actually delivered the face-to-face IIC - Licensed Services documented on the form. If no IIC - Licensed Services are being documented on the form, this item should be left blank.

c. In the yellow shaded box labeled "State" enter the state of the business address of the provider agency who employed the person who actually delivered the face-to-face IIC - Licensed Services documented on the form. If no IIC - Licensed Services are being documented on the form, this item should be left blank.

d. In the yellow shaded box labeled "Zip" enter the zip code of the business address of the provider agency who employed the person who actually delivered the face-to-face IIC - Licensed Services documented on the form. If no IIC - Licensed Services are being documented on the form, this item should be left blank.

Item label: 17c. Business Phone ↓

Purpose of item: To record the business telephone number of the person who actually delivered the face-to-face IIC - Licensed Services documented on the form. If no IIC - Licensed Services are being documented on the form, this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Area Code" ender the three-digit area code of the business telephone number of the person who actually delivered the face-to-face IIC - Licensed Services documented on the form. If no IIC - Licensed Services are being documented on the form, this item should be left blank.

b. In the yellow shaded box one box to the right of the yellow shaded box labeled "Area Code" enter the three-digit exchange of the business telephone number of the person who actually delivered the face-to-face IIC - Licensed Services documented on the form. If no IIC - Licensed Services are being documented on the form, this item should be left blank.

c. In the yellow shaded box two boxes to the right of the yellow shaded box labeled "Area Code" enter the last four digits of the business telephone number of the person who actually delivered the face-to-face IIC - Licensed Services documented on the form. If no IIC - Licensed Services are being documented on the form, this item should be left blank.

Item label: 17d. Progress Notes on file? ↓

Purpose of item: This item was added to the Intensive In-Community Service Delivery Encounter Documentation Form at the request of service providers. The purpose of this item is to indicate whether or not the

required progress notes on the delivered services documented on the form are maintained on file in the service provider's office. If no IIC – Licensed Clinical Services are being documented on the form; this item should be left blank.

Instructions for completing the item:

To complete this item, use the mouse to move the screen arrow to the box next to the correct response. Left click on the box and an "X" will appear in the box. Please be sure to select only one box. If you inadvertently select the wrong box, simply left click on it again and the "X" will disappear, then left click on the correct box. If no IIC – Licensed Clinical Services are being documented on the form; this item should be left blank.

Item label: 17e. Certification and License No.↓

Purpose of item: To document with a signature the certification of the person who actually delivered the face-to-face IIC – Licensed Clinical services, that he or she possesses the minimum qualifications required for providers of the service and that services were rendered exactly as documented on the completed form.

The minimum credentials required to provide Licensed Clinical IIC services are published at N.J.A.C. 10:77-5.7(a) 3. and (d) as follows:

> 3. Clinical services (intensive in-community services delivered by a clinically licensed behavioral health care practitioner).
>
> (d) Clinical services shall be delivered by a licensed clinical professional, including, but not limited to, a psychiatrist, a psychologist, an advanced practice nurse, a licensed clinical social worker or a mental health professional licensed in accordance with the Board of Marriage and Family Therapy Examiners (N.J.A.C. 13:34), who, within the scope of his or her practice, is authorized to provide or supervise the provision of mental health services. Clinical-level intensive in-community services may include, but are not limited to, all services described at (c) above, provided without additional clinical supervision. Clinical services shall be targeted to children and families requiring a more clinically intensive level of service provision, based upon clinical evaluation and determination of need. All services shall be provided by professionals with the appropriate licensure and/or specialty certification in accordance with all State rules and statutes.

Note that signed certification statements on the Intensive In-Community Service Delivery Documentation Form attest to:

a. truth and accuracy of the information submitted on the completed form;

b. certification of the certifier's credentials.

Providers are reminded that as a recipient of both federal and state dollars, all of the services provided under BA and IIC, must meet all the requirements set forth in the Medicaid/NJ FamilyCare regulations and the policies issued by DCBHS, whether the claims have been reimbursed through Unisys, the Medicaid fiscal agent, or through the DCBHS broker agencies.

Submitting claims for reimbursement and receiving funds for services which do not meet all of the requirements can be construed to be fraud and abuse, depending on the scope and circumstances of the inappropriate billings. If found upon audit by federal, state, or other governmental entities the provider may be subject to fines and penalties, as well as the recovery of the identified inappropriately reimbursed funds. Providers may also be subject to federal and/or state criminal charges, as well as suspension, termination, or debarment from the program.

Instructions for completing the item:

a. The service provider who actually delivered the face-to-face IIC - Licensed Services should read the certification statement, ensure that it is true, and then sign the form on the signature line. If no IIC - Licensed Services are being documented on the form, this item should be left blank.

b. Enter the license number of the service provider who actually delivered the face-to-face IIC – Licensed Services. If no IIC - Licensed Services are being documented on the form, this item should be left blank.

Item label: 18. Agency Signatory's Certification ↓

Purpose of item: Items 18a. through 18e. are to identify and obtain certification of the delivery of services from the official employed by the provider agency who is authorized as an official representative of the agency to sign binding certifications on behalf of the agency.

These items are to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number.

Item label: 18a. Signatory Name and Agency's Medicaid/NJ FamilyCare Provider Number ↓

Purpose of item: To record the name of the signatory and the Medicaid/NJ FamilyCare provider number of the agency that delivered the face-to-face services documented on the form.

The agency signatory is the official employed by the provider agency who is authorized as an official representative of the agency to sign binding certifications on behalf of the agency.

Instructions for completing the item:

a. In the yellow shaded box labeled "Last Name," enter as many characters as will fit of the last name of the agency signatory. This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number. If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

b. In the yellow shaded box labeled "First Name" enter as many characters as will fit of the first name of the agency signatory. This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number. If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

c. In the yellow shaded box labeled "M.I." (an abbreviation for Middle Initial) enter the middle initial of the agency signatory. This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number. If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

d. In the yellow shaded box labeled "Medicaid/NJ FamilyCare Provider Number" enter the seven-digit Medicaid/NJ FamilyCare Provider number of the agency under whose Medicaid/NJ FamilyCare provider number the services will be billed. This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number. If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

Item label: 18b. Agency Address ↓

Purpose of item: To record the address of the agency that delivered the face-to-face services documented on the form.

This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing

for reimbursement under the agency's Medicaid/NJ FamilyCare provider number.

If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Street," enter the street address of the agency under whose Medicaid/NJ FamilyCare number the services will be billed. This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number. If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

b. In the yellow shaded box labeled "City," enter the city of the address of the agency under whose Medicaid/NJ FamilyCare number the services will be billed. This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number. If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

c. In the yellow shaded box labeled "State," enter the state of the address of the agency under whose Medicaid/NJ FamilyCare number the services will be billed. This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number. If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

d. In the yellow shaded box labeled "Zip," enter the zip code of the address of the agency under whose Medicaid/NJ FamilyCare number the services will be billed. This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number. If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

Item label: 18c. Signatory's Phone ↓

Purpose of item: To record the business telephone number of the authorized signatory of the agency that delivered the face-to-face services documented on the form.

This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number.

If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

Instructions for completing the item:

a. In the yellow shaded box labeled "Area Code" enter the three-digit area code of the telephone number of the signatory identified in item "18a. Signatory Name and Agency's Medicaid/NJ FamilyCare Provider No. ↓." This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number. If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

b. In the yellow shaded box one box to the right of the yellow shaded box labeled "Area Code" enter the three-digit exchange of the signatory identified in item "18a. Signatory Name and Agency's Medicaid/NJ FamilyCare Provider No. ↓." This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number. If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

c. In the yellow shaded box two boxes to the right of the yellow shaded box labeled "Area Code" enter the last four digits of the business telephone number of the signatory identified in item "18a. Signatory Name and Agency's Medicaid/NJ FamilyCare Provider No. ↓." This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number. If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or

contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

Item label: 18d. Agency Name ↓

Purpose of item: To record the name of the agency that delivered the face-to-face services documented on the form. This name should be consistent with the name of the Medicaid/NJ FamilyCare provider as listed.

This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number.

If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

Instructions for completing the item:

In the yellow shaded box labeled "18d. Agency Name ↓" enter as many characters that will fit of the name of the agency under whose Medicaid/NJ FamilyCare provider number the services will be billed. This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number. If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

Item label: 18e. Agency Signatory's Certification↓

Purpose of item: To document with a signature the certification of the authorized signatory of the agency that the services delivered were delivered as indicated on the form.

This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number.

If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's

Medicaid/NJ FamilyCare provider number, this item should be left blank.

Note that signed certification statements on the Intensive In-Community Service Delivery Documentation Form attest to:

a. truth and accuracy of the information submitted on the completed form;

b. certification of the certifier's credentials.

Providers are reminded that as a recipient of both federal and state dollars, all of the services provided under BA and IIC, must meet all the requirements set forth in the Medicaid/NJ FamilyCare regulations and the policies issued by DCBHS, whether the claims have been reimbursed through Unisys, the Medicaid fiscal agent, or through the DCBHS broker agencies.

Submitting claims for reimbursement and receiving funds for services which do not meet all of the requirements can be construed to be fraud and abuse, depending on the scope and circumstances of the inappropriate billings. If found upon audit by federal, state, or other governmental entities the provider may be subject to fines and penalties, as well as the recovery of the identified inappropriately reimbursed funds. Providers may also be subject to federal and/or state criminal charges, as well as suspension, termination, or debarment from the program.

Instructions for completing the item:

The authorized signatory of the agency that provided the services documented on the completed Intensive In-Community Service Delivery Encounter Documentation Form should read the certification statement, ensure that it is true, and then sign the form on the signature line. A stamped signature of the authorized signatory is permitted on this signature line. This item is to be completed only if the Intensive In-Community Service Delivery Encounter Documentation Form includes documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number. If the form does not include documentation of the delivery of Behavioral Assistance or IIC Services by employees or contractors of an agency who are billing for reimbursement under the agency's Medicaid/NJ FamilyCare provider number, this item should be left blank.

Item label: 19. For Provider Use

Purpose of item: This item was added to the form at the request of service providers to be used to make notations of their own directly on the form.

Instructions for completing the item:

Providers may type notes directly in the box. Note that all notations are considered to be part of the certified document and the provider's billing records. This information should be treated as such for documentation purposes.

Directions for Completing Side Two of the Form

Side two of the Intensive In-Community Service Delivery Documentation Form is composed of six service delivery encounter rows, each of which is completed following a service delivery encounter. Each of the six encounter rows is completed in exactly the same way according to the directions below.

Item label: Encounter Date ↓

Purpose of item: To record the actual date of the face-to-face service delivery encounter.

Instructions for completing the item:

a. In the yellow shaded box labeled "Month" enter the month of the date of the face-to-face service delivery encounter in two-digit numerical format (e.g. January = 01 and November = 11)

b. In the yellow shaded box labeled "Day" enter the day of the month of the date of the face-to-face service delivery encounter in two digit numerical format (e.g. the first of the month = 01 and the thirtieth of the month = 30)

c. In the yellow shaded box labeled "Year" enter the year of the date of the face-to-face service delivery encounter in two-digit numerical format (e.g. 2006 = 06 and 2007 = 07)

Item label: Encounter Time ↓

Purpose of item: To record the actual time of the face-to-face service delivery encounter.

Instructions for completing the item:

a. In the yellow shaded box labeled "Start" enter the start time of the face-to-face service delivery encounter in seven character format (e.g. 12 o'clock noon = 12:00PM and half past 8 o'clock in the morning = 08:30AM).

b. In the yellow shaded box labeled "Finish" enter the finish time of the face-to-face service delivery encounter in seven character format (e.g. 12 o'clock noon = 12:00PM and half past 8 o'clock in the morning = 08:30AM).

Item label: Type of Service Delivery Site (if other than home) ↓

Purpose of item: To document the type of place at which services were delivered (e.g. child's school, after school program, YMCA, Grandmother's home, etc.) This item is to be completed only if the service delivery site is other than the address indicated on side one of the form at "6. Recipient Home Address ↓." A blank "Type of Service Delivery Site (if other than home) ↓" box will be interpreted as indicating that services were delivered at the recipient's home at the address indicated on side one of the form at "6. Recipient Home Address ↓."

Instructions for completing the item:

In the yellow shaded box labeled "Type of Service Delivery Site (if other than home) 🡻 enter as many characters as will fit of words describing the site – other than the service recipient's home at the address appearing on side one of the form at "6. Recipient Home Address 🡻" – where face-to-face services were delivered.

Item label: Address of Service Delivery Site (if other than home) 🡻

Purpose of item: To document the address of the service delivery site. This item is to be completed only if the service delivery site is other than the address indicated on side one of the form at "6. Recipient Home Address 🡻." A blank "Address of Service Delivery Site (if other than home) 🡻" box will be interpreted as indicating that services were delivered at the recipient's home at the address indicated on side one of the form at "6. Recipient Home Address 🡻."

Instructions for completing the item:

a. In the yellow shaded box labeled "Street," enter the street address of the service delivery site. Include in this box an apartment or unit number if needed.

b. In the yellow shaded box labeled "City," enter the name of the municipality of the address of the service delivery site.

c. In the yellow shaded box labeled "State" enter the state of the address of the service delivery site.

d. In the yellow shaded box labeled "Zip" enter the zip code of the address of the service delivery site.

e. In the yellow shaded box labeled "County" enter the county of the address of the service delivery site.

Item label: Service Delivery Site Phone 🡻

Purpose of item: To document the telephone number of the service delivery site. This item is to be completed only if services were delivered at a site other than the address and telephone number indicated on side one of the form at "6. Recipient Home Address 🡻" and "7. Recipient Telephone Number & Area Code." A blank "Service Delivery Site Phone 🡻" box will be interpreted as indicating that services were delivered at the recipient's home at the address and telephone number indicated on side one of the form at "6. Recipient Home Address 🡻" and "7. Recipient Telephone Number & Area Code."

Instructions for completing the item:

a. In the yellow shaded box labeled "Area" enter the three-digit area code of the phone number of the service delivery site.

b. In the yellow shaded box to right of the box labeled "Area" enter the three-digit exchange of the telephone number of the service delivery site.

c. In the yellow shaded box two boxes to the right of the box labeled "Area" enter the last four digits of the telephone number of the service delivery site.

Item label: Services Delivered ↓

Purpose of item: This item is designed to document two pieces of information:

1. The type of service delivered during the service delivery encounter being documented on the form and
2. Whether or the service was delivered to an "Individual" child or family member or a "Group" of children and/or family members.

This is significant because Behavioral Assistance and IIC services are delivered under different regulatory guidelines and billed at different rates depending on whether they are delivered to an individual or a to group.

IIC and BA services provided in a "group" setting may be provided to the family member(s) and/or caregiver(s) of up to 3 youth in one session.

Instructions for completing the item:

a. To select the type of service use the mouse to point the screen arrow to the small box to the left of the service to be selected and then left click once. An "X" will appear in the selected box. To avoid confusion, please be sure to select only one service. If you inadvertently select the wrong box, simply left click on it again and the "X" will disappear, then left click on the correct box.

b. To select "Individual" use the mouse to point the screen arrow to the small box to the left of the word "Individual" and left click once. An "X" will appear in the selected box.

c. To select "Group" enter in two-digit format (e.g. 01=1, 02=2 and 03=3, etc.) the number of individuals in the group on yellow shaded line next to the word "Group."

d. To avoid confusion, please be sure to select either "Individual" or enter a number next to "Group". If you inadvertently incorrectly select "Individual", simply left click on the box again and the "X" will disappear, then enter the two-digit entry on the line next to "Group."

Item label: ☐ Guardian or ☐ Responsible Party

Purpose of item: To document that the person certifying that services were delivered as documented in the service encounter row is either the Guardian of the child who received services or another Responsible Party, if the recipient is not otherwise 14 or older and not certifying on their own behalf.

Note the following with regard to this item:

a. Completion of this item is mandatory for service recipients who are children under the age of fourteen whose certification of service delivery must be certified by the child's legal guardian or by a Responsible Party who witnessed service delivery.

b. A Responsible Party may certify that services were delivered as documented only in the absence of the child's legal guardian.

c. A Responsible Party is defined a person aged 18 or older who, in the absence of the child's parent or guardian, can certify the delivery of services to a child under the age of fourteen.

Instructions for completing the item:

A selection is made by using the mouse to point the screen arrow to the small box to the left of the person to be selected and then left clicking once. An "X" will appear in the selected box. To avoid confusion, please be sure to select only one person. If you inadvertently select the wrong box, simply left click on it again and the "X" will disappear, then left click on the correct box.

Item label: ☐ Guardian or ☐ Responsible Party's Name 🡻

Purpose of item: To document the name of the Guardian or Responsible Party (whichever is selected above) who will be certifying the delivery of services as documented on the service encounter row.

Instructions for completing the item:

In the yellow shaded box labeled "☐ Guardian or ☐ Responsible Party's Name 🡻" enter as many characters as will fit of the first name, middle initial and last name of either the Guardian or the Responsible Party who will be certifying the delivery of services to a child under the age of fourteen.

Item label: Guardian or Responsible Party's Address 🡻

Purpose of item: To document the address of the Guardian or Responsible Party who will be certifying the delivery of services to a child under the age of fourteen as documented in the service delivery encounter row.

Note the following with regard to this item:

a. This item must be completed if the "Responsible Party" box is selected above.

b. This item must be completed if the Guardian check box is selected above and the Guardian's address is not the same as the recipient home address recorded on page one of the form at "6. Recipient Home Address 🡻."

c. This item **need not be completed** if the Guardian check box is selected above and the Guardian's address is the same as the recipient home address recorded on page one of the form at "6. Recipient Home Address 🡻." Blank boxes in this item will be interpreted to mean that the Guardian's address is in fact the same as the recipient home address recorded on page one of the form at "6. Recipient Home Address 🡻."

Instructions for completing the item:

a. In the yellow shaded box labeled "Street," enter the street address of the Guardian or Responsible Party's address. Include in this box an apartment or unit number if needed.

b. In the yellow shaded box labeled "City," enter the name of the municipality of the Guardian or Responsible Party's address.

c. In the yellow shaded box labeled "State" enter the state of the Guardian or Responsible Party's address.

d. In the yellow shaded box labeled "Zip" enter the zip code of the Guardian or Responsible Party's address.

e. In the yellow shaded box labeled "County" enter the county of the Guardian or Responsible Party's address.

Item label: Guardian or Responsible Party's Certification ↓

Purpose of item: To establish the relationship of the Responsible Party to the child under age fourteen for whom s/he is certifying the delivery of services and to record the Guardian or Responsible Party's signature and the date on which the signature was inscribed on the form.

Note that the item labeled "Relationship to Child" was added to the form at the request of service providers and need be completed only if the document is to be certified by a Responsible Party instead of the child's Guardian.

Instructions for completing the item:

a. If the form is to be signed by a Responsible Party, that person's relationship to the child for whom they are certifying the delivery of services as documented in the service encounter row must be entered in the yellow shaded box labeled "Relationship to Child" (e.g. Grandmother, Uncle, Teacher, Baseball Coach, Neighbor, YMCA Counselor).

b. The Guardian or Responsible party should read the certification statement, ensure that its true and, on the line labeled "Signature" inscribe their signature.

c. On the line labeled "Date Signed" the Guardian or Responsible Party should write in the date that he or she signed the form.

Item label: Service Recipient's Certification

Purpose of item: To obtain from either:

a. Service recipients aged fourteen years old or older

– **OR** –

b. The parents or legal guardians of service recipients under age fourteen

The following:

1. Authorization to release any medical or other information necessary to process claims associated with services delivered as documented on the completed form
2. Authorization of payment of medical benefits to the supplier(s) identified at numbers 14 through 18 on this form for services described on this form.

and

3. Attestation that the signatory is aged fourteen or older and has received services as documented on the completed form

– **OR** –

4. Attestation that the signatory is the parent or legal guardian of a child under the age of fourteen and that the child received services as documented on this form.

Note that children under the age of fourteen may not sign or certify the Service Delivery Encounter Documentation Form – only the parents or legal guardians of service recipients under the age of fourteen may sign the Service Delivery Encounter Documentation Form.

Instructions for completing the item:

Service recipients aged fourteen years old or older – OR – parents or legal guardians of service recipients under the age of fourteen should:

a. Review the service delivery encounter documentation form to ensure its accuracy;
b. Read the authorization and certification statements;
c. Inscribe her or his signature on the line labeled “Signature”; and
d. Write the date he or she signed the completed form on the line labeled “Date Signed.”

****NOTE: NOTHING IN THIS ITEM SHALL BE CONSIDERED TO SUPERSEDE MEDICAID/NJ FAMILYCARE, HIPAA OR ANY OTHER STATUATORY REQUIREMENTS.****