

Ancillary & Facility Application Data Form

OhioRISE, specialized behavioral health care from Aetna Better Health of Ohio

**You don’t join us, we join you!** We appreciate and thank you for your interest in allowing us to join you to serve all Aetna Better Health of OhioRISE members. Please complete this data application accurately and correctly. Failure to provide all required data elements result in delay in processing your application. If there are any questions, please email us at

[OhioRISE-Network@aetna.com](mailto: OhioRise-Network@aetna.com)

**ASAM Certification Level**

**Select ASAM level of care certification(s) by checking the applicable boxes below\*.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ASAM Level 1 | ASAM Level 2 WM | ASAM Level 2.1 | ASAM Level 2.5 | ASAM Level 3.1 |
| ASAM Level 3.2 WM | ASAM Level 3.3 | ASAM Level 3.5 | ASAM 3.7 WM | ASAM Level 3.7 |
| ASAM Level 4 | Other: \_\_\_\_\_\_\_\_\_\_\_\_ | Other: \_\_\_\_\_\_\_\_\_\_\_\_ | Other: \_\_\_\_\_\_\_\_\_\_\_\_ | Other: \_\_\_\_\_\_\_\_\_\_\_\_ |

**Note**: WM= Withdrawal Management

**Specialized Education/Certification**

Education/Training\*:

Select additional areas of education/training.

|  |  |  |
| --- | --- | --- |
| **Type:** | **Provider Level** | **Group Level** |
| Applied Behavioral Analysis (ABA) | YES NO | YES NO |
| First Episode Psychosis (FEP) Early Psychosis (EEP) | YES NO | YES NO |
| Integrated Dual Disorder Treatment (IDDT) | YES NO | YES NO |
| Medication Assisted Treatment (MAT) | YES NO | YES NO |
| Office-Based Opioid Treatment (OBOT) | YES NO | YES NO |
| Screening Brief Intervention Referral to Treatment (SBIRT)  ASAM | YES NO | YES NO |
| Trauma Informed Care (TIC) | YES NO | YES NO |
| Registered Play Therapy | YES NO | YES NO |
| Trauma Systems Therapy (TST) | YES NO | YES NO |
| Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) | YES NO | YES NO |
| Attachment, Self-Regulation, and Competence (ARC) | YES NO | YES NO |
| Cue-Centered Therapy (CCT) | YES NO | YES NO |
| Child-Parent Psychotherapy (CPP) | YES NO | YES NO |
| Eye Movement Desensitization and Reprocessing (EMDR) | YES NO | YES NO |
| Skills Training in Affective and Interpersonal Regulation/Narrative Story Telling (STAIR/NT) | YES NO | YES NO |
| Group therapy for adolescents with complex trauma (TF-CBT) | YES NO | YES NO |
| Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) | YES NO | YES NO |
| Trauma Affect Regulation: Guide for Education and Therapy (TARGET) | YES NO | YES NO |
| Dialectical Behavior Therapy (DBT) | YES NO | YES NO |
| High Fidelity Wraparound | YES NO | YES NO |
| Wraparound-informed Approach | YES NO | YES NO |
| Multisystemic Therapy (MST) | YES NO | YES NO |
| Substance Use Disorder Treatment | YES NO | YES NO |

**Additional Services Provided**

If additional services are provided, please complete the below section.

Entity Name (if different from above):

Mark applicable service with ‘X’:

|  |  |
| --- | --- |
| **Service Category** | **Service Provided?**  (Mark with X) |
| Adaptive Aids |  |
| Adult Foster Care |  |
| Assisted Living Residential Services in a 1 to 3-person home |  |
| Assisted Living Residential Services in a 4 to 6-person ALF |  |
| Cognitive Rehabilitation Therapy |  |
| Emergency Response Services |  |
| Employment Assistance |  |
| Financial Management Services |  |
| Home Delivered Meals |  |
| Minor Home Modifications |  |
| Nursing |  |
| Personal Assistance Services |  |
| Protective Supervision |  |
| Respite |  |
| Supportive Consultation |  |
| Supported Employment |  |
| Transition Assistance Services |  |
| Primary Home Care |  |
| Day Activity and Health Services |  |
| Physical Therapy |  |
| Speech Therapy |  |
| Occupational Therapy |  |
| Value Added |  |
| Personal Attendant Services for Community First Choice (CFC) only |  |

**Certification**

To the best of my knowledge, I hereby certify that the information provided above is accurate.

Signature\*:

Name\* Date\*:

Designation\*: