PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

PerformCare Licensed Psychologist Attestation
LSW, LCSW, LPC, LMFT and Non-Licensed Practitioners

I (Supervising Psychologist), _____ intend to supervise and/or employ the following person: an LSW, LCSW, LPC, LMFT, CRNP, PA or unlicensed masters level practitioner to see PerformCare HealthChoices Members and bill using my Medical Assistance Identification Number: _____.

Agency/Organization Name: _____

Supervisee Name: _____

License Number & Type, if applicable: _____

Date of Birth (for identification purposes only): _____

I understand and acknowledge that I may employ an LSW, LCSW, LPC, LMFT, or other unlicensed practitioner in accordance to and in compliance with all State Board of Psychology licensing regulations and requirements. I also acknowledge that for purposes of billing PerformCare, a licensed psychologist is only permitted to supervise three (3) full-time equivalent staff who have "graduate training in psychology" but are not licensed, not preparing for licensure, or considered to be "qualified members of other recognized professions", and I agree to adhere to this requirement.

I attest and affirm that these persons will perform in accordance with PA Code, Chapter 41.58, State Board of Psychology, which states psychologists licensed by the Board may employ "professional employees with graduate training in psychology," who "shall perform their duties under the full direction, control and supervision of a licensed psychologist" and according to Policy Clarification RFP 11-97-66 & RFP 3-96-181, which permits billing for applicable services rendered under the practitioners MAID in the HealthChoices program.

I further attest that:

1) I have verified at the primary source the highest level of education for each individual employed and who providers services described herein. _____ Initial here

2) I have verified that the employed individual meets all requirements as outlined in PA Code Chapter 41. _____ Initial here

3) I have verified that this individual has no Medicare or Medicaid sanctions against him/her and have consulted with the appropriate authorities to ensure that they are not excluded from participation in federal or state healthcare programs. _____ Initial here

4) This individual will not see PerformCare Members until notified of PerformCare approval. _____ Initial here

5) The staff I am supervising have received all training required pursuant to state and federal regulation and guidance, as well as per current applicable professional standards and will receive ongoing supervision as required per PA Code Chapter 41. _____ Initial here

6) I have provided PerformCare with a current resume outlining each individuals work history. _____
Initial here

7) I have provided a copy to PerformCare of the primary source of the highest level of education for each individual employed and who provides services described herein. _____
Initial here

Will this individual be performing Best Practice Evaluations? (Yes/No) _____ _____
Yes No

How many hours per week will this individual be working at your agency under your supervision? _____
Number of hours/wk

_____ _____ _____
Licensed Psychologist Signature License Number & Type Date

PerformCare Use:

Verified by: _____ Date: _____

Provider Notification Date: _____

Method of notice: Fax/Mail/Email (keep cover sheet/letter/ email confirming delivery): _____