Date: Click here to enter a date.

This is a request to seek the approval of Children’s Behavioral Health Services, DHHS, for the agency to seek reimbursement for the Specialized Service Rate under MBM, Section 28, RCS services. Please refer to the most current version of Section 28 in the MBM for specific information about Specialized Services, including rate information.

This request will be considered upon receipt of this fully completed form and all supporting documentation. Reimbursement under the Specialized Services rate will not be available until final approval.

Please submit this request via email to the appropriate Resource Coordinator assigned to the Region in which your agency’s main office is located. If you are unsure, you may contact any of the Resource Coordinators listed below:

Cathy Register (South) at cathy.register@maine.gov, tele. (207) 822-2331
Kellie Pelletier (Central) at kellie.pelletier@maine.gov, tele (207) 513-6821
Cheryl Hathaway (North) at cheryl.hathaway@maine.gov, tele. (207) 561-4204

Agency Information:
1. Agency name: Click here to enter text.

2. Agency contact (name, position in agency, address, telephone, fax, email, TTY, cell):
   Click here to enter text.

Service Information:
1. Target population (include age, diagnosis, range of functioning as determined by Department approved tools, geographic location, any other information):
   Click here to enter text.

2. Treatment (complete description of how your agency will implement all aspects of treatment, including individual and group intervention, location(s), methods, frequency of intervention on a daily and weekly basis, expected duration, etc.):
   Click here to enter text.

3. Please attach copies/examples of all forms/documents that will be used to implement the treatment to include, but not limited to:
   a. Functional Behavioral Assessment
   b. Preference Assessment
   c. Positive Behavioral Support Plan
   d. Individualized Treatment Plan (ITP)
   e. Progress Notes
   f. Data Collection/Analysis
   g. Individualized Crisis plan, including proactive and reactive strategies
4. Describe the agency’s experience with providing treatment/support services to individuals with developmental/intellectual disabilities/Autism Spectrum Disorder:
Click here to enter text.

5. Describe in detail how the agency will ensure fidelity to the treatment model:
Click here to enter text.

6. How will the agency address externalizing behaviors that may result in injury to the client or staff?
Click here to enter text.

7. Describe fully how families will be involved in treatment (include hours per week and methods):
Click here to enter text.

8. Provide staffing and supervision by individual to include names, positions, educational degrees, certifications, licenses, years of experience with this service, functions in the service delivery, any other information:
Click here to enter text.

**Service Need and Development:**

1. Describe your understanding of the need for this service in the indicated geographic area:
Click here to enter text.

2. Projected number of children to be served during the first year by geographic location (include the basis for the number):
Click here to enter text.

**Other information or additional documents (please attach) that may assist in considering the request:**
Click here to enter text.