COUNTY MENTAL HEALTH PLAN
COUNTY CONTRACT RATE

1. **County Mental Health Plan** _____

2. **Please check the box if you would like the State to reimbursement claims for services provided by contract providers based upon the amount claimed:** ☐

3a. **Please check the box if you would like the State to limit reimbursement of claims for services provided by contract providers to a county contract rate:** ☐

3b. **If you checked item # 3a above, please enter the county contract rate per unit of service that you would like the State to use to limit reimbursement for each appropriate mode and service function:**

Service Function	Unit of Service	Rate Per Unit
Acute Psychiatric Inpatient Hospital Services	Client day	$
Administrative Day Services	Client day	$
Psychiatric Health Facility Services	Client day	$
Crisis Residential Services	Client day	$
Adult Residential Services	Client day	$
Crisis Stabilization – Emergency Room	Client hour	$
Crisis Stabilization – Urgent Care	Client hour	$
Day Treatment Intensive – Half Day	Client half-day	$
Day Treatment Intensive – Full Day	Client full day	$
Day Rehabilitation – Half Day	Client half-day	$
Day Rehabilitation – Full Day	Client full day	$
Case Management/Brokerage/ICC	Staff minute	$
Mental Health Services/IHBS/STRTP	Staff minute	$
Medication Support Services	Staff minute	$
Crisis Intervention	Staff minute	$

_____ _____
County Mental Health Director **Date**