

**COUNTY MENTAL HEALTH PLAN
COUNTY CONTRACT RATE**

1. County Mental Health Plan _____
2. Please check the box if you would like the State to reimburse 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 the claims for services provided by contact providers to a county contract rate:
- 3b. If you checked item #3a above, please enter the county contract rate per unit of service 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	\$
Adult 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	Staff minute	\$
Medication Support Services	Staff minute	\$
Crisis Intervention	Staff minute	\$

County Mental Health Director

Date