Outpatient Behavioral Health Outcome Tool Selection Form

Fax to: 888-977-0776

If you are a multi-site organization, please only submit one form for the entire organization.

Provider Information
Provider type

- Individual practitioner or non-hospital-based group
- Facility or hospital-based group

Practice name

Practice address

City ___________________________ State ___________ ZIP ___________

Provider name ___________________________ Title ___________

E-mail address ___________________________

Network Health-approved assessment tools Please indicate all tools you have chosen to implement.

- Adolescent Treatment Outcomes Module (ATOM)
- Patient Health Questionnaire (PHQ)
- Behavioral and Emotional Rating Scale (BERS)
- Personal Experience Inventory (PEI, PEI-Adult)
- Behavior and Symptom Identification Scale (BASIS)
- Quality of Life Inventory (QOLI)
- Brief Psychiatric Rating Scale (BPRS) – Adult and child
- SF8, 12, 36
- Brief Symptom Inventory (BSI)
- SOCRATES
- Child-Adolescent Functional Assessment Scale (CAFAS/PECFAS)
- Symptom Checklist-90 – Revised (SCL-90-R)
- Child and Adolescent Needs and Strengths (CANS)*
- Treatment Outcome Package (TOP, TOP-SA)
- Child Behavior Checklist (CBCL)
- Youth Outcome Questionnaire (YOQ)
- Connor’s Rating Scales – Revised (CRS-R)
- Current Evaluation of Risk and Functioning – Revised (CERF-R)
- Global Appraisal of Individual Needs (GAIN)
- Methadone Treatment Quality Assurance System (MTQAS)
- Other: ___________________________

Please also fill out the alternate assessment tools section below.

* The CANS assessment is required for all Network Health Together® members younger than 21

Alternate assessment tools If you have checked “other” above, please fill in detail below.

List the alternate assessment tools you are requesting approval to use: ___________________________

With which population(s) will you administer the tool?

- Children
- Adolescents — mental health
- Adults — mental health
- Adolescents — substance use
- Adults — substance use

Describe why you want to use an alternate assessment tool instead of a Network Health-approved assessment tool: ___________________________

I understand that the chosen instrument(s) are to be administered to all Network Health members receiving treatment and that the information I have provided is subject to onsite or telephonic review. I also understand that if there are changes to the information I have provided, it is my responsibility to notify Network Health by updating the information on this page. I verify that all statements are accurate to the best of my knowledge.

Provider signature ___________________________ Date ___________

Form available at www.Network-Health.org Phone: 888-257-1985