

SPECIALIZED THERAPEUTIC FOSTER CARE PROVIDER AGENCY CERTIFICATION

This is to certify that:

Agency Name

Address

Phone Number () _____ Agency Medicaid No. _____ (if enrolled)

has met the qualifications for certification as a provider of Specialized Therapeutic Foster Care based upon a review by Substance Abuse and Mental Health Program Office of the following: 1) Qualifications as outlined in the Florida Medicaid Community Behavioral Health Coverage and Limitations Services handbook for all clinical staff who will provide this service; 2) An approved pre-service and in-service training plan; 3) Their list of foster parents, who are licensed by the Department of Children and Families; 4) The financial and therapeutic agreement between the agency and foster parents; 5) Sufficient administrative capacity to operate the program; 6) Policies and procedures that address good therapeutic practice, ensure therapeutic foster parents are the primary therapeutic agent, provide appropriate treatment plans and documentation, and protects the rights of children and families; and 7) a program evaluation system.

Begin date: _____ End date: _____

District Substance Abuse and Mental Health Representative	Date
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District Family Safety or Community Based Care Representative	Date
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OR

District Juvenile Justice Representative	Date
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AND

Area Medicaid Representative	Date
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Submit this form with your Florida Medicaid Provider Enrollment Application to the address listed below.

**EDS
Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070**