Kentucky CCBHC Demonstration
Designated Collaborating Organization (DCO)
Request

CCBHC Information

CCBHC Agency Name: ______________________________________ Request Date: ___________________

CCBHC DCO Designated Lead: _________________________________

CCBHC DCO Designated Lead Email: ____

DCO Information

DCO Agency Name: ____

DCO Address: ____ Phone: _________________________

DCO Primary Contact Name: ________________________________ Email: __________________________

Expected Start Date: ___________________ Proposed length of Contract: ____________________________

Applicable DCO Medicaid provider number(s): ____

Is DCO also operating as a CCBHC?: Yes No

Service Information

List Service(s) proposed to be provided by the DCO:

List CCBHC Service Code(s) to be used:

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Please provide information on why these services should be provided by a DCO.

Does the CCBHC retain the ability to provide the services listed above: Yes No

Is the need for this DCO relationship confirmed by the Community Needs Assessment: Yes No

CCBHC Attestations

Agency Name ___________________________ CCBHC Authorized Personnel Name: __________________________

1. Attests to the ability to continue to provide the proposed DCO services: YES NO
2. Attests to the understanding that the CCBHC organization will directly deliver the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through DCOs. YES NO
3. Attests to develop and implement a plan within two-years from submission of attestation to focus on ways to improve care coordination between the CCBHC and DCO using a health IT system. YES NO

CCBHC Authorized Personnel Signature/Date: __________________________________ _______________________

Documents *(to be provided with this request)*:

Proposed DCO Contract
CCBHC DCO Monitoring Plan
CCBHC DCO Data Collection Plan
CCBHC Attestation to DCO Integrity
CCBHC DCO Training Plan