RESET

REQUEST FOR ABOVE LEVEL IV PAYMENT

DATE OF REQUEST: _____
SERVICE PERIOD: _____

AGENCY NAME: _____ **AGENCY DVN:** _____
CHILD'S NAME: _____ **CHILD'S DCN:** _____

CERTIFICATION

I, _____, as the Authorized Agent of _____ do hereby certify that the request for payment of services and programming claimed herein occurred in the manner in which they have been described and are supported by adequate documentation which shall be retained as specified in the Residential Treatment Services Contract and charged at a rate not greater than the rate in effect on January 1, 2020. I further acknowledge that all services and programming claimed as above Level IV are subject to the payment conditions outlined in Section 5, Payments to the Contractor, of the Residential Treatment Services Contract.

Increased Supervision (Staff: Child Ratio)
Hours of increased supervision provided during the reporting period:

	Rate per Hour	Number of Hours	Total Cost
☐ 1:1			
☐ 1:2			
☐ 1:3			
☐ Other:			

Increased Counseling Sessions
Sessions provided during the reporting period:

	Number of Sessions	Duration
☐ Individual		
☐ Group		
☐ Family		
☐ Other:		

Specialized Psychological, Psychiatric, and Other Evaluations
Services provided during the reporting period:

Service Type: _____
Hourly rate or flat fee: _____
Total cost for reporting period: _____

Specialized Therapeutic Services
Participation during the reporting period:

Program	Days Participated	Days Absent
☐ Autism Spectrum		
☐ Youth with Problem Sexual Behaviors		
☐ Substance Use/Dependency Treatment		
☐ Sex Trafficking		
☐ Other specialized program:)		