U.S. Probation & U.S. Pretrial Services

Treatment
and
Billing Information

Vendor Requirements

- Services will not be provided without a Contract Program Plan (Prob 45)
- Transition of services and discharge summaries
- Referral packet
- What is entailed in a staffing?
- Due dates for assessments and reports
- Request for services should be as detailed as possible
- Reports to be sent directly to the PO/PSO
- Electronic Reporting System/Service Provider Communication
- Documents to be provided to agency billing staff

Contract Program Plan (Prob 45) - Initial

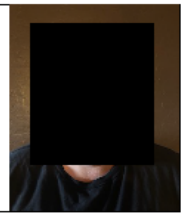
Prob. Form 45
Today's Date: 8/24/21

Initial

TREATMENT SERVICES CONTRACT PROGRAM PLAN

Client Identifying Information

Client:	[redacted]	PACTS #:	[redacted]
Address:	[redacted]	Pretrial/Post Conviction:	Post Conviction
Officer:	Clever, Cory P.	Client Phone:	[redacted]
Officer Phone:	928-286-5759	DOB:	[redacted]



Provider Information

0970-2022-xxxx

Provider:	[redacted]	Procurement No:	[redacted]
Provider Location:	[redacted]	Effective Date:	10/26/2020
Attn:	[redacted]	Termination Date:	
Location Address:	[redacted]		
Phone:	[redacted]		
Fax:	[redacted]		

Effective Date determines authorization for billing

Authorized Services

Your agency is authorized to provide the following services beginning on the plan effective date indicated above. Any services provided outside of those listed below and/or outside the Effective and Termination Dates of the Plan will not be authorized for payment.

Services Ordered Only bill for authorized services

Project Code	Description Of Services	Phase	Frequency (Units)	Interval	Copay Amount (per unit)
6090	Treatment Readiness Group/Sex Offender		32.0	Per Plan	$0.00
6022	Group Counseling / Sex Offender		4.0	Weekly	$5.00
6012	Individual Counseling / Sex Offender		2.0	Weekly	$5.00

Copayment Amount

Copayment Source

Defendant/Offender

Instructions to Provider Regarding Client Needs and Goals of Treatment

Telehealth authorized due to COVID 19 Pandemic

Officer: Clever, Cory P. | Referral Agent: | Client: [redacted]

Both the officer and referral agent signatures are required to execute the referral

Page 1

Contract Program Plan (Prob 45) - Amended

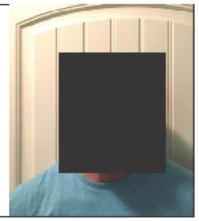
Prob. Form 45
Today's Date: 6/2/21

Amended

TREATMENT SERVICES CONTRACT PROGRAM PLAN

Client Identifying Information

Client:	[redacted]	PACTS #:	[redacted]
Address:	[redacted]	Pretrial/Post Conviction:	Post Conviction
Officer:	Domschot, Joshua	Client Phone:	[redacted]
Officer Phone:	602-682-4304	DOB:	[redacted]



Provider Information

0970-2022-xxxx

Provider:	[redacted]	Procurement No:	[redacted]
Provider Location:	[redacted]	Effective Date:	06/02/2021
Attn:	[redacted]	Termination Date:	
Location Address:	[redacted]		
Phone:	[redacted]		
Fax:			

All services listed are effective as of this date

Authorized Services

Your agency is authorized to provide the following services beginning on the plan effective date indicated above. Any services provided outside of those listed below and/or outside the Effective and Termination Dates of the Plan will not be authorized for payment.

Any services no longer listed are not authorized

Services Ordered

Project Code	Description Of Services	Phase	Frequency (Units)	Interval	Copay Amount (per unit)
2010	Individual Substance Abuse Counseling		2.0	Weekly	$5.00

Copayment Amount

Copayment Source

Defendant/Offender

Instructions to Provider Regarding Client Needs and Goals of Treatment

It was recommended Thomas complete 10 SA sessions at Lifeline PCS. $5 co pay per session. Please contact this officer at end of every month for staffing's, or sooner to address any non-compliance at 602-550-8540. Thank you

Officer: Domschot, Joshua | Referral Agent: | Client: [redacted]

Both the officer and referral agent signatures are required to execute the referral

Page 1

Contract Program Plan (Prob 45) - Terminated

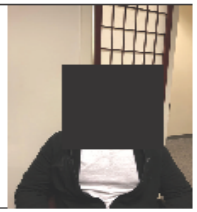
Prob. Form 45
Today's Date: 4/16/21

Terminated

TREATMENT SERVICES CONTRACT PROGRAM PLAN

Client Identifying Information

Client:	[redacted]	PACTS #:	[redacted]
Address:	[redacted]	Pretrial/Post Conviction:	Post Conviction
Officer:	Peterson, Kimberly	Client Phone:	[redacted]
Officer Phone:	602-682-4358	DOB:	[redacted]



Provider Information

0970-2022-xxxx

Provider:	[redacted]	Procurement No:	[redacted]
Provider Location:	[redacted]	Effective Date:	04/16/2021
Attn:	[redacted]	Termination Date:	04/16/2021
Location Address:	[redacted]		
Phone:	[redacted]		
Fax:	[redacted]		

Services are not authorized Beyond the termination date

Authorized Services

Your agency is authorized to provide the following services beginning on the plan effective date indicated above. Any services provided outside of those listed below and/or outside the Effective and Termination Dates of the Plan will not be authorized for payment.

Services Ordered

Project Code	Description Of Services	Phase	Frequency (Units)	Interval	Copay Amount (per unit)

Instructions to Provider Regarding Client Needs and Goals of Treatment

please terminate all prior tx contracts, as tx not recommended in assessment.

Officer: Peterson, Kimberly Referral Agent: Client: [redacted]

Both the officer and referral agent signatures are required to execute the termination

Page 1

Transition of Services

Individual meetings will occur for vendors receiving clients from an expiring vendor. Discharge summaries will be provided by officers with the referral process.

Referral Packet

- Contract Program Plan (Prob 45)
- Signed Release of Information Form
- Referral Letter (Probation)
- All Pretrial reports and addendums (Pretrial)

Staffings

- Initial Staffing
- 30-Day Staffing
- Discharge Summary
- Upon Request – Issue Driven Staffing

Local Needs

- Individual and group services local needs for COVID-19
- Individual and group services local needs for telemedicine

Local Needs for Probation Referrals Only

- Individualized Comprehensive Quarterly Treatment Plan:
  - Dynamic Risk Factors
  - Type and Frequency of Services
  - Risk/Needs/Responsivity
  - Planned Strategies to address Clinical Issues and RNR
  - Treatment Goals/Measurable Objectives
  - Anticipated time frame for treatment completion / need for continued treatment

Monthly Treatment Reports (Prob 46)

- Individualized
- Stage of Change
- Strategies used for increased behavior change
- Officer interventions and how the officer is addressing risk factors
- Input from referral

Due Dates

- **SU Assessments** – A typed report is due within **10 calendar days** of first face-to face contact with person under supervision
- **MH Assessment** – A typed report is due within **15 calendar days** after the vendor's first personal contact
- **Evaluations** – A typed report is due within **15 calendar days** after completion of any of the evaluation services
- **Polygraphs** – A typed report is due within **10 calendar days**
- **Sex Offense Specific Evaluation & Report** – A typed report is due **15 calendar days after completion of evaluation.**

Monitoring Visits

The first monitoring visit is to be conducted within 120 days of award of agreement. Second monitoring visit to be conducted if deficiencies or problems were noted in the first report, or at least 120 days prior to exercising the option to renew a Blanket Purchase Agreement.

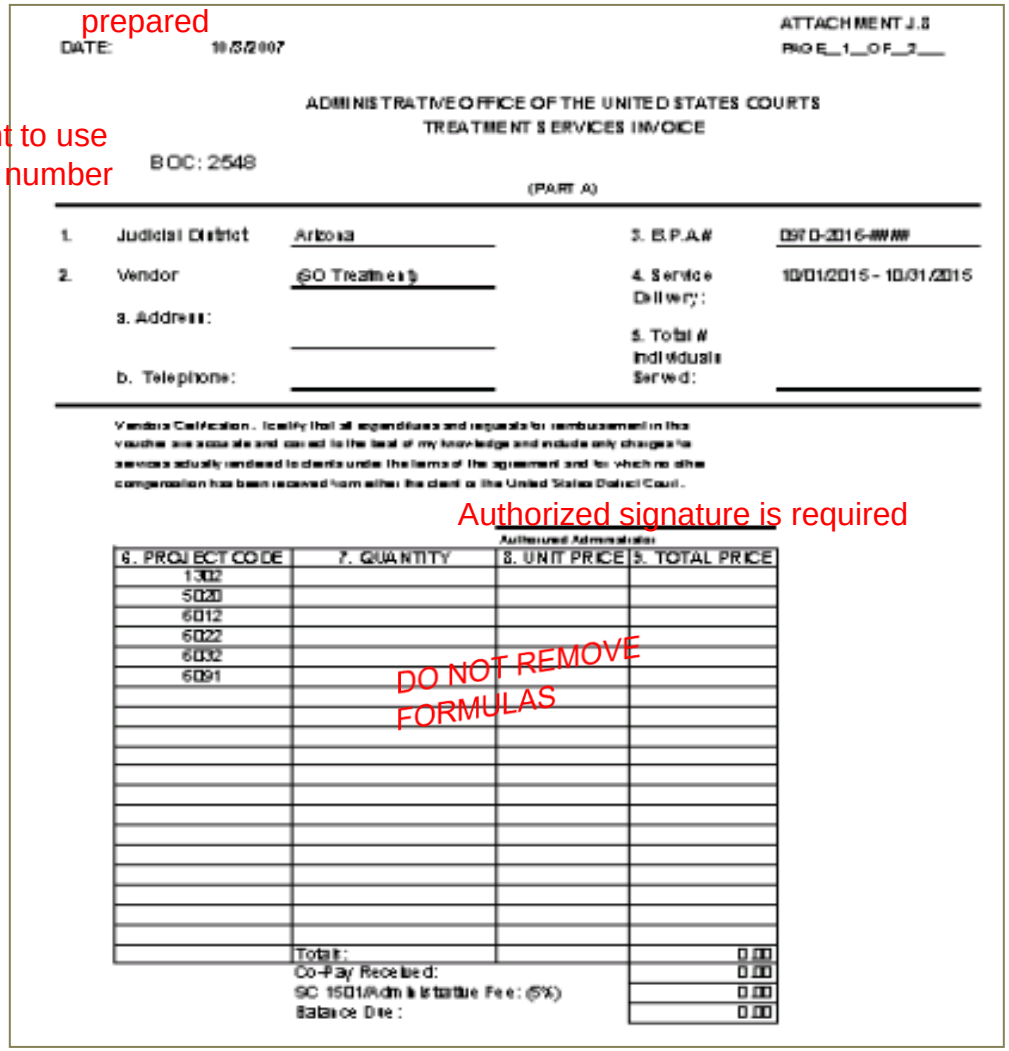
Invoice – Part A

Include the date the invoice is prepared

It is important to use correct BOC number

Add a unique invoice number each month

Include the dates of services.



ATTACHMENT J.8
PAGE 1 OF 2

DATE: 10/3/2007

ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS
TREATMENT SERVICES INVOICE

BOC: 2548

(PART A)

1.	Judicial District	Arizona	3. B.P.A.#	0970-2016-####
2.	Vendor	GO Treatments	4. Service Delivery:	10/01/2015 - 10/31/2015
	a. Address:		5. Total # Individuals Served:	
	b. Telephone:			

Vendor Certification. I certify that all expenditures and requests for reimbursement in this voucher are accurate and correct to the best of my knowledge and include only charges for services actually rendered to clients under the terms of the agreement and for which no other compensation has been received from either the client or the United States District Court.

Authorized signature is required

Authorized Administrator

6. PROJECT CODE	7. QUANTITY	8. UNIT PRICE	9. TOTAL PRICE
1302			
5020			
6012			
6022			
6032			
6091			
	Total:		0.00
	Co-Pay Received:		0.00
	SC 1501/Administrative Fee: (5%)		0.00
	Balance Due:		0.00

DO NOT REMOVE FORMULAS

Invoice – Part B

ADMINISTRATIVE OFFICE OF THE UNITED STATES COURTS

TREATMENT SERVICES INVOICE

INVOICE DETAIL

Fill-in the relevant information. The total units of each service rendered and their unit price will be transferred to the invoice on the next page.

(PART B)

Entries below will automatically total and carry to Prob. Summary Tab

Co-payments must be listed

1.CLIENT NAME	2.CLIENT NUMBER	3. DATES OF SERVICE	4. SERVICE RENDERED	5. QUANTITY (UNITS)	6. UNIT PRICE	7. COST	8. CO-PAY REQUIRED	9. CO-PAY RECEIVED	Project Code	Unit Price
					$ -	$ -	$ -	$ -	1020	1.89
					$ -	$ -	$ -	$ -	1022	1.50
					$ -	$ -	$ -	$ -	1032	3.40
					$ -	$ -	$ -	$ -	1033	3.40
					$ -	$ -	$ -	$ -	1034	3.30
					$ -	$ -	$ -	$ -	1035	2.85
					$ -	$ -	$ -	$ -	1036	3.95
					$ -	$ -	$ -	$ -	1037	3.95
					$ -	$ -	$ -	$ -	1038	3.85
					$ -	$ -	$ -	$ -	1039	0.20
					$ -	$ -	$ -	$ -		

DO NOT REMOVE FORMULAS

Client's name and PACTS number must match PROB 45

PACTS number is provided on the PROB 45 (Contract Program Plan)

Invoice Documentation

- **Prob 45s**
  - For all services listed on invoice covering time frame
  - Clients may have more than one Prob 45 to cover the month
- **Sign-in Logs** for each client per month
  - Signature required for each service
- **Monthly Treatment Reports**
  - Required for each client in treatment
  - Not required for UA collection only or Polygraphs
  - Copay must be documented
  - Each section must be completed, including items A thru H
- **Receipts for Copayments**
  - Provide copies of receipts for copayments received
- **Mileage Logs**
  - Must have traveler's signature, dates and odometer readings for each destination
  - Must list names of persons under supervision & PACTS# or mileage requested
- **Pharmacy Receipts for Meds**
  - Client, Date, Medication & Cost
- **Lab Receipts for Lab Studies**
  - Client Date(s), Itemized tests provided & cost

Daily Treatment Log/Sign-in Log

Attachment J.6

DAILY TREATMENT LOG

COMPLETE ONE FORM PER CLIENT PER MONTH

Co-payment amount must be listed

Client Name _____ Month/Year _____

Date	Client's Signature/Initials	Time In	Purpose of Visit	Co-Pay Collected	Time Out	Client's Initials	Vendor's Initials

Note treatment times, not arrival/departure times.

All columns must be filled in legibly

Urinalysis Testing Log

Attachment J.9

URINALYSIS TESTING LOG

COMPLETE ONE FORM PER CLIENT PER MONTH

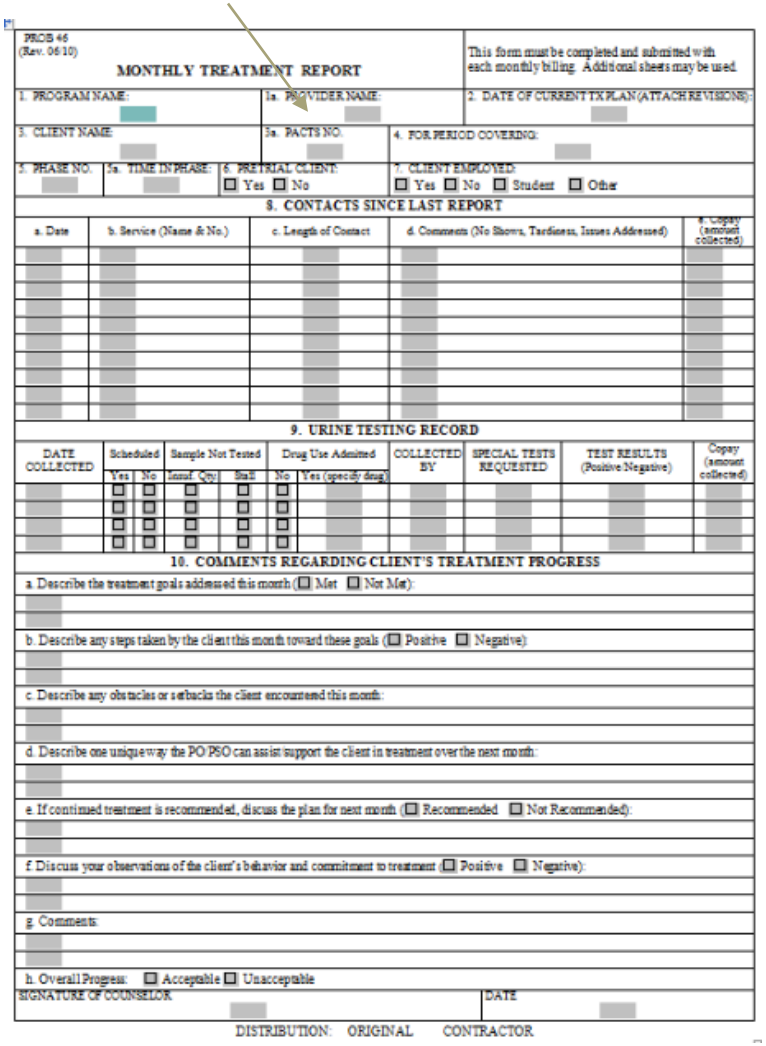
Co-payment amount must be listed

Client Name _____ PACTS # _____ Month/Year_____

Date Collected	Client's Signature/Initials	Bar Code Number	Special Tests	Medications Taken	Collector's Initials	Test Results/Date Received	Co-Pay Collected

Monthly Treatment Report

PACTS numbers must be listed & correct.
Please compare PACTS numbers to the PROB 45 to ensure accuracy.



PROB 46
(Rev. 06/10)

MONTHLY TREATMENT REPORT

This form must be completed and submitted with each monthly billing. Additional sheets may be used.

1. PROGRAM NAME:
1a. PROVIDER NAME:
2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS):
3. CLIENT NAME:
3a. PACTS NO.
4. FOR PERIOD COVERING:
5. PHASE NO.
5a. TIME IN PHASE:
6. PRETRIAL CLIENT: ☐ Yes ☐ No
7. CLIENT EMPLOYED: ☐ Yes ☐ No ☐ Student ☐ Other

8. CONTACTS SINCE LAST REPORT

a. Date	b. Service (Name & No.)	c. Length of Contact	d. Comments (No Shows, Tardiness, Issues Addressed)	e. Copay (amount collected)

9. URINE TESTING RECORD

DATE COLLECTED	Scheduled Yes	Scheduled No	Sample Not Tested Insuf. Qty	Sample Not Tested Shall	Drug Use Admitted No	Drug Use Admitted Yes (specify drug)	COLLECTED BY	SPECIAL TESTS REQUESTED	TEST RESULTS (Positive/Negative)	Copay (amount collected)
	☐	☐	☐	☐	☐					
	☐	☐	☐	☐	☐					
	☐	☐	☐	☐	☐					
	☐	☐	☐	☐	☐					

10. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS

a. Describe the treatment goals addressed this month (☐ Met ☐ Not Met):

b. Describe any steps taken by the client this month toward these goals (☐ Positive ☐ Negative)

c. Describe any obstacles or setbacks the client encountered this month:

d. Describe one unique way the PO/PSO can assist support the client in treatment over the next month:

e. If continued treatment is recommended, discuss the plan for next month (☐ Recommended ☐ Not Recommended):

f. Discuss your observations of the client's behavior and commitment to treatment (☐ Positive ☐ Negative):

g. Comments:

h. Overall Progress: ☐ Acceptable ☐ Unacceptable

SIGNATURE OF COUNSELOR | DATE

DISTRIBUTION: ORIGINAL CONTRACTOR

Co-payments must be listed on MTR

Budget object codes

- 2526
  - Substance Use Treatment
- 2530
  - Mental Health Treatment
- 2548
  - Sex Offender Treatment
- 2527
  - Pretrial Services Treatment (all inclusive)

Project Codes - Substance Use

- 1010 Urine Collection/Testing & Reporting
- 2011 SU Intake Assessment & Report
- 2000 Case Management Services
- 2010 Individual Counseling
- 2020 Group Counseling
- 2021 CBT Clinical Group
- 2022 Manualized Group
- 2030 Family Counseling
- 2080 Intensive Out-patient Group
- 2090 Treatment Readiness Group

Project Codes - Mental Health

- General Mental Health Codes
  - 4010 Physical Examination & Report
  - 4020 Laboratory Studies & Report
  - 5011 Mental Health Intake Assessment & Report
  - 5010 Psychological Evaluation & Report
  - 5020 Psychological Testing & Report
  - 5030 Psychiatric Evaluation & Report
  - 6000 Case Management Services
  - 6010 Individual Counseling
  - 6020 Group Counseling
  - 6028 Cognitive-Behavioral Group
  - 6030 Family Counseling
  - 6040 Psychotropic Medications
  - 6051 Medication Monitoring

- Integrated Treatment for Co-occurring Disorders
  - 6015 Individual Counseling
  - 6026 Group Counseling
  - 6027 Treatment Readiness Group
  - 6036 Family Counseling

Project Codes - Sex Offender

- 5012 SO Psychophysiological Eval
- 5020 Psychological Testing & Report
- 5021 Penile Plethysmograph & Report
- 5022 Sexual History or Instant Offense Examination
- 5023 Maintenance Examination
- 5025 Visual Reaction Time (VRT) Report
- 6012 Individual Counseling
- 6022 Group Counseling
- 6032 Family Counseling
- 6090 Treatment Readiness Group
- 6091* Chaperone Training & Support

***Language for 6091 from the Statement of Work: Chaperone Training and Support is a psycho-educational/specialized training for one (1) or more significant others, or family members of a defendant/offender charged with or convicted of a sex offense. The goal is to provide a means of certifying individuals designated by the probation/pretrial services officer to act as a chaperone for a defendant/offender and safeguard for the community.**

U.S. Pretrial Project Codes – Sex Offender

- Specialized Treatment for Pretrial Defendants Charged with Sex Offenses
    - 7013 – Individual Treatment
    - 7023 – Group Treatment

The vendor shall not ask any questions pertaining to the instant offense or ask questions or administer tests that compel the defendant to make incriminating statements or to provide information that could be used in the issue of guilty or innocence. If such information is divulged, it shall not be included on the written report.

Project Codes - Admin.

- Administrative Codes
  - 1202 Client Transportation Expenses
  - 1401 Contractor's Local Travel

The current government travel mileage rate is 56 cents per mile, and you will be notified should it change in the future. Only agreements with 1401 and/or 1202 on their agreement are authorized to bill for mileage. The 1401 code should only be utilized as needed on an individual basis as approved by the Prob 45.

- 1201 Admin Fee for Client Transportation Expenses
- 1501 Admin Fee for Collecting Copay
- 6041 Admin Fee for Psych Meds

These fees are 5% of client transportation expenses, 5% of copay collected, and 5% of the actual cost of medications provided and billed on the invoice. Only agreements with these codes are authorized to bill for administrative costs.

Project Codes - Residential

- Residential Codes
  - 2001 Short-term Residential Treatment
  - 1001 Therapeutic Community Treatment (Juvenile Only)
  - 6001 Short-term Residential Treatment for Co-occurring Disorders

Pretrial Services will pay for services as indicated on the Prob Form 45 and will not assist in funding self-pay, AHCCCS, or insurance placements without prior approval from the assigned officer.

Probation only uses the 2001 and 6001 codes and will pay for services up to 30-day increments upon advanced approval by the Contracts Administrator. We do not contribute to pay for self-pay, AHCCCS or insurance placements.

Project Codes – Halfway House

- 9905 Provision of Shelter/Halfway House Placement

Pretrial Services only.

Billing Units

- 1 Unit Per Service or Report
- 1 Unit Per Day
- 30-Minute Increments
- Actual Costs
- All costs should have been included your no-show factor

“The vendor shall not include a charge for a ‘No-Show’ as a separate item.” (Statement of Work, Section G.3, f)

One Unit Per Service or Report

- UAs
- Reports
  - Assessments, Evaluations, Polygraphs
- Tests
  - MSI II, Abel, VRT…etc.

One Unit Per Day

- Intensive Out-Patient
  - (1) This service must be used in conjunction with one (1) hour a month of individual counseling which is ordered separately under code 2010; and
  - (2) Group counseling sessions at least three (3) days per week for a minimum length of three (3) hours per session
- Residential
- Halfway House Placement

30-Minute Increments

- Individual
- Group

Assume that the rate of service is $10.00 per half hour.

Time Spent (in minutes)	Charge
0 - 15	$ 0.00
16 - 30	$10.00
31 - 45	$15.00
46 - 60	$20.00

Actual Costs

- Mileage
  - 1401
- Administrative Fees
  - 1501 (5% of Copay Collected)
  - 6041 (5% of the Cost of Meds)
- Lab Studies (Must be valid tests tied to psych meds)
  - 4020
- Psychotropic Medication
  - 6040

Requirements

- Submit billing packet electronically via ERS/SPCS
- Packet Includes: Prob 45s for all clients, Sign-in Logs and MTRs
- No copy required
- Due no later than 10th of the following month
- Include a unique invoice number
- Separate invoices for SU, MH, SO for Probation; and one invoice per BPA for Pretrial (all services)
- Copay should be deducted from the total and the Admin Fee of 5% of copay collected is added to the total
- We do our best to adhere to a 30-day time frame for payment

Questions

Treatment
And
Billing Information

Thank you for your attendance!

The U.S. Probation & U.S. Pretrial Services
Treatment Team