Intensive Infant and Early Childhood Mental Health (IECMH) Services Attestation

I,_____, hereby attest that by placing a check next to
Name of Provider, Group or Facility
either of the specialties listed below, that I (or affiliated provider of an agency or a facility) meet the **Intensive Infant and Early Childhood Mental Health (IECMH) Services** specialty criteria requirement(s) and would like the specialty designation/s added to my provider record and agree to accept referrals.

QUALIFICATIONS TO COMPLETE ASSESSMENT AND PROVIDE TREATMENT:

_____ **License:** The provider's counseling professional is independently licensed to provide counseling services. Independently licensed professionals must hold, at least, a master's degree in the mental/behavioral health discipline and, if not independently licensed to provide counseling services, be under the direct supervision of a licensed mental health provider practicing within their scope of licensure as outlined in Tennessee Code 33-1-101.[1] The entity must be contracted with the member's TENNCARE MCO to provide supervision under these guidelines. In order for an unlicensed master's level therapist to deliver therapy services in a TennCare contracted mental health agency, the following criteria must currently be met as outlined in the current policy:

- The facility in which the therapist is practicing must be licensed as a Mental Health Outpatient Facility by the Tennessee Department of Mental Health and Substance Abuse Services.
- The facility in which the therapist is practicing contracts with one or more TennCare managed care organizations (MCOs) in a manner that allows for the unlicensed therapist to render behavioral health services while under the supervision of a licensed professional.

https://www.tn.gov/content/dam/tn/tenncare/documents2/pro-22-002.pdf

_____ **Education:** Verifiable education/training in the following areas:

1. Assessment, developmental screening of 0-5,
2. Trauma screening of children ages 0-5 and caregiver
3. Relationship-based assessment

AND ONE OR MORE OF THE FOLLOWING:

_____ **Endorsement and/or Evidence-Based Practice:** Fulfilling the criteria of at least one of the following categories- Endorsement and/or Evidenced-Based Practice:

Endorsement:

- Infant Mental Health (IMH) Endorsement® for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health (IMH-E®) with endorsement as an Infant Family Specialist or above (categories 2, 3, or 4).

Evidence-Based Practice (EBP):

- Certified/rostered or current participant in an evidence-based treatment (EBT) for infants and young children with verification from a trainer certified by the developer or certified through the official training organization (Child-Parent Psychotherapy, Attachment Biobehavioral Catch-up; Parent Child Interaction Therapy; Parent Child Interaction Therapy-Toddler, Circle of Security, etc.).

OR

- The therapist can attest the evidenced-based practice domain by doing one of the following:
    1. Submit a letter from the EBP trainer that the person is participating in one of the EBT learning collaboratives or trainings.

OR

2. Submit a certificate that the person has completed one of the EBTs for infants and young children.

Attestation: By completing and submitting, Provider attests that he/she has reviewed, complies with, and agrees to participate in continuing education, abide by the Intensive Infant and Early Childhood Mental Health (IECMH) Services billing requirements, the most recent program description/guidelines, quality review standards, and Medical Necessity Criteria specific to the delivery of Intensive Infant and Early Childhood Mental Health (IECMH) Services. Provider hereby attests that the information above is true and accurate to the best of my knowledge. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the Managed Care Organization's Plan network.

Printed Name of Provider/Group/Facility	**Tax Identification Number/EIN**
Provider/Practice Email Address	**Provider/Practice Secure Fax Number**
Printed Name of Authorized Signature	**Authorized/Signature**
Date	

Please return this form by email to [Email] or by fax [Fax].