Reset Form

Ohio Department of Children and Youth

CREDENTIALS OF PROFESSIONAL PROVIDERS OF PASSS FUNDED THERAPEUTIC SERVICES AND MEMORANDUM OF UNDERSTANDING

Child's Name *(first and last)*	Date of Birth
Specify the therapy being provided to the child What is the diagnosis, including diagnosis code, being treated If applicable, what is the billing code for this diagnosis	
Professional Experience (please describe your professional experience with the therapy you will provide to the child)	
Education and Training (please list all specific education and training relative to the therapy you will provide to the child)	
Professional Credentials	
Name of Provider *(first and last)*	
Name of Practice/Office	NPI number
Street Address of Practice/Office	
City, State and Zip Code	*(Area Code)* Telephone Number
Ohio License #	Licensing Board
Medicaid Provider ☐ Yes ☐ No	If yes, which Managed Care Network(s)
My therapeutic interventions will comply with all treatment aspects contained in Ohio Administrative Code rules 5122-26-16 "Seclusion, restraint and time-out," 5122-26-16.1 "Mechanical restraint and seclusion," and 5122-26-16.2 "Physical restraint" I proclaim competence to the therapeutic technique(s) specified and acknowledge that my practice is governed under laws and rules of the occupational regulatory board specified above.	
Signature of Provider of Service(s)	Date

INSTRUCTIONS FOR COMPLETING THE DCY 01052,
CREDENTIALS FOR PROVIDERS OF PASSS FUNDED THERAPEUTIC SERVICES AND MEMORANDUM OF UNDERSTANDING

Child's names: Enter the first and last name of the child.

Date of Birth: Enter the child's date of birth.

Specify the therapy service: Provide a clear written statement of the type of therapeutic service that will be provided to the child. Per Ohio Administrative Code (OAC) 5101:2-44-13.1 (D)(1).

Professional Experience: describe the professional experience with the therapy provided to the child**. (Include whether the professional will directly provide or supervise requested service).**

Education and Training: list the education and training of the professional relative to the therapy being provided to the child.

Professional Credentials: Example PhD, LPC LSW, or LISW.

Name of Provider: Enter the first and last name of the provider who will directly provide the therapeutic service.

Name of Practice: Enter the name of the practice.

NPI number: Enter the provider or practice's 10-digit National Provider Identifier (NPI).

Street Address of Practice: Enter the street address of the practice.

City, State and Zip Code: Enter the city, state and zip code where the practice is located.

Telephone Number: Enter the area code and telephone number of the practice.

Ohio License #: Enter the license number of the profession.

Licensing Board: Enter the name of the Licensing Board in which the provider is authorized to practice.

Medicaid Provider: Indicate if the provider or practice is a provider for Medicaid by checking the appropriate response.

If yes, which Managed Care Network(s): If the provider or practice is Medicaid provider, enter which Medicaid Manage Care Networks the provider or practice is a part of.