# Provider certification telemedicine only application

**Required:**

Practitioner EIN/SSN #: _____

Practitioner NPI #: _____

**Note:** This application is intended for practitioners that **only** provide services via telemedicine and **do not** have a brick and mortar location. Practitioners that offer in-person services should not use this application, and instead visit HumanaMilitary.com/certify to complete the applicable practitioner certification application online.

**Applicant information**

Request date: _____

First name: _____ Middle initial: ____ Last name: _____

Phone #: _____ National Provider Identifier (NPI) #: _____

Federal tax ID #: _____ ☐ EIN ☐ SSN Are you joining an established group practice? ☐ Yes ☐ No

If Yes, group name: _____

Date you began filing with the group: _____ Group NPI #: _____

Office location (street address): _____

City: _____ State: _____ ZIP Code: _____

Billing address (if different): _____

City: _____ State: _____ ZIP Code: _____

Office phone #: _____ Billing phone #: _____ Fax #: _____

**Contact information**

Point of contact information if additional information is needed (may be practitioner or group representative):

Name: _____ Phone #: _____

Email: _____

**I am applying for certification as a:**

☐ Anesthesiologist Assistant (AA)*
☐ Audiologist
☐ Certified Clinical Social Worker (CSW)*
☐ Certified Marriage and Family Therapist* (CMFT)
☐ Certified Nurse Midwife* (CNM)
☐ Certified Nurse Practitioner (CNP)
☐ Certified Registered Nurse Anesthetist (CRNA)*
☐ Certified Psychiatric Nurse Specialist (CPNS)*
☐ Clinical psychologist*
☐ Dietitian/Nutritionist*
☐ Lactation consultant*
☐ Lactation counselor*
☐ Mental health counselor*
☐ Occupational Therapist (OT)
☐ Pastoral counselor*
☐ Physical Therapist (PT)
☐ Physician
☐ Physician assistant*
☐ Registered Nurse (RN)
☐ Speech Therapist (SP, SLP)

**Specialties that must meet special requirements per TRICARE policy as specified in Section 2*

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# Provider certification telemedicine only application

To apply for certification as a TRICARE-authorized provider, read and complete all sections of this application and return it with all attachments.

**Licensure**

Providers rendering telemedicine services must follow telemedicine-specific regulatory, licensing, credentialing and privileging, malpractice and insurance laws and rules for their profession in both the jurisdiction (site) in which they are practicing as well as the jurisdiction (site) where the patient is receiving care, and shall ensure compliance as required by appropriate regulatory and accrediting agencies. See *TRICARE Policy Manual, Ch. 7, Sec. 22.1 Telemedicine/Telehealth* for full details.

Practitioners shall complete **Section 3 Additional License** to list license information for all states where telemedicine services will be provided and include a copy of each.

Enclose copy of licensure/certification: License #: _____ ☐ Temporary/Limited ☐ Permanent

Issuing state: _____ Date license was first issued: _____ Expiration date: _____

Medicare #: _____ Primary specialty: _____

If licensing is not required, but you are a member (or eligible) in the state or national association setting standards for your profession, please indicate. ☐ State ☐ National ☐ Member ☐ Eligible

State or national organization: _____

Do you have current or past disciplinary actions/sanctions against your license/certification, including but not limited to suspension, reduction of privileges, probation, revocation, cancellation, non-renewal or voluntary surrender in any state? ☐ Yes* ☐ No

**If yes, you must provide a signed, detailed explanation*

**Education**

Have you earned a degree for your specialty from an accredited institution? ☐ Yes ☐ No

If Yes, school name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Degree earned: _____ Year earned: _____

Are you transferring from another state where you had an established practice? ☐ Yes ☐ No If Yes, state: _____

**Are you:**

Hospital-salaried/employed physician? ☐ Yes ☐ No

National Health Service Corporation (NHSC) physician? ☐ Yes ☐ No

Are you employed by the US Government? ☐ Yes ☐ No

Intern? ☐ Yes ☐ No

Teaching-setting physician? ☐ Yes ☐ No

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# Provider certification telemedicine only application

**Dual compensation/Conflict of interest statement for TRICARE providers**

Federal law *(Title 5 U.S.C. 5536)* prohibits medical personnel, who are active duty members or civilian employees of the government, compensation above their normal pay and allowances for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary. Claims for TRICARE benefits will be denied in any situation where either a uniform member or civilian employee of the uniform services has the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to one or more providers on a selective basis.

Are you employed or under a contract which provides for payment to the individual professional provider by an institutional provider?
☐ Yes* ☐ No **If Yes, your application cannot be considered. Hospital employees are not eligible for additional provider numbers outside the realm of the hospital.*

## Section 2: Additional requirements per specialty

Provider specialties listed in this section must meet specific TRICARE requirements as indicated to be eligible as a TRICARE-authorized provider. All fields must be completed. If your specialty is not listed, you may skip to Section 3.

**Anesthesiologist Assistant (AA)**

1. Works under direct supervision of a licensed anesthesiologist
2. Graduate of masters level anesthesiologist assistant educational program which meets the following criteria:
   a. Is accredited by the Commission on Accreditation of Allied Health Educational Programs (CAAHEP)
   b. Includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background

Name of master's level program: _____

Institution name/state: _____

Name of supervising physician: _____

License number/state of supervising physician: _____

**Certified Clinical Social Worker (CSW)**

1. Must be able to practice independently of physician referral and supervision. Does your state licensure allow you to practice independently? ☐ Yes ☐ No
2. CSWs must also have at least a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; and have a minimum of two years or three thousand hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting, as determined by the contractor. Do you meet these requirements? ☐ Yes ☐ No

# Provider certification telemedicine only application

**Certified Marriage and Family Therapist (CMFT)**

1. Must be licensed or certified as a marriage and family therapist; even if the jurisdiction where practicing offers a license/certification on an optional basis. Must include legible photocopy of current state license which includes the expiration date and the original issue date of licensure. Note: In jurisdictions that do not offer specific licensure or certification for marriage and family therapists, the provider must be certified or be eligible for full clinical membership in, the American Association for Marriage and Family Therapy (AAMFT). If eligible for full clinical membership in the AAMFT but not a member, the provider must submit documentation obtained from the AAMFT of such eligibility. Associate members or student members of the AAMFT are not eligible for consideration as authorized certified marriage and family therapists.
2. Must provide complete name, address (home and business), and routine and emergency phone number of the applicant.

   Home address: _____

   City: _____ State: _____ ZIP Code: _____

   Emergency phone #: _____
3. Must provide legible photocopy of transcripts of professional education to include name and address of institution.
4. Must include documentation of proof of supervised clinical experience which includes name and address of institution, dates of experience, name of supervisor, and signed certification that the applicant has successfully completed the required training hours.
5. Must have at least a master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline.
6. Must meet one of the following (check the option that applies to you):

   ☐ 200 hours of approved supervision in the practice of marriage and family counseling, completed in a two to three-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and 1,000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases; **or**

   ☐ 150 hours of approved supervision in the practice of psychotherapy, completed in a two to three-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling, ordinarily to be completed within a period of not less than one nor more than two years; and 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in marriage and family counseling under approved supervision, involving at least 20 cases.
7. Must return a signed participation agreement with TRICARE. See Participation Agreement provided below.

**Certified Nurse Midwife (CNM)**

A CNM may provide otherwise covered care independent of physician and supervision provided the nurse-midwife meets the following criteria:

☐ Certified by the American Midwifery Certification Board (AMCB). To receive certification, a candidate must be a Registered Nurse (RN) who has completed successfully an educational program approved by the AMCB, and passed the AMCB National Certification Examination.

AMCB certification #: _____

# Provider certification telemedicine only application

**Certified Psychiatric Nurse Specialist (CPNS)**

1. Must be a licensed, registered nurse
2. Have at least a master's degree in nursing with a specialization in psychiatric and mental health nursing
3. Meet one of the following (check the option that applies to you):

☐ Have at least two years of post-master's degree practice in the field of psychiatric and mental health nursing, including an average of eight hours of direct patient contact per week; or

☐ Certification by the American Nurses Association through the American Nurses Credentialing Center (ANCC) as one of the following:

☐ Adult of psychiatric and mental health Clinical Nurse Specialist (CNS)

☐ Child/Adolescent – psychiatric and mental health CNS

☐ Adult psychiatric mental health Nurse Practitioner (NP)

☐ Family psychiatric mental health NP

☐ Psychiatric and mental health NP

**Certified Registered Nurse Anesthetist (CRNA)**

A CRNA must be certified by the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA)

NBCRNA #: _____

**Clinical psychologist**

Meet one of the following (check the option that applies to you):

☐ Possess a doctoral degree in psychology from a regionally accredited university and have two years of supervised clinical experience in psychological health services of which at least one year is post-doctoral and one year (may be the post-doctoral year) is in an organized psychological health service training program; or

☐ Be listed in the National Register of Health Service Psychologists

**Dietitian/Nutritionist**

1. Must be under the supervision of a physician who is overseeing the episode of treatment or the covered program of service.

Name of supervising physician: _____

NPI of supervising physician: _____

2. Must be accredited by the American Diabetes Association (ADA). **Documentation of ADA accreditation must be included with application.**

# Provider certification telemedicine only application

**Mental health counselors**

A TRICARE Certified Mental Health Counselor (TCMHC) is an independent provider who does not require referral and oversight by a physician in order to receive reimbursement for service to a beneficiary. If you do not meet the requirements to be a TCMHC, you may qualify to be a Supervised Mental Health Counselor (SMHC). For information on certification requirements, refer to *TRICARE Policy Manual, Ch. 11, Sec. 3.11*.

TCMHCs must meet the following requirements:

1. Must be licensed for independent practice in mental health counseling by the jurisdiction where practicing. In jurisdictions that offer two or more licenses allowing for differing scopes of independent practice, the licensed mental health counselor may only practice within the scope of licensure he or she possesses
2. Has passed the National Clinical Mental Health Counselor Examination (NCMHCE) or an examination determined by the director, DHA as equal in scope, intent and content to the NCMHCE
3. Meets one of the following (please check the option that applies to you):

   ☐ A combination of:

   - Possesses a master's or higher-level degree from a mental health counseling program of education and training accredited for mental health counseling or clinical mental health counseling by the Council for Accreditation of Counseling and Related Educational Programs (CACREP); **and**
   - Has a minimum of two years of post-master's degree supervised mental health counseling practice that includes a minimum of 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervision. This supervision must be provided by mental health counselors, psychiatrists, clinical psychologists, certified Clinical Social Workers (CSW), TCMHCs or Certified Psychiatric Nurse Specialists (CPNS) who are licensed for independent practice in the jurisdiction where practicing and must be practicing within the scope of their licenses. Supervision must be conducted in a manner that is consistent with the guidelines regarding knowledge, skills and practice standards for supervision of the American Mental Health Counselors Association (AMHCA)

   ☐ At any point prior to January 1, 2017 has met all of the following requirements:

   - Possesses a master's or higher-level degree from a mental health counseling program of education and training accredited for mental health counseling or clinical mental health counseling by CACREP and has passed the National Counselor Examination (NCE) or NCMHCE
   - Pursuant to Section 716 of the NDAA for FY 2016, prior to January 1, 2021, an individual satisfies the requirement to "hold a master's or higher-level degree from a mental health counseling program of education and training accredited for Mental Health Counseling or Clinical Mental Health Counseling by CACREP" if the individual holds a master's degree or doctoral degree in counseling from a program that is accredited by any of the following:
     - Accrediting Commission for Community and Junior Colleges Western, Association of Schools and Colleges (ACCJC-WASC)
     - Higher Learning Commission (HLC)
     - Middle States Commission on Higher Education (MSCHE)
     - New England Association of Schools and Colleges Commission on Institutions of Higher Education (NEASC-CIHE)
     - Southern Association of Colleges and Schools (SACS) Commission on Colleges
     - WASC Senior College and University Commission (WASC-SCUC)

# Provider certification telemedicine only application

- Accrediting Bureau of Health Education Schools (ABHES)
- Accrediting Commission of Career Schools and Colleges (ACCSC)
- Accrediting Council for Independent Colleges and Schools (ACICS)
- Distance Education Accreditation Commission (DEAC)

- Possesses a master's or higher-level degree from a mental health counseling program of education and training accredited for mental health counseling or clinical mental health counseling from an educational institution accredited by a regional accrediting organization recognized by the Council for Higher Education Accreditation and has passed the NCMHCE
- Has a minimum of two years of post-master's degree supervised mental health counseling practice that includes a minimum of 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervision. This supervision must be provided by mental health counselors, psychiatrists, clinical psychologists, certified CCSWs, TCMHCs or CPNSs who are licensed for independent practice in the jurisdiction where practicing and that is consistent with the guidelines regarding knowledge, skills and practice standards for supervision of the AMHCA

If you do not meet the requirements to be a TCMHC, you may qualify to be a SMHC. A SMHC must meet all of the following requirements:

1. Must possess a minimum of a master's degree in mental health counseling or allied mental health field from a regionally accredited institution;
2. Has two years of post-masters experience which includes 3,000 hours of clinical work and 100 hours of face-to-face supervision;
3. Is licensed or certified to practice as a mental health counselor by the jurisdiction where practicing;
4. May only be reimbursed when the following criteria are met:
   - The TRICARE beneficiary is referred for therapy by a physician; and
   - A physician is providing ongoing oversight and supervision of the therapy being provided; and
   - The SMHC certifies on each claim for reimbursement that written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician

I certify that all of the above information is true and correct to the best of my knowledge and I meet the TRICARE requirements to be a (check one of the following): ☐ TCMHC ☐ SMHC

Signature of provider: _____ Date: _____

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# Provider certification telemedicine only application

**Pastoral counselors**

1. Must meet one of the following (check the option that applies to you):

   ☐ Be licensed/certified as a pastoral counselor if offered by the jurisdiction in which the pastoral counselor is practicing; or

   ☐ If licensure/certification is not offered, must be (or meet all the requirements to become) an Association for Clinical Pastoral Education (ACPE) Psychotherapist, as determined by the ACPE

2. Have a recognized graduate professional education with the minimum of an earner master's degree from a regionally accredited educational institution in an appropriate behavioral science field, mental health discipline

3. Experience consisting of one of the following (please check the option that applies to you):

   ☐ A combination of:

   - 200 hours of approved supervision in the practice of pastoral counseling, ordinarily to be completed in a two- to three-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases;
   - 1,000 hours of clinical experience in the practice of pastoral counseling under approved supervision, involving at least 50 different cases;

   ☐ A combination of:

   - 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a two- to three year period, of which at least 50 hours must be individual supervision; and
   - At least 50 hours of approved individual supervision in the practice of pastoral counseling, ordinarily to be completed within a period of not less than one nor more than two years; and
   - 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; and
   - At least 250 hours of clinical practice in pastoral counseling under approved supervision, involving at least 20 cases

**Physician assistants**

For the purpose of TRICARE, physician assistants must be employed and supervised by an MD. Private practice is not acceptable. For additional certification information, refer to *TRICARE Policy Manual (TPM), Ch. 11, Sec. 3.13*.

Name of supervising physician: _____

NPI of supervising physician: _____

# Provider certification telemedicine only application

## Section 3: Additional license(s)

Providers rendering telemedicine services must follow telemedicine-specific regulatory, licensing, credentialing and privileging, malpractice and insurance laws and rules for their profession in both the jurisdiction (site) in which they are practicing as well as the jurisdiction (site) where the patient is receiving care, and shall ensure compliance as required by appropriate regulatory and accrediting agencies. See *TPM, Ch. 7, Sec. 22.1 Telemedicine/Telehealth* for full details.

List license information for all states where telemedicine services will be provided. **All fields must be completed and a copy of current license for each state must be included.** If this does not apply to you, please indicate N/A on line 1.

Name: _____ NPI: _____

| | Issuing state | License # | Date license first issued | Expiration date | Primary specialty | Is this license temporary or permanent? |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |

## Section 4: Attestation and signature

I certify that all of the above information is true and correct to the best of my knowledge. I also understand that I must include copies of all attachments, as applicable, in order for my application to be considered. Incomplete or missing information will result in reject of the certification application.

Signature of provider: _____ Date: _____

Printed name of provider: _____ Date: _____

Please submit completed application and all supporting documentation via email to:

HGBCertifications@humanamilitary.com
Subject: Telemedicine Only Application

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# Participation agreement for certified marriage and family therapist

Name of certified marriage and family therapist: _____

Office address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ TRICARE provider billing #: _____

## Article 1
### Recitals

**1.1 IDENTIFICATION OF PARTIES**

This Participation Agreement is between the United States of America through the Department of Defense (DoD), Defense Health Agency (DHA) (hereinafter DHA), an agency of the Office of the Secretary of Defense (OASD), the administering activity

for the Defense Health Agency (hereinafter DHA) and _____, doing business as

_____ (hereinafter designated certified marriage and family therapist).

**1.2 AUTHORITY FOR CERTIFIED MARRIAGE AND FAMILY THERAPISTS AS AUTHORIZED PROVIDERS**

32 Code of Federal Regulations (CFR) Part 199 provides for cost-sharing of services provided by certified marriage and family therapists under certain conditions.

**1.3 PURPOSE OF PARTICIPATION AGREEMENT**

The purpose of this participation agreement is to:

a) Establish the undersigned certified marriage and family therapist as an authorized provider of mental health services;
b) Establish the terms and conditions that the undersigned certified marriage and family therapist must meet.

**1.4 BILLING NUMBER**

The certified marriage and family therapists' billing number for all mental health services rendered is the certified marriage and family therapist's Social Security Number (SSN) or Employer's Identification Number (EIN) or National Provider Identifier (NPI). This billing number must be used until the provider is officially notified by TRICARE of a change. The certified marriage and family therapist's number is shown on the face sheet of this agreement. It is the only billing number that will be accepted by TRICARE claims processors after the effective date of this agreement for becoming an authorized certified marriage and family therapist.

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# Participation agreement for certified marriage and family therapist

## ARTICLE 2
### PERFORMANCE PROVISIONS

**2.1 GENERAL AGREEMENT**

The certified marriage and family therapist agrees to render medically necessary and appropriate covered mental health services within the scope of his/her practice and licensure to eligible beneficiaries as required by this participation agreement and the **32 CFR 199.6**. The terms and conditions of **32 CFR 199.6** applicable to the participation or treatment of beneficiaries by the certified marriage and family therapist are incorporated herein by reference.

**2.2 LICENSURE AND CERTIFICATION REQUIREMENTS**

The certified marriage and family therapist certifies and attaches hereto documentation that:

a. He/she is now licensed or certified to practice as a marriage and family therapist by the state in which practicing; or
b. If practicing in a state which does not provide specific licensure or certification, the certified marriage and family therapist must be certified by or be eligible for full clinical membership in the American Association for Marriage and Family Therapy; and
c. He/she has a recognized graduate professional education with a minimum of an earned master's degree from an accredited educational institution in an appropriate behavioral science field, mental health discipline; and
d. He/she has the following experience:
    1. Either 200 hours of approved supervision in the practice of marriage and family counseling, ordinarily to be completed in a two- to three-year period, of which at least 100 hours must be in individual supervision. This supervision will occur preferably with more than one supervisor and should include a continuous process of supervision with at least three cases; and
    2. 1,000 hours of clinical experience in the practice of marriage and family counseling under approved supervision, involving at least 50 different cases; or
    3. 150 hours of approved supervision in the practice of psychotherapy, ordinarily to be completed in a two- to three-year period, of which at least 50 hours must be individual supervision; plus at least 50 hours of approved individual supervision in the practice of marriage and family counseling, ordinarily to be completed within a period of not less than one nor more than two years; and
    4. 750 hours of clinical experience in the practice of psychotherapy under approved supervision involving at least 30 cases; plus at least 250 hours of clinical practice in marriage and family counseling under approved supervision, involving at least 20 cases.

**2.3** The certified marriage and family therapist agrees that, having an exclusive election to participate as certified marriage and family therapist, he or she will not be authorized in any other category of extramedical provider, either during or subsequent to the period this agreement is in effect.

# Participation agreement for certified marriage and family therapist

## ARTICLE 3
## PAYMENT PROVISIONS

**3.1 DETERMINED ALLOWABLE CHARGE**

The determined allowable charge is the maximum amount that can be authorized for services rendered by an authorized individual professional provider of care. The determined allowable charge is determined following the provisions set forth in **32 CFR 199.14**.

**3.2 DETERMINED ALLOWABLE CHARGE AS PAYMENT IN FULL**

The certified marriage and family therapist agrees to accept the determined allowable charge as payment in full for services rendered to beneficiaries, except for applicable deductible and cost-shares.

**3.3 HOLD HARMLESS**

The certified marriage and family therapist agrees to hold eligible beneficiaries harmless for non-covered care (i.e., certified marriage and family therapist may not bill a beneficiary for non-covered care and may not balance bill the beneficiary for amounts above the determined allowable charge).

## ARTICLE 4
## TERM, TERMINATION, AND AMENDMENT

**4.1 TERM**

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until terminated by either party.

**4.2 TERMINATION OF AGREEMENT BY DHA**

The Director, DHA, or designee, may terminate this agreement upon written notice, for cause, if the certified marriage and family therapist is found not to be in compliance with the provisions set forth in **32 CFR 199.6**, or is determined to be subject to the administrative remedies involving fraud, abuse, or conflict of interest as set forth in **32 CFR 199.9**. Such written notice of termination shall be an initial determination for purposes of the appeal procedures set forth in **32 CFR 199.10**.

**4.3 TERMINATION OF AGREEMENT BY THE CERTIFIED MARRIAGE AND FAMILY THERAPIST**

The certified marriage and family therapist may terminate this agreement by giving the Director, DHA, or designee, written notice of such intent to terminate at least 60 days in advance of the effective date of termination. Effective the date of termination, the certified marriage and family therapist will no longer be recognized as an authorized provider, and reinstatement shall be disallowed for any other category of extramedical individual provider. Subsequent to termination, the certified marriage and family therapist may only be reinstated as an authorized extramedical provider by entering into a new participation agreement as a certified marriage and family therapist.

# Participation agreement for certified marriage and family therapist

**4.4 AMENDMENT BY DHA**

a. The Director, DHA, or designee, may amend the terms of this participation agreement by giving 120 days notice in writing of the proposed amendment(s) except when necessary to amend this agreement from time to time to incorporate changes to the *32 CFR 199*. When changes or modifications to this agreement result from changes to the *32 CFR 199* through rulemaking procedures, the Director, DHA, or designee, is not required to give 120 days written notice. Any such changes to *32 CFR 199* shall automatically be incorporated herein on the date the regulation amendment is effective.

b. The certified marriage and family therapist, not wishing to accept the proposed amendment(s), including any amendment resulting from changes to the *32 CFR 199* accomplished through rulemaking procedures, may terminate his or her participation as provided for in this Article. However, if the certified marriage and family therapist notice of intent to terminate participation is not given at least 60 days prior to the effective date of the proposed amendment(s), then the proposed amendment(s) shall be incorporated into this agreement for services furnished by the certified marriage and family therapist between the effective date of the amendment(s) and the effective date of termination of this agreement.

## ARTICLE 5
## EFFECTIVE DATE

**5.1 DATE SIGNED**

This participation agreement is effective on the date signed by the Director, DHA, or designee.

**Certified marriage and family therapist**

By: Typed name and title: _____

Name and title: _____

**DHA**

By: Typed name and title: _____

Name and title: _____

Executed on (date): _____