Outpatient Behavioral Health Outcome Tool Selection Form

TUFTS Health Plan
a Point32Health company

Completed forms can be faxed to the following locations:

- **Tufts Health Together**: 888-977-0776
- **Tufts Health One Care**: 857-304-6304

Note: If you are a multi-site organization, please only submit one form for the entire organization.

Provider Information

Provider type: ☐ Individual practitioner or non-hospital-based group ☐ Facility or hospital-based group

Practice name:

Practice address (*street/city/state/ZIP*):

Provider name: Title:

Email:

Tufts Health Public Plans-approved Assessment Tools

(*Please indicate all tools you have chosen to implement.*)

- ☐ Adolescent Treatment Outcomes Module (ATOM)
- ☐ Behavioral and Emotional Rating Scale (BERS)
- ☐ Behavior and Symptom Identification Scale (BASIS)
- ☐ Brief Psychiatric Rating Scale (BPRS) – Adult and child
- ☐ Brief Symptom Inventory (BSI)
- ☐ Child-Adolescent Functional Assessment Scale (CAFAS/PECFAS)
- ☐ Child and Adolescent Needs and Strengths (CANS)*
- ☐ Child Behavior Checklist (CBCL)
- ☐ Connor's Rating Scales – Revised (CRS-R)
- ☐ Current Evaluation of Risk and Functioning – Revised (CERF-R)
- ☐ Global Appraisal of Individual Needs (GAIN)
- ☐ Methadone Treatment Quality Assurance System (MTQAS)
- ☐ Patient Health Questionnaire (PHQ)
- ☐ Personal Experience Inventory (PEI, PEI-Adult)
- ☐ Quality of Life Inventory (QOLI)
- ☐ SF8, 12, 36
- ☐ SOCRATES
- ☐ Symptom Checklist-90 – Revised (SCL-90-R)
- ☐ Treatment Outcome Package (TOP, TOP-SA)
- ☐ Youth Outcome Questionnaire (YOQ)

* *The CANS assessment is required for all Tufts Health Together members younger than 21.*

☐ Other:

Alternate assessment tools (*If you have checked "Other" above, please fill in detail below.*)

☐ Children ☐ Adolescents – behavioral health ☐ Adolescents – substance use ☐ Adults – mental health ☐ Adults – substance use

Describe why you want to use an alternate assessment tool instead of a Tufts Health Public Plans-approved assessment tool:

CLEAR FORM

Please sign on the next page →

Attestation

I understand that the chosen instrument(s) are to be administered to all Tufts Health Public Plans members receiving treatment and that the information I have provided is subject to on-site or telephonic review. I also understand that if there are changes to the information I have provided, it is my responsibility to notify Tufts Health Public Plans by updating the information on this page and resubmitting this form. I verify that all statements are accurate to the best of my knowledge.

Provider Signature: Date: