Mental Health Advancement Foundation (MHAF) Provider Handbook
Contracted Mental Health Provider Guidelines

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1. Introduction

Welcome to the Mental Health Advancement Foundation (MHAF) Provider Network! We appreciate your commitment to expanding access to quality mental health care in Deep East Texas. This handbook outlines expectations, guidelines, and procedures for contracted providers delivering therapy services through MHAF.

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2. Provider Responsibilities

As a contracted provider with MHAF, you agree to:

- Deliver professional, ethical, and client-centered mental health services.
- Maintain appropriate licensure and certifications.
- Provide therapy sessions in alignment with MHAF's mission and contractual agreement.
- Adhere to all confidentiality and HIPAA regulations.
- Submit required documentation in a timely manner.

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3. Service Agreement

Session Structure & Payment:

- Providers will be compensated at **$50 per session** for an initial **8-session package** per client.
- Sessions must be completed within the designated timeframe agreed upon with the client.
- Providers must document session attendance and progress to remain in compliance with MHAF's reporting standards.

Additional Sessions:

- Providers may request up to **8 additional sessions** per client.

- Requests for additional sessions must be based on:
    - **Client progress** toward treatment goals.
    - **Client attendance and engagement** in therapy.
    - **Provider self-report** on the client's need for continued services.
- Requests should be submitted with supporting documentation for MHAF review and approval.

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4. Documentation & Reporting

Providers must submit the following:

- **Session Attendance Records** – Verified attendance for all sessions completed. See Appendix for example Attendance Record
- **Treatment Plan -** A copy of the treatment plan must be submitted by session 3 to document basic needs. See Appendix for example Treatment Plan
- **Additional Session Request Forms** – If requesting continued sessions beyond the initial 8. See Appendix for Additional Session Request
- **Final Report** – Upon service completion, a summary report must be submitted to MHAF. See Appendix for example Final Report

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5. Payment Process

- Payments will be processed **on a bi-monthly basis** upon submission of completed session records.
    - Invoices received between the 1st and 15th of the month will be processed and paid by the 22nd of the received month.
    - Invoices received between the 16th and the last day of the month will be processed and paid by the 7th of the following month.
- Providers must submit invoices and required documentation for reimbursement.
- Payments will be made via direct deposit, Paypal or Venmo transfer, or mailed check per provider preference.

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6. Ethical and Professional Standards

- Maintain professional boundaries with clients.
- Report any concerns regarding client safety immediately.
- Adhere to all state and federal mental health guidelines and ethical practices.

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7. Contact & Support

For questions, support, or documentation submission, please contact:

MHAF Board
info@mhaftx.org
936-247-MHAF
mhaftx.org

Thank you for partnering with MHAF to provide essential mental health services to our community!

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Attendance Verification & Invoicing Form

Provider Information:

Provider Name: _____Email:_____

Phone Number: _____

Payment Preference (Direct Deposit, Paypal, Venmo, Check): _____

Client Attendance Record:

Session #	Date of Session	Client Initials	Session Completed (Y/N)	Notes
1				
2				
3				
4				
5				
6				
7				
8				

Invoice Submission:

- **Total Sessions Completed: _____**
- **Total Payment Requested ($50 per session):** $_____
- **Provider Signature: _____**
- **Date: _____**

Please email completed invoice to: info@mhaftx.org

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Example Treatment Plan:

Client Information:

- **Client Name:** _____
- **Date of Birth:** _____
- **Diagnosis (if applicable):** _____
- **Provider Name:** _____
- **Date of Treatment Plan:** _____

Presenting Concerns:

Briefly describe the client's primary concerns, symptoms, and reasons for seeking therapy.

Treatment Goals:

Goal #	Goal Description	Target Completion Date
1	Example: Reduce symptoms of anxiety through cognitive-behavioral strategies.	MM/DD/YYYY
2	Example: Improve coping skills for stress management.	MM/DD/YYYY
3	Example: Strengthen interpersonal relationships and communication skills.	MM/DD/YYYY

Planned Interventions:

- **Therapeutic Approach:** (e.g., CBT, DBT, Trauma-Informed Therapy, etc.)
- **Session Activities:** (e.g., psychoeducation, coping strategies, mindfulness techniques, etc.)
- **Homework Assignments (if applicable):**

Expected Outcomes:

Describe expected improvements based on treatment interventions.

Provider Signature: _____ **Date:** _____

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Additional Session Request Form:

Provider Information:

- **Provider Name: _____**
- **Client Name: _____**
- **Date of Request: _____**

Session Details:

Session #	Date of Session	Client Attendance (Y/N)	Notes on Progress
1			
2			
3			
4			
5			
6			
7			
8			

Justification for Additional Sessions:

- **Client progress toward treatment goals:**

- **Client attendance and engagement in therapy:**

- **Provider assessment of continued need for services:**

Requested # of Additional Sessions: _____

Provider Signature: _____Date: _____

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Final Report Form:

Provider Information:

- **Provider Name: _____**
- **Client Name: _____**
- **Date of Report Submission: _____**

Attendance Record:

Session #	Date of Session	Client Attendance (Y/N)	Notes
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

Progress Summary:

- **Initial Presenting Concerns:**

- **Treatment Goals**

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- **Client Progress Toward Treatment Goals:**

- **Engagement & Responsiveness in Therapy:**

Projected Outcomes & Recommendations:

- **Progress Made & Achieved Milestones:**

- **Recommendations for Further Support (if applicable):**

Additional Comments/Concerns:

Provider Signature: _____Date: _____