# Attestation Form

| List all your agency's sites that are/will be participating in Treat First: Insert more if needed | Medicaid ID | NPI |
|---|---|---|
| Name/location of Facility Site | | |
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| The Provider Agency **attests to the following activities:** | **Yes** | **No** |
| • Is familiar with, and is following, the procedures as clarified and defined in the Treat First Model for specialized behavioral health services as used in: Medicaid Behavioral Health Policy & Billing Manual Medicaid Behavioral Health Supplement | | |
| • Has signed their Participation Agreement | | |
| • Has participated in, or scheduled, an initial Orientation session with the state. | | Or, Date Scheduled |
| • Has registered, or scheduled registration, their agency and relevant staff in the BHSDstar.org web-based data collection system. | | Or, Date Scheduled |
| • Will post the required data on a timely basis. | | |
| • Will utilize the S*elf Check-In* and *Session Check-Out* Instruments with all participating clients. | | |
| • Will participate in the scheduled Treat First Learning Community meetings. | | |
| • Staff have been/are being trained in the modules contained in https://TreatFirst.org | | |
| I attest to the accuracy of the above statements. | | |

Signature:_____

Name and Title:_____ (Print please)
Email Address:_____ Date:_____

If you are downloading this form and intend to email it (instead of submitting it directly on the treatfirst.org website) send the signed and completed Participation Agreement and Attestation forms to Treat.First@state.nm.us