



Outpatient Behavioral Health Outcome Tool Selection Form

Fax to: 888-977-0776

For Tufts Health Unify, fax to: 857-304-6304

If you are a multisite 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 _____

City _____ State _____ ZIP _____

Provider name _____ Title _____

Email address _____

Tufts Health Public Plans-approved assessment tools

Please indicate all tools you have chosen to implement.

- Checkboxes for various assessment tools: 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), Other: _____, 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.

Alternate assessment tools If you have checked “other” above, please fill in detail below.

List the alternate assessment tools you are requesting approval to use: _____

With which population(s) will you administer the tool?

- Checkboxes for population groups: Children, Adolescents — mental 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:

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 _____