

ANDREW M. CUOMO
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

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Executive Deputy Commissioner

**Self-Attestation of Compliance to Offer Telemental Health Services
14 NYCRR Section 596**

Revised: March 13, 2020

Part 596 of Title 14 NYCRR permits the provision of Telemental Health Services by Office of Mental Health (OMH) programs **licensed or designated pursuant to Article 31** of the New York State Mental Hygiene Law, if approved to do so by OMH. The following Self-Attestation must be completed and submitted to Amy Smith at amy.smith@omh.ny.gov.

**Those Self-Attestations previously submitted will be honored to include the additional provisions added on March 13, 2020. Updated attestations are not required for agencies or programs that have already submitted.*

Do you certify:

1. That the practitioner(s) will meet standards established in Part 596.6(a)(1), including a current, valid license, permit, or limited permit to practice in New York State.

Telemental health practitioner includes any professional, paraprofessional, or unlicensed behavioral health staff who deliver a qualified service via telemental health.

2. That the transmission linkages on which Telemental Health Services will be performed, will be dedicated, secure, meet minimum federal and New York State requirements (e.g., HIPAA Security Rules) and are consistent with guidelines issued by the Office of Mental Health.

Telemental health for Medicaid-reimbursable services is temporarily expanded to include:

- Telephonic; and/or
- Video, including technology commonly available on smart phones and other devices.

3. That confidentiality will be maintained as required by New York State Mental Hygiene Law Section 33.13 and 45 CFR Parts 160 and 164 (HIPAA Privacy Rules).
4. That claim modifiers "95" or "GT" will be used on each claim line that represents a service via telemental health.
5. An understanding that this approval is time-limited and effective only during the disaster emergency, and once the disaster emergency has ended the formal approval process will go back into effect.

Yes No

Agency Name: _____

Program Name(s) as identified in MHPD or PCS: _____

If Adult BH HCBS, specify each service type (CPST, PSR, Peer Support, etc.):

Signature and Title: _____

Date: _____