**SAFETY PLAN FOR TELEHEALTH**

*Use this form if you are providing a billable telehealth service, service meeting, treatment team meeting, or other contact with client using information and communication technologies*

Client:

Medicaid#:

Service:

Location of client during sessions:

Phone number of client receiving services:

Emergency contact for the client (Name, relationship to the client, and phone#):

Authorization to contact the client’s emergency contact is current and in place: YES / NO

**If a life threatening emergency occurs during the session, APS’ staff will contact 911 and provide the location of the client.**

In the event that the session is disconnected, client should contact staff at this number:

This client will need assistance from parent/caregiver to operate the telehealth equipment:

YES /NO

The parent/caregiver is:

Phone# of parent/caregiver:

Other considerations:

Person completing this plan:

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| **This form meets these standards**  |
| Authority: NC Div. of Medical Assistance, Medicaid and Health Choice Manual, Clinical Coverage Policy No: 1H, Telehealth, Virtual Communications and Remote Patient Monitoring; NC Div. of Medical Assistance, Medicaid and Health Choice Manual, Clinical Coverage Policy No: 8C, Outpatient Behavioral Health Services; CARF 2022 ECS 2.F.1-7; CARF 2022 BH 2.I.1-7 |

Date plan is completed: