O.L.A. Intervention Services for Youth & Families

SERVICE AGREEMENT

Client: _____

Referring Agency: _____

Referee: _____Phone: _____

Address: _____ City/St.: _____ Zip: _____

Funding Source/Agency: _____

Billing Address: _____City/St.: _____Zip:_____

Phone: _____

The above named agency authorizes OLA INTERVENTION SERVICES FOR YOUTH & FAMILIES (OIS) to provide services to the above named client, and is responsible for payment of these services. Payments are due within thirty- (30) days of the billing date. We agree to provide services as indicated below. Services are expected to begin _____ and end _____. OIS agrees to provide a written assessment and/or service reports, and will maintain regular contact with the referring agency to provide updates and progress. Please select the type of service(s) you're interested in:

- Intensive In-home Counseling _____$70.00/hr
- Therapeutic In-home Counseling _____$60.00/hr
- Mental Health Support Services _____$83.00/unit
- Therapeutic Day Treatment _____$38.05/unit
- Mentoring Services _____$35.00/hr
- Independent Living Skills _____$45.00/hr
- Supervised Visitation _____$60.00/hr
- Customized Services/Other _____*Call to discuss rate

Additional service detail:

Signatures: Referee: _____ Date: _____

Authorized OIS Staff: _____ Date: _____

OLA Intervention Services for Youth and Families is a Medicaid approved provider.
Rates are subject to change. Clients outside of service area may incur ancillary fees. One assessment, possibly two, are required prior to admission (the referring agency is responsible for assessment time).