



Medicaid and Behavioral Qualified Residential Treatment Programs (BQRTP)

How to Navigate Medicaid Service Guidelines

Training Objectives

- **Get to know Sunshine Health**
- **Understand medical necessity and clinical requirements**
- **Navigate authorization for service, limitations, and bed-hold rules**
- **How to meet educational, medical, clinical record, and behavioral health requirements**
- **Understand preliminary and final assessments, including CANS**
- **How to write SMART treatment goals and objectives**
- **Build compliant discharge and aftercare plans**

Behavioral Qualified Residential Treatment Program (BQRTP)

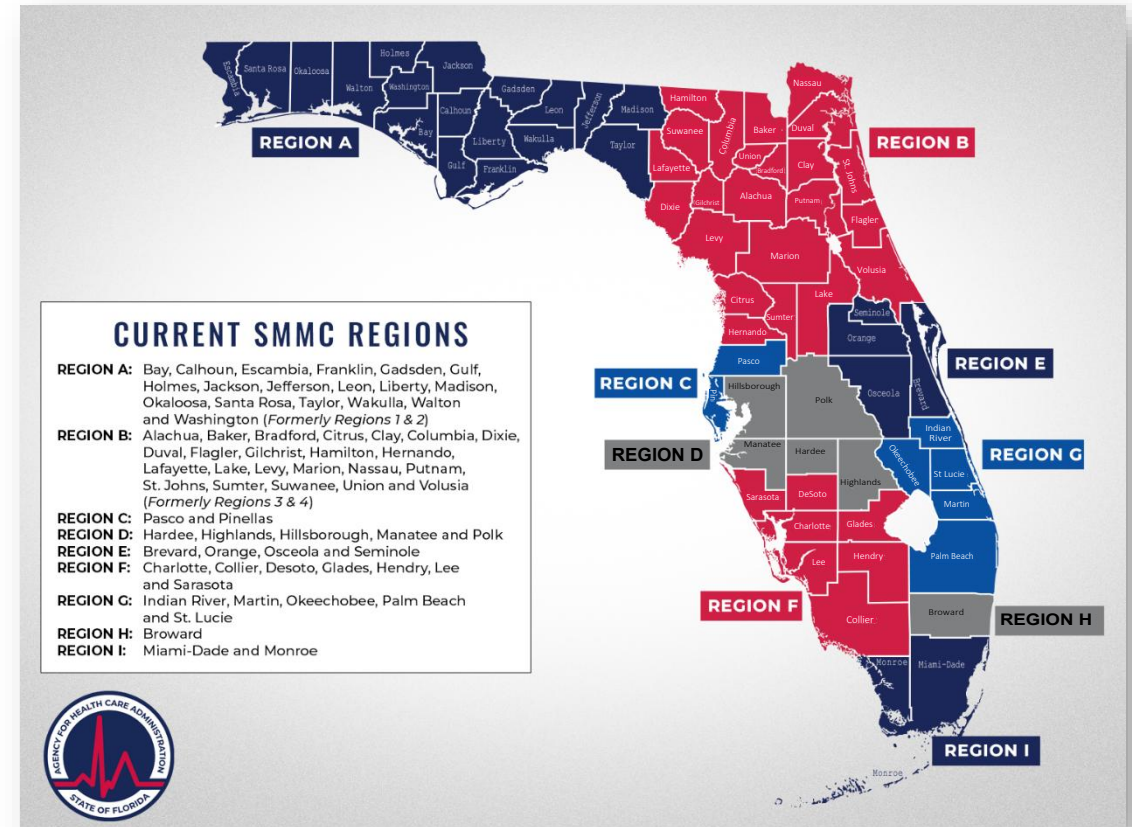
- Qualified Residential Treatment Programs (QRTP) are covered as a community behavioral health service and are designed to provide psychiatric and behavioral services to children (under 18 years old) in the child welfare system who are diagnosed with a serious emotional disturbance (SED) or behavioral disorder. Services are intended to increase coping skills and functional abilities, reduce psychiatric symptoms or disruptive behaviors enabling recipients to return to a least restrictive environment.
- A BQRTP is a therapeutic group home licensed by the Florida Department of Children and Families (DCF) in accordance with Rule 65C-46.0211, F.A.C.
- DCF funds will pay for room and board; Medicaid will pay for medical services.

**Providers must comply with QRTP services coverage policy in conjunction with Florida Medicaid's General Policies and any applicable service-specific and claim reimbursement policies*

Rule 59G-4.128: Qualified Residential Treatment Program Services (effective July 8, 2025)

About Sunshine Health

- We are a managed care organization, contracted by Florida's Agency for Healthcare Administration (AHCA) to provide statewide Medicaid services.
- We are a subsidiary of Centene Corporation.
- We are a Comprehensive health plan offering these products:
 - Sunshine Health Medicaid (MMA)
 - Comprehensive Long Term Care (LTC)
 - Sunshine Health Pathway to Shine Child Welfare Specialty Plan (CWSP)
 - Sunshine Health Power to Thrive HIV/AIDS Specialty Plan (HIV)



Sunshine Health and other Florida Managed Care Organizations (MCO) cover BQRTP in accordance with [AHCA's Qualified Residential Treatment Program Services Coverage Policy](#).

What is Sunshine Health Pathway to Shine Child Welfare Specialty Plan (CWSP)?

- One of Sunshine Health's Medicaid plans
- Specialty Medicaid plan for children under 21 years of age in foster care, permanent guardianship or adopted from foster care
- Eligible members have an open child welfare case, post adoption case, extended foster care (18+), or those children with permanent guardians receiving subsidy through the Guardianship Assistance Program
- Pathway to Shine works directly with all 18 Community Based Care (CBC) Lead agencies
- Every member in the specialty plan has a Care Manager

How to Get Started

- ✓ Obtain license with the Department of Children and Families as a BQRTP
- ✓ Enroll as a Medicaid provider in Florida with provider type PT05/specialty 203; Taxonomy 322D00000X - Residential Treatment Facility, Emotionally Disturbed Children
- ✓ Once you are licensed by DCF and have an active Medicaid ID with BQRTP, then apply to join the Sunshine Health network

To become a Sunshine Health Provider, visit:

SunshineHealth.com/join

Select **Join Our Network**

What You Need to know about the Different Departments within the Health Plan

Different departments manage different areas:

- Network/Contracting
- Quality/Risk Management
- Utilization Management (UM)
- Case Management (CM)

The Role of Network/Contracting

The Network team makes sure the health plan has enough of the right healthcare providers available to members. They establish and maintain agreements that allow those providers to serve plan members.

- Find and recruit providers
- Contract development and execution
- Build the provider network
- Monitor Network Adequacy
- Ensure providers meet the health plan's requirements
- They are your first connection with Sunshine Health and who you'll talk to when you join the health plan's network

The Role of Quality/Risk Management

The Quality/Risk Management department's role is to make sure members receive safe, appropriate, and high-quality care and to identify when something might have gone wrong.

- Collect reporting on Adverse Events and Critical Incidents
- Determine if the event is a potential quality of care concern (PQOC)
- Identify patterns, corrective action, or events that require state reporting

BQRTPs are required to report Adverse events and Critical incidents involving health plan members. Incidents should be reported to your CM/UM contact and emailed to: SUN_PQOC@centene.com

The Role of Care Managers (CM)



Sunshine Health has designated care managers assigned to each BQRTP

- Attend monthly treatment team meetings
- Assist with bridging communication between BQRTP and Community Based Care (CBC) lead agencies or other stakeholders
- Monitor member status while in BQRTP and assist with discharge planning
- Submit required reporting to AHCA on all members in BQRTP monthly

It's very important for BQRTP clinical staff to notify CM/UM of admit/discharge dates, elopements, hospitalizations, arrests, and therapeutic home visits

The Role of Utilization Management (UM)

- UM makes sure members receive the right care at the right time in the right setting. They review requests for services and determine whether the care is medically necessary. They also work with providers to help coordinate appropriate treatment and transition members to the next level of care.
- BQRTP is a service that ***requires Prior Authorization (PA)***.
- If medical necessity is met, approvals are provided for the following time frames:
 - Initial approval: up to 60 days
 - Second request: up to 120 days
 - Third request and beyond: up to 90 days
 - BQRTPs will have regular contact with UM before a member's admission and throughout the stay

Additional BQRTP Service Information

- Bill service with H0019 HM
- Billing unit is per diem and is inclusive of all Behavioral Health (BH) services
- Max length of stay is 12 months or six months for children under age 13
- Therapeutic home visits may be used for discharge planning purposes*
- Medicaid will not reimburse if youth is in DJJ
- Medicaid can reimburse during episodes of elopement (up to three days) and medical or psychiatric hospitalization (up to 14 days; no more than 4 total hospitalizations)

*Therapeutic home passes must be approved by the treatment team and documented in the treatment plan. Medicaid can reimburse for up to 21 days. Visits must be scheduled in the months leading up to discharge: up to five days 60-90 days prior to discharge, up to eight days 30-60 days prior to discharge, and up to eight days in the last 30 days prior to discharge. BQRTPs must ensure there is documented daily clinical support provided to the youth/family and a plan in place if youth needs to return to the program earlier than planned.

Rule 59G-4.295: Specialized Therapeutic Services Coverage and Limitations Handbook (effective March 3, 2014)

Documentation

Definition: Medical Necessity

Medically Necessary or Medical Necessity

The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
 - This requirement applies only to recipients age 21 years or older.
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Documentation must support the reasons each youth requires this level of care

Rule 59G-1.010: Definitions (effective June 17, 2024)

Preliminary Assessment

(a) A child may be placed in a BQRTP based on the preliminary assessment recommendation from a QI. However, the final assessment by QI must be completed within 30 calendar days to continue placement in the setting.

The preliminary assessment must include:

- Face-to-face attempt with the child
- Review of the Comprehensive Placement Assessment completed during the placement MDT staffing
- The reasons that support the preliminary recommendation for placement

Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

Rule 65C-28.021: Qualified Residential Treatment Programs (effective July 1, 2025)

Rule 59G-4.128: Qualified Residential Treatment Program Services (effective July 8, 2025)

Final Assessment

The final assessment must include:

- Short term and long term mental and behavioral health goals
- Use of the Child and Adolescent Needs and Strengths (CANS) Trauma Comprehension assessment tool
 - Find it at: flrules.org/Gateway/reference.asp?No=Ref-13092
- Review of prior treatment records and consultation with relevant parties in the child's life including but not limited to:
 - Case manager, current caregiver, the child's family, DJJ staff, treating clinical professional, guardian ad litem, and the child's attorney
- The recommendation of the child's treating clinical professional
- An interview with the child
 - Face-to-face is preferred, but telehealth may be utilized
 - If the child refuses to participate in the interview, the assessment must document good faith efforts to engage the child

Rule 65C-28.021: Qualified Residential Treatment Programs (effective July 1, 2025)

In-Depth Assessment (Example Only)

In-depth assessments for recipients ages seven and older must provide information on the following:

- History of treatment that includes the following:
 - Acute care treatment
 - Desired services and goals from the recipient's viewpoint
 - Inpatient behavioral health treatment
 - Mental health status examinations
 - Psychiatric treatment and psychotropic medication information
 - Therapy and counseling
 - Treatment recommendations or plans
- Personal history that includes the following:
 - Alcohol and other drug use
 - Educational analysis
 - Identifying information
 - Legal involvement
 - Medical information
 - Resources and strengths
 - Traumatic experiences
- Recipient's perception of problems, needs, or symptoms



In-depth assessments for recipients under the age of seven years must include the following:

- Clinical interview with the primary caretaker and observation of the caretaker and recipient
- Developmental and medical history that includes the following:
 - Developmental milestones
 - History of the mother's pregnancy and delivery
 - Past and current medical conditions
- Family functioning, cultural and communication patterns, and current environmental conditions and stressors
- Family psychosocial and medical history
- Observation and assessment of the recipient's affective, language, cognitive, motor, sensory, self-care, and social functioning
- Presenting symptoms and behaviors

In-depth assessments require completion of an integrated summary that evaluates history and assessment information collected and provides the following:

- Diagnosis
- Discharge criteria
- Evaluation of past intervention efficacy
- Service needs

Rule 59G-4.028: Behavioral Health Assessment Services (effective November 28, 2019)

Treatment Planning

The treatment plan is an individualized, structured, and goal-oriented schedule of services with measurable objectives that promotes the maximum reduction of the recipient's disability and restoration to the best possible functional level.

Individualized recipient treatment plans must directly address the primary diagnosis(es) that is(are) consistent with the assessment. The provider must document efforts to coordinate services for behavioral health diagnoses outside their expertise that, if treated, would assist meeting the recipient's goals.

The treatment plan must be completed within 14 days of admission and a psychiatrist must interview the recipient and conduct a formal treatment plan review monthly or when significant changes occur.

If the treatment plan contains an individualized behavior management component, the behavior analyst must review and sign the component. The behavior management plan must be consistent with treatment outcomes and objectives.

If a parent or guardian, team member or school personnel are not at a treatment plan meeting, the record must reflect that a staff person contacted them for their input.

The psychiatrist must interview each recipient monthly to assess progress toward meeting treatment goals, or more often if medically necessary.

The treatment plan must be jointly developed by the recipient and the treatment team. The treatment plan must be recipient-centered and consistent with the recipient's identified strengths, abilities, needs, and preferences.

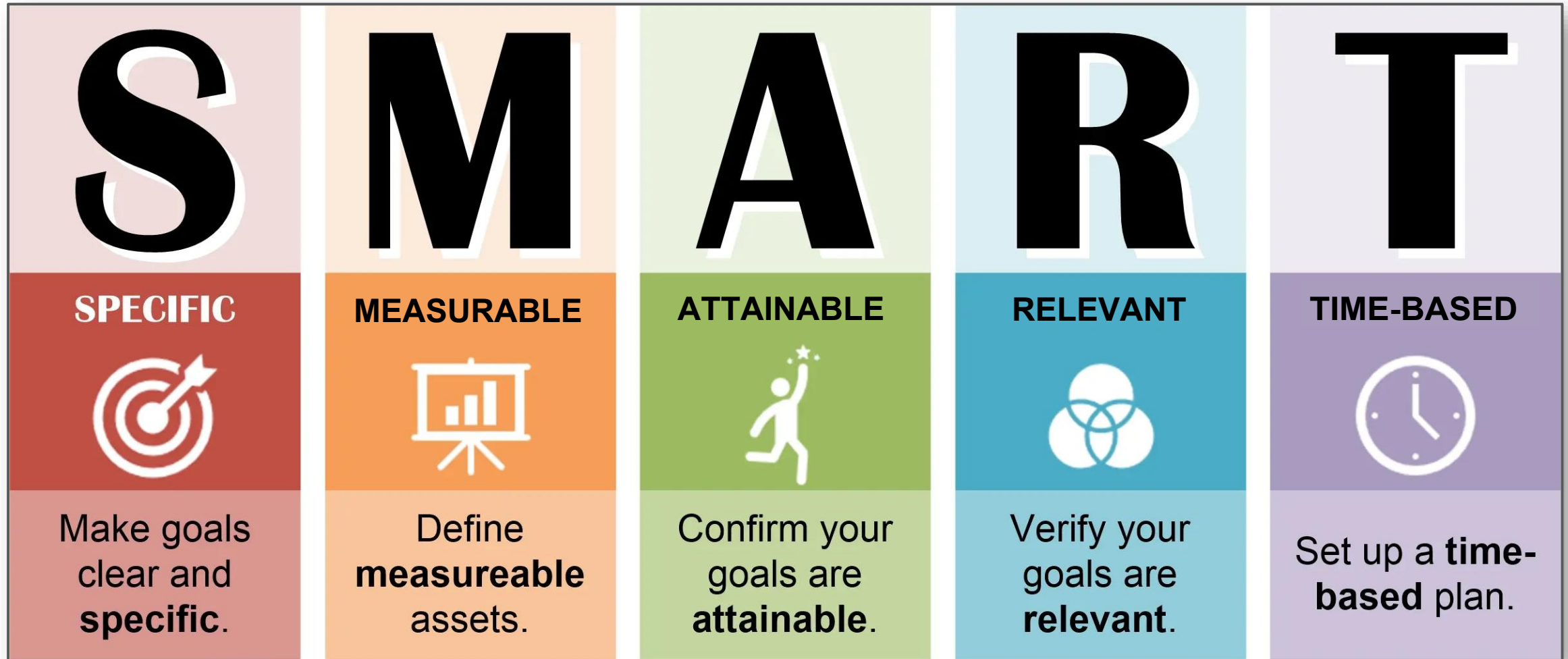
The recipient's parent or guardian should be included in the development of the recipient's individualized treatment plan, if the recipient is under the age of 18 years. Treatment planning for a recipient under the age of 18 years that does not include the recipient's parent, guardian, or legal custodian in a situation of exception requires a documented explanation.

The treatment plan must contain all of the following:

- Recipient's diagnosis code(s) consistent with assessment(s).
- Goals that are individualized, strength-based, and appropriate to the recipient's diagnosis, age, culture, strengths, abilities, preferences, and needs, as expressed by the recipient.
- Measurable objectives with target completion dates that are identified for each goal.
- List of the services to be provided (treatment plan development, treatment plan review, and evaluation or assessment services provided to establish a diagnosis and to gather information for the development of the treatment plan need not be listed).
- Amount, frequency, and duration of each service for the six-month duration of the treatment plan (e.g., four units of therapeutic behavioral on-site services two days per week for six months). It is not permissible to use the terms "as needed," "p.r.n.," or to state that the recipient will receive a service "x to y times per week."
- Dated signature of the recipient.
- Dated signature of the recipient's parent, guardian, or legal custodian (if the recipient is under the age of 18 years).
- Signatures of the treatment team members who participated in development of the plan.
- A signed and dated statement by the treating practitioner that services are medically necessary and appropriate to the recipient's diagnosis and needs.
- Discharge criteria.

Rule 59G-4.295: Specialized Therapeutic Services Coverage and Limitations Handbook (effective March 3, 2014)

SMART Goals and Objectives



SMART Goals and Objectives: Examples

- “I will practice guided meditation for five minutes, five days a week for the next three months.”
- “I will actively practice socializing in at least one new setting each week for the next month.”
- “I will journal every day for the next six weeks to help process my emotions and identify triggers related to anxiety.”
- “I will reduce the frequency of anxiety attacks from three per week to one per week within two months.”
- “I will reduce feelings of hopelessness from 7 to 5 on a scale of 10 within two months.”
- “I will reduce intrusive thoughts and flashbacks by 50% within three months.”

Educational Requirements

(b) In accordance with Section 1003.57(3)(d), F.S., the private residential care facility or a residential facility that is operated, licensed, or regulated by a public agency shall ensure that, within ten (10) business days of a student with a disability being placed in the facility, written notification of the placement is provided to the school district where the student is currently enrolled and counted for funding purposes under Section 1011.62, F.S., (sending school district) and the school district where the residential facility is located (receiving school district). If the student is not currently counted for funding purposes in the school district in which the legal residence of the student is located, the school district in which the legal residence of the student is located also shall be notified by the residential facility in writing within the required timeline. The placing agency shall collaborate with the residential facility to determine how that notification will be provided within the required timeline.

(c) In accordance with subsection 6A-6.0334(3), F.A.C., the sending school district shall take reasonable steps to promptly respond to the residential facility's request for transmittal of the student's educational records. If the student's placement in the residential care facility occurs while the notification and procedures regarding payment are pending, the student shall remain enrolled in the sending school district and the sending school district shall collaborate with the residential care facility to ensure that the student receives a free and appropriate public education, special education, and related services, including services comparable to those in the described in the current IEP, until the notification and procedures regarding payment are completed.

Rule 6A-6.0361: Contractual Agreements with Nonpublic Schools and Residential Facilities (effective May 15, 2011)

Medical Requirements

(a) The child-placing agency shall obtain available medical information and consents prior to admission of a child.

(b) Medical information and consents shall include the following:

1. Completion of a well-child check-up by a licensed physician or report of such an examination performed within twelve (12) months prior to admission.

2. The child's medical history, including immunizations, and, in the case of parenting teens, the medical history of the infant or toddler.

3. Written consent from the child's parent or guardian or a court order authorizing routine medical and dental procedures for the child, and to authorize emergency procedures when written parental consent cannot be obtained.

(c) The child-caring agency shall obtain the child's medical information that was not available prior to child's admission into the facility within 30 days of admission. Efforts to obtain the information shall be documented in the child's record.

(d) The child-caring agency shall have a written detailed policy for preventive, routine, emergency, and follow-up medical and dental care for all children.

(e) The child-caring agency is responsible for meeting the physical health needs of each child in its care.

1. The child-caring agency shall ensure that each child has an annual physical examination and follow-up care as recommended. For children under three (3) years, a well-child checkup shall be obtained in accordance with the American Academy of Pediatrics periodicity schedule.

2. The child-caring agency shall ensure that each child has a dental examination every six (6) months and follow-up care as recommended.

3. The child-caring agency shall ensure pregnant youth have prenatal and postnatal care, if not served in a maternity home. The child-caring agency shall assess pregnant youth to determine if postpartum testing and referrals are required.

(f) The child-caring agency, in conjunction with the case manager, shall provide or arrange for medically recommended glasses, hearing aids, prosthetic devices, corrective physical or dental devices, or equipment recommended by a physician for children in care.

(g) The child-caring agency shall maintain confidential medical and dental records for each child in care. The records shall include the dates of immunizations, medications, examinations, and any treatments for specific illness or medical emergencies.

Rule 65C-46.006: Health
and Medical Services
(effective May 26, 2021)

Clinical Record Requirements

Providers must maintain a clinical record for each recipient treated that contains all of the following:

- Consent for treatment that is signed by the recipient or the recipient's legal guardian. An explanation must be provided for signatures omitted in situations of exception.
- An evaluation or assessment that, at a minimum, contains the components of a brief behavioral health status examination conducted by a physician, psychiatrist, a licensed practitioner of the healing arts (LPHA), or master's level certified addictions professional for diagnostic and treatment planning purposes. For new admissions, the evaluation or assessment by an LPHA for treatment planning purposes must have been completed within the past six months.
- Copies of relevant assessments, reports and tests.
- Service notes (progress toward treatment plans and goals).
- Documentation of service eligibility, if applicable.
- Current treatment plans (within the last six months), reviews, and addenda.
- Copies of all certification forms (e.g., comprehensive behavioral health assessment).
- The practitioner's orders and results of diagnostic and laboratory tests.
- Documentation of medication assessment, prescription, and management.

Rule 59G-4.295: Specialized Therapeutic Services Coverage and Limitations Handbook (effective March 3, 2014)

Rule 59G-4.028: Behavioral Health Assessment Services (effective November 28, 2019)

Brief behavioral health status examinations consist of brief clinical, psychiatric, diagnostic, or evaluative interviews to assess behavioral stability or treatment status.

Brief behavioral health status examinations must provide information on the following:

- Diagnostic formulation
- Mental health status
- Purpose of the exam
- Summary of findings
- Treatment recommendations or plan

Behavioral Health Requirements

Florida Medicaid covers up to 365/6 days of therapeutic group care (TGC) treatment services per year, per recipient, provided in a BQ RTP or QRTP.

Providers must provide the care and services required for a recipient to attain or restore the highest practicable physical, mental, and psychosocial well-being in accordance with Rule Chapter 65C-46, F.A.C., as follows:

- Substance abuse and mental health screening and treatment, if applicable
- Family/group/individual therapy
- Behavioral management
- Psychiatric services
- Support groups
- Specialized intervention services
- Social and rehabilitative services
- Psycho-educational services
- Aftercare and follow-up services in accordance with Rule Chapter 65C-46, F.A.C.
- Coordination with the recipient's primary care physician
- Education services in accordance with Rule 6A-6.0361, F.A.C.
- Recreational services
- Vocational services (for recipients ages 16 years and older)
- Therapeutic home assignment

The provider must facilitate participation of family members in the child's treatment program including, but not limited to:

- Inclusion in family therapy
- Outreach to family members, including siblings
- Documenting how family members are integrated into the treatment process for the recipient, including post-discharge
- Documenting how sibling connections are maintained

Therapeutic home assignments require daily clinical intervention with the family by the recipient's physician, primary therapist, certified behavior analyst, or other licensed practitioner.

Rule 59G-4.128: Qualified Residential Treatment Program Services (effective July 8, 2025)

Non-Covered Services

Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Individual, family or group therapy, or behavior analysis services, reimbursed separately
- Room and board
- Services on days when a recipient is on therapeutic home assignment and no clinical intervention is provided
- Services provided to a recipient on the day of admission into the Statewide Inpatient Psychiatric Program, Therapeutic Group Care services, or another QRTP provider
- Services when the recipient is receiving any other 24-hour per day Florida Medicaid residential or institutional service

Rule 59G-4.128: Qualified Residential Treatment Program Services (effective July 8, 2025)

Documentation Requirements



Service documentation must contain all of the following:

- Recipient's name
- Date the service was rendered
- Start and end times
- Identification of the setting in which the service was rendered
- Identification of the specific problem, behavior, or skill deficit for which the service is being provided
- Identification of the service rendered.
- Updates regarding the recipient's progress toward meeting treatment related goals and objectives addressed during the provision of a service
- Dated signature of the individual who rendered the service
- Printed or stamped name identifying the signature of the individual who rendered the service and the credentials (e.g., licensed clinical social worker) or functional title (e.g., treating practitioner)

Rule 59G-4.295: Specialized Therapeutic Services Coverage and Limitations Handbook (effective March 3, 2014)

Documentation Requirements

- (1) This rule applies to providers rendering Florida Medicaid services to recipients.
- (2) Documentation Requirements.
 - (a) All Florida Medicaid providers must:
 - 1. Ensure medical records establish the medical necessity for and the extent of services provided.
 - 2. Sign and date each medical record within two business days from the date and time of service, or otherwise authenticate the record by signature, written initials, or computer entry. Electronic signatures are permissible as defined in Chapter 668, Part I, F.S.
 - 3. Initial rubber stamped signatures.
 - (b) Unless otherwise specified in Florida Medicaid coverage policies, providers must document the following information for each service visit or encounter with a Florida Medicaid recipient:
 - 1. Chief complaint of the visit.
 - 2. Date(s) of service.
 - 3. Description of services rendered (as applicable).
 - 4. Diagnosis.
 - 5. Diagnostic tests and results (as applicable).
 - 6. History and physical assessment (as applicable).
 - 7. Prescribed or provided medications and supplies (as applicable).
 - 8. Progress reports.
 - 9. Referrals to other services (as applicable).
 - 10. Scheduling frequency for follow-up or other services (as applicable).
 - 11. Treatment plan (as applicable).
- (3) Electronic Records.
 - (a) Providers that create or maintain electronic records must develop and implement an electronic records policy to comply with the applicable state and federal laws, rules, and regulations to ensure the validity and security of electronic records. Electronic record policies must address the technical safeguards required by Title 45, Code of Federal Regulations, section 164.312, where applicable.
 - (b) Providers that maintain electronic records must have the ability to produce electronic records in a paper format within a reasonable time, upon AHCA's request.
- (4) Recordkeeping Requirements. Providers must retain all business records, medical-related records, and medical records, as defined in Rule 59G-1.010, F.A.C., according to the requirements specified below, as applicable:
 - (a) Providers may maintain records on paper, magnetic material, film, or other media including electronic storage, except as otherwise required by law or Florida Medicaid requirements. All records must be accessible, legible, and comprehensible.
 - (b) Providers must retain all records related to services rendered to Florida Medicaid recipients for a period of at least five years from the date of service. Medicare crossover-only providers must retain health care service records for six years.

Rule 59G-1.054:
Recordkeeping and
Documentation
Requirements
(effective May 8, 2017)

Discharge and Aftercare Plans

(10) Discharge and Aftercare Plans.

(a) The provider shall have, and use on an ongoing basis, a written procedure on discharge planning and aftercare supports that specifies the availability of services and the persons responsible for implementation of the aftercare supports.

(b) Each BQRTP shall provide discharge planning and family-based aftercare support for at least six (6) months post-discharge.

(c) Discharge planning shall include input from the child, the child's parent or guardian, foster parents, caregiver, Department, and guardian ad litem, and a copy shall be provided to the child welfare professional.

(d) The child's diagnosis(es) shall be considered during discharge planning and development.

(e) Aftercare support plans shall be developed at least one month prior to discharge.

(f) Aftercare support shall be developed to meet the needs of a child with intent for the child to reside in the most appropriate, least restrictive setting.

(g) Aftercare Support Eligibility for Dependency Youth. Aftercare support must be offered to all children placed in a BQRTP setting. Aftercare support is not required for youth who discharge to another BQRTP setting or higher level of care to include residential treatment programs, also known as Statewide Inpatient Psychiatric Program (SIPP), or a therapeutic group home which are defined in s. 39.407(6), F.S.

(h) Aftercare Supports. Each BQRTP shall provide the following aftercare supports:

1. Community service coordination for the youth and their family/caregiver;
2. Ensure all service referrals are linked and barriers to access services are eliminated;
3. Provide a minimum of two (2) contacts per month, with at least one face to face contact, with the youth and family/caregiver;
4. Provide written progress reports every 30 calendar days to the youth's child welfare professional, if in foster care.

(i) When a youth is discharged to a placement setting outside a 50-mile radius of the provider, the BQRTP must coordinate aftercare support with the community-based care lead agency having jurisdiction of the youth. The community-based care lead agency shall resume responsibility for the aftercare support services provided to the dependency youth.

(j) Each BQRTP may contract/sub-contract with a community provider qualified to provide aftercare services.

Rule 65C-46.0211: Standards for Licensed Behavioral Qualified Residential Treatment Programs (effective January 28, 2024)

State Resources



[AHCA Florida
Medicaid
Adopted Rules](#)



[AHCA Florida
Medicaid Adopted
Rules and Service-
Specific Policies](#)



[AHCA Rule 59G-
4.002, Provider
Reimbursement
Schedules and
Billing Codes](#)

Behavioral Qualified Residential Treatment Programs (BQRTP) Training from DCF

The Florida Department of Children and Families (DCF) prepared this presentation to educate providers about BQRTP.



[DCF Behavioral Qualified Residential Treatment Program \(BQRTP\) Presentation:](#)

Helpful Links

Provider Landing Page: SunshineHealth.com/provider

Training: SunshineHealth.com/training

Become a Provider: SunshineHealth.com/join

Quick Reference Guides: SunshineHealth.com/claims

Provider Resources: SunshineHealth.com/resources

Vendors: SunshineHealth.com/vendors

Secure Provider Portal: SunshineHealth.com/login

Questions?