DISCLOSURE BY STATE EMPLOYEE OF FINANCIAL INTEREST
IN A CONTRACT TO PROVIDE SOCIAL SERVICES
PURSUANT TO 930 CMR 6.07

	STATE EMPLOYEE INFORMATION
Name of state employee:	Mi-Haita James
Title/ Position:	Assistant Commissioner for the DMH Division of Child, Youth and Family Services
Agency/Department:	Department of Mental Health
Agency Address:	25 Staniford Street, Boston, MA 02114
Office phone:	(617) 780-9408
Office e-mail	MI-HAITA.JAMES3@MASS.GOV
	I am a state employee, and I seek to have a financial interest in a contract or agreement made by a state agency listed below, or by a provider or organization funded by a state agency listed below: A state agency within the following Executive Offices: Executive Office of Health and Human Services, including the Human Service Transportation Office; Executive Office of Public Safety and Security, Executive Office of Elder Affairs, Executive Office of Veteran's Services, or A sheriff's office. The purpose of the contract is: - To provide personal services to a person or persons who receive services from, or have services paid for by, these state agencies; or - To provide educational services to people who work for these state agencies or for providers or organizations funded by these state agencies. I seek approval of the arrangement from the agency for which I serve as a state employee and from the state agency above that made the contract.
	FINANCIAL INTEREST IN A CONTRACT WITH A STATE AGENCY
	PLEASE CHECK OFF ONE OF THE THREE STATEMENTS BELOW AND PROVIDE THE REQUESTED INFORMATION.
1) Service to a state agency	___ I will provide personal or educational services to a state agency listed above. Please identify the state agency and also the Executive Office it is in, if applicable.

2) Service to a provider or organization	__x_ I will provide personal or educational services to a provider or organization funded by a state agency listed above. Please provide the name and address of the provider or organization. **Community Services Institute** 1695 Main St., Ste 400 Springfield, MA 01103 1100 Washington St., Ste 206 Dorchester, MA 02124 Please identify the state agency that funds the provider or organization, and also the Executive Office it is in, if applicable. Within my role as a LICSW clinician and outpatient therapist, assignment of clients covered by MassHealth is likely. MassHealth is an office within EOHHS.
3) Service to a person or persons	___ I will provide personal services directly to a person or persons who receive services from, or have services paid for by, a state agency listed above. Please identify the state agency that provides services to, or pays for services for, the person or persons, and also the Executive Office it is in, if applicable. Within my role as a LICSW clinician and outpatient therapist, assignment of clients covered by MassHealth is likely. MassHealth is an office within EOHHS.
Please describe the services you will provide.	Please provide information about the type of personal or educational services you will provide. **Please do not include the name of any individual who receives services.** In my role as an LICSW clinician, I manage a part-time outpatient caseload of 5 to 12 clients, conducting comprehensive clinical assessments, diagnostic formulations, and individualized treatment plans. These responsibilities are carried out after traditional work hours between the hours of 5-8pm and on the weekends. The practice regularly serves individuals covered by MassHealth. Additionally, I evaluate clinical necessity to facilitate referrals for specialized services and essential care coordination funded through MassHealth. Lastly, within this role, I may be assigned clients that are involved with state agencies such as DCF, MDH, DYS, etc.
What will you be paid, or what other financial interest will you have?	Please include a dollar amount, if possible. My rate averages $49.00 per hour with some variable rates for assessment completion.
Employee signature	Mi-Haita James
Date:	10/7/2026
	APPROVAL BY AGENCY YOU SERVE AS A STATE EMPLOYEE
Name and title of appointing authority	Charlene Zuffante Deputy Commissioner, CYF
Office phone	617-626-8335

Office e-mail	Charlene.Zuffante@mass.gov
Signature by appointing authority	By signing here, I indicate that I have reviewed the facts that the state employee has disclosed above and approve the arrangement proposed by the state employee.
Date:	10/15/2026
	APPROVAL BY AGENCY THAT MADE THE CONTRACT (IF DIFFERENT)
Name and title of person giving approval at the state agency that made the contract	Lee Robinson Chief of Accountable Care and Behavioral Health MassHealth (Massachusetts Medicaid & Children's Health Insurance Program) Office of Accountable Care & Behavioral Health
Office phone	508-254-1987
Office e-mail	Lee.Robinson@mass.gov
Signature by person giving approval	By signing here, I indicate that I have reviewed the facts that the state employee has disclosed above and approve the arrangement proposed by the state employee.
Date:	10/26/26

Attach additional pages if necessary.

File with:

State Ethics Commission
One Ashburton Place, Room 619
Boston, MA 02108

Form revised February, 2012