COUNTY-OWNED AND OPERATED PROVIDER CERTIFICATION APPLICATION

PART I: PROVIDER INFORMATION

Instructions: The Local Mental Health Director or designee must submit a separate application for each provider.
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IDENTIFYING INFORMATION	Name of Provider:	Provider No.: NPI No.:
	Street Address, City, State, and Zip	
	Telephone No.	County
NAME AND ADDRESS OF LEGAL ENTITY		
TYPE OF ORGANIZATION	**Check One** ☐ County Government ☐ City Government	
HEAD OF SERVICE NAME:	**Head of Service is:** ☐ Psychiatrist ☐ Registered Nurse ☐ Psychologist ☐ Psychiatric Technician ☐ Licensed Clinical Social Worker ☐ Licensed Vocational Nurse ☐ Marriage Family Therapist ☐ MH Rehab Specialist (include resume)	
SHORT DOYLE/MEDI-CAL SERVICE MODES TO BE PROVIDED	☐ SD/MC Mode 18 ☐ Crisis Stabilization ER S9484 (10/20) ☐ Crisis Stabilization UC S9484 (10/25) ☐ Day TX Intensive Half Day H2012 (10/81) ☐ Day TX Intensive Full Day H2012 (10/85) ☐ Day Rehab. Half Day H2012 (10/91) ☐ Day Rehab. Full Day H2012 (10/95) ☐ Case Manage./Brokerage T1017 (15/01) ☐ Therapeutic Behavioral Svcs H2019 (15/58) • Intensive Care Coordination (ICC) T1017 (15/07) ☐ Medication Support H2010 (15/60) ☐ Mental Health Services H2015 (15/30) ☐ Crisis Intervention H2011 (15/70) • Intensive Home Based Services (IHBS) H2015 (15/57)	
IS THE PROVIDER CURRENTLY LICENSED BY A STATE AGENCY?	☐ Yes If yes, which agency? ☐ DHCS ☐ DSS ☐ No ☐ Drug & Alcohol ☐ Other	
FIRE SAFETY	☐ Attached is documentation of the most recent fire safety inspection. (Date of Fire Clearance must be within 1 year of site visit) ☐ All services are provided at a public school site and meet school fire safety rules and regulations.	

I certify that this application is true, correct, and complete. I agree that if approval is granted that all services rendered by the Rehabilitative Mental Health Program shall be in conformity with federal, state, and local laws.
I further understand that a violation of such laws will constitute grounds for withdrawal of certification. This information may be released to any persons or organizations outside the official administrative channels.

Local Entity Authorized Signature *Date:*

Local Mental Health Director or Designee Signature *Date:*

PART II: SHORT-DOYLE/MEDI-CAL PROGRAM PROVIDER AGREEMENT CLAIM CERTIFICATION

CERTIFICATION STATEMENT

The Provider agrees and shall certify under penalty of perjury that all claims for services provided to county mental health clients have been provided to the clients by the Provider. The services were, to the best of the Provider's knowledge, provided in accordance with the client's written treatment plan. The Provider shall also certify that all information submitted to the Department of Health Care Services is accurate and complete. The provider understands that payment of these claims will be from federal and/or state funds, and any falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the content of services furnished to the client. The Provider agrees to furnish these records and the information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives. The Provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

THE PROVIDER AGREES TO INCLUDE WITH EACH CLAIM SUBMITTED TO THE DEPARTMENT OF HEALTH CARE SERVICES A CERTIFICATION STATEMENT TO THE ABOVE TERMS AND CONDITIONS WHICH SHALL BE PRINTED ON THE REVERSE SIDE OF EACH PROVIDER CLAIM FORM.

I certify that the undersigned will be a licensed or certified provider of Short-Doyle/Medi-Cal services upon submission of this agreement to the Department of Health Care Services and satisfaction of the requirements pursuant to Title 9, California Code of Regulations, and compliance with the requirements for providers of service set out in Welfare and Institutions Code, Division 9, Part 3, and California Code of Regulations, Title 22.

(original signed by)
Program Oversight and
Compliance Branch
Mental Health Services Division
Department of Health Care Services

Signature of Provider *Date:*

PART III: MEDI-CAL PROVIDER DATA FORM

1. Pay to Address (If different than page 1)	Number	Street	Telephone Number
City	County	State	Zip Code
2. List previous Medi-Cal provider numbers that the owner(s) have been issued.			
3. Is this a teaching facility for residents and/or interns who are salaried by a hospital? ☐ Yes ☐ No			
I certify that the above information is true, accurate, and complete to the best of my knowledge.			
4. Applicant's Typed or Printed Name		5. Applicant's Typed or Printed Title	
6. Applicant's Signature		7. Date	

RETURN TO:

Carol Sakai, LCSW, Chief
Compliance Section
Mental Health Services Division
Department of Health Care Services
1500 Capitol Ave., Suite 72.442, MS 2703
Sacramento, CA 95814

OR: DMHCertification@dhcs.ca.gov