

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>I certify that the above information is true, accurate, and complete to the best of my knowledge.</i>			
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