

County-owned or Operated Provider Certification Application Form (DHCS 1736) Instructions

The County-Owned or Operated Provider Certification Application form (DHCS 1736) is required to Medi-Cal activate and request provider certification to a County-owned or Operated provider in the Department of Health Care Services (DHCS) Online Provider System (OPS). Any County Mental Health Plan (MHP) provider providing mental health services to a Medi-Cal beneficiary must be certified by the DHCS in order to claim and be reimbursed for services.

Both pages of the DHCS 1736 must be completed, signed, dated, and submitted, along with (1) a valid current fire clearance, (2) a current Head of Service license (or a resume or certification by the MHP that the Head of Service meets Title 9 Requirements to be a Mental Health Rehabilitation Specialist), and (3) a program description that includes hours of operation to the certification mailbox, DMHCertification@dhcs.ca.gov, or the documents may be faxed to the Certification Unit fax (916) 440-5497.

Once the form, valid fire clearance, Head of Service license, and program description is received, DHCS' Program Oversight and Compliance Branch certification analyst will review the documents for content, accuracy, and confirm the information matches the provider's information on the National Plan and Provider Enumerator System (NPPES) and OPS. If the documents are accurate, the DHCS has six (6) months from the date of receipt of the final and complete packet to perform the on-site provider certification and Medi-Cal activate the provider.

Required Fields:

PART I: PROVIDER INFORMATION

1. **Provider Name:** Name of provider must match NPI/NPPES registry and the OPS.
2. **Provider number:** The four (4) digit number designated by DHCS MedCCC.
3. **Street address, City, State, and Zip:** Location where provider provides services to Medi-Cal Beneficiaries. Must match NPI/NPPES registry and OPS.
4. **NPI #:** Provider's 10-digit National Provider Identifier. Must match NPI/NPPES registry and the OPS.
5. **Telephone No:** Provider's phone number.
6. **County:** The name of the county where services will be provided.
7. **Name and Address of Legal Entity:** Enter the name and address of legal entity over the provider identified in items 1, 2, and 3.
8. **Type of Organization:** Indicate County or City Government.
9. **Head of Service Name/Licensure:** Indicate name of Head of Service, and identify their licensure.

10. Short Doyle/Medi-Cal Service Modes To Be Provided: Identify the mode of services that will be provided and need to be certified at this site. Those modes must all have been included when initiating the Provider in the OPS (ProviderFile@dhcs.ca.gov).
11. Is The Provider Currently Licensed by A State Agency? If Yes, which agency?: Indicate response.
12. Fire Safety: Attach the most current fire safety inspection clearance.
13. Local Entity Authorized Signature and Date:
14. Local Mental Health Director or Designee Signature and Date:

Anyone may complete the form, but the person who signs the application must be the Director or their Designee on file with DHCS.

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

Read the Certification Statement.

1. The Provider Signature (Local Mental Health Director or Designee) and the day's Date are required.

PART III: MEDI-CAL PROVIDER DATA FORM

1. Pay to Address (If different than page 1): The address where provider wishes to receive payment.
2. List previous Medi-Cal provider numbers that the owner(s) have been issued: If this provider has had prior Medi-Cal provider numbers indicate those numbers here.
3. Is this a teaching facility for residents and/or interns who are salaried by a hospital?: Respond 'yes' or 'no'.
4. Applicant's Typed or Printed name and title:
5. Applicant Signature: The Local Mental Health Director or Designee's signature is required.

THE APPLICATION PACKET IS CONSIDERED A LEGAL DOCUMENT AND ALL REQUIRED INFORMATION MUST BE ACCURATE, COMPLETE AND LEGIBLE.

If you have any questions contact the certification mailbox,
DMHCertification@dhcs.ca.gov