DRUG MEDI-CAL APPLICATION

(Substance Abuse Clinics)

STATE OF CALIFORNIA

HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES

PROVIDER ENROLLMENT DIVISION, MS 4704

PO Box 997412

Sacramento, CA 95899-7412

(800) 541-5555 or (916) 323-1945

Department of Health Care Services
Provider Enrollment Division
Sacramento, CA 95899-7412

DRUG MEDI-CAL APPLICATION INSTRUCTIONS

This application package contains the materials necessary to apply for Drug Medi-Cal (DMC) program participation as a substance abuse clinic as well as to submit information regarding changes in clinic information with the Department of Health Care Services (DHCS). The applicant may apply for multiple services on one application, as long as the services are provided at the same address.

It is vital that you carefully read each component within this application.

Substance abuse clinics are certified for Medi-Cal program participation by DHCS. To apply for certification, complete pages 6-12 of the attached application and submit the completed application to:

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Provider Enrollment Division, MS 4704
PO Box 997412
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The Medi-Cal certification requirements for substance abuse clinics are contained in the Drug Medi-Cal Certification Standards for Substance Abuse Clinics, effective July 1, 2004; the Standards for Drug Treatment Programs; and Title 22, California Code of Regulations Sections 51341.1, 51490.1, and 51516.1, which are linked online at www.dhcs.ca.gov/services/adp/pages/drug_medical.aspx. Reading each of these documents before completing an application is important.

In addition to completing the attached DMC application and supplying the DHCS with the required supportive documentation, applicants must also complete and submit the Medi-Cal Disclosure Statement (MCDS) (Form DHCS 6207, rev. 11/11), available at www.dhcs.ca.gov/services/adp/documents/03enrollment_DHCS6207.pdf. Please see the MCDS for detailed instructions on all persons required to be listed in Section IV of this form, including but not limited to, any individual with a 5% or greater, direct or indirect, ownership or controlling interest, any partnership interest, all officers, directors and managing employees. Attach a separate Section IV, Part B and C for each person listed in Section IV, Part A. Submit a current and legible copy of each individual's driver's license or state-issued identification listed in Section IV, Part A. Upon completion, the MCDS must be notarized by a California Notary Public. The original MCDS form shall be submitted with the application. **Photocopies will not be accepted.**

Listed below are specific instructions for completing the DMC application for different types of DMC certification actions. All applicable portions of the DMC application must be fully and accurately completed with current information. Supportive documents must accompany the application. The applicant may apply for multiple services on one application, as long as the services are provided at the same address. Retain a copy for your records.

Please be aware that DMC reimbursement is unavailable for applicant-requested DMC services provided at a new site until certification of the new site has been completed by DHCS. Reimbursement for DMC services rendered at an uncertified site shall be recovered by DHCS.

The following lists the sections of the DMC application that must be completed for each of the types of DMC certification actions:

Original

A substance abuse clinic or satellite site applying for initial DMC certification must complete all Sections of the seven page application and supply all required documentation. If a section is not applicable, please enter the notation N/A in the space provided. In addition, a completed Medi-Cal Disclosure Statement (DHCS form 6207, rev 11/11), as referenced above, must accompany the application.

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Additional Services

A substance abuse clinic or satellite site applying for additional services must complete sections I, II, V, VI, VII, VIII (for each additional service), IX (if applicable), X (if applicable), XI and XIV of this application, and any other sections necessary to report a change in information.

Adding Satellite Site

A substance abuse clinic adding a satellite site clinic (which is defined as providing substance abuse treatment services 20 hours or less per week) must complete sections I, II, V, VI, VII, VIII, IX (if applicable), XI, XII, XIII, and XIV.

Relocation or Expansion

A substance abuse clinic or satellite site that is moving or expanding (adding additional suites, room, floor numbers, and/or buildings) must complete sections I, II, V, VI, VII, IX (if applicable), X (if applicable), XI, XII, XIII (outpatient facilities only), XIV, and any other sections necessary to report a change in information.

Note: The Drug Medi-Cal Certification Standards for Substance Abuse Clinics, effective July 1, 2004 require at least 60 days' notice prior to relocation of a parent or satellite site. Failure to provide 60 days advance notification or complete documentation may result in suspension from participation in the Medi-Cal program. **Services provided at the new location shall not be DMC reimbursable until certification of the new site has been completed by DHCS. Payment for services rendered at an uncertified site will be recovered by DHCS.**

Change of Ownership

Any change of ownership is considered an original application. A substance abuse clinic applying for a change of ownership must complete all sections of the seven-page application and supply all required documentation. In addition, a Medi-Cal Disclosure Statement (form DHCS 6207, rev 11/11) must accompany the application. If the change of ownership involves satellite locations, a separate application is required for each site, including all documentation requirements.

Upon completion of the application, attach a cover letter describing your request. Include any additional information that would be helpful to the Department in processing your application. Be sure that the application is signed on the final page, including submission of all required documentation.

It is important to note that substance abuse clinics cannot be reimbursed under the DMC program until the new clinic, service, location, or ownership has been certified. The certification process includes an on-site review to validate the information submitted with the application.

The following instructions are designed to clarify certain sections on the application. Instructions are listed by section number for easy reference. No instructions are given for sections DHCS considered self-explanatory. These instructions apply to clinics and satellite sites.

Section I. Indicate the name and address of the legal entity in control of the clinic. If the applicant is a corporation, indicate the name as it appears on the Articles of Incorporation. If the applicant is a partnership, identify the name as it appears on the partnership agreement. If the applicant is a county, indicate the name as it appears on the county charter. If the applicant is a sole proprietor, the name of the sole proprietor must be listed, including the social security number in the F.E.I.N. section of the application. Sole proprietors must also complete the Applicant Supplement for Sole Proprietors, which may be located at http://www.dhcs.ca.gov/formsandpubs/forms/Forms/SUDCD/DHCS_5111.pdf.

Include the four-digit Drug Medi-Cal Provider number if the application is for additional services, to add a satellite site, or for relocation/expansion.

Insert the 6-digit number under which the program reports participant information, i.e., California Outcomes Measurement System (CalOMS) number, if any. CalOMS information may be located at http://www.adp.ca.gov/CalOMS/caloms-treatment.shtml.

Include the 10-digit National Provider Identifier (NPI) used to identify health care providers on Health Insurance Portability and Accountability Act (HIPAA) covered transactions. If the provider does not have a NPI, contact the federal entity that assigns the NPI at (800) 465-3203 or https://nppes.cms.hhs.gov. **Your application will not be accepted without this number.**

Provide the mailing address for the substance abuse clinic (e.g., mail includes items such as the compliance report, Certification and Transmittal, DHCS notifications regarding the DMC program, etc.).

Section II. Include the name of the clinical director (the individual responsible for the day-to-day operation of the clinic) and the executive director (the individual responsible for representing the legal entity in the operation of the clinic).

Section III. Identify the type of legal entity in control of the clinic and attach the specified documentation. For a corporation, attach a copy of the Articles of Incorporation (as filed with and endorsed or stamped by the Secretary of State). For a partnership, attach a current copy of the partnership agreement.

Section V. If the entire DMC program is relocating, please check that box and provide the prior address of the DMC program and the proposed effective date of the DMC program relocation. If the DMC certified program operates at the same address as a program providing another type of substance abuse service, (e.g., driving under the influence or certified alcohol and/or other drug program), and the entire program is relocating, check that box. If only a portion of the DMC services provided at the DMC clinic are relocating, check that box.

Section VI. Enter **all** services to be provided by the DMC clinic, including existing services and additional services or program types being requested by this application. ***Note – Perinatal and non-perinatal residential services require a residential alcoholism or drug abuse recovery or treatment facility license issued by DHCS. A Narcotic Treatment Program (NTP) license issued by DHCS is required to provide NTP services. Facility licensing and NTP information and applications are available online at*** *www.dhcs.ca.gov/provgovpart/pages/SUD-ProvPartners.aspx.*

Section VIII. The applicant is required to submit with the application an alcohol and drug protocol for each DMC service being requested. Please see California Code of Regulations, Title 22, section 51341.1 and the "Drug Medi-Cal Certification Standards for Substance Abuse Clinics" for the definitions of the DMC services being requested. The protocol must be a detailed plan of how the applicant shall comply with the requirements of California Code of Regulations, Title 22, the Drug Medi-Cal Certification Standards, and the State of California Standards for Drug Treatment Standards in order to guide program operation and provide the requested DMC services to the clients.

Section X. A residential alcoholism or drug abuse recovery or treatment facility must have a license issued by DHCS to provide DMC adult residential substance abuse services. The facility is limited to a maximum treatment capacity of 16 beds or less. Beds occupied by children who stay in the facility with their mothers are not counted in the 16-bed maximum capacity. DHCS may be contacted at http://www.dhcs.ca.gov/provgovpart/Pages/FacilityLicensing.aspx for all residential licensing requirements and procedures.

If the residential site is licensed as a community care facility by the Department of Social Services (DSS), attach a written waiver from the DSS District Office to allow the use of the facility or grounds for nonlicensed service activities. DSS may be contacted at http://www.cdss.ca.gov/cdssweb/PG69.htm for all licensing requirements and procedures.

Note – The Department of Public Health (DPH) licenses primary care clinics and hospitals. Refer to Health and Safety Code section 1201 regarding the licensure requirements for these entities. DPH may be contacted at http://www.cdph.cagov/programs/LnC/Pages/LnC.aspx for all licensing and certification requirements and procedures.

Section XII. Attach a copy of an approved fire clearance for the address specified in Section I that has been conducted within the previous 12 months and that clearly identifies the clinic by name and street address. The fire clearance must be completed on Form STD 850 if applying for residential services. A STD 850 is available online at http://www.documents.dgs.ca.gov/osp/pdf/std850.pdf. A fire clearance is not required if the clinic is located entirely on public school grounds. A letter, on school or district letterhead, from the principal authorizing that services may be conducted by the provider on school grounds and certifying that all locations where services are provided meet fire safety rules and regulations is sufficient.

Section XIII. Local zoning approval is required for all clinics except:

(1) Clinics located on public school grounds, and
(2) Clinics operated in a building that is owned or leased by a public entity.

For a clinic located on public school grounds, attach a letter, on school or district letterhead, from the principal allowing the applicant to provide services on public school grounds. Please include the name of the school For a clinic operated in a building that is owned or leased by a public entity, local zoning approval is not required. A letter on the letterhead from the public entity is required. A Zoning Approval Form is available online at http://www.dhcs.ca.gov/formsandpubs/forms/Forms/SUDCD/DHCS_5115.PDF.

Section XIV. Please follow the guidelines listed for your entity type:

(1) If the applicant is a firm, association, or corporation, the application shall be signed by the officer or individual legally responsible for the representing entity; you must attach a copy of the resolution or Board minutes authorizing the individual to sign. The full legal name of the person signing, including the driver license number, date of birth, and gender shall be listed.
(2) If the applicant is a partnership, the application shall be signed by each partner. The full legal name of each partner must be listed, including the driver license number, date of birth, and gender.
(3) If the applicant is a government entity, the application shall be signed by the authorized official.
(4) If the applicant is a sole proprietor, the sole proprietor must sign the application, and include the social security number in the F.E.I.N. section of the application; sole proprietors must also submit their driver license number, date of birth, gender, and complete the Applicant Supplement for Sole Proprietors, which may be located at http://www.dhcs.ca.gov/formsandpubs/forms/Forms/SUDCD/DHCS_5111.pdf.

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Drug Medi-Cal Application

(Substance Abuse Clinics)

This form must be completed for each site desiring to participate in the Drug Medi-Cal program. See the General and Specific Instructions for instructions on completing this application.

I. **Identifying Information for Substance Abuse Clinic**	Legal Entity Name (for entity in control of clinic or satellite site)	4-digit Drug Medi-Cal Provider Number, if assigned:
	Program/Clinic Name	Do you have a 6-digit number (CalOMS) under which you report client information? No ☐ Yes ☐, write number below:
	School Name	
	Street Address **(where services will be provided)** Suite#/Room #/Floor#	Program Telephone Number: ( )
	City, State, Zip Code	Type of location (clinic, doctor's office, residential facility, etc.)
	Mailing Address	10-digit National Provider Identifier (NPI)
	City, State, Zip Code	
	Website Address	
	If clinic site is leased or rented, provide the following: Full name of owner Address of owner _____ _____ (Include a copy of the lease/rental agreement or verification from the space owner, if the space is donated at no cost)	Federal Employer Identification Number (FEIN): County of program operation
II. **Administration**	Clinic Director:_____NPI# (if any):_____ Telephone Number: ( )_____Email:_____	
	Executive Director: _____NPI# (if any):_____ Telephone Number: ( )_____Email: _____	
III. **Type of Legal Agency or Entity in Control of Clinic**	Check one and complete or attach additional information for the type of legal entity: ☐ Sole proprietorship (Attach copy of fictitious business name permit/statement) ☐ Partnership (Attach copy of partnership agreement) ☐ Not for profit corporation (Attach copy of Articles of Incorporation) ☐ Other corporation (Attach copy of Articles of Incorporation) ☐ Government entity ☐ Other	

IV. **Funding Sources**	Identify the sources of funds and income for operations (i.e. client fees, third party payers [insurance companies, employee health plans] county funds, state funds [include department and fund source, if known] other public funds, etc.)
V. **Type of Application**	Check all that apply ☐ Original Application Adding ☐ Satellite Site (20 hours of less of service per week) ☐ Additional Services and/or Program Types _____ ☐ Relocation, From: Proposed Effective Date: _____ Is this a relocation of the entire program ☐ or only the Drug Medi-Cal component? ☐ ☐ Change of ownership, From: ☐ Other, please specify:
VI. **Service Modality(ies)**	Identify the service modality(ies) and treatment component (non-perinatal or perinatal) requested for the site. If the site is currently certified, include service modality(ies) and treatment component(s) that the provider applicant wishes to continue as well as those to be added. **Applicants for residential services must first obtain a residential license issued by DHCS prior to application submission for DMC residential services.**

Type of Services	Current and/or requested treatment components	
Narcotic Treatment Program (NTP) License #:	Non-perinatal ☐	Perinatal ☐
Intensive Outpatient Treatment (IOP)	Non-perinatal ☐	Perinatal ☐
Outpatient Drug Free (ODF)	Non-perinatal ☐	Perinatal ☐
Residential License #:	Non-perinatal ☐	Perinatal ☐
Naltrexone	Non-perinatal ☐	

VII. **Hours of Service Provision**	☐ More than 20 hours per week (substance abuse clinic) ☐ 20 hours a week or less (satellite site)
VIII. **Drug Protocol**	☐ Attached is a drug protocol for each service modality being requested (narcotic treatment program, residential, intensive outpatient, naltrexone, outpatient drug free) ***– See instructions page for protocol requirements.***
IX. **Federally Qualified Health Center**	☐ The facility is a federally qualified health center (FQHC) or in the process of applying for FQHC status with Health Resources Services Administration. ☐ The facility is a federally certified rural health clinic (RHC) or in the process of applying for rural health clinic designation with The Centers for Medicare & Medicaid Services.

X.

For Residential Substance Abuse Applicants Only

Is the facility separately licensed by the DHCS?

Yes ☐ License #: _____ No ☐ Number of treatment beds: _____

If 'No,' you must first obtain a residential license prior to application submission for DMC residential services.

NOTE: Residential programs cannot have more than 16 treatment beds.

Are all food, shelter, and alcohol or drug recovery or treatment services provided at the licensed facility?

Yes ☐ No ☐

If no, what services are provided on site, what services are provided offsite, who provides the services and at what address are the services provided?

Service(s) Provided: Onsite:	Offsite:	Provider of Services: (Legal Entity)	Address of Facility:

Attach additional sheets if necessary.

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XI. Staff

MEDICAL DIRECTOR

All programs must designate a medical director.

NAME: _____ Medical License #:_____ NPI#_____

☐ Attached is a copy of the Medical Director's current license from the Medical Board of California or the Osteopathic Medical Board of California.

PROGRAM STAFF

Personnel files must match information on application. List the staff that will provide direct treatment services at this location. Include staff under contract. Attach a separate piece of paper if necessary.

Total number of staff employed **at this facility**: _____

Total number of staff **at this facility** who perform alcohol and drug counseling duties: _____

Total number of staff employed at this facility who are currently licensed, certified or registered counselors: _____

Please use pages 10 and 11 of this application to provide information for program staff other than the Medical Director and Clinical Director. Attach additional sheets if necessary, which can be downloaded at http://www.dhcs.ca.gov/formsandpubs/forms/Forms/SUDCD/DHCS_5050.pdf

*** APPROVED CERTIFYING ORGANIZATIONS**

1. Board for Certification of Addiction Specialists (CAARR)
2. California Certification Board of Alcohol and Drug Counselors (CAADAC)
3. California Association of Alcohol/Drug Educators (CAADE)
4. Breining Institute
5. California Association of Drinking Driver Treatment Programs (CADDTP)
6. American Academy of Health Care Providers in the Addictive Disorder (AAHCPAD)

**** LICENSED PROFESSIONALS AND INTERN QUALIFICATION REQUIREMENTS**

Licensed professional means a physician licensed by the Medical Board of California or by the Osteopathic Medical Board of California; a psychologist licensed by the Board of Psychology; or a clinical social worker or MFT licensed by the California Board of Behavioral Sciences, or an intern registered with the California Board of Behavioral Sciences or with the Board of Psychology.

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XI (continued). Staff

******* Pursuant to the CCR, Title 9, Section 13010, at least thirty percent (30%) of staff providing counseling services in all SUD programs licensed and/or certified by DHCS shall be licensed or certified pursuant to the requirements of this chapter. All other counseling staff shall be registered pursuant to Section 13035(f). Licensed professionals may include LCSW, MFT, Licensed Psychologist, Physician, or registered Intern, as specified in Section 13015.

INSTRUCTIONS: Use this form to identify all staff of the facility. Designate volunteers by placing a "V" after their names. Use additional sheets as needed.

Employee Information:	**Date Hired**	**Alcohol & Drug Treatment Exp. - in Years**	**Last TB Test Date**	**First Aid and CPR required for licensed facilities only.**		**Licensed?** Yes/No/NA	**Certified?** Yes/No/NA	**Registered?** Yes/No/NA	*** Certified/Registered By:** (Provide certification/registration # and organization (from pg 8) **OR** **** Licensed As:** A. Psychologist B. MFT C. Physician D. LCSW E. Registered Intern Per Page 8 of this Application	**Effective and expiration dates of: Licensure, Certification, or Registration.**
				First Aid: Date of last Training	**CPR: Date of last Training**					
_____ **Title:** _____ **Scheduled hours per week:**_____									_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date
_____ **Title:** _____ **Scheduled hours per week:**_____									_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date
__ _____ **Title:** _____ **Scheduled hours per week:**_____									_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date
_____ **Title:** _____ **Scheduled hours per week:**_____									_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date
_____ **Title:** _____ **Schedule hours per week:** _____									_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date

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XI (continued). Staff

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				First Aid: Date of last Training	**CPR: Date of last Training**					
_____ **Title:** _____ **Scheduled hours per week:**_____									_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date
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_____ **Title:** _____ **Scheduled hours per week:**_____									_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date

XII. **Fire Clearance**	☐ Attached is a valid fire clearance from the local authority assuring that all fire safety requirements have been met and issued no more than 12 months prior to the date of this application: Outpatient Fire Clearances are available online at http://www.dhcs.ca.gov/formsandpubs/forms/Forms/SUDCD/DHCS_5104.pdf ***The fire clearance for residential services must be on Form STD 850*** and is available online at http://www.documents.dgs.ca.gov/osp/pdf/std850.pdf . ☐ The site is located entirely on public school grounds. Attached is a letter, on school or district letterhead from the school principal certifying that all locations where substance abuse services are provided meet fire safety rules and regulations.
XIII. **Local Zoning Approval**	Check one of the following that applies to the site: ☐ Attached is documentation of local zoning approval for the site and services requested ***(Applicants for residential services are not required to submit local zoning approval with the application; however, the applicant must check with local authorities for zoning approval requirements)***. A Zoning Approval Form is available online at http://www.dhcs.ca.gov/formsandpubs/forms/Forms/SUDCD/DHCS_5115.PDF . ☐ The site is located entirely on public school grounds. Attached is a letter from the principal, on school or district letterhead authorizing the provision of services. ☐ The site is located entirely within a building that is owned or leased by a city, county, or state and is exempt from zoning approval requirements. Attached is a letter, on the public entity letterhead, from the local agency. ☐ The site is not required to obtain local zoning approval. Attached is a letter from the local agency responsible for issuing zoning approval stating that zoning approval is not required.
XIV. **For Individual Signing the Application**	**PLEASE SEE INSTRUCTIONS FOR SIGNATURE AND DOCUMENTATION REQUIREMENTS**

I certify that the legal entity/provider applying to participate in the Drug Medi-Cal program is not barred from certification under Section 14043.36 of the Welfare and Institutions Code and that the information contained iin this application and supporting documentation is true and correct.

The applicant understands they must comply with all requirements established in Title 22, California Code of Regulations, Division 3, Chapter 3, Article 4, Section 51341.1; the Drug Medical Certification Standards for Drug Treatment Programs; the Standards for Drug Treatment Programs; and have all records, documents, policies, and procedures immediately available upon request during an onsite inspection. It is the responsibility of the applicant to ensure that its systems, programs, policies, processes, and related activities comply with all aforementioned requirements.

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct (please attach additional sheets, if necessary).

Signature of Authorized Individual	Full Legal Name of Authorized Individual	Title	Date of Birth	Gender	Driver's License State/Number	Date