

# PROVIDER SITE RE/CERTIFICATION PROTOCOL

COUNTY: \_\_\_\_\_ DATE: \_\_\_\_\_

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| <b>PROVIDER NUMBER:</b><br><b>NAME:</b><br><b>ADDRESS:</b><br><b>PHONE NUMBER:</b>   | <b>NPI#</b>  | <b>DAYS/HOURS OF OPERATION:</b>  |
| TYPE OF REVIEW<br><i>(Please specify):</i>   | <input type="checkbox"/> CERTIFICATION                               | <input type="checkbox"/> RECERTIFICATION                                 |
| <b>DMH REVIEWER(S):</b>  |  | <b>COUNTY/ PROVIDER REPRESENTATIVE(S):</b>                               |
| <b>SERVICES PROVIDED</b><br><i>(Compare services to original application and DMH Provider File prior to review)</i>  |  |  |
| <input type="checkbox"/> Non-Hospital PHF    H2013    (05/20)  | <input type="checkbox"/> Day Tx Int (1/2 day)    H2012    (10/81)    | <input type="checkbox"/> Case Manage./Brokerage    T1017    (15/01)      |
| <input type="checkbox"/> Crisis Residential    H0018    (05/40)  | <input type="checkbox"/> Day Tx Int (full day)    H2012    (10/85)   | <input type="checkbox"/> Mental Health Svcs    H2015    (15/30)          |
| <input type="checkbox"/> Adult Residential    H0019    (05/65)   | <input type="checkbox"/> Day Tx Rehab (1/2 day)    H2012    (10/91)  | <input type="checkbox"/> Therapeutic Behavioral Svcs    H2019    (15/58) |
| <input type="checkbox"/> Crisis Stab. ERm    S9484    (10/20)  | <input type="checkbox"/> Day Tx Rehab (full day)    H2012    (10/95) | <input type="checkbox"/> Medication Support    H2010    (15/60)          |
| <input type="checkbox"/> Crisis Stab. UCare    S9484    (10/25)  |  | <input type="checkbox"/> Crisis Intervention    H2011    (15/70)         |
| <i>(List the names, addresses, phone numbers, and hours of operation of school and satellite sites and indicate which sites store medications or provide day treatment.)</i> |  |  |

- See Attachment A for definitions of these services

COUNTY: \_\_\_\_\_ DATE: \_\_\_\_\_

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| Category 1: POSTED BROCHURES AND NOTICES   |     | Criteria Met |   |
|--|-----|--------------|---|
| EVALUATION CRITERIA  | YES | NO           | COMMENTS  |
| <p>1) Regarding written information in English and the threshold languages to assist beneficiaries in accessing specialty mental health services, at a minimum, does the provider have the following information available:</p> <p style="margin-left: 20px;">A) The beneficiary brochure per MHP procedures?</p> <p style="margin-left: 20px;">B) The provider list per MHP procedures?</p> <p style="margin-left: 20px;">C) The posted notice explaining grievance, appeal, and fair hearings processes?</p> <p style="margin-left: 20px;">D) The grievance forms, appeal forms, and self-addressed envelopes?</p> <p><i>CCR, Title 9, Chapter 11, Section 1850.205 (c)(1) (B) (C); MHP Contract, Exhibit A, Attachment 1, Section V</i></p> |     |              | <p><u>NOTE:</u> Prior to site visit, check threshold language(s) requirements for this provider.</p> <p><u>NOTE:</u> The informing materials (beneficiary brochure and provider list) must be available upon intake and upon request in English and in threshold languages onsite or in a manner approved by the MHP.</p> <p><u>NOTE:</u> There must be a posted notice explaining the grievance, appeal, and fair hearings processes in English and in the threshold language(s).</p> <p><u>NOTE:</u> There must be grievance forms and appeal forms in English and the threshold language(s) and self addressed envelopes available without the need to make a verbal or written request.</p> |
| Category 2: LICENSES/CERTIFICATION—ADULT AND CRISIS RESIDENTIAL TREATMENT FACILITIES   |     |              |   |
| <p>2) Is the provider currently licensed by the State Department of Social Services and currently certified by the State DMH?</p> <p><i>MHP Contract, Exhibit A, Attachment 1, Appendix D, Item 1</i></p>  |     |              | <p><u>NOTE:</u> N/A if not an Adult or Crisis Residential Treatment facility.</p> <p><u>NOTE:</u> Adult and Crisis Residential Treatment facilities must be licensed as a Social Rehabilitation Facility or Community Care Facility by the State Department of Social Services and certified as a Social Rehabilitation Program by the State DMH.</p> <ul style="list-style-type: none"> <li>• View current license and certification.</li> </ul>   |

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| <b>Category 3: FIRE SAFETY INSPECTION</b>  |                     |           |  |
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| <p>3) Does the provider have a fire safety inspection that meets local fire codes?</p> <p><i>MHP Contract, Exhibit A, Attachment 1, Appendix D, Item 2</i></p>   |                     |           | <p><u>NOTE</u>: The facility cannot be certified without a fire safety inspection that meets local fire codes.</p> <p><u>NOTE</u>: A new fire safety inspection may be required if the facility undergoes major renovation or other structural changes.</p> <p><u>NOTE</u>: Efforts should be made to have the facility re-inspected prior to the tri-ennial recertification onsite visit. Review evidence of efforts.</p> <p><u>NOTE</u>: Review local fire code requirements to determine reinspection schedule.</p> |
| <b>Category 4: PHYSICAL PLANT</b>  | <b>Criteria Met</b> |           |  |
| <b>EVALUATION CRITERIA</b>   | <b>YES</b>          | <b>NO</b> | <b>COMMENTS</b>  |
| <p>4) Is the facility and its property clean, sanitary, and in good repair?</p> <p><i>MHP Contract, Exhibit A, Attachment 1, Appendix D, Item 3</i></p>  |                     |           | <ul style="list-style-type: none"> <li>Make a tour of the facility.</li> <li>Observe the building and grounds for actual and potential hazards.</li> </ul>   |
| <b>Category 5: POLICIES AND PROCEDURES</b>   |                     |           |  |
| <p>5) Does the provider have the following policies and procedures:</p> <p style="margin-left: 40px;">A) Protected Health Information?</p> <p><i>MHP Contract, Exhibit D, Section 6; W&amp;IC Section 5328</i></p> |                     |           | <ul style="list-style-type: none"> <li>Verify that confidentiality of beneficiary information is maintained and is consistent with HIPAA requirements.</li> </ul>  |
|  |                     |           |  |
| <p style="margin-left: 40px;">B) Personnel policies and procedures?</p> <p><i>MHP Contract, Exhibit A, Attachment 1, Appendix D, Item 5</i></p>  |                     |           |  |
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|---|---------------------|-----------|--|
| <p>C) General operating procedures?</p> <p><i>MHP Contract, Exhibit A, Attachment 1, Appendix D, Item 5</i></p>   |                     |           |  |
|   |                     |           |  |
| <p>D) Maintenance policy to ensure the safety and well being of beneficiaries and staff?</p> <p><i>MHP Contract, Exhibit A, Attachment 1, Appendix D Item 4</i></p>       |                     |           | <ul style="list-style-type: none"> <li>Review the building maintenance policy or agreement.</li> </ul>   |
| <b>Category 5: POLICIES AND PROCEDURES</b>  | <b>Criteria Met</b> |           |  |
| <b>EVALUATION CRITERIA</b>  | <b>YES</b>          | <b>NO</b> | <b>COMMENTS</b>  |
| <p>E) Service delivery policies?</p> <p><i>MHP Contract, Exhibit A, Attachment 1, Appendix D, Item 5</i></p>  |                     |           | <p><u>NOTE</u>: For Day Treatment, refer to Categories 9 and 10 of this protocol.</p> <p><u>NOTE</u>: Written program description must describe the specific activities of the service.</p> <ul style="list-style-type: none"> <li>Review the written program description of services provided.</li> </ul> |
|   |                     |           |  |
| <p>F) Unusual occurrence reporting procedures relating to health and safety issues?</p> <p><i>MHP Contract, Exhibit A, Attachment 1, Appendix D, Item 5</i></p>           |                     |           |  |
|   |                     |           |  |
| <p>G) Written procedures for referring individuals to a psychiatrist when necessary, or to a physician who is not a psychiatrist, if a psychiatrist is not available?</p> |                     |           |  |

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| <i>MHP Contract, Exhibit A, Attachment 1, Appendix D, Item 8</i>   |                     |           |  |
| <b>Category 6: HEAD OF SERVICE</b>   |                     |           |  |
| <p>6) Does the provider have a Head of Service that meets <u>CCR</u>, Title 9, Sections 622-630 requirements?</p> <p><i>MHP Contract, Exhibit A, Attachment 1, Appendix D, Item 9</i></p>  |                     |           | <p><u>NOTE</u>: Request a copy of the Head of Service’s current license or, if a Mental Health Rehabilitation Specialist (MHRS), a resume or certification by the MHP that the Head of Service meets Title 9 requirements to be a MHRS.</p> <p><u>NOTE</u>: Review Sections 622-630 for specific requirements. (See Attachment A for specifics.)</p>   |
| <b>Category 7: CRISIS STABILIZATION</b>  | <b>Criteria Met</b> |           |  |
| <b>EVALUATION CRITERIA</b>   | <b>YES</b>          | <b>NO</b> | <b>COMMENTS</b>  |
| <p>7) Regarding Crisis Stabilization services:</p> <p style="padding-left: 40px;">A) Does the provider have qualified staff available to meet the 4:1 (client: staff) ratio during times Crisis Stabilization services are provided?</p> |                     |           | <ul style="list-style-type: none"> <li>Review policies and procedures that should make clear how A-G will be assured.</li> <li>Review staffing patterns for A-G.</li> </ul> <p><u>NOTE</u>: At a minimum there must be a ratio of at least one licensed/waivered/registered mental health professional on site for each four beneficiaries or other patients receiving Crisis Stabilization services.</p> <ul style="list-style-type: none"> <li>Review staff licenses/waivers/registrations and information on service activity to show compliance with 4:1 ratio.</li> </ul> |
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| <p>B) Does the provider have at least one Registered Nurse, Psychiatric Technician, or Licensed Vocational Nurse on site at all times beneficiaries are receiving Crisis Stabilization services?</p> |                            |                  | <ul style="list-style-type: none"> <li>Review for staffing availability</li> </ul>   |
|  |                            |                  |  |
| <p>C) Does the provider have medical backup services available either on site or by written contract or agreement with a hospital?</p>   |                            |                  | <p><u>NOTE</u>: Medical backup means immediate access within reasonable proximity to health care for medical emergencies.</p> <p><u>NOTE</u>: Immediate access and reasonable proximity is to be defined by the Mental Health Plan.</p> <p><u>NOTE</u>: A physician must be on call at all times for the provision of those Crisis Stabilization Services which can only be provided by a Physician.</p> |
|  |                            |                  |  |
| <p><b>Category 7: CRISIS STABILIZATION</b></p>   | <p><b>Criteria Met</b></p> |                  |  |
| <p><b>EVALUATION CRITERIA</b></p>  | <p><b>YES</b></p>          | <p><b>NO</b></p> | <p><b>COMMENTS</b></p>   |
| <p>D) Does the provider have medications available on an as needed basis and the staffing available to prescribe or administer it?</p>   |                            |                  |  |
|  |                            |                  |  |
| <p>E) Do all beneficiaries receiving Crisis Stabilization services receive a physical and mental health assessment?</p>  |                            |                  |  |
|  |                            |                  |  |
| <p>F) If a beneficiary is evaluated as needing service</p>   |                            |                  | <p><u>NOTE</u>: To the extent resources are available, if outside services</p>   |

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| <p>activities that can only be provided by a specific type of licensed professional, does the provider make such persons available?</p>   |                     |           | <p>are needed; a referral corresponding with the beneficiary's needs must be made.</p>  |
|   |                     |           |   |
| <p>G) If Crisis Stabilization services are co-located with other specialty mental health services, does the provider use staff providing Crisis Stabilization that are separate and distinct from persons providing other services?</p> <p><i>CCR, Title 9, Sections 1840.338 and 1840.348; MHP Contract, Exhibit A, Attachment 1, Appendix D, Item 7</i></p> |                     |           | <p><b>NOTE:</b> Persons included in required Crisis Stabilization ratios and minimums may not be counted toward meeting ratios and minimums for other services.</p>                             |
| <b>Category 8: PHARMACEUTICAL SERVICES</b>  | <b>Criteria Met</b> |           |   |
| <b>EVALUATION CRITERIA</b>  | <b>YES</b>          | <b>NO</b> | <b>COMMENTS</b>   |
| <p>8) Are there policies and procedures in place for dispensing, administering, and storing medications for each of the following and do practices match policies and procedures:</p> <p>A) Are all medications obtained by prescription labeled in compliance with federal and state laws?</p>   |                     |           | <ul style="list-style-type: none"> <li>• Review policies and procedures for A-F.</li> </ul> <p><b>NOTE:</b> Prescription labels may be altered only by persons legally authorized to do so.</p> |
|   |                     |           |   |
| <p>B) Are medications intended for external-use-only stored separately?</p>   |                     |           |   |
|   |                     |           |   |
| <p>C) Are all medications stored at proper temperatures:</p> <ul style="list-style-type: none"> <li>• Room temperature medications at 59-86 Degrees F?</li> <li>• Refrigerated medications at 36-46 degrees F?</li> </ul>   |                     |           |   |

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|  |                     |           |   |
| D) Are medications stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication?  |                     |           |   |
|  |                     |           |   |
| E) Are medications disposed of after the expiration date?  |                     |           | <u>NOTE:</u> IM multi-dose vials must be dated and initialed when opened. |
|  |                     |           |   |
| F) Is a medication log maintained to ensure the provider disposes of expired, contaminated, deteriorated and abandoned medications in a manner consistent with state and federal laws?<br><br><i>MHP Contract, Exhibit A, &amp; Attachment 1, Appendix D, Item 10A-F</i> |                     |           |   |
| <b>Category 9: INTENSIVE DAY TREATMENT PROGRAM COMPONENTS</b>  | <b>Criteria Met</b> |           |   |
| <b>EVALUATION CRITERIA</b>   | <b>YES</b>          | <b>NO</b> | <b>COMMENTS</b>   |
| 9) Is evidence presented and/or does the written description   |                     |           |   |



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| of the Intensive Day Treatment program include the following components:<br><br>A) Community meetings that:<br>1) Occur at least once a day?   |                     |           |   |
| 2) Includes a staff whose scope of practice includes psychotherapy?  |                     |           |   |
| 3) Address relevant items including, but not limited to, what the schedule for the day will be, any current event, individual issues clients or staff wish to discuss to elicit support of the group, conflict resolution within the milieu, planning for the day, the week, or for special events, old business from previous meetings or from previous day treatment experiences, and debriefing or wrap-up. |                     |           |   |
|  |                     |           |   |
| B) Therapeutic milieu that:<br>1) Meets minimum program hours per day requirement?   |                     |           | <u>NOTE</u> : Full-Day minimum is four plus hours per day and Half Day minimum are three hours per day.   |
| 2) Is continuous?  |                     |           | <u>NOTE</u> : Program must be continuous except for lunch and short breaks; but lunch and break time do not count in the program time.  |
| 3) Includes skill building groups, adjunctive therapies, and psychotherapy for average daily/weekly hour requirements for two hours/half-day and three hours/full-day program?   |                     |           | <u>NOTE</u> : Skill building groups help beneficiaries identify psychiatric and psychological barriers to attaining their objectives and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.<br><u>NOTE</u> : Adjunctive therapies utilize self-expression (art, recreation, dance, music, etc.) as the therapeutic intervention. |
| <b>Category 9: INTENSIVE DAY TREATMENT PROGRAM COMPONENTS</b>  | <b>Criteria Met</b> |           |   |
| <b>EVALUATION CRITERIA</b>   | <b>YES</b>          | <b>NO</b> | <b>COMMENTS</b>   |
| C) Protocol for responding to clients experiencing a mental health crisis?   |                     |           | <u>NOTE</u> : The protocol must assure the availability of appropriately trained and qualified staff. If beneficiaries will be referred to crisis   |

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|  |                     |           |  |
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|  |                     |           | services outside of the day treatment program, the provider must have the capacity to handle the crisis until the beneficiary is linked to outside crisis services.  |
|  |                     |           |  |
| D) A detailed written weekly schedule?   |                     |           | <p><u>NOTE</u>: The schedule must identify when and where the service components will be provided and by whom.</p> <p><u>NOTE</u>: The schedule must specify the program staff, their qualifications, and the scope of their responsibilities.</p>   |
|  |                     |           |  |
| E) How required staffing ratios of qualified staff are maintained?   |                     |           | <p><u>NOTE</u>: Staffing ratio is eight clients (M/C and non M/C) to one staff during the period the program is open.</p> <p><u>NOTE</u>: List of qualified staff is as follows: Physician, licensed/waivered psychologist, licensed/waivered/registered social worker, licensed/waivered/registered Marriage and Family Therapist, Registered Nurse, Licensed Vocational Nurse, Psychiatric Technician, Occupational Therapist, and Mental Health Rehabilitation Specialist.</p> <p><u>NOTE</u>: If over 12 clients, must have at least one person from each of two of the above groups of qualified staff.</p> <ul style="list-style-type: none"> <li>• Check staffing pattern.</li> <li>• Check the daily client census log.</li> </ul> |
|  |                     |           |  |
| F) Description of how at least one staff person will be present and available to the group in the therapeutic milieu for all scheduled hours of operation? |                     |           |  |
| <b>Category 9: INTENSIVE DAY TREATMENT PROGRAM COMPONENTS</b>  | <b>Criteria Met</b> |           |  |
| <b>EVALUATION CRITERIA</b>   | <b>YES</b>          | <b>NO</b> | <b>COMMENTS</b>  |

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| <p>G) If staff have other responsibilities (group home, school), documentation of the scope of responsibilities and the specific times in which day treatment activities are being performed exclusive of other activities?</p>  |                            |                  | <p><u>NOTE:</u> Persons who are not solely used to provide day treatment services may be utilized according to program need, but shall not be included as part of the ratio formula.</p> <ul style="list-style-type: none"> <li>• Check the provider's staffing pattern, duties and responsibilities of these staff, as well as hours of operation of the program.</li> </ul>  |
|  |                            |                  |  |
| <p>H) An expectation that the beneficiary will be present for all scheduled hours of operation for each day and that beneficiaries are present at least 50% of the scheduled hours of operation/day before Federal Financial Participation (FFP) will be claimed for that day?</p>   |                            |                  |  |
|  |                            |                  |  |
| <p>I) Description of how documentation standards will be met?</p>  |                            |                  | <p><u>NOTE:</u> Documentation standards are: Daily progress notes on activities and a weekly clinical summary reviewed and signed by a physician, licensed/ waived/registered psychologist, licensed/waivered/registered social worker, licensed/waivered/registered Marriage and Family Therapist, Registered Nurse, who is either staff to the day treatment program or the person directing the service.</p> <ul style="list-style-type: none"> <li>• Check beneficiary records as needed.</li> </ul> |
|  |                            |                  |  |
| <p>J) Description of at least one contact per month with a family member, caregiver, significant support person, or legally responsible adult?</p> <p><i>CCR, Title 9, Section 1810.213, Section 1840.318 (a)(b)(1)(2), and Section 1840.350(a)&amp;(c); DMH Contract, Exhibit A, Attachment 1, Section X, 1a-h, Attachment 1, Appendix C, and Appendix D, No. 11; DMH Letter No. 03-03.</i></p> |                            |                  | <p><u>NOTE:</u> Adult beneficiaries may choose to not have this service done for them.</p> <p><u>NOTE:</u> There is an expectation that this contact will occur outside the hours of operation and therapeutic milieu.</p> <p><u>NOTE:</u> The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration.</p>   |
|  |                            |                  |  |
| <p><b>Category 10: DAY REHABILITATION PROGRAM COMPONENTS</b></p>   | <p><b>Criteria Met</b></p> |                  |  |
| <p><b>EVALUATION CRITERIA</b></p>  | <p><b>YES</b></p>          | <p><b>NO</b></p> | <p><b>COMMENTS</b></p>   |
| <p>10) Is evidence presented and/or does the written description of the Day Rehabilitation Treatment program include the following</p>   |                            |                  |  |

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| components:<br>A) Community meetings that:<br>1) Occur at least once a day?<br>2) Includes a qualified staff?  |                     |           | NOTE: Qualified staff means a physician, licensed/waivered/registered psychologist, LCSW, MFT, RN, PT, LVN, or Mental Health Rehabilitation Specialist.   |
| 3) Includes skill building groups, adjunctive therapies, and psychotherapy for average daily/weekly hour requirements for two hours/half-day and three hours/full-day program?   |                     |           | NOTE: Skill building groups help beneficiaries identify psychiatric and psychological barriers to attaining their objectives and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.<br>NOTE: Adjunctive therapies utilize self-expression (art, recreation, dance, music, etc.) as the therapeutic intervention.   |
| 4) Address relevant items including, but not limited to, what the schedule for the day will be, any current event, individual issues clients or staff wish to discuss to elicit support of the group, conflict resolution within the milieu, planning for the day, the week, or for special events, old business from previous meetings or from previous day treatment experiences, and debriefing or wrap-up. |                     |           |   |
| B) Therapeutic milieu that:<br>1) Meets minimum program hours/day requirement?   |                     |           | NOTE: Full-Day minimum is four plus hours/day and Half Day minimum is three hours/day.  |
| 2) Is continuous?  |                     |           | NOTE: Program must be continuous except for lunch and short breaks; but lunch and break time do not count in the program time.  |
| 3) Includes skill building groups, adjunctive therapies, and process groups (or psychotherapy) for two hours/half-day and three hours/full-day program?  |                     |           | NOTE: Skill building groups help beneficiaries identify psychiatric and psychological barriers to attaining their objectives and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors.<br>NOTE: Adjunctive therapies utilize self-expression (art, recreation, dance, music, etc.) as the therapeutic intervention.<br>NOTE: Process groups help beneficiaries develop skills to deal with problems and issues by using the group process to provide peer interaction and feedback in resolving problems. |
| <b>Category 10: DAY REHABILITATION PROGRAM COMPONENTS</b>  | <b>Criteria Met</b> |           |   |
| <b>EVALUATION CRITERIA</b>   | <b>YES</b>          | <b>NO</b> | <b>COMMENTS</b>   |

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| A) Protocol for responding to clients experiencing a mental health crisis?   |                     |           | <p><u>NOTE:</u> The protocol must assure the availability of appropriately trained and qualified staff. If beneficiaries will be referred to crisis services outside of the day treatment program, the provider must have the capacity to handle the crisis until the beneficiary is linked to outside crisis services.</p>  |
|  |                     |           |  |
| B) A detailed written weekly schedule?   |                     |           | <p><u>NOTE:</u> The schedule must identify when and where the service components will be provided and by whom.</p> <p><u>NOTE:</u> The schedule must specify the program staff, their qualifications, and the scope of their responsibilities.</p>   |
|  |                     |           |  |
| C) How required staffing ratios of qualified staff are maintained?   |                     |           | <p><u>NOTE:</u> Staffing ratio is ten clients (M/C and non M/C) to one staff during the period the program is open.</p> <p><u>NOTE:</u> List of qualified staff is as follows: Physician, licensed/waivered psychologist, licensed/waivered/registered social worker, licensed/waivered/registered Marriage and Family Therapist, Registered Nurse, Licensed Vocational Nurse, Psychiatric Technician, Occupational Therapist, and Mental Health Rehabilitation Therapist.</p> <p><u>NOTE:</u> If over 12 clients, must have at least one person from each of two of the above groups of qualified staff</p> <ul style="list-style-type: none"> <li>• Check staffing pattern.</li> <li>• Check the daily client census log.</li> </ul> |
|  |                     |           |  |
| D) Description of how at least one staff person will be present and available to the group in the therapeutic milieu for all scheduled hours of operation? |                     |           |  |
|  |                     |           |  |
| <b>Category 10: DAY REHABILITATION PROGRAM COMPONENTS</b>  | <b>Criteria Met</b> |           |  |
| <b>EVALUATION CRITERIA</b>   | <b>YES</b>          | <b>NO</b> | <b>COMMENTS</b>  |

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| <p>E) If staff have other responsibilities (group home, school), documentation of the scope of responsibilities and the specific times in which day treatment activities are being performed exclusive of other activities?</p>  |  |  | <p><b>NOTE:</b> Persons who are not solely used to provide day treatment services may be utilized according to program need, but must not be included as part of the ratio formula.</p> <ul style="list-style-type: none"> <li>• Check the provider's staffing pattern, duties and responsibilities of these staff, as well as hours of operation of the program.</li> </ul>               |
|  |  |  |  |
| <p>F) An expectation that the beneficiary will be present for all scheduled hours of operation for each day and that beneficiaries are present at least 50% of the scheduled hours of operation/day before claiming FFP for that day?</p>  |  |  |  |
|  |  |  |  |
| <p>G) Description of how documentation standards will be met?</p>  |  |  | <ul style="list-style-type: none"> <li>• Check beneficiary records as needed.</li> </ul>   |
| <p>H) Description of at least one contact per month with a family member, caregiver, significant support person, or legally responsible adult?</p> <p><i>CCR, Title 9, Section 1810.213, Section 1840.318 (a)(b)(1)(2), and Section 1840.352(a)&amp;(c); DMH Contract, Exhibit A, Attachment 1, Section X, 1a-h, Attachment 1, Appendix C, and Appendix D, No. 11; DMH Letter No. 03-03.</i></p> |  |  | <p><b>NOTE:</b> Adult beneficiaries may choose to not have this service done for them.</p> <p><b>NOTE:</b> There is an expectation that this contact will occur outside the hours of operation and therapeutic milieu.</p> <p><b>NOTE:</b> The contacts and involvement should focus on the role of the significant support person in supporting the client's community reintegration.</p> |

**IF APPLICABLE, DATE PLAN OF CORRECTION REQUIRED:**

*(Plan of Correction required for each item where criteria not met. See Plan of Correction for details.)*

\_\_\_\_\_

**PROVIDER SITE RE/CERTIFICATION PROTOCOL**

**IF APPLICABLE, DATE PLAN OF CORRECTION APPROVED:** \_\_\_\_\_



- a) Date certification application received in regional Medi-Cal Oversight office \_\_\_\_\_
- b) Date of fire clearance \_\_\_\_\_
- c) Date provider was operational \_\_\_\_\_

**DATE RE/CERTIFICATION APPROVAL DATE:** *(Certification date is the latest date all of the following are in place: a) Date certification application received in regional Medi-Cal Oversight office, b) date of fire clearance, c) date provider was operational.)* \_\_\_\_\_



**COMMENTS:**

**REPORT COMPLETED BY:** \_\_\_\_\_

**DATE:** \_\_\_\_\_