# MEDI-CAL CERTIFICATION AND TRANSMITTAL

## PART A COUNTY INFORMATION

COUNTY SUBMITTING FORM: _____ PROVIDER #: _____ NPI#: _____

## PART B TYPE OF TRANSACTION *(Check all that apply)*

- ☐ Medi-Cal Activation — Activation date: _____
- ☐ Medi-Cal Termination — Termination date: _____
- ☐ Medi-Cal Recertification — Recertification date: _____
- ☐ Address Change — Effective date: _____
- ☐ Name Change — Effective date: _____
- ☐ New Provider
- ☐ All Services
- ☐ Mode/Service Function
- ☐ Mode/Service Function

Re-certification required. Complete parts A-G.
Please complete parts C and G only.

## PART C PROVIDER INFORMATION

Provider Name: _____

Address: _____ City: _____ Zip Code: _____

## PART D MEDI-CAL ACTIVATION DATE

**Per the MHP contract, the Medi-Cal activation date cannot be earlier than the latest of the following dates:**

1). Date the provider requested certification: _____ 2). Date the site was operational: _____

3). Date of the fire clearance **(must be within 1 year of the onsite review):** _____

4). Date of the onsite review **(The onsite review must be completed within 6 months of the activation date.):** _____

5). Is this an out-of-county certification or re-certification? ☐ Yes ☐ No

If the answer to question 5 is yes, enter the name of the host county that conducted the onsite review? _____

## PART E RESIDENTIAL SERVICES

☐ Adult Residential H0019 (05/65) ☐ Crisis Residential H0018 (05/40) ☐ Non-Hospital PHF H2013 (05/20)

Number of Beds **(maximum of 16)**: ☐

**Note: All residential certifications & recertifications require submission of the residential license and MUST be 16 beds or less.**

## PART F OUTPATIENT SERVICES

**Mode (Check ONLY one)** ☐ **(12) Hospital Outpatient** ☐ **(18) Non-Hospital Outpatient**

| | | | |
|---|---|---|---|
| ☐ Case Manage/Brokerage | T1017 (15/01) | ☐ Crisis Stabilization ER | S9484 (10/20) |
| - Intensive Care Coordination (ICC) | T1017 (15/07) | ☐ Crisis Stabilization UC | S9484 (10/25) |
| ☐ Mental Health Services | H2015 (15/30) | ☐ Day TX Intensive Half Day | H2012 (10/81) |
| - Intensive Home Based Services (IHBS) | H2015 (15/57) | Day TX Intensive Full Day | H2012 (10/85) |
| ☐ Therapeutic Behavioral Services (TBS) | H2019 (15/58) | ☐ Day Rehab. Half Day | H2012 (10/91) |
| ☐ Medication Support | H2010(15/60) | ☐ Day Rehab. Full Day | H2012 (10/95) |
| ☐ Crisis Intervention | H2011 (15/70) | | |

## PART G AUTHORIZED SIGNATURE (S)

*The above named provider is certified by this agency to participate in the Short-Doyle/Medi-Cal program. I attest that the above named provider site complies with requirements of the CCR, Title 9, Sections 1810.435-436 and the terms of the contract between the MHP and the Department.*

_____ County Email: _____
Print name of person completing form

_____ Phone: _____ Date: _____
Authorized Signature Signed by: ☐ County Mental Health Director or Designee ☐ DHCS Compliance Section

**E-MAIL OR FAX signed and completed form to: EMAIL: *DMHCertification@dhcs.ca.gov* or by FAX: (916) 440-5497**

## PART H DHCS COMPLIANCE SECTION APPROVAL TO TRANSMIT DATA TO DHCS

DHCS Compliance Section: _____ Date: _____