MHP RE-CERTIFICATION of COUNTY-OWNED AND OPERATED PROVIDERS SELF SURVEY FORM

Please provide the following information:

COUNTY SUBMITTING FORM:_____COUNTY CODE:_____NPI #_____

PROVIDER NUMBER:_____PROVIDER NAME:_____

PROVIDER ADDRESS:_____

PROVIDER CITY:_____PROVIDER ZIP CODE:_____

SERVICES PROVIDED: (Please check all that apply): Name Change ☐ Activating Mode ☐

☐ **15/01** T1017 Case Management/Brokerage • Intensive Care Coordination (ICC) T1017 (15/07)	☐ **15/30** H2015 Mental Health Services • Intensive Home Based Services (IHBS) H2015 (15/57)	☐ **15/58** H2019 Therapeutic Behavioral Services	☐ **15/60** H2010 Medication Support ☐ **15/70** H2011 Crisis Intervention	☐ **05/20** H2013 Non-Hospital PHF ☐ **05/40** H0018 Crisis Residential ☐ **05/65** H0019 Adult Residential	Note: All residential certifications & recertifications require submission of the residential license and be 16 beds or less.

EVALUATION CRITERIA

		Yes	No	N/A
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:			
	A) The beneficiary brochure per MHP procedures? *MHP Contract, Exhibit A, Attachment I, § 7A; CCR, Title 9, § 1810.360 (b)(3),(d) and (e)* *CCR, Title 9, § 1810.410 (e)(4)*	☐	☐	☐
	B) The provider list per MHP procedures? *MHP Contract, Exhibit A, Attachment I, § 7A; CCR, Title 9, § 1810.360 (b)(3),(d)and (e)* *CCR, Title 9, § 1810.410 (e)(4)*	☐	☐	☐
	C) The posted notice explaining grievance, appeal, and fair hearings processes? *MHP Contract, Exhibit A, Attachment I, § 15A(3)(a)(ii), CCR, Title 9, § 1850.205 (c)(1)(B)* *CCR, Title 9, § 1810.410 (e)(4)*	☐	☐	☐
	D) The grievance forms, appeal forms, and self-addressed envelopes? *MHP Contract, Exhibit A, Attachment I, § 15A(3)(a)(iii), CCR, Title 9, §1850.205 (c)(1)(C);CCR, Title 9, §1810.410 (e)(4)*	☐	☐	☐
2.	Does the space owned, leased or operated by the provider and used for services or staff meet local fire codes? ***(A copy of the most recent fire safety inspection notice from the local fire authority must be submitted with this form)*** *MHP Contract, Exhibit A, Attachment I, §4L(2); CCR, Title 9, § 1810.435 (b)(2)*	☐	☐	☐
3.	Is the facility and its property clean, sanitary, and in good repair? *MHP Contract, Exhibit A, Attachment I, §4L(3); CCR, Title 9, § 1810.435 (b) (2)*	☐	☐	☐
4.	Does the provider have the following policies and procedures: A) Protected Health Information? *MHP Contract, Exhibit F, CCR, Title 9, §1810.310 (a)(10) CCR, Title 9, §1810.435 (b)(4)*	☐	☐	☐
	B) Personnel policies and procedures? *MHP Contract, Exhibit A, Attachment I, §4L(5), CCR, Title 9, §1840.314*	☐	☐	☐
	C) General operating procedures? *MHP Contract, Exhibit A, Attachment I, §4L(5), CCR, Title 9, § 533*	☐	☐	☐
	D) Maintenance policy to ensure the safety and well being of beneficiaries and staff? *MHP Contract, Exhibit A, Attachment I, §4L(4), CCR, Title 9, § 1810.435(b)(2)*	☐	☐	☐
	E) Service Delivery Policies? *MHP Contract, Exhibit A, Attachment I, §4L(5), CCR, Title 9, § 1810.209-210 § 1810.212 213 § 1810.225, 1810.227 and 1810.249*	☐	☐	☐
	F) Unusual occurrence reporting (UOR) procedures relating to health and safety issues? *MHP Contract, Exhibit A, Attachment I, §4L(5)*	☐	☐	☐
	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? *MHP Contract, Exhibit A, Attachment I, § 4L(8)*	☐	☐	☐

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		Yes	No	N/A
5.	Does the provider have as head of service a licensed mental health professional or other appropriate individual as described in CCR, Title 9, § 622 through 630? *CCR, Title 9, § 680 (a); CCR, Title 9, § 1810.435 (c)(3); CCR, Title 9, §§ 622 through 630; MHP Contract, Exhibit A, Attachment I, § 4L(9)* ***(A copy of HOS license must be submitted with this form.)***	☐	☐	☐
6.	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: ***(For providers of "Prescription Only" Med Support (15/60), please check N/A for questions 6A-G)***			
	A) All drugs obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are alterted only by persons legally authorized to do so. *MHP Contract, Exhibit A, Attachment I, § 4L(10)(a)*	☐	☐	☐
	B) Drugs intended for external use only and food stuffs are stored separately from drugs intended for internal use. *MHP Contract, Exhibit A, Attachment I, § 4L(10)(b)*	☐	☐	☐
	C) All drugs are stored at proper temperatures: room temperature drugs at 59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit. *MHP Contract, Exhibit A, Attachment I, § 4L(10)(c); CCR, Title 9, § 1810.435(b) (3)*	☐	☐	☐
	D) Drugs are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication. *MHP Contract, Exhibit A, Attachment I, § 4L(10)(d); CCR, Title 9, § 1810.435 (b) (3)*	☐	☐	☐
	E) Drugs are not retained after the expiration date. Intramuscular multi-dose vials are dated and initialed when opened. *MHP Contract, Exhibit A, Attachment I, § 4L(10)(e); CCR, Title 22, § 73369*	☐	☐	☐
	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? Is there a dispensing log used to record the date, name of the beneficiary, name of drug, amount of drug, lot number, route of administration, and identifying information regarding the bottle, vial, etc from which the medication was obtained for all medications which are dispensed from house supply? *MHP Contract, Exhibit A, Attachment I, § 4L(10)(f)*	☐	☐	☐
	G) Policies and procedures are in place for dispensing, administering and storing medications. MHP Contract, Exhibit A, Attachment I, *§ 4L(10)(g)*	☐	☐	☐

A) Date of Fire Clearance: _____ B) Recertification Date: _____

C) For Activating Modes of Services: Date site was operational: _____ Activation Date: _____

_____ _____ _____
Print Name & Title of Person Completing Form | Signature of Person Completing Form | Date

I hearby certify under penalty of perjury that to the best of my knowledge, information and belief, the above list of items are in compliance with Federal and State requirements and are available and accessible to the Department of Health Care Services upon request. I am aware that the above items may be requested at any time, including during an onsite review. I am also aware that a new DHCS Recertification form shall be completed and submitted to the DHCS on a triennial basis.

_____ _____ _____
Print Name of MH Director/Designee | Signature of MH Director/Designee | Date

FAX, PDF, or MAIL completed form and required documentation (Items 2 & 5) prior to triennial provider recertifcation date to:

FAX: (916) 440-5497
EMAIL: DMHCertification@dhcs.ca.gov

MAIL:

State of California
Department of Health Care Services
Mental Health Services Division
Program Oversight and Compliance Branch
P.O. Box 997413, MS 2703
Sacramento, CA 95899-7413

| For DHCS Use Only: |
| Rec'd By:_____ |
| Date: _____ |
| Approved By:_____ |
| Date: _____ |

If you need additional information, please call (916) 319-0985 and ask for Certifications or email **DMHCertification@dhcs.ca.gov**
DHCS MHSD Certifications Internet Address (http://www.dhcs.ca.gov/services/MH/Pages/Certifications.aspx)