

**MHP RE-CERTIFICATION of COUNTY- OWNED & OPERATED PROVIDERS SURVEY FORM**

Please provide the following information:

COUNTY SUBMITTING FORM: \_\_\_\_\_ COUNTY CODE:

PROVIDER NUMBER:    PROVIDER NAME: \_\_\_\_\_

PROVIDER ADDRESS: \_\_\_\_\_

PROVIDER CITY: \_\_\_\_\_ PROVIDER ZIP CODE: \_\_\_\_\_

**SERVICES PROVIDED:** (Please check all that apply):

<input type="checkbox"/> <b>05/20</b> H2013 Non-Hospital PHF	<input type="checkbox"/> <b>05/40</b> H0018 Crisis Residential	<input type="checkbox"/> <b>05/65</b> H0019 Adult Residential		
<input type="checkbox"/> <b>10/20</b> S9484 Crisis Stabilization: Emer Room	<input type="checkbox"/> <b>10/81</b> H2012 Day Tx Int: 1/2 Day	<input type="checkbox"/> <b>10/91</b> H2012 Day Rehab: 1/2 Day		
<input type="checkbox"/> <b>10/25</b> S9484 Crisis Stabilization: Urgent Care	<input type="checkbox"/> <b>10/85</b> H2012 Day Tx Int: Full Day	<input type="checkbox"/> <b>10/95</b> H2012 Day Rehab Full Day		
<input type="checkbox"/> <b>15/01</b> T1017 Case Mgmt/Brokerage	<input type="checkbox"/> <b>15/30</b> H2015 MH Services	<input type="checkbox"/> <b>15/58</b> H2019 TBS	<input type="checkbox"/> <b>15/60</b> H2010 Medication Support	<input type="checkbox"/> <b>15/70</b> H2011 Crisis Intervention

**EVALUATION CRITERIA**

		Yes	No	N/A
<b>1</b>	Regarding written information in English and the threshold languages to assist beneficiaries in accessing specialty mental health services, at a minimum, is the following information available:			
	A. The beneficiary booklet? <i>MHP Contract Exhibit A, Att. 1, Sec. V; CCR Title 9, Sec. 1810.360(3), (d)</i>			
	B. The provider list? <i>MHP Contract Exhibit A, Att. 1, Sec. V; CCR Title 9, Sec. 1810.360(3), (d)</i>			
	C. Posted notices explaining grievance, appeals and fair hearing processes? <i>MHP Contract Exhibit A, Att. 1, Sec. V; CCR Title 9, Sec. 1850.205 (B)</i>			
	D. Making forms that may be used to file grievances, appeals, and expedited appeals, and self addressed envelopes available for beneficiaries to pick up at all MHP sites without having to make a verbal or written request to anyone? <i>MHP Contract Exhibit A, Att. 1, Sec. V; CCR Title 9, Sec. 1850.205 (C)</i>			
<b>2</b>	Do you have a fire safety inspection that meets local fire codes? <b>(A copy of the most recent fire safety inspection notice from the local fire authority must be submitted with this form)</b> <i>MHP Contract Exhibit A, Att. 1, App. D, Item 2</i>			
<b>3</b>	Is the facility and its property clean, sanitary and in good repair? <i>MHP Contract Exhibit A, Att. 1, App. D, Item 3</i>			
<b>4</b>	Do you have the following written policies and procedures in place?	Yes	No	N/A
	<b>A. Protected Health Information/HIPAA</b> <i>MHP Contract, Exhibit D, Sec. F; MHP Contract, Exhibit E, Sec. E; W&amp;I Sec.14100.2; Title 42 Code of Federal Regulations Sec. 431.300</i>			
	<b>B. Personnel policies and procedures</b> <i>MHP Contract Exhibit A, Att. 1, App. D, Item 5, MHP Contract Exhibit D, Item 6</i>			
	<b>C. General operating procedures</b> <i>MHP Contract Exhibit A, Att. 1, App. D, Item 5</i>			
	<b>D. Maintenance policy</b> <i>MHP Contract Exhibit A, Att. 1, App. D, Item 4</i>			
	<b>E. Service delivery policies</b> <i>MHP Contract Exhibit A, Att. 1, App. D, Item 5</i>			
	<b>F. Unusual occurrence reporting procedures</b> <i>MHP Contract Exhibit A, Att. 1, App. D, Item 5</i>			
<b>G. Referral of individuals to a psychiatrist when necessary, or to a physician who is not a psychiatrist, if a psychiatrist is not available</b> <i>MHP Contract Exhibit A, Att. 1, App. D, Item 8</i>				

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5	Does Head of Service (HOS) meet CCR, Title 9, Sec 622-630 requirements? <i>MHP Contract Exhibit A, Att. 1, App. D, Item 9 (A copy of HOS license must be submitted with this form).</i>			
6	Do the providers that provide or store medications, store and dispense medications in compliance with all pertinent state and federal standards? <i>(For providers of "Prescription Only" Med Support (15/60), please answer questions 6A-G "N/A")</i>	Yes	No	N/A
	A. All drugs obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so.			
	B. Drugs intended for external-use-only or food stuffs are stored separately from drugs for internal use.			
	C. All drugs are stored at proper temperatures: 1. Room-temperature drugs in the range of 59 to 86 degrees Fahrenheit.			
	2. Refrigerated drugs in the range of 36 to 46 degrees Fahrenheit.			
	D. Drugs are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication.			
	E. Drugs are not retained after their expiration date. IM multi-dose vials are dated and initialed when opened.			
	F. A drug log is maintained to ensure the provider disposes of expired, contaminated, deteriorated and abandoned drugs in a manner consistent with state and federal laws.			
	G. Policies and procedures are in place for dispensing, administering and storing medications. <i>MHP Contract Exhibit A, Att. 1, App. D, Item 10A-G</i>			

**A) Date of Fire Clearance:** \_\_\_\_\_

**B) Re-certification Date:** \_\_\_\_\_

\_\_\_\_\_  
Print Name & Title of Person Completing Form

\_\_\_\_\_  
Signature of Person Completing Form

\_\_\_\_\_  
Date

*I hereby 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 Mental Health 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 MHP Re-certification form shall be completed and submitted to the DMH on a triennial basis.*

\_\_\_\_\_  
Print Name of MH Director/Designee

\_\_\_\_\_  
Signature of MH Director/Designee

\_\_\_\_\_  
Date

- FAX** completed form and required documentation (Items 2 & 5) prior to triennial provider re-certification date to:
- MAIL** completed original form (and required documentation) prior to triennial provider re-certification date to:

**Fax) 916-651-3921**

**Dept of Mental Health  
Medi-Cal Oversight-North  
Attn: Certifications  
1600 9<sup>th</sup> Street, Rm. 410  
Sacramento CA 95814**

**For DMH Use Only**

Rec'd By: \_\_\_\_\_

Date: \_\_\_\_\_

Approved By: \_\_\_\_\_

Date: \_\_\_\_\_

If you need additional information, please call (916) 651-3838 and ask for "Certifications"