DIRECTOR'S DESIGNEE FORM INSTRUCTIONS

County Mental Health Directors: The "Director's Designee Form," is to be completed by the Director's Designee (if applicable) and signed by the Mental Health Plan's (MHP) Director.

The form designates who is approved by the MHP Director to sign the **Medi-Cal Certification and Transmittal Form (DHCS 1735), the County-Owned and Operated Provider Certification Application (DHCS 1736), and/or the County-Owned and Operated Provider Self-Survey Form (DHCS 1737).**

The MHP Director or their Designee's signature is required on the above-mentioned forms to attest that the information provided to Department of Health Care Services (DHCS) is accurate and complete and the provider complies with all State and Federal contract requirements.

The DHCS Certification Unit will retain this form and will not accept anyone's signature other than the Director, the Director's Designee, or the Directors Designee's backup to sign the above-mentioned forms.

Thank you,

Certification Unit

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

If you need additional information, please call (916) 319-0985 and ask for the Certification Unit or email DMHCertification@dhcs.ca.gov

Director's Designee Information

I, _____ ,

Director of _____ Mental Health Plan,
(County)

Designate(s) the following individuals:

Designee Name: _____ Title: _____

Phone Number: _____ Email Address: _____

and/or

Designee Backup Name: _____ Title: _____

Phone Number: _____ Email Address: _____

to sign/approve the following Department of Health Care Services (DHCS) forms for _____ Mental Health Plan, effective _____:
(County)

Medi-Cal Certification and Transmittal (DHCS 1735)

County-Owned and Operated Provider Certification Application (DHCS 1736)

Re-Certification of MHPCounty-Owned and Operated Provider Self-Survey Form (DHCS 1737)

Note: The MHP must notify the Department when the Director's Designees change or if the contact information changes. Return this form to DMHCertification@dhcs.ca.gov or fax to (916) 440-5497.

_____ _____
Signature of Mental Health Director Date