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: _____ ☐ New Provider ☐ Mode/Service Function

☐ Medi-Cal Termination Termination date: _____ ☐ All Services ☐ Mode/Service Function

☐ Medi-Cal Recertification Recertification date: _____

☐ Address Change Effective date:_____ Re-certification required. Complete parts A-G.

☐ Name Change Effective date:_____ 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: _____