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| IDENTIFYING  INFORMATION: | **Name of Provider:** Click here to enter text.  STRTP | | |
| Provider #: Click here to enter text. | NPI #: Click here to enter text. | |
|  | Street Address: Click here to enter text.  City: Click here to enter text.  State: Click here to enter text. Zip Code (9 digits): Click here to enter text. | | |
| Telephone #: Click here to enter text. | | County: Click here to enter text. |
| LEGAL ENTITY INFORMATION: | **Name of Legal Entity:** Click here to enter text.  **Legal Entity #:**Click here to enter text. | | |
| Street Address: Click here to enter text.  City: Click here to enter text.  State: Click here to enter text. Zip Code (9 digits): Click here to enter text. | | |
| ORGANIZATION INFORMATION: | **Type of Organization:**  Non-profit Corporation  Partnership or Corporation | | |
| HEAD OF SERVICE INFORMATION: | **Name:** Click here to enter text. | | |
| HEAD OF SERVICE (HOS) INFORMATION: | **Head of Service (HOS) qualification(s):**  Psychiatrist  Licensed Clinical Social Worker  Psychiatric Technician  Psychologist  Licensed Prof. Clinical Counselor  Marriage Family Therapist  Registered Nurse  MH Rehab Specialist (include resume)  Licensed Vocational Nurse | | |
| MODE  (Check only one) | Hospital Outpatient (Mode 12)  Non-Hospital Outpatient (Mode 18) | | |
| SHORT DOYLE/MEDI-CAL SERVICE MODES TO BE PROVIDED: | Case Manage/Brokerage T1017 (15/01) -Intensive Care Coordination (ICC) T107 (15/07)  Mental Health Services H2015 (15/30) -Intensive Home Based Services (IHBS) H2015 (15/57)  Therapeutic Behavioral Services H2019 (15/58)  Medication Support H2010 (15/60)  Crisis Intervention H2011 (15/70)  Crisis Residential H0018 (05/40) | | |
| LICENSING INFORMATION: | Is the provider currently licensed by a state agency? Yes No  If yes, enter agency name Click here to enter text.  DHCS DSS | | |
| FIRE SAFETY: | Attached is documentation of the most recent fire safety inspection.  (Date of Fire Clearance must be within 1 year of site visit)  All services are provided at a public school site and meet school fire safety rules and regulations. | | |

*I certify that this application is true, correct, and complete. I agree that if approval is granted that all services rendered by the Rehabilitative Mental Health Program shall be in conformity with federal, state, and local laws. I further understand that a violation of such laws will constitute grounds for withdrawal of certification. This information may be released to any persons or organizations outside the official administrative channels.*

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Local Entity Authorized Signature of Contract Provider Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Agency Director or Designee Signature Date

**PART II: SHORT-DOYLE/MEDI-CAL CONTRACT PROVIDER AGREEMENT CLAIM CERTIFICATION**

**CERTIFICATION STATEMENT**

The Provider agrees and shall certify under penalty of perjury that all claims for services provided to county mental health clients have been provided to the clients by the Provider. The services were, to the best of the Provider's knowledge, provided in accordance with the client's written treatment plan. The Provider shall also certify that all information submitted to the Orange County Health Care Agency is accurate and complete. The Provider understands that payment of these claims will be from federal and /or state funds, and any falsification or concealment of a material fact may be persecuted under federal and/or state laws. The Provider agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the content of services furnished to the client. The Provider agrees to furnish these records and the information regarding payments claimed for providing the services, on request, within the State of California, to the Orange County Health Care Agency, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives. The Provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

*I certify that the undersigned will be a licensed or certified provider of Short-Doyle/Medi-Cal services upon submission of this agreement to the Department of Health Care Services and satisfaction of the requirements pursuant to Title 9, California Code of Regulations, and compliance with the requirements for providers of service set out in Welfare and Institutions Code, Division 9, Part 3, and California Code of Regulations, Title 22.*

*Date:*

*Local Entity Authorized Signature of Contract Provider*

*Health Care Agency Director or Designee Signature*

*Date*

*Date:*

*Local Entity Authorized Signature of Contract Provider*

*Health Care Agency Director or Designee Signature*

*Date::*

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*Local Entity Authorized Signature of Contract Provider Date*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Health Care Agency Director or Designee Signature Date*

**PART III MEDI-CAL CONTRACT PROVIDER DATA FORM**

|  |
| --- |
| **1. Pay to Address Telephone #:** Click here to enter text. |
| **Street Address:** Click here to enter text. |
| **City:** Click here to enter text. **County:** Click here to enter text.  **State:** Click here to enter text. **Zip code:** Click here to enter text. |
|  |
| **2. List previous Medi-Cal provider numbers that the owner(s) have been issued (use additional sheet of paper if needed).**  Click here to enter text.Click here to enter text.Click here to enter text.Click here to enter text. |
| **3. Is this a teaching facility for residents and/or interns who are salaried by a hospital?  Yes  No** |

***I certify that the above information is true, accurate, and complete to the best of my knowledge.***

|  |  |
| --- | --- |
| Click here to enter text.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Applicant’s Typed or Printed Name | Click here to enter text.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  5. Applicant’s Typed or Printed Title |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  6. Applicant’s Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  7. Date |

**MEDI-CAL CONTRACT PROVIDER DISCLOSURE STATEMENT OF SIGNIFICANT BENEFICIAL INTERESTS**

Name: Click here to enter text. Type of Provider: Short Doyle/Medi-Cal

Address: Click here to enter text. Medi-Cal Provider Number: Click here to enter text.

NPI #: Click here to enter text.

Tax ID #: Click here to enter text.

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| --- | --- | --- | --- | --- | --- | --- |
|  | **Type of Provider** | **Address** | **Name of Relative(s) Who Holds The Interest** | **Relation** | **Type of Interest** | **Percentage and/or Dollar Amount of the Interest** |
| **1. Name of Provider in Which interest is Held:**  Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Date of Birth:**  Click here to enter text. |
| **Social Security # for individual only with ≥ 5% interest in company:**  Click here to enter text. |
| **2. Name of Provider in Which interest is Held:**  Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Date of Birth:**  Click here to enter text. |
| **Social Security # for individual only with ≥ 5% interest in company:**  Click here to enter text. |
| **3. Name of Provider in Which interest is Held:**  Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Date of Birth:**  Click here to enter text. |
| **Social Security # for individual only with ≥ 5% interest in company:**  Click here to enter text. |

**MEDI-CAL CONTRACT PROVIDER DISCLOSURE STATEMENT OF SIGNIFICANT BENEFICIAL INTERESTS -cont**

|  |  |  |  |
| --- | --- | --- | --- |
| **Other Tax ID #’s for Corporations with ≥ 5% Control** | Click here to enter text. | Click here to enter text. | Click here to enter text. |

*I hereby certify under penalty of perjury that all the above statements are true and correct to the best of my knowledge.*

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Local Entity Authorized Signature of Contract Provider Date

**INSTRUCTIONS**

Section 14022 of the Welfare and Institutions Code provides that no payment shall be made to a Medi-Cal provider or to any facility or organization in which he or his immediate family has a “significant beneficial interest” unless the provider has a statement on file disclosing his or the interest his immediate family has in other Medi-Cal providers to which they refer beneficiaries. The applicable section under Medi-Cal program regulations is Section 51466, Article 6, Chapter 3, subdivision 1 of Division 3 of Title 22 of the California Administrative Code. This regulation is shown below.

1. Every provider must complete this form.

2. Disclosure must be made for each member of the provider's immediate family - spouse, parents, spouse's parents, children, and spouses of children. 3. “Significant beneficial interest” means any financial interest that represents either five percent of the total interest or a value of $25,000 irrespective

of the percentage ownership. How different types of interests are to be valued can be determined by referring to Section 51466.

4. If a provider has no “significant beneficial interest” in other providers, to which Medi-Cal recipients are referred, place “no interests” on the first line

and sign the statement.

**51466. Disclosure of Significant Beneficial Interest**

|  |  |
| --- | --- |
| (a) A provider shall not bill or submit a claim for service involving the  referral of a beneficiary to or from another provider unless each  provider has disclosed any significant beneficial interest existing  between the providers. Disclosures shall be accomplished by  completing and submitting a Medi-Cal Personal Disclosure  Statement of Significant Beneficial Interest form as provided by the  Department.  (b) A provider that fails to comply with (a) or that submits a false or  incorrect disclosure shall be subject to a suspension from  participation or payment under the Medi-Cal program.  **(c) For the purpose of this section:**  (1) “Significant beneficial interest” means any financial interest  held by a provider, or a member of the provider's immediate  family, in another provider that is equal to or greater than the  lesser of the following:  (A) Five percent of the whole.  (B) $25,000.00.  (2) “Immediate family” means spouse, son, daughter, father,  mother, father-in-law, mother-in-law, son-in-law, or daughter-  In-law.  (d) Interests held by a provider and members of that provider's immediate family shall be combined and valued as a single interest.  **(1) The extent of financial interest shall be determined as follows:**  (A) Full ownership shall be considered as 100 percent financial  interest and control regardless of mortgages or other  encumbrances. | (B) Interest in a partnership shall be determined on the basis of the percentage of ownership specified in either a written or verbal partnership agreement.  (C) Interest in a corporation shall be determined by computing the percentage of stock or bonds owned or the total outstanding shares or bonds of the corporation as of the last working day of the month preceding compliance with (a).  (D) All other financial arrangements shall require establishment of a fair and reasonable dollar value for both the interest and the whole. The percentage interest shall be computed as the percentage the dollar value of the interest represents of the whole.  (2) The dollar value of the following types of interests shall be  determined as follows:  (A) Bonds, over-the-counter stocks and stocks listed on the major  stock exchanges shall be valued at the closing selling price on the  last working day of the month preceding compliance with (a).  (B) Stocks in a closely held corporation shall be valued at the original  purchase price, par value, or current market value, whichever is  greater.  (C) Partnership interests shall be valued at the total dollar amount  invested in organizing the partnership. A fair and reasonable dollar  equivalent shall be determined if investment is not in form of  monies.  (D) All other financial arrangements shall be valued at the actual dollar  investment or a fair and reasonable dollar equivalent for  investments not in the form of monies. |

**RETURN ALL ORIGINAL SIGNED & COMPLETED PAGES TO:**

**FOR AQIS USE ONLY**

Rec’d by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Approved by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

BlancaRosa Craig, LMFT, AMII

Authority Quality & Improvement Services

Health Care Agency, Behavioral Health Services

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