COUNTY-OWNED AND OPERATED PROVIDER CERTIFICATION APPLICATION

PART I: PROVIDER INFORMATION

Instructions: The Local Mental Health Director or designee must submit a separate application for each provider.

IDENTIFYING INFORMATION:	**Name of Provider:**
	Provider No.: NPI No.:
	Street Address: City: State: CA Zip Code:
	Telephone No.: County: Orange
LEGAL ENTITY INFORMATION:	**Name of Legal Entity:** County of Orange
	Street Address: 405 West 5th Street Suite 776 City: Santa Ana State: CA Zip Code:
ORGANIZATION INFORMATION:	**Type of Organization:** ☑ County Government ☐ City Government
HEAD OF SERVICE (HOS) INFORMATION:	**Name:**
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:	☐ Crisis Stabilization ER S9484 (10/20) ☐ Crisis Stabilization UC S9484 (10/25) ☐ Day TX Intensive Half Day H2012 (10/81) ☐ Day TX Intensive Full Day H2012 (10/85) ☐ Day Rehab. Half Day H2012 (10/91) ☐ Day Rehab. Full Day H2012 (10/95) ☐ Case Manage/Brokerage T1017 (15/01) ☐ Therapeutic Behavioral Svcs H2019 (15/58) - Intensive Care Coordination (ICC) T1017 (15/07) ☐ Medication Support H2010 (15/60) ☐ Mental Health Services H2015 (15/30) ☐ Crisis Intervention H2011 (15/70) - Intensive Home Based Services (IHBS) H2015 (15/57)
LICENSING INFORMATION:	Is the provider currently licensed by a state agency? ☐ Yes ☑ No If yes, enter agency below. ☐ DHCS ☐ DSS ☐ Other: _____
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.

_____
Local Entity Authorized Signature *Date:*

_____
Local Mental Health Director or Designee Signature *Date:*

PART II: SHORT-DOYLE/MEDI-CAL PROGRAM 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 Department of Health Care Services 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 prosecuted 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 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.

THE PROVIDER AGREES TO INCLUDE WITH EACH CLAIM SUBMITTED TO THE DEPARTMENT OF HEALTH CARE SERVICES A CERTIFICATION STATEMENT TO THE ABOVE TERMS AND CONDITIONS WHICH SHALL BE PRINTED ON THE REVERSE SIDE OF EACH PROVIDER CLAIM FORM.

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.

(original signed by)
Program Oversight and Compliance Branch, MHSD, DHCS *Date:*

Signature of Provider *Date:*

PART III: MEDI-CAL PROVIDER DATA FORM

1. Pay to Address

405 Number	W 5th Street Suite 776 Street		714-568-5614 Telephone Number
Santa Ana City	Orange County	CA State	92701-4599 Zip Code

2. List previous Medi-Cal provider numbers that the owner(s) have been issued (use additional sheet of paper if needed).

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.

4. Applicant's Typed or Printed Name	5. Applicant's Typed or Printed Title
6. Applicant's Signature	7. Date

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

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

FOR DHCS USE ONLY
Rec'd By:_____
Date:_____
Approved By:_____
Date:_____