NEW SHORT-DOYLE/MEDI-CAL PROVIDER CERTIFICATION APPLICATION

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

IDENTIFYING INFORMATION	Name of Provider: (limit to 27 characters)	Provider No.: NPI No.:
	Street Address, City, State, and Zip	
	Telephone No.	County
NAME AND ADDRESS OF LEGAL ENTITY		
HEAD OF SERVICE NAME:	Head of Service is: ☐ Psychiatrist ☐ Registered Nurse ☐ Psychologist ☐ Psychiatric Technician ☐ Licensed Clinical Social Worker ☐ Licensed Vocational Nurse ☐ Marriage Family Therapist ☐ MH Rehab Specialist	
SHORT DOYLE/MEDI-CAL SERVICE MODES TO BE PROVIDED	☐ SD/MC Mode 05 ☐ Crisis Residential H0018 (05/40) ☐ Adult Residential H0019 (05/65) ☐ SD/MC Mode 18 ☐ 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) ☐ Mental Health Services H2015 (10/30) ☐ Therapeutic Behav Svcs H2019 (15/58) ☐ Medication Support H2010 (15/60) ☐ Crisis Intervention H2011 (15/70)	
IS THE PROVIDER CURRENTLY LICENSED BY A STATE AGENCY?	☐ Yes If yes, which agency? ☐ No	☐ DMH ☐ DHS ☐ DSS ☐ Drug & Alcohol ☐ Other
FIRE SAFETY	☐ Attached is documentation of the most recent fire safety inspection. ☐ 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:

SHORT-DOYLE/MEDI-CAL PROGRAM PROVIDER AGREEMENT
CLAIM CERTIFICATION

Name of Provider (*Please type or print*)

NPI #:

Address

Telephone | Provider Number | County Name

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 Mental Health 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 Mental Health; 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 MENTAL HEALTH 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 Mental Health 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)
CAROLYNN MICHAELS, MBA
Deputy Director, Program Compliance
Department of Mental Health

Signature of Provider | Date

State of California - Health and Welfare Agency Department of Mental Health MEDI-CAL PROVIDER DATA FORM

1. Facility Name	4. NPI No.	5. Fiscal Year End Month

2. Facility Address Number Street Telephone Number	6A. Type of Organization (Check one)
City County State Zip Code	☐ State Government ☐ Nongovernmental Non Profit ☐ County Government ☐ Nongovernmental for Profit ☐ City Government ☐ Other (specify)
3. Pay to Address (If different) Number Street Telephone Number	6B. Type of Ownership (Check one)
City County State Zip Code	☐ Individual ☐ Corporation ☐ Partnership ☐ Other (specify)

7. List facility owner(s). List owner(s) professional license numbers, if applicable. (For corporations, list corporate name only.)
(Attach a separate sheet of paper if more space is needed.)

Name	Professional State License Number	Name	Professional State License Number

8. In addition to this facility, please indicate other facilities or practices that the owner(s) may have.
(Attach a separate sheet of paper if more space is needed.)

Address (Actual Facility or Practice Location)	Name Used For Billing From This Location	Provider Number Assigned To This Location

9. List previous Medi-Cal provider numbers that the owner(s) have been issued.

10. 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.

11. Applicant's Typed or Printed Name	12. Applicant's Typed or Printed Title
13. Applicant's Signature	14. Date

State of California - Health and Welfare Agency Department of Mental Health

MEDI-CAL PROVIDER DISCLOSURE STATEMENT OF SIGNIFICANT BENEFICIAL INTERESTS

Name: Type of Provider: Address:

Medi-Cal Provider Number: NPI No.:

Name of Provider in Which Interest is Held	Type of Provider	Address	Name of Relative(s) Who Holds The Interest	Relation	Type of Interest	Percentage and/or Dollar Amount of the Interest

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

Signature Date

RETURN TO: **Quality Management**
225 37th Ave. Room 320
San Mateo, CA 94403

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.