|  |  |
| --- | --- |
| IDENTIFYINGINFORMATION: | **Name of Provider:** Click here to enter text. |
| 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 of Head of Service (HOS):** 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 |
| RESIDENTIAL SERVICE MODES: | [ ]  Non-Hospital PHF (05/20)[ ]  Crisis Residential (05/40)[ ]  Adult Residential (05/65) [ ]  Therapeutic Foster Care (05/95)[ ]  Short-Term Residential Therapeutic Program (STRTP)  |
| MODE (Check only one) | [ ]  Hospital Outpatient (Mode 12) [ ]  Non-Hospital Outpatient (Mode 18)[ ]  No Outpatient Modes |
| OUTPATIENT SERVICE MODES: | [ ]  Crisis Stabilization E R (10/20) [ ]  Crisis Stabilization U C (10/25)[ ]  Day Tx Intensive Half Day (10/81)[ ]  Day Tx Intensive Full Day (10/85)[ ]  Day Rehab. Half Day (10/91)[ ]  Day Rehab. Full Day (10/95)[ ]  Case Management/Brokerage (15/01)[ ]  Child Family Team (15/06)[ ]  Intensive Care Coordination (ICC) (15/07)[ ]  Peer Support Services (15/20)[ ]  Mental Health Services (15/30)[ ]  Child Family Team (15/56)[ ]  Intensive Home Based Services (IHBS) (15/57)[ ]  Therapeutic Behavioral Services (15/58)[ ]  Medication Support (15/60)[ ]  Crisis Intervention (15/70) |
| 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. (check if yes)Date of Fire Clearance: Click or tap to enter a date. |
| ADDITIONAL INFORMATION: | Date the site was, or is expected to be, operational: Click or tap to enter a date. Date of Certification: Click or tap to enter a date. |

*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.*

[ ]  I agree with the above statement.

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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**

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

**FOR QMS USE ONLY**

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

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

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

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

Hilary Peralta, PsyD, SCII

Quality Management Services

Health Care Agency, Mental Health & Recovery Services

400 W. Civic Center Drive, 4th Floor

Santa Ana, CA 92701