|  |  |  |  |
| --- | --- | --- | --- |
| IDENTIFYING  INFORMATION: | **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)  Medication Room  Prescription Only  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