



COUNTY OF SAN BERNARDINO
STANDARD PRACTICE

NO 5-1.10

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APPROVED

DEPARTMENT

BEHAVIORAL HEALTH

SUBJECT

CERTIFICATION OF DBH CLINIC SERVICES FOR
SD/MC REIMBURSEMENT-REHABILITATION OPTION


Rudy Lopez, Director

I. PURPOSE

To provide an established and uniform procedure for department and contract providers to apply for Short-Doyle/Medi-Cal (SD/MC) clinic designation under the Rehabilitation Option.

II. PROCEDURES

A. SD/MC provider certification is required for all providers as defined below. Fire safety requirements apply to all sites (including satellites) owned, leased or operated by a legal entity.

1. Legal Entity:

A county or city mental health department or agency, or a corporation, partnership, agency or individual practitioner providing public mental health services under contract with the County department.

2. Provider:

A specific site or group of sites (including satellites) owned, leased or operated by a legal entity, and utilized to provide SD/MC services.

A provider is assigned its own unique provider number and enters into a provider agreement with the State Department of Health Services. Satellites are not assigned a unique provider number, and may store open charts/individual records at the satellite site.

3. Satellite Site:

A site which is owned, leased or operated by a legal entity where SD/MC services are delivered for less than twenty (20) hours per week on separate premises from the parent provider, but which remains under the administrative direction and professional supervision of the parent provider.

A satellite is not assigned a unique provider number and must be part of the same legal entity as the parent provider. In order to receive initial certification for the SD/MC program, a satellite must meet all fire safety requirements specified in this document under "General Requirements." At the discretion of the State Department of Mental Health (DMH), a satellite may be subject to an on-site inspection. Claims for SD/MC reimbursement for services delivered by the satellite are included with the claim submitted by the parent provider.

When requesting certification of a provider with a satellite, the local mental health director or designee must confirm that the parent provider exercises direction and professional supervision of the satellite and that services will not be provided until the satellite location has met all fire safety requirements specified in this document under "General Requirements."

4. **Public School Site:**

A public school site where SD/MC services are provided may or may not be assigned its own unique provider number or be classified as a satellite site. This is at the discretion of the legal entity, regardless of the number of hours services are delivered. Fire safety requirements for public school sites are described under "General Requirements."

The mental health program operating at the public school site must be a part of a provider that exercises direction and professional supervision over the school site. Staffing ratios for Day Treatment Intensive and Day Rehabilitation Services must be consistent with certification requirements identified under "Program Requirements". The provider must identify its school sites at the time of the certification review. At the discretion of State DMH, a school site may be subject to an on-site inspection. A written program narrative, including the Day Treatment Intensive or Day Rehabilitation Services, is to be on file at the provider site. The narrative may include the type of program, objectives, location, days and hours of operation, services provided, staff assigned by discipline, target population, program capacity, admission and discharge criteria and any unique components.

B. General Requirements

A provider must meet all of the following requirements before applying for SD/MC certification.

1. Fire Safety:

Space owned, leased, or operated by providers, including satellites, and used for services or staff shall meet local fire codes. Documentation of fire safety inspections and corrections of any deficiencies shall be made available to certification reviewers on request.

All providers seeking certification for services at public school sites must conform to school fire safety rules and regulations under the Education Code. Providers need not have available fire safety inspections and corrections for buildings owned by public schools.

2. Use Permits:

Approval, when necessary, shall be secured from the local agency authorized to provide a building use permit.

3. Physical Plant:

The physical plant of certified site owned, occupied, or leased by providers shall be clean, sanitary and in good repair. Maintenance policies shall be established and implemented to ensure the safety and well being of individuals and staff.

4. Administrative Policies:

Administrative policies shall be written and implemented, and shall address the following:

- personnel policies and records
- individuals' charts
- general operating procedures
- service delivery policies
- reporting of unusual occurrences relating to health and safety issues.

Policies shall be in accordance with state requirements.

5. **Audit Trails:**

Providers will maintain documentation that will create audit trails for all services provided by and reimbursed through the SD/MC system.

6. **Quality Assurance System:**

The provider shall have a quality assurance/quality management plan that is part of a system approved by the State DMH .

7. **Charts/Individual Records:**

Each provider shall establish and maintain a chart/individual record for every individual receiving SD/MC services.

Chart/Individual records shall be permanent. All records of discharged clients shall be completed and filed within thirty (30) days after discharge and shall be kept at least one (1) year after the minor has reached the age of eighteen (18) but in no case less than seven (7) years.

Information contained in charts/individual records shall be confidential and shall be disclosed only to authorized persons in accordance with federal and state laws. Providers shall be responsible to store charts/individual records in such a manner as to safeguard confidentiality.

Open charts/individual records shall only be stored at the following locations:

- A provider site owned, leased or operated by a legal entity and utilized to provide SD/MC services.
- A satellite site where SD/MC services are provided.
- A public school where SD/MC services are provided.

C. **Program Requirements**

Rehabilitation Mental Health Services and Targeted Case Management:

Staff who are employed by a Certified Mental Health Rehabilitation Provider may deliver services inside or outside of the certified site and bill SD/MC. All services provided must comply with all federal, state and local laws and regulations pertaining to rehabilitative services for persons with mental illness.

Physician availability:

Providers shall have a written procedure for referring individuals to a psychiatrist when necessary. If a psychiatrist is not available, a physician may be utilized in this capacity. The provider shall maintain a list of psychiatrists and physicians available to provide consultation or direct service.

Staffing:

1. Scope of Practice

Services shall be provided within the staff person's scope of practice. The local mental health director shall be responsible for assuring that services provided are commensurate with the professionalism and experience of the staff utilized.

2. Head of Service

Each provider shall have a staff person who meets requirements specified in Title 9, Section 622-630.

3. Day Treatment

Each provider shall maintain a minimum qualifying staff/individuals ratio of 1:8 for Day Treatment Intensive or 1:10 for Day Rehabilitation.

4. Crisis Stabilization/Emergency Room and Crisis Stabilization/Urgent Care

Each provider shall maintain a minimum qualifying staff/individuals ratio of 1:4.

Pharmaceutical Services:

Programs that provide/store medications must be in compliance with state and federal laws. Programs must have written policies, reviewed and signed by someone licensed to prescribe or dispense medications, which address the following:

- Administration
- Labeling and storage
- Orders (prescribing)
- Disposal of drugs
- Dispensing

Please see page 7-20 and 7-21 of the Short-Doyle/Medi-Cal Manual for the Rehabilitation Option and Targeted Case Management for state standards related to pharmaceutical services.

D. Requests for Participation of DBH Clinics.

1. Requests for participation in the SD/MC Program must be submitted to the State Department of Mental Health by the Department of Behavioral Health's (DBH) Director or designee through the DBH Deputy Director of Administrative Services. Requests submitted directly from providers will not be accepted.
2. Request for DBH clinics require the program manager to complete the following forms and send to the Deputy Director of Administrative Services for forwarding to the State.
 - a. Short-Doyle/Medi-Cal Provider Certification Application. (Attachment 1)
 - b. Short-Doyle/Medi-Cal Provider Agreement. (Attachment 2)
 - c. Medi-Cal Provider Data Form. (Attachment 3)
 - d. Medi-Cal Provider Disclosure Statement of Significant Beneficial Interests. (Attachment 4)
 - e. Fire Safety Inspection Request Form STD. 850 (Attachment 5) or Fire Clearance Certificate.
3. The Deputy Director of Administrative Services or designee shall send requests for DBH owned or operated clinics to:

Moss T. Nader, Ph.D., Regional Chief
State Department of Mental Health
Medi-Cal Oversight, Southern Region
P.O. Box 59063
Norwalk, CA 90652-0063
(562) 868-2273

4. If the Clinic does not have a State Provider Number, the Program Manager should complete Form No. MH 3829, "Provider File Update" (Attachment 6), indicating the transaction is an addition and send to the Deputy Director of Administrative Services who will review the form and send to the Statistics and Data Analysis Section of the State Department of Mental Health, 1600 Ninth Street, Sacramento, CA 95814 for updating into the Provider File System.

5. The earliest date a new provider can be certified, regardless of the actual on-site review, is the latest date all the following conditions have been met:
 - a. Complete application is received in the Medi-Cal Oversight Regional Office;
 - b. The date the program is operational;
 - c. The date of the fire clearance.

Until the County DBH Clinic appears on the Provider Listing generated by the State DMH , the provider is not considered Medi-Cal certified.

E. Changes to Short-Doyle Medi-Cal Clinics

The Clinic shall notify Program Manager of changes by letter. The Program Manager will send the letter to Contract Administration Unit which shall complete and send the following form to the State Medi-Cal Oversight Office:

- a. "Medi-Cal Certification and Transmittal" (Attachment 7)

F. Requests for Participation of Contract Providers (refer to SPM no. 5-1.11).

G. Recertification:

Confirmation of continued compliance with all SD/MC requirements. Routine SD/MC provider recertification reviews which are done every two years are based on the State DMH, Medi-Cal Oversight's Regional recertification review schedule. Additional certification reviews may become necessary if:

1. The provider makes major staffing changes.
2. The provider makes organizational and/or corporate structure changes (example: conversion from nonprofit status).
3. The provider adds day treatment or medication support services when medications will be administered or dispensed from the provider site.
4. There are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance).
5. There is a change of ownership or location.
6. There are complaints regarding the provider.
7. There are unusual events, accidents, or injuries requiring medical treatment for clients, staff or members of the community. (See page 7 – 12 of the Short-Doyle/Medi-Cal Manual.)

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		Provider No (If one has already been assigned)	
	Street Address, City, State and Zip			
	Telephone No		County	
	Contract Agency <input type="checkbox"/> or County Operated <input type="checkbox"/>			
NAME AND ADDRESS OF LEGAL ENTITY				
HEAD OF SERVICE NAME	Head of Service is	Psychiatrist <input type="checkbox"/>	Licensed Vocational Nurse <input type="checkbox"/>	
		Registered Nurse <input type="checkbox"/>	Psychologist <input type="checkbox"/>	
		Psychiatric Technician <input type="checkbox"/>	Licensed Clinical Social Worker <input type="checkbox"/>	
		Marriage, Family and Child Counselor <input type="checkbox"/>	Mental Health Rehab Specialist <input type="checkbox"/>	
SHORT-DOYLE/MEDI-CAL SERVICES TO BE PROVIDED	INDICATE WHICH SERVICES YOU WISH TO PROVIDE			
	SD/MC Mode 05	Crisis Residential <input type="checkbox"/>	Adult Residential <input type="checkbox"/>	PHF <input type="checkbox"/>
	SD/MC Mode 18	Mental Health Services <input type="checkbox"/>	Medication Support Services <input type="checkbox"/>	Day Treatment Intensive <input type="checkbox"/>
		Day Rehabilitation <input type="checkbox"/>	Crisis Intervention <input type="checkbox"/>	Crisis Stabilization <input type="checkbox"/>
		Crisis Stabilization ER & UC <input type="checkbox"/>	Case Management/Brokerage <input type="checkbox"/>	
IS THE PROVIDER CURRENTLY LICENSED BY A STATE AGENCY?	Yes <input type="checkbox"/>	If Yes, which agency?	DMH <input type="checkbox"/>	DHS <input type="checkbox"/>
	No <input type="checkbox"/>		DSS <input type="checkbox"/>	Drug & Alcohol <input type="checkbox"/>
			Other <input type="checkbox"/>	_____
FIRE SAFETY	Attached is documentation of the most recent fire safety inspection and correction of deficiencies or a statement from the Local Mental Health Director assuring that all fire safety requirements have been met			<input type="checkbox"/>
	All services are provided at a public school site and meet fire safety rules and regulations			<input type="checkbox"/>
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	

State of California - Health and Welfare Agency

MEDI-CAL PROVIDER DATA FORM

1. Facility Name				4. Federal Employer's Tax ID Number (FEIN)	5. Fiscal Year End Month
2. Facility Address				6A. Type of Organization (Check one)	
Number	Street	Telephone Number		<input type="checkbox"/> State Government <input type="checkbox"/> Nongovernmental Non Profit <input type="checkbox"/> County Government <input type="checkbox"/> Nongovernmental for Profit <input type="checkbox"/> City Government <input type="checkbox"/> Other (specify)	
City	County	State	Zip Code		
3. Pay to Address (If different)				6B. Type of Ownership (Check one)	
Number	Street	Telephone Number		<input type="checkbox"/> Individual <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other (specify)	
City	County	State	Zip Code		

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

FIRE SAFETY INSPECTION REQUEST

STD. 69D (REV. 10-94)

See instructions on reverse.

CONTACT'S NAME		TELEPHONE NUMBER ()		REQUEST DATE	PROGRAM	
EVALUATOR'S NAME		REQUESTING AGENCY FACILITY NUMBER			REQUEST CODE	
LICENSING AGENCY NAME AND ADDRESS <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> DEPARTMENT OF MENTAL HEALTH MEDICAL OVERSIGHT SOUTHERN REGION P.O. BOX 59083 NORWALK, CA 90652-0083 </div>					CODES	
					1. ORIGINAL 2. RENEWAL 3. CAPACITY CHANGE 4. OWNERSHIP CHANGE 5. ADDRESS CHANGE 6. NAME CHANGE 7. OTHER	A. FIRE CLEARANCE B. LIFE SAFETY
AMBULATORY		NONAMBULATORY		BEDRIDDEN		TOTAL CAPACITY
CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	
FACILITY NAME					LICENSE CATEGORY	
STREET ADDRESS (Actual Location)					NUMBER OF BUILDINGS	
CITY					RESTRAINT	
FACILITY CONTACT PERSON'S NAME					HOURS	
CONDITIONS						

TO BE COMPLETED BY INSPECTING AUTHORITY

FIRE AUTHORITY NAME AND ADDRESS <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> (Empty) </div>				CLEARANCE / DENIAL CODE		
				CODES 1. FIRE CLEARANCE GRANTED 2. FIRE CLEARANCE DENIED A. EXITS B. CONSTRUCTION C. FIRE ALARM D. SPRINKLERS E. HOUSEKEEPING F. SPECIAL HAZARD G. OTHER		
INSPECTOR'S NAME (Typed or Printed)		TELEPHONE NUMBER ()	CFIRS NUMBER	OCCUPANCY CLASS		
INSPECTION DATE	INSPECTOR'S SIGNATURE (Typed or Printed) <i>[Signature]</i>					
EXPLAIN DENIAL OR LIST SPECIAL CONDITIONS						

STATE OF CALIFORNIA

FIRE SAFETY INSPECTION REQUEST

REV. 10-84) (REVERSE)

INSTRUCTIONS

This form is designed for use with a window envelope
Licensing or Requesting Agencies—Complete the following 19 sections on this form
before submitting it to the fire authority having jurisdiction.

1. **AGENCY CONTACT, 2. TELEPHONE NUMBER, 5. EVALUATOR.** Enter the name and telephone number of agency contact person.
3. **PROGRAM.** Licensing agency use.
4. **REQUEST DATE.** Enter date request was prepared.
6. **REQUESTING AGENCY FACILITY NUMBER.** This is the file number assigned by the licensing agency.
7. **REQUEST CODE.** Use the seven codes shown and insert the appropriate number in the box following "Request Code". If NAME CHANGE, please list previous name. Insert date of original request is other than an original.
3. **AGENCY NAME AND ADDRESS.** Enter the name and address of the licensing facility requesting the inspection.
3. **AMBULATORY—NONAMBULATORY—BEDRIDDEN.**
Capacity: Insert in the appropriate section, the capacity of licensed ambulatory or nonambulatory occupants covered by this request.
Previous Capacity: If request is for renewal or capacity change, insert capacity of previous clearance.
Total Capacity: Show total licensed capacity. If the facility is intended to house part ambulatory, nonambulatory, and part bedridden, show the total of the three types of occupants.
10. **FACILITY NAME.** Insert the name of the facility as will appear on the license. List identifying sub name known (i.e., Hacienda Corp/Medina Lodge).
11. **LICENSE CATEGORY.** Insert the category of license being sought as it will appear on the license certificate.
12. **ADDRESS.** Insert street address and city only. A post office box is not acceptable as only location.
13. **NUMBER OF BUILDINGS.** Insert the total number of buildings to be used for housing of the occupants covered by the license.
14. **RESTRAINT.** Indicate if physical restraint (locked in room or the building) is to be used in the housing of the occupants.
15. **FACILITY CONTACT PERSON—TELEPHONE NUMBER.** Indicate the name and telephone number of the responsible individual at the facility to be contacted by the fire authority.
16. **HOURS.** Indicate the number of hours the occupants are housed at the facility (less than 24 or 24+).
17. **SPECIAL CONDITIONS.** Indicate any conditions unique to this request. As an example, if the inspector request is for one building in a multi-building facility.

FIRE AUTHORITY CONDUCTING THE INSPECTION—COMPLETE THE FOLLOWING:

8. **FIRE AUTHORITY, NAME AND ADDRESS.** Insert the name and address of the fire authority where the facility is located.
9. **CLEARANCE/DENIAL CODE.** Use the two codes: 1 for clearance granted, and 2 for clearance denied. If denied, also include the appropriate letter code. As an example, Denial based upon exiting would be coded 2A.
0. **INSPECTOR'S NAME.** Print the initial of the inspector's first name and full last name; insert the telephone number where the inspector may be contacted.
1. **CFIRS I.D. NUMBER.** Insert the fire department's number assigned by California Fire Incident Reporting System.
22. **OCCUPANCY CLASSIFICATION.** Use California Building Code occupancy classifications and insert the occupancy determined by the inspector.
23. **INSPECTION DATE.** Enter the actual date of the inspection.
24. **INSPECTOR'S SIGNATURE.** To be signed by the inspector conducting the inspection.
25. **EXPLAIN DENIAL OR SPECIAL CONDITIONS.** If clearance code #2 is used, briefly explain reason. This space is also to be used to specify any additional limitations placed by the fire authority, such as the use of certain floors or sleeping rooms approved for nonambulatory clients.

MEDI-CAL CERTIFICATION AND TRANSMITTAL

Part A Provide the following information:

COUNTY SUBMITTING FORM: _____ COUNTY CODE: _____

TYPE OF TRANSACTION (Check One): Activate **Change** Terminate
 If **Change**, indicate one or more type(s): Name Address Mode Effective Date

PROVIDER NUMBER: _____

PROVIDER NAME: _____

PROVIDER ADDRESS: _____

PROVIDER CITY: _____ PROVIDER ZIP CODE: _____

MEDI-CAL ELIGIBILITY DATE: ACTIVATED _____ TERMINATED _____

IF CHANGE, EFFECTIVE DATE OF CHANGE: _____

SD/MC MODE OF SERVICE	DESCRIPTION OF SERVICES
<input type="checkbox"/> (07) General Hospital	_____
<input type="checkbox"/> (08) Psych Hosp Age < 21	_____
<input type="checkbox"/> (09) Psych Hosp Age > 64	_____
<input type="checkbox"/> (05) Residential/PHF	<input type="checkbox"/> Crisis Residential <input type="checkbox"/> Adult Residential <input type="checkbox"/> Psychiatric Health Facility

Check only one Mode (either 12 or 18):

(12) Hospital Outpatient (18) Non-Hospital Outpatient

Indicate Services (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Crisis Intervention | <input type="checkbox"/> Crisis Stabilization | <input type="checkbox"/> Mental Health Services |
| <input type="checkbox"/> Case Management/Brokerage | <input type="checkbox"/> Medication Support | |
| <input type="checkbox"/> Day Treatment Intensive Half Day | <input type="checkbox"/> Day Treatment Intensive Full Day | |
| <input type="checkbox"/> Day Rehabilitation Half Day | <input type="checkbox"/> Day Rehabilitation Full Day | |

The above named provider is certified by this agency to participate in Short-Doyle/Medi-Cal programs. I attest that the above named provider site complies with requirements of the CCR, Title 9, Sections 1810.435-436, the terms of the contract between the MHP and the Department, and the MHP's Implementation Plan pursuant to CCR, Title 9, Section 1810.310

 Signature on above line and check below to indicate person signing

- County Mental Health Director or Designee Medi-Cal Oversight, South / North

To be submitted to Medi-Cal Oversight for signature below.

Part B: Medi-Cal Oversight Approval to Transmit Data to DHS

 Medi-Cal Oversight, Southern/Northern Region Date _____