

## MHP RE-CERTIFICATION of COUNTY-OWNED or OPERATED PROVIDERS SELF SURVEY FORM

Please provide the following information:

COUNTY SUBMITTING FORM: \_\_\_\_\_ COUNTY CODE: \_\_\_\_\_ NPI # \_\_\_\_\_

PROVIDER NUMBER: \_\_\_\_\_ PROVIDER NAME: \_\_\_\_\_ Name Change

PROVIDER ADDRESS: \_\_\_\_\_

PROVIDER CITY: \_\_\_\_\_ PROVIDER ZIP CODE: \_\_\_\_\_

**SERVICES PROVIDED:** (Please check all that apply): Activating Mode

<input type="checkbox"/> <b>15/01</b> T1017 Case Management/Brokerage • Intensive Care Coordination (ICC) T1017 (15/07)	<input type="checkbox"/> <b>15/30</b> H2015 Mental Health Services • Intensive Home Based Services (IHBS) H2015 (15/57)	<input type="checkbox"/> <b>15/58</b> H2019 Therapeutic Behavioral Services	<input type="checkbox"/> <b>15/60</b> H2010 Medication Support	<input type="checkbox"/> <b>15/70</b> H2011 Crisis Intervention
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**EVALUATION CRITERIA**

		Yes	No	N/A
<b>1.</b>	Regarding written information in English and the threshold languages to assist beneficiaries in accessing specialty mental health services, at a minimum, does the provider have the following information available:			
	A) The beneficiary brochure per MHP procedures? <i>MHP Contract, Exhibit A, Attachment I, §7A, CCR, Title 9, § 1810.360 (b)(3),(d) and (e) CCR, Title 9, § 1810.410 (e)(4)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B) The provider list per MHP procedures? <i>MHP Contract, Exhibit A, Attachment I, §7A, CCR, Title 9, § 1810.360 (b)(3),(d)and (e) CCR, Title 9, § 1810.410 (e)(4)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C) The posted notice explaining grievance, appeal, and fair hearings processes? <i>MHP Contract, Exhibit A, Attachment I, §15A(3)(a)(ii), CCR, Title 9, § 1850.205 (c)(1)(B) CCR, Title 9, § 1810.410 (e)(4)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	D) The grievance forms, appeal forms, and self-addressed envelopes? <i>MHP Contract, Exhibit A, Attachment I, §15A(3)(a)(iii), CCR, Title 9, §1850.205 (c)(1)(C);CCR, Title 9, §1810.410 (e)(4)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2.</b>	Does the space owned, leased or operated by the provider and used for services or staff meet local fire codes? <b>(A copy of the most recent fire safety inspection notice from the local fire authority must be submitted with this form)</b> <i>MHP Contract, Exhibit A, Attachment I, §4L(2), CCR, Title 9, § 1810.435 (b)(2)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3.</b>	Is the facility and its property clean, sanitary, and in good repair? <i>MHP Contract, Exhibit A, Attachment I, §4L(3), CCR, Title 9, § 1810.435 (b) (2)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4.</b>	Does the provider have the following policies and procedures:			
	A) Protected Health Information? <i>MHP Contract, Exhibit F, CCR, Title 9, §1810.310 (a)(10) CCR, Title 9, §1810.435 (b)(4)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	B) Personnel policies and procedures? <i>MHP Contract, Exhibit A, Attachment I, §4L(5), CCR, Title 9, §1840.314</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C) General operating procedures? <i>MHP Contract, Exhibit A, Attachment I, §4L(5), CCR, Title 9, § 533</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	D) Maintenance policy to ensure the safety and well being of beneficiaries and staff? <i>MHP Contract, Exhibit A, Attachment I, §4L(4), CCR, Title 9, § 1810.435(b)(2)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	E) Service Delivery Policies? <i>MHP Contract, Exhibit A, Attachment I, §4L(5), CCR, Title 9, § 1810.209-210 § 1810.212 213 § 1810.225, 1810.227 and 1810.249</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	F) Unusual occurrence reporting (UOR) procedures relating to health and safety issues? <i>MHP Contract, Exhibit A, Attachment I, §4L(5)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	G) Written procedures for referring individuals to a psychiatrist when necessary, or to a physician who is not a psychiatrist, if a psychiatrist is not available? <i>MHP Contract, Exhibit A, Attachment I, §4L(8)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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		Yes	No	N/A
5.	Does the provider have as head of service a licensed mental health professional or other appropriate individual as described in CCR, Title 9, § 622 through 630? <i>CCR, Title 9, § 680 (a); CCR, Title 9, § 1810.435 (c)(3); CCR, Title 9, §§ 622 through 630; MHP Contract, Exhibit A, Attachment I, §4L(9) (A copy of HOS license must be submitted with this form.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	For organizational providers that provide or store medications, the provider stores and dispenses medications in compliance with all pertinent state and federal standards. In particular: <b>(For providers of "Prescription Only" Med Support (15/60), please check N/A for questions 6A-G)</b>			
A)	All drugs obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so. <i>MHP Contract, Exhibit A, Attachment I, §4L(10)(a)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B)	Drugs intended for external use only and food stuffs are stored separately from drugs intended for internal use. <i>MHP Contract, Exhibit A, Attachment I, §4L(10)(b)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C)	All drugs are stored at proper temperatures: room temperature drugs at 59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit. <i>MHP Contract, Exhibit A, Attachment I, §4L(10)(c), CCR, Title 9, § 1810.435(b) (3)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D)	Drugs are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication. <i>MHP Contract, Exhibit A, Attachment I, §4L(10)(d), CCR, Title 9, § 1810.435 (b) (3)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E)	Drugs are not retained after the expiration date. Intramuscular multi-dose vials are dated and initialed when opened. <i>MHP Contract, Exhibit A, Attachment I, §4L(10)(e), CCR, Title 22, § 73369</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F)	Is a medication log maintained to ensure the provider disposes of expired, contaminated, deteriorated and abandoned medications in a manner consistent with state and federal laws? Is there a dispensing log used to record the date, name of the beneficiary, name of drug, amount of drug, lot number, route of administration, and identifying information regarding the bottle, vial, etc from which the medication was obtained for all medications which are <u>dispensed from house supply</u> ? <i>MHP Contract, Exhibit A, Attachment I, §4L(10)(f)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G)	Policies and procedures are in place for dispensing, administering and storing medications. <i>MHP Contract, Exhibit A, Attachment I, §4L(10)(g)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A) Date of Fire Clearance: \_\_\_\_\_

B) Recertification Date: \_\_\_\_\_

\_\_\_\_\_  
Print Name & Title of Person Completing Form

\_\_\_\_\_  
Signature of Person Completing Form

\_\_\_\_\_  
Date

*I hereby certify under penalty of perjury that to the best of my knowledge, information and belief, the above list of items are in compliance with Federal and State requirements and are available and accessible to the Department of Health Care Services upon request. I am aware that the above items may be requested at any time, including during an onsite review. I am also aware that a new DHCS Recertification form shall be completed and submitted to the DHCS on a triennial basis.*

\_\_\_\_\_  
Print Name of MH Director/Designee

\_\_\_\_\_  
Signature of MH Director/Designee

\_\_\_\_\_  
Date

**FAX, PDF, or MAIL** completed form and required documentation (Items 2 & 5) prior to triennial provider recertification date to:

**FAX: (916) 440-5497**  
**EMAIL: [DMHCertification@dhcs.ca.gov](mailto:DMHCertification@dhcs.ca.gov)**

**MAIL:**

State of California  
Department of Health Care Services  
Mental Health Services Division  
Program Oversight and Compliance Branch  
P.O. Box 997413, MS 2703  
Sacramento, CA 95899-7413

<b>For DHCS Use Only:</b>	
Rec'd By: _____	
Date: _____	
Approved By: _____	
Date: _____	

If you need additional information, please call (916) 319-0985 and ask for Certifications or email [DMHCertification@dhcs.ca.gov](mailto:DMHCertification@dhcs.ca.gov)  
[DHCS MHSD Certifications Internet Address \( http://www.dhcs.ca.gov/services/MH/Pages/Certifications.aspx \)](http://www.dhcs.ca.gov/services/MH/Pages/Certifications.aspx)