County of San Bernardino
Department of Behavioral Health

Definitions/Instructions

These instructions are a guide on how to complete the Reporting Unit (RU) Set-Up Form. This form is for establishing new RU's information into InSyst (Simon). Information must be submitted sixty-days (60) before the effective date to the DBH Administration Services Deputy Director for approval.

FSP Program ID Code or CSS Plan #
The MHSA - FSP Program ID Code or CSS Plan# listed in the San Bernardino FSP Program ID Codes form, listed on the web.

Effective Date:
The effective date is the month and year when services are to become effective for Provider/Program.

Program Name:
Enter the full name of the program. You can use up to 30 characters. No two providers should have the same program name

Program Short Name:
Enter an abbreviated name for the program. This cannot exceed 12 letters. Because it will appear on screens and reports, the Program Short Name should be clear and distinct. No two providers can have the same Short Name.

Umbrella Organization
Check the appropriate box that describes your type of agency.

Region/Support Service Type
Region/Support services are used to describe groups of programs or regional location. Some reports subtotal statistics by region. Check the box that describes the appropriate region/support type for your location.

Mode of Service:
A mode of service identifies the different groups of services or activities provided in the local mental health program. Check the box that describes the appropriate mode of service for this location.

Financial Responsibility
This determines what sources the system will attempt to bill for the services. Check all the payor sources that the computer will bill for services in this provider/program

Days of Operation
Circle the days of the week that the provider will be open for business.

CDS RU Name
This will be the same provider name that is used as the provider name on the Short-Doyle/Medi-Cal Provider Certification Application.

Requester will be notified via e-mail when all modifications have been completed.
SEND form to**:**

Department of Behavioral Health
268 W. Hospitality Ln, Suite 400
Attn: DBH Administration Services Deputy Director
San Bernardino, Ca 92415-0026

cc: Application Services Group, Contract Unit, Quality Management, Business Office, Fiscal Services.

County of San Bernardino
Department of Behavioral Health

Reporting Unit Set -Up Form

Complete and submit this form to DBH Regional Program Manager of your region when requesting a new Reporting Unit number sixty days prior to the effective date of opening.

COUNTY: SAN BERNARDINO - 36

CDS Provider Number: ______________________
Reporting Unit Number: ______________________
FSP Program ID Code or CSS Plan #

EFFECTIVE DATE: ______________________

PROGRAM NAME: ______________________________ (30 Characters) SHORT NAME: ____________________ (11 Characters)

STREET ADDRESS ____

CITY ____ STATE ______ ZIP _________ - ________

PHONE NUMBER: (   ) ____________________ COST CENTER: ____________

UMBRELLA ORGANIZATION *(Check One)*:

☐ 01 - DMH Services (County Facilities Only) ☐ 02 - Contract Services

REGION/SUPPORT SERVICE TYPE (Check One):

☐ 01- Adult Services ☐ 03- Forensics Programs ☐ 05- Desert/Mountain ☐ 07- East Valley
☐ 02-Children's Services ☐ 04- Central Valley ☐ 06- West Valley

UB92 REFERRALS- SOURCE: 2 DESTINATION: 01

OSHPD REFERRALS: ADMISSION: 9 DISPOSITION: 01

MODE OF SERVICE (Check Only One, or One and Mode 45)

☐ 05 Acute and Residential 24-Hour Services ☐ 45 Outreach and Community Programs
☐ 10 Day Treatment Programs & Crisis Stabilization ☐ 55 MAA Services
☐ 15 Mental Health Service Programs ☐ 60 Support Services

FINANCIAL RESPONSIBILITY

This determines what funding sources the services should attempt to be billed. Check all the payor sources that the computer will bill for services in this provider/program.

☐ County ☐ Insurance ☐ MHSA - **FSP Program ID Code or CSS Plan # must be identified.**

☐ Medicaid ☐ Client

☐ Medicare ☐ Fee/Adj*

DAYS OF OPERATION: Please check the days this program is open.

S	M	T	W	Th	F	S
☐	☐	☐	☐	☐	☐	☐

CDS RU NAME: ______________________________

SIGNATURES:

______________________ ______________________ ____________
Regional Program Manager Name Signature Date

Authorized Deputy Director ☐ Approved ☐ Denied

______________________ ______________________ ____________
Print Name Signature Date

Denied Reason: ____