COUNTY OF SAN BERNARDINO STANDARD PRACTICE	NO 5-1.20	Revised ISSUE 10/99 PAGE 1 OF 3
	BY Claudette Babino	EFFECTIVE 07/01/94
DEPARTMENT BEHAVIORAL HEALTH	APPROVED	
SUBJECT SHORT-DOYLE AND SHORT-DOYLE/MEDI-CAL CLINIC CHANGE OF OWNERSHIP OR LOCATION	Rudy Lopez, Director	

I. PURPOSE

To acquaint staff with the procedures to follow when a Short-Doyle/Medi-Cal (SD/MC) clinic or non-Short-Doyle/Medi-Cal clinic changes ownership or location.

II. PROCEDURES

A. Change of Ownership and Change of Location information and requests for Provider Numbers are to be initiated by the responsible program manager or contract agency director and returned to the Deputy Director of Administrative Services. The Deputy Director of Administrative Services or designee will review and send the change information to appropriate State agency or Department of Behavioral Health unit and obtain a new Provider Number, if needed.

B. Change of Ownership (SD/MC)

1. Sixty (60) days prior to the change of ownership, the Local Mental Health Director through the Deputy Director of Administrative Services must request a new provider number by sending a completed Provider File Update (Attachment 1, instructions are Attachment 2) to State Department of Mental Health (DMH), Statistics and Data Analysis, 1600 Ninth Street, Sacramento, CA 95814 or faxing to (916) 653-5939.

2. The Local Mental Health Director through the Deputy Director of Administrative Services must send a Medi-Cal Provider Data Form (Attachment 3) and Medi-Cal Provider Disclosure Form (Attachment 4), completed by the responsible program manager or contract agency director, to Regional Chief, Department of Mental Health, Medi-Cal Oversight Southern Region, P.O. Box 59063, Norwalk, CA 90652-0063, (562) 406-3937.

   Sixty (60) days prior to the change of ownership, the Local Mental Health Director or designee must notify the State DMH at the address provided in Paragraph 2 above, of the following information:

   a. The old provider name, provider number, and the date of termination.

   b. The name and address of the new provider.

c. Provider number of the new provider.

d. The date of ownership change.

e. Any changes of staff or services offered.

f. Name, title, and phone number of on-site contact person.

g. Request a fire clearance for the new location. (This is to be requested by the on-site clinic supervisor or contract agency director).

Failure to notify the Medi-Cal Oversight Office sixty (60) days prior to the change of ownership may result in a delay or actual loss of SD/MC revenue for services provided during the non-certified period.

C. Change of Location (SD/MC)

Sixty (60) days prior to the change of clinic location, the local Mental Health Director must notify DMH of the following:

1. Provider number.
2. Provider name.
3. Old address.
4. New address.
5. Anticipated date of location change.
6. Verification of fire clearance.
7. Any changes in staff or services offered.
8. Name, title and phone number of on-site contact.
9. Involuntary changes of location due to disaster should be reported as soon as possible and are not subject to the sixty (60) days prior to notification requirement.

The notification is to be sent to the same address as in "Change of Ownership" above.

D. Program Changes (SD/MC)

Sixty (60) days prior to the changes noted below, the Local Mental Health Director must notify DMH of the following:

1. Planned structural changes requiring a new fire clearance.

2. The provider adds day treatment or medication support services when medications will be administered or dispensed from the provider site.

E. Certification (SD/MC)

The Medi-Cal Oversight Office (for County clinics) or DBH Authorization Review/Utilization Review Unit (for Contract Agency clinics) will make an on-site survey for certification where there are significant changes in staffing or services offered. If an on-site survey is required and standards are met, the facility will be certified as of the date of the change of location or ownership. If an on-site survey reveals the facility to be out of compliance with any of the critical standards, clinics are allowed sixty (60) days to come into compliance before decertification action is taken by the State.

F. Change of Location or Ownership (Non SD/MC)

When a non-Short-Doyle/Medi-Cal provider changes ownership or location, the responsible program manager or contract agency director must notify the Deputy Director of Administrative Services, who will complete a Provider File Update and send to Statistics and Data Analysis of the State Department of Mental Health.

STATE OF CALIFORNIA – HEALTH AND WELFARE AGENCY DEPARTMENT OF MENTAL HEALTH

PROVIDER FILE UPDATE
MH 3829 (8/97)

COUNTY SUBMITTING FORM: _____

TYPE OF TRANSACTION *(Check one)*: ☐ Add ☐ Change ☐ Inactive

FISCAL YEARS: |__|__| |__|__| |__|__|

Is this Provider a satellite clinic? *(Check one)*: ☐ Yes ☐ No

COUNTY CODE: |__|__|

LEGAL ENTITY NUMBER: |__|__|__|__|__|__| (If a Legal Entity number has not been assigned, complete Legal Entity File Update form.)

PROVIDER NUMBER: |__|__|__|__|

PROVIDER NAME: _____

PROVIDER ADDRESS: _____

PROVIDER CITY: _____

ZIP CODE OF PROVIDER: |__|__|__|__|__|

DATE PROVIDER SERVICES: Started |__|__|__|__| (M M Y Y) Ended |__|__|__|__| (M M Y Y)

SHORT-DOYLE/MEDI-CAL PROVIDER? *(Check one)*: ☐ Yes ☐ No

PROVIDER TYPE: |__|__| CONTRACT TYPE: |__|

MODE OF SERVICE	SERVICE FUNCTION							
|__|__|	|__|__|	|__|__|	|__|__|	|__|__|	|__|__|	|__|__|	|__|__|	|__|__|
|__|__|	|__|__|	|__|__|	|__|__|	|__|__|	|__|__|	|__|__|	|__|__|
|__|__|	|__|__|	|__|__|	|__|__|	|__|__|	|__|__|	|__|__|	|__|__|
|__|__|	|__|__|	|__|__|	|__|__|	|__|__|	|__|__|	|__|__|	|__|__|

COUNTY CONTACT PERSON: _____ PHONE: (___) _____ DATE. _____

FOLLOWING SECTION IS FOR STATE DMH USE ONLY:

SD/MC Mode of Service	Start Date (M M D D Y Y)	End Date (M M D D Y Y)
|__|__|	|__|__|__|__|__|__|	|__|__|__|__|__|__|
|__|__|	|__|__|__|__|__|__|	|__|__|__|__|__|__|

PROVIDER FILE UPDATE INSTRUCTIONS

FISCAL YEARS: List the fiscal year(s) to which the transaction applies; e.g., 98 for July 1, 1997 to June 30, 1998 and 99 for July 1, 1998 to June 30, 1999.

A **satellite clinic** is a clinic that is open less than 20 hours a week and reports services using the parent clinic provider number. Parent clinics are assigned a 0 (zero). Satellite clinics are assigned a number from 1-9. These numbers are listed in the Parent/Satellite (P/S) field.

LEGAL ENTITY NUMBER: Legal Entity Numbers are assigned by **the State Department of Mental Health, Statistics and Data Analysis.** If a number has not been assigned, then complete the Legal Entity File Update form.

PROVIDER NUMBER: If this is a new provider, **the State Department of Mental Health, Statistics and Data Analysis will assign the number.**

DATE PROVIDER SERVICES STARTED: The month and year the county first contracts with the **provider.** A date of 9999 means the provider number was assigned prior to July 1, 1984.

DATE PROVIDER SERVICES ENDED: The month and year the county no longer contracts with the **provider.**

SHORT-DOYLE/MEDI-CAL PROVIDER eligibility will be determined by the State Department of Mental Health, Medi-Cal Oversight. **Statistics and Data Analysis will update the provider file when the HCFA 1539 form is received** from Medi-Cal Oversight.

PROVIDER TYPE: The type of facility or license of the provider.

01	= State Hospital	12	= Family Day Home	22	= Psychiatrist
02	= Psychiatric Hospital	13	= Preschool Center	23	= Psychologist
03	= General Hospital	14	= Day Care Center	24	= LCSW
04	= Psychiatric Health Facility	15	= Sheltered Workshop	25	= MFCC
05	= Skilled Nursing Facility	16	= Social Rehabilitation Center	26	= RN
06	= Intermediate Care Facility	17	= Social Rehabilitation Facility	27	= Mixed Specialty Practice
07	= Outpatient Clinic	18	= Vocational Rehab Center	28	= Community Treatment Center (CTF)
09	= Small Family Home	19	= Special Service Center		
10	= Large Family Home	20	= Home Finding Agency	99	= Other
11	= Group Home	21	= Case Management Agency		

CONTRACT TYPE:

1	= County Mental Health Staffed	3	= Private Contract	5	= County MH Staff "Patch" at a Contract Provider
2	= County Interagency Agreement	4	= State Contract		

MODE OF SERVICE:

05	= 24-Hour Services	25	= Research and Evaluation	45	= Community Outreach
10	= Day Services	40	= Formal Training	55	= Medi-Cal Administration
15	= Outpatient Services	41	= Contract Administration	60	= Support Services
20	= Administrative Support	42	= Utilization Review		

SERVICE FUNCTION: See the Cost Report Manual for valid codes.

SEND the form to: **Department of Mental Health, Statistics and Data Analysis**
1600 Ninth Street
Sacramento, CA 95814

or **FAX** the form to: **(916) 327-9337**

MEDI-CAL PROVIDER DATA FORM

1. Facility Name				4. Federal Employer's Tax ID Number (FEIN)	5. Fiscal Y End Mo
2. Facility Address	Number	Street	Telephone Number	6A. Type of Organization (Check one)	
				☐ State Government ☐ Nongovernmental Non	
City	County	State	Zip Code	☐ County Government ☐ Nongovernmental for I	
				☐ City Government ☐ Other (specify)	
3. Pay to Address (If different)	Number	Street	Telephone Number	6B. Type of Ownership (Check one)	
				☐ Individual ☐ Corporation	
City	County	State	Zip Code	☐ Partnership ☐ Other (specify)	

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	Professio State Lice Numbe

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 Nu Assigned This Locati

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

MEDI-CAL PROVIDER DISCLOSURE STATEMENT OF SIGNIFICANT BENEFICIAL INTERESTS

Name: _____ Type of Provider: _____

Address: _____

_____ Medi-Cal Provider Number: _____

_____

Name of Provider in Which Interest is Held	Type of Provider	Address	Name of Relative(s) Who Holds The Interest	Relation	Type of Interest	Percentage and/or Dollar Amount of the Inter

I hereby certify under penalty of perjury that all the above statements are true and correct to the best of my knowledge.

Signature _____ Date _____

INSTRUCTIONS

Section 14022 of the Welfare and Institutions Code provides that no payment shall be made to a Medi-Cal provider or to any facility or organizati in which he or his immediate family has a "significant beneficial interest" unless the provider has a statement on file disclosing his or the interest i immediate family has in other Medi-Cal providers to which they refer beneficiaries. The applicable section under Medi-Cal program regulations Section 51466, Article 6, Chapter 3, subdivision 1 of Division 3 of Title 22 of the California Administrative Code. This regulation is shown below.

1. Every provider must complete this form.
2. Disclosure must be made for each member of the provider's immediate family - spouse, parents, spouse's parents, children, and spouses children.
3. "Significant beneficial interest" means any financial interest that represents either five percent of the total interest or a value of $25,0 irrespective of the percentage ownership. How different types of interests are to be valued can be determined by referring to Section 5146
4. If a provider has no "significant beneficial interest" in other providers to which Medi-Cal recipients are referred, place "no interests" on t first line and sign the statement.

51466. Disclosure of Significant Beneficial Interest.

(a) A provider shall not bill or submit a claim for service involving the referral of a beneficiary to or from another provider unless each provider has disclosed any significant beneficial interest existing between the providers. Disclosures shall be accomplished by completing and submitting a Medi-Cal Personal Disclosure Statement of Significant Beneficial Interest form as provided by the Department.

(b) A provider that fails to comply with (a) or that submits a false or incorrect disclosure shall be subject to a suspension from participation or payment under the Medi-Cal program.

(c) For the purpose of this section:

(1) "Significant beneficial interest" means any financial interest held by a provider, or a member of the provider's immediate family, in another provider that is equal to or greater than the lesser of the following:

(A) Five percent of the whole.

(B) $25,000.00.

(2) "Immediate family" means spouse, son, daughter, father, mother, father-in-law, mother-in-law, son-in-law, or daughter-in-law.

(d) Interests held by a provider and members of that provider's immediate family shall be combined and valued as a single interest.

(1) The extent of financial interest shall be determined as follows:

(A) Full ownership shall be considered as 100 percent financial interest and control regardless of mortgages or other encumbrances.

(B) Interest in a partnership shall be determined on the basis of th percentage of ownership specified in either a written or verbal partnershi agreement.

(C) Interest in a corporation shall be determined by computing th percentage of stock or bonds owned or the total outstanding shares or bond of the corporation as of the last working day of the month precedin compliance with (a).

(D) All other financial arrangements shall require establishment of a fai and reasonable dollar value for both the interest and the whole. Th percentage interest shall be computed as the percentage the dollar value o the interest represents of the whole.

(2) The dollar value of the following types of interests shall b determined as follows:

(A) Bonds, over-the-counter stocks and stocks listed on the major stocl exchanges shall be valued at the closing selling price on the last working da of the month preceding compliance with (a).

(B) Stocks in a closely held corporation shall be valued at the origina purchase price, par value, or current market value, whichever is greater.

(C) Partnership interests shall be valued at the total dollar amoun invested in organizing the partnership. A fair and reasonable dolla equivalent shall be determined if investment is not in form of monies.

(D) All other financial arrangements shall be valued at the actual dolla investment or a fair and reasonable dollar equivalent for investments not ir the form of monies.