MEDI-CAL MENTAL HEALTH PLAN (MHP)
FEE-FOR-SERVICE (FFS)
PROVIDER NETWORK MANUAL

ACCESS UNIT

Local: (909) 386-8256
Toll Free: (888) 743-1478
Fax: (909) 890-0353

Established:
July 26, 2010

Amended:
May 3, 2019

Table of Contents

Medi-Cal Outpatient Provider Manual **4**
Welcome 4
County of San Bernardino Department of Behavioral Health Local Mental Health Plan **5**
Important Numbers 5
Provider Listing 5
State Department of Health Services Medi-Cal Field Office **6**
Important Phone Numbers 6
Department of Behavioral Health Vision, Mission & Values **6**
Vision 6
Mission 6
Values 6
Fee-for-Service Provider Area Map **7**
Maps by Region 7
Fee-For-Service Provider Network **8**
Overview 8
Becoming a Provider 8
Provider Updates 9
Provider Suspensions 9
After Hours Requirement for DBH FFS Network **10**
Telephone Message/ Answering Service 10
Initial Contact Log Requirement **11**
Initial Contact Log Instructions 11
Client Eligibility **12**
Overview 12
How to Determine Eligibility Prior to Providing Services 12
Client Registration **13**
Overview 13
Client Registration by Providers 13
Referrals, Service Delivery & Reimbursement **14**
Referrals to Providers 14
Linguistic and Cultural Competence 14
Authorized Services 14
Authorization Process 15
Re-Authorization Process 15
Gap in Service 16
Request for Additional Authorization 16
Crisis/ Urgent Services 16
Faxing of Documents 17
Retroactive Medi-Cal 17
Transition of Services 17
Termination of Services 17
Specialized Authorizations: Specialty Mental Health Inpatient Professional Services 17
Institutions for Mental Diseases (IMD) Authorization Procedures 18
Psychiatric Services **18**
Medication Services 18
Medical Necessity **19**
Requirements for Meeting Medical Necessity 19
Early Periodic Screening Diagnosis and Treatment (EPSDT) **21**
EPSDT Criteria 21
Excluded Diagnosis 21
Excluded Services 21

Dysfunctional Levels for Treatment Authorization Determination 22
Overview 22
Mild: Little or minor impact on daily functioning 22
Moderate: Significant impact on daily functioning 24
Severe: Constant and significant interference with daily functioning 24
CPT Codes Overview 24
Required Treatment Records 25
Overview 25
Standards of Treatment Record Documentation 26
Overview 26
MHP Assessment Plan 26
Diagnosis Sheet 26
Change of Diagnosis Form 26
Client Plan 27
Re-Authorization Request (if applicable) 28
DBH Consent for Outpatient Treatment 28
Acknowledgement of Receipt of Notice of Privacy Practices 28
Medication Consent Form 28
Progress Notes 28
Medication Order Sheet 29
Aims Scale 29
Physical Assessment Notification 29
Maintenance of Medical Records 30
Overview 30
Claims Processing 31
Overview 31
Provider Problem Resolution & Appeal Process 33
Statement of Problem (Verbal or Written) 33
Payment / Credentialing Reviews 33
Compliance Program / Quality Management 34
Overview 34
Quality Improvement, Audits and Technical Assistance 34
MHP Provider Responsibilities 34
Provider Revocation Suspension or Termination of Agreement 35
Recovery of Overpayments 35
Provider Notification and Corrective Action Process 36
Administrative Review 36
Research with Beneficiaries 36
Beneficiary Problem Resolution 37
Overview 37
Grievances 37
Appeals Process by Clients (Verbal and/or Written) 37
Request for a State Fair Hearing 38
Additional Points 38
Request for Second Opinion 39
Appendix 1: Access Units for All California Counties 40
Contact Information 40
Appendix 2: Beneficiary Rights & Forms 47
Beneficiary Rights & Forms 47
Appendix 3: Forms 48
Provider Forms 48
Psychiatric Forms 48
Appendix 4: Useful Tools 92
Useful Tools 92
Medi-Cal Codes for California Counties 93
County Code Listing 94
Frequently Used Provider Reimbursement Rates 94
Rates as of February 1, 2016 94

Master Treatment Goals 95
Required Treatment Records 96
Instructions for Completing the CMS-1500 Form 97
Title 9 of The California Code Of Regulations, Section § 1830.205 100
Title 9 of The California Code Of Regulations, Section § 1850.205 102
Appendix 5: Research Policy & Application Process 105
Research Policy & Application Process 105

Welcome

Welcome to the County of San Bernardino County (SB) Department of Behavioral Health (DBH) Mental Health Plan (MHP).

On June 1, 1998, under a State mandate, the MHP began implementing the Phase ll Consolidation of Medi-Cal Specialty Mental Health Services. Phase ll consolidated specialty mental health services are delivered by licensed Psychiatrists (MD/DO), Psychologists (PhD/PsyD), Clinical Social Workers (LCSW), Marriage and Family Therapists (LMFT), Professional Clinical Counselors (LPCC) through the Fee-For-Service (FFS) system of the California Department of Health Care Services (DHCS).

The purpose of the MHP is to administer all Medi-Cal and State funds for specialty mental health services that are compliant and consistent with the Health Insurance Portability and Accountability Act (HIPAA), and designed to ensure availability and accessibility of quality specialty mental health care to Medi-Cal beneficiaries. These services include but are not limited to inpatient, outpatient, and psychological testing.

This Provider Manual will guide the FFS Provider Network through the processes involved in partnering with the County of San Bernardino County Department of Behavioral Health MHP in the delivery of high quality, cost-effective mental health care services.

Key areas on which to focus are:

- Participation in the MHP Fee-For-Service (FFS) Provider Network;
- Access to services for Medi-Cal beneficiaries;
- Verification of Medi-Cal beneficiary eligibility and determining medical necessity;
- FFS Network Provider responsibilities to provide verbal and written information to Medi-Cal beneficiaries;
- Treatment authorization;
- Psychological testing;
- Claims for services rendered;
- Problem Resolution Process
- Care coordination with other mental health plans; and
- Available support services for FFS Network Providers and Medi-Cal beneficiaries.

As an important link in SB DBH's system of care, your successful participation in the FFS Provider Network is vital to our success. We look forward to working with you to ensure the delivery of specialty mental health services to eligible Medi-Cal beneficiaries.

Should you have any questions, comments or suggestions regarding the information in this manual, please direct your calls to the Access Unit at (888) 743-1478.

Important Phone Numbers

Access Unit	(909) 386-8256 / (888) 743-1478
Community Crisis Response Team: West Valley Region *(Chino, Chino Hills, Fontana, Montclair, Ontario, Rancho Cucamonga, Upland)*	(909) 458-1517 / Pager: (909) 535-1316
Community Crisis Response Team: East Valley Region *(Bloomington, Colton, Highland, Redlands, Rialto, San Bernardino, Yucaipa)*	(909) 421-9233 / Pager: (909) 420-0560
Community Crisis Response Team: High Desert Region *(Adelanto, Apple Valley, Barstow, Hesperia, Phelan, Oak Hills, Oro Grande, Silver Lakes, Victorville)*	(760) 956-2345 / Pager: (760) 734-8093
Community Crisis Response Team: Morongo Basin Region *(29 Palms, Morongo Basin, Yucca Valley)*	(760) 499-4429
Compliance	(800) 398-9736
Inpatient Authorization	(909) 386-8219
Medical Records	(909) 421-9350
Patients' Rights	(800) 440-2391
Quality Management Division	(909) 386-8227
Workforce Education & Training	(800) 722-9866
Office of Cultural Competence and Ethnic Services	(909) 382-3083

Provider Listing

The FFS Provider Network listing is updated on an ongoing basis. Providers are listed on the SB DBH website on the **Fee-For-Service Provider Network** webpage by clicking on *Fee-for Service Providers by Area* under **Provider List** at: http://wp.sbcounty.gov/dbh/for-providers/ffs-provider-network/

California Department of Health Care Services

Important Phone Numbers

California Department of Health Care Services
https://www.dhcs.ca.gov/Pages/default.aspx
Phone number: 1-800-541-5555

Department of Behavioral Health Vision,Mission & Values

Vision

We envision a County of San Bernardino where all persons have the opportunity to enjoy optimum wellness, whether they have experienced mental illness, substance abuse or other addictions.

Mission

The County of San Bernardino Behavioral Health Programs strive to be recognized as a progressive system of seamless, accessible and effective services that promote prevention, intervention, recovery and resiliency for individuals, families and communities.

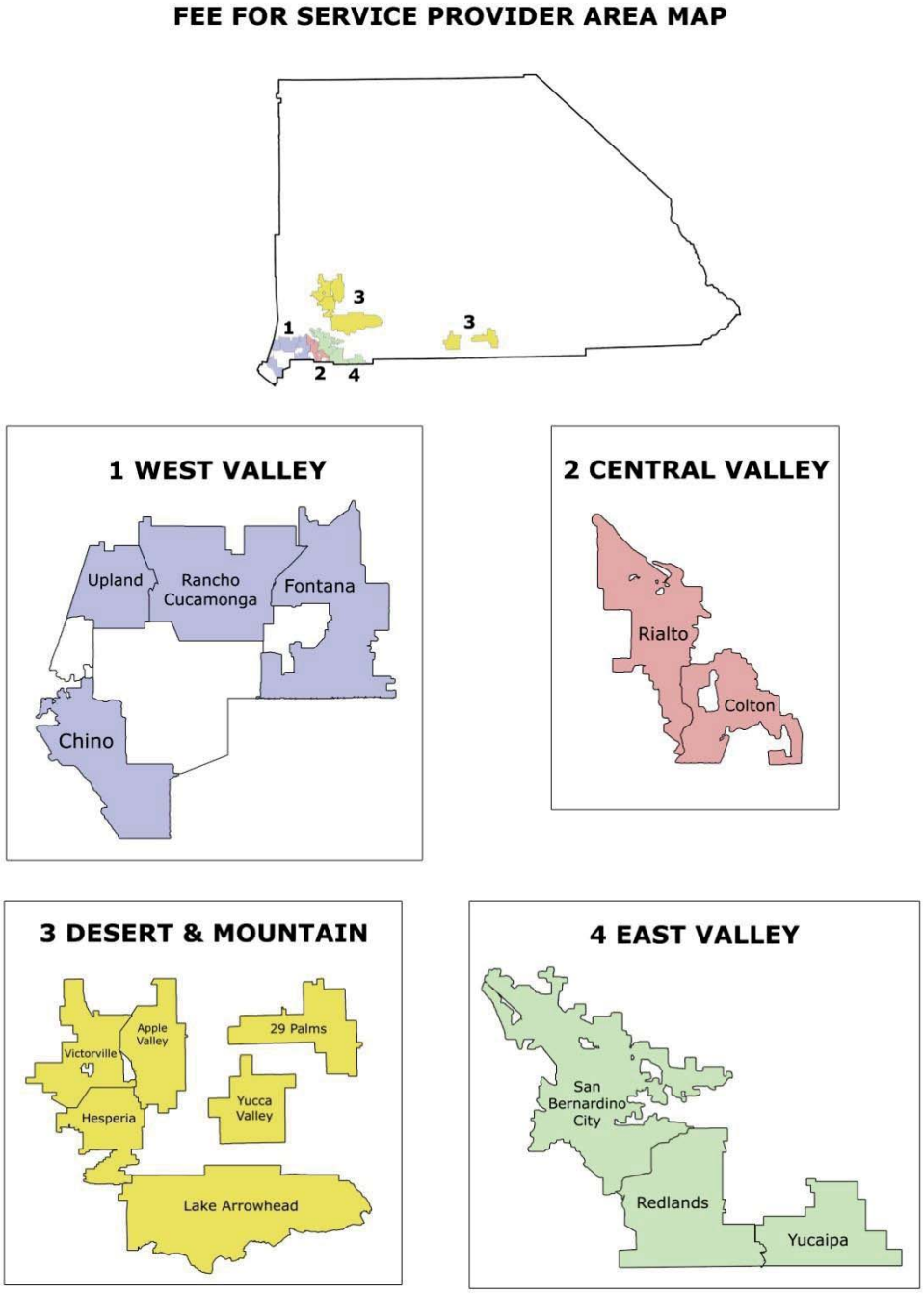
Values

We embrace the followingvalues:

- Clients and families as central to the purpose of our Vision and Mission.
- Sensitivity to and respect for all clients, families, communities, cultures and languages.
- Effective services in the least intrusive and/or restrictive environment.
- Positive and supportive settings with state-of-the-art technologies.
- Open and honest dialogue among all stakeholders.
- Partnerships and collaborations that share leadership, decision-making, ownership and accountability.
- Each other as our most valuable asset, and collectively the empowerment that this provides.
- A well-trained and competentworkforce.
- Empowering and supporting staff in their personal and professional development.
- Responsible use of our resources to ensure financial sustainability.

Fee-for-Service Provider Network Area Map

Maps by Region



Fee-For-Service Provider Network

Overview

The County of San Bernardino Department of Behavioral Health (DBH) Access Unit manages the MHP Fee-for Services (FFS) Provider Network, including the credentialing of qualified providers. Qualified providers include licensed Psychiatrists (MD/DO), Psychologists (PhD/PsyD), Clinical Social Workers (LCSW), Marriage and Family Therapists (LMFT), Professional Clinical Counselors (LPCC) who have been credentialed by the Mental Health Plan (MHP). Other licensed mental health providers may be authorized as service providers at the discretion of the MHP.

Becoming a Provider

Qualified <u>outpatient</u> providers may apply for MHP credentialing by completing the following:

- MHP application
- Med Advantageapplication
- A credentialing fee payable to Med Advantage
- W-9 Form
- Provider Service AgreementForm
- Attestation Form
- ConflictofInterestForm*
- (*This form is applicable only to County of San Bernardino employees with an agency contracted with the MHP. This form must be updated annually and/or within 10 days of a change in circumstances.)
- Code of Conduct Acknowledgment Form (Updated Annually)
- Fee-for-Service Site Certification
- Provider's NPI Number Form

Additionally each applicant must submit:

- A current copy of their California Professional License
- A current copy of their Malpractice Insurance
- A current copy of their DEA (MD/DO)
- A current email address

Qualified <u>inpatient</u> providers (MD/DO) may apply for MHP as an inpatient ONLY provider by completing the following:

- MHP application
- W-9 Form
- Provider Service AgreementForm
- Attestation Form
- Conflict of Interest Form
- Provider's NPI Number Form

Additionally each applicant must submit:

- A current copy of their California Professional License
- A current copy of their Malpractice Insurance
- A current copy of their DEA Authorization(if applicable)
- FFS Site Certification Form (if applicable)
  (This form must be updated every three years or when a change occurs.)
- A current email address

All credentialed providers must complete orientation training on authorization process and claims and procedures with the Access Unit. It is also highly recommended that office managers attend the orientation training to understand the billing process and paperwork. Contact the Access Unit Provider Relations at (909) 386-8249 or DBH-access@dbh.sbcounty.gov if you have any additional questions.

Every three (3) years, the Access Unit Provider Relations Representative will contact the provider for re- credentialing.

NOTE: It is not the responsibility of the MHP to check the related data bases for license validity, insurance coverage or DEA certificate validation. Providers are responsible for such verification.

For each new or additional location, a new Fee-for-Service Certification Form is to be submitted. Forms may be obtained by contacting the Access Unit Provider Relations Representative at (909) 386-8249.

Provider Updates

- The MHP provides periodic email/fax updates to providers detailing changes in forms and procedures and offers updated information as necessary.
- The MHP provides the following website for providers' use for State Informing Materials: http://wp.sbcounty.gov/dbh/for-providers/ffs-provider-network/
- The MHP encourages providers to attend scheduled MHP clinical and clerical trainings to obtain updated information.

Provider Suspensions

If a provider is suspended from being credentialed, all pending authorizations, approved re-authorizations, and existing approved authorizations for that provider are placed on hold, until such time as an audit is conducted and a decision by the MHP administration is reached. This means that payment may be suspended during the time an investigation is being completed. Suspension may occur due to the following but is not limited to:

- Loss of State License
- Convictions due to illegal activity
- Violation of ethical standards for the profession
- Fraudulent billing/claims activity
- Sexual involvement with beneficiary or beneficiary's family members
- Violation of the terms of the Provider Agreement for the MHP

Additional information on provider revocation, suspension or termination can be found under *Provider Revocation Suspension* or *Termination of Agreement* section.

After Hours Requirement for Fee-For-Service Provider Network

Telephone Message/ Answering Service

As a provider in the FFS Provider Network, you must ensure you have an after-hours message when you are unavailable. All providers are required to add the following language to their normal telephone message/recording:

"If you are a County of San Bernardino Medi-Cal beneficiary and need immediate assistance, call the Access Unit at 1 (888) 743-1478. If you are experiencing a life threatening emergency, please call 9-1-1".

FFS providers are also required to have this same message in Spanish. Additionally, if you speak more than one language in your practice, you must duplicate the message in all of those languages. If you do not have Spanish speaking staff, you may call the Office of Cultural Competency and Ethnic Services at (909) 252-4001 for assistance.

An example of what you may state on the message or have the answering service say:

"You have reached (name of clinic). We are currently closed. Our normal hours of operation are (0:00 am to 0:00 pm). If you wish to make an appointment, please call back when we are open. If you have a life threatening emergency, call 9-1-1. For other urgent needs, you may call (XXX-XXX-XXXX ans. svc, pager, home, etc…) and someone will speak with you shortly. If you have County of San Bernardino Medi-Cal and need immediate assistance, you may contact the Access Unit at 1-888-743-1478."

Initial Contact Log Requirement

Initial Contact Log Instructions

Each FFS Provider is required to keep and complete an initial contact log daily to track client requests for services. The Initial Contact Log is used when a beneficiary contacts you by telephone or as a walk in and was **not** referred by the Access Unit or a DBH clinic. (See Initial Contact Log, Appendix 3: Forms.)

- Fill in the date and time the beneficiary contacted you under **DATE/TIME**.
- Fill in the name of the beneficiary, last name first under **NAME OF BENEFICIARY**.
- Fill in caller name if different than the beneficiary, last name first and relationship to beneficiary under **CALLER NAME**.
- Fill in the reason for contact, what the client was requesting, under **REASON FOR CONTACT**.
- Fill in the initial disposition; did you refer the client out or did you schedule an appointment. If so, put in the appointment date under **INITIAL DISPOSITION**.
- If the beneficiary's contact was urgent, check Y for yes and if not urgent, check N for no under **URGENT**. If Urgent, put the amount of minutes it took for you to respond to the urgency in minutes under **TIME TO RESPOND TO URGENT NEED**.
- ***MHP REQUIRES A MAXIMUM RESPONSE TIME OF 2 HOURS FOR ALL REQUESTS FOR URGENT SERVICES.***
- If interpreter services were needed, check Y for yes and N for no and if offered. Check Y for yes and N for no under **INTERPRETER SERVICES NEEDED? OFFERED?**
- Circle N/A if not applicable, accepted if accepted or refused for refused under **RESPONSE TO OFFER OF INTERPRETING**.
- Under **STAFF NAME**, write the name of the staff that answered the phone or greeted the client, last name first.

FFS Providers are required to fax the Initial Contact Log to the Access Unit at 909-890-0353 each month. If you did not receive any contacts, write **NO CONTACTS**, the month and year, and the provider name.

Client Eligibility

Overview

Those persons eligible for County of San Bernardino Medi-Cal mental health services can be identified by the first two numbers on their Medi-Cal Beneficiary Identification Card (BIC). The County Code for San Bernardino is **36**. **However**, **to ensure that your services will be reimbursed**, check with the Access Unit of the county issuing the client's Medi-Cal or check the State data base. Medi-Cal codes of the 58 County Access Units in California counties can be found under Medi-Cal Codes for California Counties. (See Medi-Cal Codes for California Counties, Appendix 4: Useful Tools.)

The San Bernardino County Access Unit will assist Mental Health Plan Providers in determining the eligibility of Medi-Cal beneficiaries. It is strongly encouraged that providers contact the appropriate county Medi-Cal office directly regarding client Medi-Cal eligibility status if client has out-of-county Medi-Cal.

How to Determine Eligibility Prior to Providing Services

It is the provider's responsibility to determine the client's Medi-Cal eligibility by contacting the AEVS (Automated Eligibility Verification System) from the State at (800) 456-2387, or by contacting the DBH Access Unit.

If a client is found ineligible due to 1) lack of Medi-Cal eligibility, 2) lack of medical necessity, or 3) lack of need for specialty mental health services, the client may be referred to other community treatment or non-treatment resources. Contact the Access Unit for a list of community referrals.

If a client is eligible but has **other primary care health insurance** (or other additional coverage such as workers compensation, auto accident or other accident related coverage),it is the responsibility of the provider to submit a claim to the other insurance first.

The other insurance will either pay or deny the claim. If the other insurance denies the claim, the provider must submit a copy of the denial letter, an EOB (explanation of benefit) letter, with a CMS1500 approved OMB-0938-0999 claim form for determination of reimbursement. (This form is specifically highlighted with the spaces for the NPI numbers to be placed in sections numbered 17a, 32a, 33a, 24j.)

Client Registration

Overview

Each time a Medi-Cal beneficiary contacts you, you must verify Medi-Cal eligibility. You may see the beneficiary for one (1) pre-authorized assessment session. All clients must be registered **prior** to receiving any service and prior to claiming payment for services. (See Beneficiary Registration Sheet, Appendix 3:Forms.)

Most Medi-Cal specialty mental health services require advance approval from the Access Unit before the provider may perform them. The only services which do not require advance authorization are the following:

One (1) initial outpatient Psychiatric Diagnostic Interview Examination with a new patient (CPT Code 90792 for MD or DO, CPT Code 90791 for PhD/PsyD, LMFT, LCSW)

One (1) initial Psychiatric Diagnostic Interview Examination with a new patient in a skilled nursing facility by a Psychiatrist (MD/DO) or Psychologist (PsyD/ PhD).

Client Registration

If a beneficiary approaches a provider directly for services, the provider must register the potential client with the MHP by faxing the Beneficiary Registration Sheet to (909) 890-0353, before delivering services to the beneficiary. (See Beneficiary Registration Sheet Appendix 3: Forms.)

Referrals, Service Delivery & Reimbursement

Referrals to Providers

The County of San Bernardino Access Unit serves as the call center for County of San Bernardino Medi-Cal beneficiaries. Beneficiaries calling into the Access Unit requesting services may be referred to a county clinic, contract agency or FFS Provider. Access Unit referrals will be based on geographic accessibility, American Disabilities Act (ADA) office accessibility, provider specialty, language or cultural capacities, past treatment contacts with the client, and on client request.

Providers are required to accept Access Unit referrals, unless they have notified the Access Unit that they are temporarily not accepting new cases. Providers will conduct initial client appointments in a timely manner; for most cases within five (5) working days of referral.

Linguistic and Cultural Competence

Every effort will be made to refer clients to providers who can communicate in the client's preferred language and/or have the cultural knowledge and/or sensitivity to understand and relate to the client in a way that will facilitate treatment.

Providers who find themselves unable to provide quality services to a client due to linguistic or cultural factors should refer the client to the Access Unit for referral to a more appropriate provider. The MHP offers cultural competency training for providers. FFS Providers are also encouraged to seek out additional culturally relevant training opportunities offered by the MHP and scheduled by DBH Workforce Education and Training.

Authorized Services

Services provided must be consistent with what has been requested in the MHP Treatment Authorization Request (TAR) and authorized by the Access Unit. Services not authorized by the Access Unit are not eligible for reimbursement and will not be paid except under rare circumstances as determined by the MHP. (See FFS Provider Outpatient Treatment Authorization Request (TAR) form, Appendix 3: Forms.)

Authorization Process

The Provider must submit a completed Treatment Authorization Request (TAR form and a signed Medication Consent form. (See FFS provider outpatient Treatment Authorization Request (TAR) form, Appendix 3: Forms.)

If the provider determines that a client does not meet medical necessity criteria for services, then the provider must complete a Notice of Adverse Benefit Determination (NOABD) form and deliver it to the client within three (3) days as well as forward a copy to the Access Unit. (See Notice of Actions – A, Appendix 2: Beneficiary Rights & Forms.)

The provider negotiates one (1) or at most two (2) acceptable treatment goals from the Master Treatment Goals list with the client. The goal is entered on the Client Plan, along with the behaviorally specific objectives, including a baseline and a target date to reach objective; thereby assisting the determination of a termination date. (See Master Treatment Goals, Appendix 4: Useful Tools.)

It is a requirement of the California Department of Health Care Services that there be proof of the client's participation in the treatment plan. The client's signature on the Client Plan is the means of providing the proof. It is preferable and highly encouraged, in the case of minors, to have the children sign the plan themselves (when able; document when unable). Signatures from the provider, client aged 12 and over, parent and legal representative are required.

Processing Timeline:

The Access Unit has 14 calendar days to process the TAR from the date the completed paperwork is received at the Access Unit. If more information is needed from the provider, the Access Unit may contact the provider for clarification. The provider must reply to inquiries within this 14 day timeline. If the provider is unable to meet this timeline, the provider or MHP may submit a request to extend the timeline for an additional 14 calendar days. If the requested information is not received by the Access Unit by the end of the initial 14 day timeline, or by the end of the extension period if requested, the authorization will be denied and a NOABD will be faxed to the provider and client.

The Access Unit will review the information (TAR) submitted and make a determination on medical necessity. Based on this review, an authorization may be approved, modified or denied. If denied, a Notice of Adverse Benefit Determination form will be issued to the provider and client.

The effective date of the authorization for all continuing treatment, (CPT codes 99213, 90834, 90847, etc.), is the date the completed paperwork is received by the Access Unit. The date the initial assessment (90791, 90792) is authorized for payment is based on the "Initial Assessment date" provided on the TAR form.

When treatment is authorized, the Access Unit will send an authorization letter to the provider.

The Access Unit authorizes services for the following periods:

1. For Adult Psychiatry – Twelve month cycles
2. For Child Psychiatry – Six month cycles
3. For Psychotherapy – Six month cycles

It is the MHP providers' responsibility to contact the Access Unit if a response is not received within 14 days of original fax request.

Therapeutic sessions which occur outside of an authorization period will not be reimbursed. It is the provider's responsibility to review the effective date and expiration date of each authorization.

For beneficiaries in residential care settings, including board and care and skilled nursing facilities, specialty mental health services are authorized in the same manner and under the same guidelines as when delivered in other outpatient settings.

Re-Authorization Process

A Treatment Authorization Request (TAR) must be submitted to the Access Unit to request services occurring beyond the expiration date of the authorization period. For services to continue without interruption, the TAR may be submitted with 30 days of the expiration of the current authorization period.

The TAR must include updates to the beneficiary's clinical status such as changes in diagnosis, current behaviorally specific problems, areas of progress, current treatment interventions, etc. (See FFS Provider Outpatient Treatment Authorization Request (TAR) form, Appendix 3: Forms.)

Note: The Axis I diagnosis reported on claims for reimbursement must be consistent with the Axis I diagnosis reported on the TAR.

Changes in Service

Contact the Access Unit if there is a need to change the services being delivered during an active authorization period by submitting a Treatment Authorization Request form to the Access Unit.

The Access Unit may refer clients to DBH clinics at any time if it is determined that the client would benefit from DBH clinic resources.

Gap in Service

If there is a gap between sessions of six (6) months or more with the same provider, the provider must submit a Discharge Summary to close the prior authorization, a new TAR, and a signed Medication Consent form (for medication support services) in order to be paid for a new assessment. Clients may be discharged after 6 months of inactivity. (See Discharge Summary, Appendix 3: Forms.)

Request for Additional Authorization

The Treatment Authorization Request (TAR) form is used to request additional treatment sessions for the current authorization period in the event that all treatment sessions will be exhausted for that period.

Providers must select “change to authorization” on the TAR and identify the number of additional sessions being requested. Documentation must clearly establish medical necessity/impairment in function for increased/change in level of care. Services are effective the date the Access Unit receives the completed TAR. (See FFS Provider Outpatient Treatment Authorization Request (TAR) form, Appendix 3: Forms.)

Crisis/ Urgent Services

The need for crisis services (urgent conditions) is defined as a circumstance in which, without immediate attention, the client is likely to need emergency care (i.e., admission to a psychiatric inpatient hospital). . All crisis services reimbursement requests must include clearly documented rationale for the intervention. Contact the DBH Crisis Response Team if crisis services are needed. If imminent danger exists, call 9-1-1. In some circumstances it is acceptable to use one of the already authorized sessions for the service and later request a replacement session clearly documenting such justification. Refer to the *Request for Additional Authorization* section on of this manual for information on how to request additional sessions. (See Important Phone Numbers on page 6 of this manual.)

California Code of Regulations (CCR) Title 9 § 1810.253 Urgent Condition.

"Urgent Condition" means a situation experienced by a beneficiary that, without timely intervention, is highly likely to result in an immediate emergency psychiatric condition

Faxing of Documents

All documentation sent to the Access Unit by fax machines needs to have a fax record kept for purposes of verification, by the provider. Any appeals for reconsideration of lost documentation will only be considered if the provider can show evidence that the disputed items were sent via fax.

Retroactive Medi-Cal

If a client is Medi-Cal eligible and applies for Medi-Cal, services that were provided between the date of application and the date of approval will be reimbursable if the provider has followed all MHP procedures relevant to Medi-Cal for those services (including registration of the client, requesting authorization of services, etc.).That is, the provider has operated as though the beneficiary has benefits. Chart documentation of services must be to Medi-Cal standards to be eligible for reimbursement. If a provider requests authorization for retroactive Medi-Cal services, the MHP may request review of the chart documentation to verify Medi-Cal standards are met.

Transition of Services

When providers discontinue Medi-Cal services to clients, they are required to send written notification to the Access Unit and to plan for an orderly transition of services to clients. (See Discharge Summary, Appendix 3: Forms.)

If, for any reason a provider refuses services to a client who meets medical necessity/Tier III criteria for specialty mental health services, the provider must refer the client to the Access Unit for referral to an alternate mental health provider. Providers must not stop treatment to a beneficiary without making reasonable efforts to arrange for ongoing/continuing care if needed.

Termination of Services

Termination of treatment will take place when any of the following occur:

1. The behaviorally specific objectives in the Client Plan are accomplished (even if all authorized visits have not been used),
2. The client has reached maximum benefit from treatment (even if the behaviorally specific objectives have not been reached), the authorization period expires,
3. Further authorization has not been requested by the provider.

Medicare/Medi-Cal does not require authorizations from the Access Unit. (See the *Claims Processing Medicare/Medi-Cal* section of this manual.)

Specialized Authorizations: Specialty Mental Health Inpatient Professional Services

Specialty Mental Health Inpatient Professional Services are services delivered in a mental health unit of a psychiatric or general acute care hospital. Approval of these services is determined by State Medical Necessity criteria and by the Treatment Authorization Request for Mental Health Stay in Hospital guidelines. It is the responsibility for the hospital where these services are performed to complete the Treatment Authorization Request for Mental Health Stay in Hospital form (Medi-Cal Authorization form 18-3) and submit it to the Inpatient Authorization Unit. It is the responsibility of the FFS Network provider to submit the completed claim form to the Inpatient Authorization Unit for reimbursement of these services.

Institutions for Mental Diseases (IMD) Authorization Procedures

All IMD services must be pre-authorized. In order for an authorization to be given for any client residing in an IMD facility the client must be receiving case management services by a San Bernardino County Adult Residential Services staff member (see IMD facility Administrator to verify if the client is a San Bernardino Countycase).

Since IMD services are not Medi-Cal reimbursable, Medi-Cal eligibility is not pertinent for IMD clients. It is imperative the provider verify whether the client is a San Bernardino County client prior to requesting authorization..

A request and authorization of IMD services will be provided via a referral from the San Bernardino County Adult Residential Services staff. Once the referral is approved the IMD facility accepts a San Bernardino County client, the following forms will be completed.

- Public Guardian Letter of Authorization
- Department of Behavioral Health Rate Letter
- IMD Admission Form

Psychiatric Services

Medication Services

Medication services are treated similarly to other services in terms of charting requirements and authorization. The physician's order sheet, a medication consent form, an AIMS scale form, and a physical assessment notification should be included in the provider's office chart. (See Outpatient Medication Record, Appendix 3: Forms.)

Medicines used to treat various conditions will be reviewed by the Access Unit and in some cases by the MHP Quality Improvement Committee for comparison to standards of practice in the community. Providers will be asked to conform to Medi-Cal approved choices and dosages of medications.

- Medication Order Sheet

- AIMS Scale
  - Should be completed annually if the provider prescribes psychotropic medications.

- Physical Assessment Notification
  - Should be completed annually if provider prescribes medications.

- Release of Information Forms
  - (Includes client authorization for providers and MHP to communicate about clinical and authorization aspects of treatment)

- Discharge Summary (Closed Cases)
  - Should be mailed to the Access Unit following termination

Medical Necessity

Requirements for Meeting Medical Necessity

In order for services to be authorized, all clients must either:

(1) Meet "medical necessity" criteria according to California Code of Regulations (CCR) Title 9, Section 1830.205 or Title 9, Section 1830.210 (See Appendix regarding medical necessity rules for specialty mental health services established by the State, or;

(2) Be qualified and eligible for EPSDT (Early and Periodic Screening, Diagnosis and Treatment) services.

The FFS provider and subsequently the MHP Access Unit is responsible for determining whether or not each client meets these requirements. If the client does not meet medical necessity, a Notice of Action form must be completed and given or mailed to the client. (See Notice of Actions – A, Appendix 2: Beneficiary Rights and Forms.)

Criteria for Medi-Cal Medical Necessity and for EPSDT Services
Medi-Cal reimbursement for Specialty Mental Health services is the responsibility of the MHP. The following criteria are used in determining medical necessity for Specialty Mental Health services.

The beneficiary must meet criteria outlined in (1), (2) and (3) below to be eligible for services:

(1) Be diagnosed by the MHP with one of the following diagnoses in the ICD-10 CM, published by the World Health Organization (WHO).

- Pervasive developmental disorders, except autistic disorders
- Disruptive behavior and attention deficit disorders
- Feeding and eating disorders of infancy and early childhood
- Elimination disorders
- Other disorders of infancy, childhood or adolescence
- Schizophrenia and other psychotic disorders
- Mood disorders
- Anxiety disorders
- Somatoform disorders
- Factitious disorders
- Dissociative disorders
- Paraphilias and Gender Identity Disorder in children
- Eating disorders
- Impulse control disorders not elsewhere classified
- Adjustment disorders
- Medication-induced movement disorders related to other included diagnoses

(2) Must have at least one of the following impairments as a result of the mental disorders listed in (1) above:

- A significant impairment in an important area of life functioning
- A reasonable probability of significant deterioration in an important area of life functioning without treatment.
- Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate without treatment. For the purpose of this section, a child is a person under the age of 21 years.

(3) Must meet each of the intervention criteria listed below:

- The focus of the proposed intervention is to address the condition identified in (2) above
- The expectation is that the proposed intervention will:
  - significantly diminish the impairment, or
  - prevent significant deterioration in an important area of life functioning, or

  Except as provided in Section 1830.210, allow the child to developmentally progress as individually Appropriate. The condition would not be responsive to physical health care-based treatment.

When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in section (1) even if a diagnosis that is not included in section (1) is also present.

EarlyPeriodic Screening Diagnosis and Treatment (EPSDT)

EPSDT Criteria

For beneficiaries less than 21 years of age who do not meet the medical necessity requirements listed immediately above, medical necessity criteria for specialty mental health services covered by the MHP shall be met when all of the following exist:

1. The beneficiary meets the diagnostic criteria,
2. The beneficiary has a condition that would not be responsive to physical health care-based treatment, and
3. The services are necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services.

Excluded Diagnosis

- Mental Retardation
- Learning Disorders
- Motor Skills Disorders
- Communication Disorders
- Sleep Disorders
- Antisocial PersonalityDisorder
- Autistic Disorders, Other Pervasive Developmental Disorders are included
- Tic Disorders
- Delirium, Dementia, and Amnesic and other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance Related Disorders
- Sexual and Gender Identity Disorders, except Paraphilias and Gender Identity Disorders in Children which are included
- Other Conditions that may be a Focus of Clinical Attention, except Medication Induced Movement Disorders which are included
- Relational Problems (V-Codes)

Note: A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present.

Excluded Services

CCR Title 9 § 1810.355 Excluded Services.

- *Marriage Counseling is not a covered service by Medi-Cal.*

MHPs shall not be responsible to provide or arrange and pay for the following services:
(a) Medi-Cal services, which are those services described in Title 22, Division 3, Subdivision 1, Chapter 3, Section 51001 et seq., that are not specialty mental health services for which the MHP is responsible pursuant to Section 1810.345.

Dysfunctional Levels for Treatment Authorization Determination

Overview

Dysfunction must be due to mental disorder. All criteria need not be present but are examples to guide the determination of the general level of dysfunction.

Mild: Little or minor impact on daily functioning

- Causes minor disruption in stable employment (verbal squabbles with boss or co-workers, suspended 1-2 days per year).
- Money management results in having to borrow from others to make it through the month once or twice a year.
- May have to move once every two years due to conflicts or non-payment, but always finds a place to go.
- Occasionally or frequently disciplined by teacher.
- Occasionally sent to principal's office.
- Held back one grade.
- Child does not do homework.
- Child has only a few playmates and occasionally alienates other children.
- Child's conflicts with parents have noticeable impact on his/her motivation and performance in school.
- Inappropriate but not harmful discipline of children.
- Occasionally misses fixing meals for children.
- Shoplifting arrest once a year.
- Occasional drug fines.
- Police called by others once a year or less due to client's behavior.
- Occasional suicidal thoughts or wishes to be dead.
- Occasional poor choices or judgments resulting in failed opportunities or more frequent stresses and abrupt changes in life.
- Occasional fighting without need for significant medical attention afterward for self or others.
- Once or twice per month misses meals due to lack of food.

Moderate: Significant impact on daily functioning

- Loses jobs once a year.
- When loses job doesn't get new job for a month.
- Suspended for more than two days per year. Occasional physical fights at work.
- Job performance at a level that client is on the edge of losing job two or more times per year.
- When unable to continue previous work is uninterested or unmotivated to retrain or find another area of work.
- Money management results in having to borrow from others to make it through the month three to five times per year.
- Homeless once or more in last two years.
- More than one grade level behind in school.
- Sent to principal's office five or more times per year.
- Disciplined daily by teacher.
- Child completely refuses assigned responsibilities in the home.
- Parental discipline of children which could be reportable as child abuse.
- Serious neglect of children resulting in marginally acceptable health of safety of children.
- Serious negative impact on the emotions and self of child due to criticism, accusations, put-downs, etc.
- Arrests or court fines more than once per year.
- Police called on client more than once per year.
- Physically self-harming behavior once a year which results in need for medical attention (whether obtained or not).
- Two suicide attempts in last four years.
- Occasional or frequent fighting, often involving significant injuries to self or others.

- Misses several meals each week due to lack of food.
- Frequent poor choices or judgment resulting in significant turmoil for others at least monthly.

Severe: Constant and significant interference with daily functioning

- Unable to hold a job.
- Out of work more than one third of the time.
- Occasionallycompletely unable to obtain food for days at a time.
- Runs out of money before end of month six or more times per year.
- Thrown out of residences more than once in last two years due to behavior.
- Homeless twice or more in last two years.
- Suspended from school more than two weeks in last year.
- Placed in home study by school due to lack of manageability.
- Child is completely unable to relate to peers or has no friends.
- Child sent to juvenile hall due to disorder-related behavior.
- Almost totally neglects childcare.
- Is a serious danger to children in thehome?
- Caused child to be in hospital due to injuries inflicted.
- Children taken by CPS.
- Child sent to juvenile hall due to disorder-related behavior.
- Adult is in jail several times per year.
- Aggression or fighting in last two years that has caused a person to be hospitalized.
- Chronically "gravely disabled".
- Wants to die more than half of the time.
- Self-mutilation requiring medical attention two or more times per year.
- More than two suicide attempts in last four years.
- Not allowed to live with others or avoided by most others due to disruptions caused by poor choices orjudgments.

CPT Codes Overview

Listed below are descriptions of some of the Specialty Mental Health services used by the County of San Bernardino:

CPT 90791 "Psychiatric Diagnostic Evaluation (no Medical Services)" – (intake evaluation) is defined as an assessment done by the provider with the consumer to see if the person meets medical necessity for services.

CPT 90792 "Psychiatric Diagnostic Evaluation (with Medical Services)' – (intake evaluation) is defined as an assessment done by the provider with the consume rto see if the person meets medical necessity for services.

CPT 90834 "Individual Psychotherapy" - 45 min is defined as a therapy session between the provider and the consumer.

CPT 90847 "Family Psychotherapy" is defined as a therapy session between the provider and the consumer's family member(s) with the consumer present in which the focus of the session is related to the consumer's treatment goals.

CPT 99213 "Pharmacological Management" – (15 minutes) as defined as a qualified physician evaluating the individual's needs for psychotropic medications, providing a prescription, and monitoring those medications.

CPT 99448 "Case Conference" (30 minutes) is defined as a communication with the consumer's school personnel, teachers, counselors, social worker, medical/hospital personnel, probation officers, court officials, group home staff, etc. for the purpose of assisting treatment goal.

CPT 99221 Inpatient Acute Hospital Initial Care (30 minutes) is defined as a psychiatric diagnostic interview exam on a psychiatric unit, an assessment done by the provider with the consumer to see if they meet medical necessity for services. The problems requiring admission are of low severity.

CPT 99231 In-patient Acute Hospital Subsequent Care (15 minutes) as defined as return visits to the psychiatric unit by the provider for evaluation and management of the patient including 2 of the 3 key components:

- A problem focused interval history;
- A problem focused examination;
- Medical decision making that is straightforward or of low complexity.

CPT 99232 In-patient Acute Hospital Subsequent Care (25 minutes) as defined as return visits to the psychiatric unit by the provider for evaluation and management of the patient including 2 of the 3 key components:

- An expanded problem focused interval history;
- An expanded problem focused examination;
- Medical decision making of moderate complexity.

CPT 99233 In-patient Acute Hospital Subsequent Care (35 minutes) as defined as return visits to the psychiatric unit by the provider for evaluation and management of the patient including 2 of the 3 key components:

- A detailed interval history;
- A detailed focused examination;
- Medical decision making of high complexity.

Required Treatment Records

Overview

DBH is responsible to the California Department of Health Care Services (DHCS), and the Centers for Medicare and Medicaid Services (CMS) for specialty mental health services. Specific information and documentation is required to be part of the client's medical/treatment record. Below is a list of those documents, which must be included in the client chart.

Providers may include additional forms and other types of documentation in their client record.

MHP forms are available on the DBH website:

http://wp.sbcounty.gov/dbh/for-providers/ffs-provider-network/. Additional assistance may be requested by contacting Provider Relations at 1(888) 743-1478.

The following documents must be included in the client's record. These records are subject to periodic audit.

Consents:

- DBH consent for Outpatient Treatment (includes client authorization for providers and MHP to communicate about clinical and authorization aspects of treatment).
- Advance Directive
- Medication Consent form (if medications are prescribed by the provider)
- Release of information forms (as needed)

Clinical:

- Initial Assessment (MHP assessment form or provider's own form)
- Diagnosis Sheet
- Client Plan
- Re-Authorization Request (ifapplicable)
- Progress Notes for each assessment or treatment sessions (as outlined in the State DHCS Documentation Standards)
- Medication Order Sheet (if medications are prescribed by the provider)
- AIMS Scale (annually, if medications are prescribed by the provider)
- Physical Assessment Notification (annual, if medications are prescribed by the provider)
- Discharge Summary (faxed to Access Unit following termination)

Financial Agreements and Billing:

- Insurance information
- Authorization approval letters
- Claims

Standards of Treatment Record Documentation

Overview

It is the responsibility of every MHP FFS provider to maintain treatment records that document client eligibility and medical necessity for each Medi-Cal client served.

MHP – Record Keeping: Clinical Assessment Components

The following areas will be included as appropriate as a part of a comprehensive client record:

1. Presenting problems and relevant conditions affecting the client's physical and mental health status will be documented, for example: living situation, daily activities, employment, and social support.
2. Special status situations that present a risk to client or others will be documented and updated as appropriate. History of suicidal/homicidal behavior.
3. Relevant physical health conditions reported by the client will be identified and updated as appropriate.
4. Documentation will describe client's strengths in achieving client goals for treatment.
5. Documentation will include current and past medications.
6. Client self-report of allergies and adverse reactions to medications, or lack of known allergies/sensitivities will be documented.
7. A mental health history, including previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information, lab tests, consultation reports and prior hospitalizations.
8. For children and adolescents, pre-natal and perinatal events and complete developmental history will be documented including perinatal exposure to alcohol and other substances.
9. Documentation will include past and present use of tobacco, alcohol and caffeine, as well as illicit, prescribed and over the counter drugs.
10. Medications, dosages, date of initial prescription and refills, informed consent.
11. A relevant mental health status examination will be documented.
12. Dysfunction rating and how symptoms impair functioning.
13. Medical Necessity is documented.
14. Culture and language are appropriately taken into account in understanding the client's problems.
15. Provider's signature and title anddate.
16. A five axis diagnosis from the most current DSMIV-TR will be documented
17. The record is legible.
18. If other agencies are involved in the treatment of the individual, then the provider needs to indicate what those agencies are and their contact phone numbers.
19. Standards of Practice issues are to be addressed and adhered to at all times.

Diagnosis Sheet

1. Includes a complete five-axis diagnosis, written out completely with corresponding diagnosis code.
2. If client reports no active medical problems, this should be stated on Axis III and represented as none reported.
3. GAF score should correspond with the assessed level of impairment on page 3 of the MHP Assessment Form.

Change of Diagnosis

Providers must include updated diagnosis in next submitted TAR. (See Change/Addition of Diagnosis, Appendix 3: Forms.)

Client Plan

A client plan needs to be present in each client's chart and sent to the Access Unit with the initial Assessment and Diagnosis form. Clients will be given a copyof the client plan upon request.

1. Client Plan is consistent with statement of the Current Problem on the MHP Assessment Form and five axisdiagnoses.
2. Plan should include a goal from the list of Master Treatment Goals
3. The proposed termination date should be the date on which the provider believes the entire treatment (not just the first authorization period) will end.
4. The plan needs to include the signature of the client/parent/guardian indicating client's participation and understanding of plan. Plan must be signed by the client even when the client is a minor unless client is too young to be able to write or print his/her name and have parent/guardian signature. The authorization will not be given without signature.
5. The plan includes the signature and title of the staff providing direction, M.D, D.O., PsyD, PhD, LCSW, LMFT, or LPCC.
6. The plan includes specific, observable and quantifiable and time limited objectives that include a baseline of client's behaviors.
7. The plan includes the modality and number of sessions requested.
8. The plan includes medicalnecessity.
9. The provider's interventions are consistent with the client plan goals.
10. The record is legible.

Examples:

Client will decrease anger outbursts from 4X daily to 1X weekly by parent report by 6/30/2019.
Client will decrease psychiatric emergency visits or psychiatric hospitalization from 3 in the last six months to zero for 3 months by 6/30/2019.
Client will increase friends from none to two friends by 6/30/2010 by client report.*****
Client will increase social contacts outside the home from zero to 2 per week by client report by 6/30/2019.*****
Client will participate in a community support group (currently does not participate) by client report by 6/30/2019.*****

****** *Lack of friends must be attributable to impairments connected to the mental health condition.*

Re-Authorization Request (if applicable)

DBH Consent for Outpatient Treatment	1. Consent is signed and dated by client/conservator/parent/guardian as applicable.
Acknowledgement of Receipt of Notice of Privacy Practices	(See Notice of Privacy Practices (NOPP), Appendix 2: Beneficiary Rights & Forms.)
Acknowledgement of Receipt of Advance Directive Notice	(See Advance Health Care Directive Brochure, Appendix 2: Beneficiary Rights & Forms.)
Medication Consent Form	1. Includes the specific names of all medications prescribed. 2. Is updated when new medications are added to the client's regimen.
Progress Notes	Required for each assessment or treatment session (as outlined in the State of California DHCS Documentation Standards) Each contact with client is documented on a progress note in the chart. 1. Each note includes the date, duration and location of service and type of service such as individual or group or CPT code. 2. Adequately describe the service rendered, including the intervention(s) preformed, and a plan for follow up when appropriate. 3. Each note includes the provider's signature, license and printed or stamped signature. 4. Each note contains client name, DOB and Provider name. 5. The note adequately describes the service, including clinical decisions and interventions (What you did to assist the client). 6. The client's response to the intervention is described. 7. The client's progress toward achieving the goals is tracked. 8. The documentation justifies the amount of time billed. 9. Referrals to community resources are documented when appropriate. 10. Culture and language are appropriately taken into account in understanding the client's problems. 11. The record is legible.

Medication Order Sheet

Aims Scale	Should be completed annually if the provider prescribes psychotropic medications.
Physical Assessment Notification	Should be completed annually if provider prescribes medications.
Release of Information forms	Includes client authorization for providers and MHP to communicate about clinical and authorization aspects of treatment.
Discharge Summary (closed cases)	Should be mailed or faxed to the Access Unit following termination of authorized services or if completed in conjunction with an assessment and confirming services are not requested.

Maintenance of Medical Records

Overview

Providers must maintain treatment records for minimum of seven (7) years following the last service to the client. When treating a minor, records must be kept for 7 years after the client achieves the age of majority. Additionally, providers must keep and make available client records to the County of San Bernardino as well as State and Federal agencies upon request. Even if you no longer remain in business, you must make the records available as well as maintain storage requirements as defined by law. Failure to do so could result in thefollowing:

- Report to the applicable state licensing board(s) for failure to maintain client records;
- Disallowance for missing chart(s);
- Utilization of law enforcement to retrieve medical records;
- Collection of monies returned to the State.

Claims Processing

Overview

The MHP will reimburse for authorized and approved services rendered to County of San Bernardino Medi-Cal beneficiaries. Reimbursement will be based on rates developed by the MHP and approved by the County of San Bernardino Board of Supervisors.

Medi-Cal eligibility is determined on a monthly basis and is subject to change. It is the individual provider's responsibility to verify Medi-Cal eligibility every calendar month prior to rendering services. (Molina and IEHP Medi-Cal are covered under the MHP. Authorization from Molina or IEHP is not required prior to claiming for specialty mental health services rendered to their enrolled beneficiaries). If the POS or AEVS indicates information other than what the beneficiary is stating (i.e.; no longer covered by insurance, etc.), it is the beneficiary's responsibility to get the information corrected via their eligibility worker at the Medi-Cal office.

In addition, providers are required to verify the requested services are covered by Medi-Cal as some Medi-Cal beneficiaries have limited Medi-Cal benefits based on their aid code. (For a current list of aid codes, go to www.medi-cal.ca.gov.)

Claims must be submitted by mail to:

County of San Bernardino Access Unit
303 East Vanderbilt Way
San Bernardino, CA 92415
If faxing: to (909) 890-0353

- Claims must be submitted using an **original,** red ink printed, HICF (Health Insurance Claim Form)-CMS-1500 form with the required fields completed. CMS-1500 forms may be purchased at office supply stores. (See Sample CMS-1500 Form, Appendix 4: Useful Tools.)

  Instructions for completing the form are copied below and can also be accessed at: (*http://www.cms.hhs.gov/cmsforms/downloads/CMS1500805.pdf*).

- All fields must be completed in order to receive payment.

- Claims must be received within three (3) months from the service delivery date. Payment for claims received after three (3) months from the service delivery date may be denied. Three months equals ninety (90) sequential calendar days from the date of service.

- The diagnosis listed on the claim must match the diagnosis listed in the authorization. If diagnostic changes occur, complete the Change of Diagnosis Form and submit to the Access Unit. (See Change/Addition of Diagnosis Form, Appendix 3: Forms.)

- All claims must have the provider signature or the provider may submit a Signature Authorization Form if they wish to assign a designee to sign the claims for them. (See FFS Provider Signature Authorization Form , Appendix 3: Forms,)

- Providers are required to complete a Claims Certification and Program Integrity Form each time claim(s) are submitted for reimbursement certifying that the claim(s) are in compliance as stated in the County of San Bernardino DBH Provider Manual and the Provider Service Agreement. If you are submitting more than one claim at a time, a single certification form will be sufficient each time you submit your packet of multiple claim(s). (See Claims Certification and Program Integrity Form, Appendix 3: Forms.)

- If a claim is returned to the provider for correction, the correction must be completed and returned to the Access Unit within 14 days or payment may be denied.

- ***Outpatient Services***: Once submitted a claim has been submitted, allow at least 30 days to receive payment. If there are irregularities in billing or other extenuating circumstances at the MHP, payment may be briefly delayed.

  NOTE: If the provider has not received either a payment or a denial for services rendered after 30 days from the date the claim was submitted a Claim Inquiry Form may be submitted to the Access Unit by fax (909-890-0353) or by mail. (See Claims Inquiry For, Appendix 3: Forms.)

- ***Inpatient Services:*** Claims for inpatient services are processed once the TAR is received from the hospital. Payment for services is approved based on medical necessity criteria. If the TAR is denied due to medical necessity criteria, payment to the provider for those services will be denied.
  NOTE: The provider is responsible for working with the hospital to ensure TARs have been submitted on a timely manner.

- **Medi-Cal is the payer of last resort.** If the Medi-Cal beneficiary has other health coverage, the provider is required to bill the other health coverage first. If the other health coverage agency denies payment or pays only a portion of the bill, the provider must submit proof of denial or payment (EOB) from the other health coverage along with your CMS-1500 form to the Access Unit. The EOB must match the date of service being claimed.
  NOTE: If the beneficiary no longer has insurance coverage, it is the beneficiary's responsibility to have the information corrected via their eligibility worker.

- Providers **must not** bill the beneficiary for private insurance cost-sharing amounts such as deductibles or co-payments. Such payments are covered by Medi-Cal up to the Medi-Cal maximum allowances (proof of deductible or co-payment must be submitted with claim).

- Providers are responsibility for collecting any Share of Cost from the Medi-Cal beneficiary and clearing it prior to submitting a claim for payment.

- **NO SHOWS are not billable**

- Medicare/Medi-Cal is excluded from Mental Health Plan coverage. Claims for services for a Medicare/Medi-Cal beneficiary are to be submitted to:

EDS Corporation
ATTN: Crossover Unit
P.O. Box 15700
Sacramento, CA 95852-1700

Provider Problem Resolution & Appeal Process

Statement of Problem (Verbal or Written)

Provider concerns regarding the system-of-care procedures shall be directed either verbally or in writing to the Access Unit Supervisor, who will discuss the matter with the provider to determine exact issues involved and then determine whether resolution is possible for the stated concern.

The Access Unit Supervisor will:

- Place a phone call to the provider at the number given by the provider and seek first to discuss the concern and to clarify it, with the possibility of resolve.
- If the concern is in written form, then send a letter of receipt plus a written explanation addressing the concern. Alternately, the Supervisor may request an appointment to call or meet with the provider
- If no resolve is possible and the provider feels the explanation provided is inadequate, then the Access Unit Supervisor will recommend that the provider submit a written statement in order to begin the Provider Appeal Process. That statement will be reviewed by the Quality Management Division Program Manager.

Any of the above bulleted items may be taken to the next level, the written Provider Appeal Process, only after the concern has first been presented to the Access Unit Supervisor.

Payment / Credentialing Reviews

In response to a **denied** or **modified** request for payment authorization, or a dispute concerning the **processing** or **payment** of a claim, or a **credentialing issue** which affects the active status of the provider within the Managed Care System of the County; a provider may make use of the written Provider Appeal Process only after first addressing their concerns with the Access Unit Supervisor. The process will follow these guidelines:

- The written appeal must be sent to the Access Unit Supervisor within 90 calendar days of receipt of the non-approval of payment or within 90 calendar days of the Mental Health Plan's failure to act on a request.
- The Program Manager, who is over the Access Unit Supervisor or their designee, will respond to the provider within 60 calendar days of receipt of the appeal in writing. The response will include:
    1. A statement of the reasons for the decision that addresses each issue raised by the provider.
    2. Any action required by the provider to implement the decision.
    3. If applicable, the provider shall submit a revised request for MHP payment authorization within 30 calendar days from the receipt of the MHP's decision as calculated by the date on the faxed/mailed document from the MHP, if the decision is to approve the payment authorization request.
- If the Program Manager, or their designee, does not respond to the Appeal within 60 calendar days of receiving it, the Appeal shall be considered denied by the MHP.

Compliance Program / Quality Management

Overview

The County of San Bernardino Mental Health Plan (MHP) Compliance and Quality Management Programs are committed to maintaining and improving the quality of clinical care provided to beneficiaries. The MHP has established a quality improvement process to review and monitor the quality of care provided by credentialed MHP providers, and to ensure their adherence to State and Federal regulations, MHP requirements, and licensing and professional standards. The quality improvement monitoring activities focus on clinically significant issues that affect beneficiaries, including:

- Accessibility of services
- Timeliness of services
- Service delivery capacity
- Cultural sensitivity and linguistic appropriateness of services
- Beneficiary, family and provider satisfaction
- Coordination and continuity with physical healthcare
- Evaluation of beneficiary grievances and requests for State Fair Hearings
- Review of provider appeals

Quality Improvement, Audits and Technical Assistance

The MHP has established qualitative and quantitative measures to monitor the services rendered by MHP providers. Quality of care issues may be identified through members of the Access Unit, Quality Management or Compliance staff, or through quality improvement activities. The Quality Improvement Department will review the findings and issues involved and recommend appropriate corrective actions. MHP FFS providers are required to submit a plan of correction in a timely manner when requested to do so. Failure to correct deficiencies may result in being placed on inactive status, followed by suspension or termination of MHP provider status.

The Access Unit is responsible for preparing authorization documents for regular State conducted audits by the State. In order to continue the positive outcomes received in past audits, Access Unit routinely examines authorizations for irregularities, both from clinical and fiscal standpoints. If irregularities are noted, an internal audit may be conducted. If those irregularities are substantiated, then the MHP Director of Behavioral Health or her designee of Compliance may suspend payments of claims, referral of Clients, or in extreme cases, revoke/suspend a provider's credential with the MHP.

MHP Provider Responsibilities

1. Providers are required to maintain clinical records in accordance with State and Federal regulations, as well as the requirements of the MHP. (Also see Maintenance of Medical Records on page 36 of this manual.)
2. Clinical records must be made available to authorized representatives of the County, State and/or Federal government for the purpose of oversight, program review, and/or audit.
3. Providers must respond in a timely manner and within stated timelines to requests for documentation and information generated by the County of San Bernardino Department of Behavioral Health Committee on Interdisciplinary Practice, the Quality Management Committees, and authorized representatives of the MHP.
4. Providers must notify the County of San Bernardino Department of Behavioral Health immediately of loss of license or actions against their licenses to practice independently, loss or limitation of privileges, or disciplinary actions. Such notice must go to the Office of Compliance and to the Access Unit which maintains credentials of FFS providers.
5. Code of Conduct-The MHP is committed to complying with state and federal laws and regulations, as evidenced by the County of San Bernardino Department of

Behavioral Health Code of Conduct (see Appendix). Providers are required to acknowledge that they have read, understood, and agree to comply with the Code of Conduct. Providers are required to submit signed acknowledgements within thirty (30) days of executing the provider contract and on an annual basis. Providers are to submit acknowledgements to:

DBH Office of Compliance
303 East Vanderbilt Way
San Bernardino, CA 92415
(909) 388-0879
(800) 398-9736 Compliance Hotline

Provider Revocation Suspension or Termination of Agreement

The MHP shall, as appropriate, place a provider on inactive status, revoke credentials, suspend or terminate the privileges and credentials of a provider affecting their privilege to participate in the MHP Fee-for-Service Program if it is determined that a provider:

- Does not comply with the credentialing or re-credentialing procedures,
- Fails to comply with any of the provisions set forth in the Provider Agreement,
- Poses an immediate threat to the health and safety of any individual, including prospective beneficiaries,
- Does not meet the standards in this manual,
- Fails to adhere to applicable state and federal laws and regulations,
- Fails to provide care in a manner consistent with professional standards or fails to provide quality patient care,
- Violates professional ethics,
- Submits fraudulent billing,
- Fails to disclose a conflict of interest,
- Becomes convicted of a crime related to health care or substance abuse or other crime the commission of which demonstrates dishonesty or lack of fitness to provide care within the network,
- Becomes subject to licensure restrictions that limits the practice of the provider or requires professional oversight for care provided, and/or
- Becomes excluded or restricted by federal, state or local authorities from participation in any program of government or health care reimbursement.

If a provider's credential is made inactive, revoked or terminated, pending authorizations, re-authorizations, and existing authorizations shall cease immediately and the provider will be given a minimum of thirty (30) days to transfer clients to another provider. If a provider is suspended, all pending authorizations, re-authorizations and existing authorizations will be placed on hold until the disposition of the suspension is determined. Claims may remain unpaid during the suspension. Dependent on the disposition, the MHP may require the provider submit a current client listing to ensure continuity of care for Medi-Cal beneficiaries.

Note: The decision to make inactive, revoke, suspend or terminate the privileges of a provider is at the discretion of the MHP Director or designee.

Recovery of Overpayments

When an audit or review performed by County, State and/or Federal governments or by any other authorized agency discloses that the Provider has been overpaid, the overpayment under this Agreement shall be due by the FFS Provider to the County.

For Federal audit exceptions, Federal audit appeal processes shall be followed. County recovery of Federal overpayment shall be made in accordance with all applicable Federal laws, regulations, manuals, guidelines and directives.

For State, County and other authorized agency audits and/or review exceptions, County shall recover the payment from Provider within sixty days of the date of the applicable audit report or other determination of overpayment.

If the State recovers the overpayment from County before the end of such sixty days, then County shall immediately recover the overpayment from Provider. Within ten days after written notification by County to Provider of any overpayment due by Provider to County, Provider shall notify County as to which of the following two payment options Provider requests be used as the method by which the overpayment shall be recovered by County.

Any overpayment shall be: 1) paid in one cash payment by Provider to County or 2) paid by cash payment(s) by Provider to County over a period not to exceed sixty days or 3) deducted from amounts payable by the County to the Provider for other services. If Provider does not notify County within such ten days or if Provider fails to make payment of any overpayment to County as required, then the total amount of the overpayment, as determined by Director, shall be immediately due and payable. In its sole discretion, County may withhold future payments to Provider under this Agreement to recover overpayments in the event that Provider fails to comply with the remedies set forth in this paragraph.

Provider Notification and Corrective Action Process

Should there be documented findings regarding an MHP provider's adverse performance, conduct, or occurrences of poor quality of care or billing issues, the MHP notifies the provider in writing within 90 days of such findings. The provider notification process includes specific identification of the issue(s), history of the attempts to correct the issue(s), documentation regarding the issue(s) and the justification for the action taken.

The provider has 30 calendar days from the receipt of the notification to respond in writing to the MHP and to provide a response statement with appropriate documentation regarding the issues identified. Upon receipt and review of the documentation and findings, the Director of Behavioral Health, or her designee may decide on the appropriate course of action. The Director or designee may initiate an investigation, when there is reliable information indicating that a provider may have exhibited acts, demeanor or conduct that is reasonably likely to be detrimental to client safety or to the delivery of quality client care or to the funding received by the MHP. If the MHP provider fails to respond and does not provide the requested documentation within the 30-calendar-day period, the Director or designee determines the corrective action to be taken based on the review of the findings in relation to the statutory, regulatory and contractual obligations of the MHP. In cases where immediate action is warranted due to client safety, the Director of Behavioral Health or designee may suspend, revoke or terminate the provider's MHP privileges and make alternative arrangements for client care and safety until the results of the investigation are complete. (This process is effectuated by the Access Unit sending Notice of Actions to the beneficiaries 30 days in advance advising that the provider is no longer providing services.)

Administrative Review

Providers have the opportunity to request an Administrative Review from the MHP only if the following is determined:

- Amount owed by the provider is due to disallowance for overpayment and/or
- Termination or revocation of provider privileges.

Upon issuance of the letter of findings by the MHP, the provider may request an Administrative Review within five business days. The Administrative Review process allows the provider the ability to meet with MHP designees to determine if the findings issued by the MHP were reasonable and valid. The MHP Director is the final authority as to the decision regarding the Administrative Review.

Research with Beneficiaries

Providers are required to adhere to the DBH Research Policy and Application Process with regard to any research activities with beneficiaries. The MHP requires that all providers who conduct research acknowledge the welfare and rights of the subjects in mind by following ethical guidelines. The MHP requires clients' rights are protected and beneficiaries are thoroughly knowledgeable of and sign a documentation of informed consent. Providers who failure to follow the research policy, application process and procedure potentially risk the quality of care of beneficiaries, which is grounds for suspension, revocation or termination of provider privileges.

Beneficiary Problem Resolution

Overview

Title 9 of the California Code of Regulations (CCR), Section 1850.205 requires that the MHP and its Fee-for-Service providers give verbal and written information to Medi-Cal Beneficiaries. Federal Medicaid regulations 42 of Code of Federal Regulations (CFR) impact MHP'S beneficiary problem resolution processes regarding:

- How to access specialty mental health services
- How to file a grievance about services
- How to request an Appeal
- How to file for a State Fair Hearing

The State has developed a Guide to Medi-Cal Mental Health Services. The MHP has developed a Grievance Process Poster, and forms for Grievance, Appeal, and Request for Second Opinion and Request for Change of Provider. All of these beneficiary materials **must** be posted in prominent locations where Medi-Cal beneficiaries receive outpatient specialty mental health services, including the waiting rooms of providers' places of service. In addition, a small supply of envelopes addressed to the Access Unit (303 East Vanderbilt Way, San Bernardino, CA 92415-0026) should be available to clients in provider's service locations. You are not required to provide postage. The goal here is to enable a client to file a grievance without having to ask the provider for assistance. (See Appendix 2: Beneficiary Rights and Forms.)

Grievances

Grievances received by the MHP that involve the services and quality of care rendered by MHP providers are reviewed by the Quality Improvement Committee to determine whether these are quality of care issues. Providers cited by a beneficiary or otherwise involved in the grievance will be notified of the final disposition of the matter. The findings are forwarded to the MHP administration, as well as to the Director of Behavioral Health for review and appropriate action.

Grievances by Clients (Verbal and Written)

A grievance is a verbal or written expression of unhappiness about anything regarding a beneficiary's specialty mental health services

Beneficiaries are encouraged to discuss issues and concerns regarding their mental health services directly with their provider(s). Beneficiary grievances, including those made by families, legal guardians, or conservators of clients, may be directed to the provider, to the Access Unit, and/or to the Department's Patients' Rights Office. Grievance forms, as well as envelopes already addressed to the Access Unit, must be available at all providers' offices in locations where the client may obtain them without making a verbal request. If they have questions regarding the grievance process, clients may contact their providers, the Access Unit, or the Office of Patients' Rights. A decision on the grievance will take place within 60 days of receipt of the grievance and the affected parties will be notified. An extension of up to 14 days may be granted if the beneficiary requests it or the MHP determines that there is a need for additional information and the delay is in the beneficiary's interest. Grievances are tracked by the Access Unit and sent to Quality Management after resolution. Any grievance initiated with a provider by a beneficiary should be immediately forwarded from the provider to the Access Unit.

Appeals Process by Clients (Verbal and/or Written)

An appeal is a verbal or written statement of the client's concerns with the results of the Action. A verbal appeal must be followed up in writing.

An Action is defined as:

1. Denial or limitation of authorization of a requested service, including the type or level of service;
2. Reduction, suspension, or termination of a previously authorized service;
3. Denial, in whole or in part, of payment for a service;
4. The provider failed to provide services in a timely manner, as determined by the MHP

5. The MHP failed to act within the timeframes for disposition of standard grievances, the resolution of standard appeals, or the resolution of expedited appeals.

An appeal to an "action" must be filed within 90 days from the date of the action (*Notice of Action*). If the client does not receive a Notice of Action, there are no deadlines for filing an appeal. The individuals who decide the appeal must not have been involved in any of the previous levels of the dispute.

The beneficiary has a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing. A decision on the appeal will take place within 45 calendar days of receipt of the appeal and the affected parties will be notified. An extension of up to 14 days may be extended if the beneficiary requests it or the MHP determines that there is a need for additional information and the delay is in the beneficiary's interest.

If the appeal is not resolved wholly in favor of the beneficiary, the notice must contain information regarding the beneficiary's right to a state fair hearing and the procedure for filing for a state fair hearing.

An expedited Review Process for Appeals will take place if the MHP determines, or the beneficiary and/or provider requests, that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function. The expedited process will notify the parties no later than 3 working days after the MHP has received the appeal. An extension of up to 14 days may be extended if the beneficiary requests it or the MHP determines that there is a need for additional information and the delay is in the beneficiary's interest.

Request for a State Fair Hearing

CCR Title 9 § 1850.215 Continuation of Services Pending Fair Hearing Decision.
(d) Before requesting a state fair hearing, the beneficiary must exhaust the MHP's problem resolution processes as described in Section 1850.205.

To request a State Fair Hearing, the client should call or write to:

California Department of Social Services
State Hearing Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430 or call:
Telephone: (800) 952-5253
TDD: (800) 952-8349 or fax to:
Fax: (916) 229-4110

Additional Points

1. At any time during the grievance, appeal, or State Fair Hearing process, the client may authorize a person to act on his or her behalf, to use the Problem Resolution Process on his or her behalf, or to assist him or her withthe process.

2. Filing a grievance will not restrict or compromise the client's access to mental health services.

3. At any time during the grievance process, the client may contact the Access Unit at (888) 743-1478 or the Patients' Rights Office at (800) 440-2391 for assistance.

Grievances Regarding Providers and Services

Grievances by beneficiaries about providers or mental health services may be made to the Access Unit or to the Patients' Rights Office. Grievances will be reviewed and investigated by the appropriate office within the Department of Behavioral Health, and Quality Management will review the issues contained therein. Providers cited by the beneficiary or otherwise involved in the grievance process will be notified of the final disposition of that grievance.

Concerns of the Department regarding a provider's possible unprofessional, unethical, incompetent, or breach-of-contract behavior will be investigated by the Patients' Rights Office or other department, by appropriate state licensing authorities, or by the Quality Improvement Committee. In extreme cases in which the client may be at risk, the Director may suspend the provider's credentialed status while an investigation proceeds.

Providers shall prominently display and make available printed materials, which announce and explain the Grievance, Appeal and State Fair Hearing processes without the beneficiary having to make a verbal or written request for these materials. Any grievance, which a provider receives from a beneficiary, should be forwarded to the Access Unit immediately.

The Guide to Medi-Cal Mental Health Services is available in both English and Spanish. This guide should be given at the first visit. To order guides from the Access Unit please call (888) 743-1478. (See Guide to Medi-Cal Mental Health Services, Appendix 2: Beneficiary Rights & Forms.)

Request for Second Opinion

If a Medi-Cal beneficiary does not meet medical necessity as determined by a provider and the client does not agree with this determination, the beneficiary may request a second opinion of the MHP by contacting the Access Unit by telephone or filling out the Request for Second Opinion form and mailing/faxing it to the Access Unit. The MHP will provide a second opinion by a licensed mental health professional. (See Second Opinion Forms, Appendix 2: Beneficiary Rights and Forms.)

Appendix 1: Access Units for All California Counties

Contact Information

Providers who verify that clients have Medi-Cal from counties other than San Bernardino should contact the county corresponding to the client's Medi-Cal status to request treatment authorization.

Alameda County Mental Health Plan - 01
2025 Fairmont
San Leandro, CA 94578
Local: (510) 346-1010
ACCESS—Toll-free: (800) 491-9099

Alpine County Behavioral Health - 02
75-C Diamond Valley Rd.
Markleeville, CA 96120
Local: (530) 694-1816
ACCESS—Toll-free: (800) 318-8212

Amador County Mental Health Plan - 03
1001 Broadway, Suite 201
Jackson, CA 95642
Local: (209) 223-6412
ACCESS—Toll-free: (888) 310-6555

Butte County Department of Behavioral Health - 04
592 Rio Lindo Avenue
Chico, CA 95926
Local: (530) 891-2999
ACCESS—Toll-free: (800) 334-6622
Crisis Line (530) 891-2810

Calaveras County Mental Health Department - 05
891 Mountain Ranch Road
San Andreas, CA 95249
Local: (209) 754-6525
ACCESS—Toll-free: (800) 499-3030

Colusa County Department of Behavioral Health Services - 06
162 E. Carson Street
Colusa, CA 95932
Local: (530) 458-0520
ACCESS—Toll-free: (888) 793-6580
After hours—Toll-free: (800) 700-3577

Contra Costa County Mental Health Plan - 07
2500 Alhambra Avenue, 3C
Martinez, CA 94553
Local: (925) 370-5704
ACCESS--Toll-free: (888) 678-7277

Del Norte County Mental Health - 08
206 Williams Drive
Crescent City, CA 95531
Local: (707) 464-7224
ACCESS—Toll-free (888) 446-4408

El Dorado County Mental Health - 09
344 Placerville Drive, Suite 20— Administration (530) 621-6200
Placerville, CA 95667 Suite 17— Placerville Clinic (530) 621-6290
South Lake Tahoe Clinic (530) 573-3251
Local: (530) 621-6210
ACCESS—Toll-free: (800) 929-1955

Fresno Managed Care - 10
2536 N. Grove Industrial Drive
Fresno, CA 93727
Local: (559) 488-2796
ACCESS—Toll-free: (800) 654-3937

Glenn County Mental Health - 11
242 North Villa
Willows, CA 95988
Local: (530) 934-6582
ACCESS—Toll-free: (800) 500-6582 (days)
After hours—Toll-free: (800) 700-3577

Humboldt County Medi-Cal Managed Care - 12
Mental Health Care
720 Wood Street
Eureka, CA 95501
Local: (707) 268-2990
ACCESS—Toll-free: (888) 849-5728

Imperial County Mental Health Plan - 13
202 N. Eighth Street
El Centro, CA 92243
Local: (760) 482-4000
ACCESS—Toll-free: (800) 817-5292
Providers call: (760) 452-4501

Inyo County Mental Health Plan - 14
162-J Grove Street
Bishop, CA 93514
Local: (760) 873-6533
ACCESS—Toll-free: (800) 841-5011

Kern County Mental Health Department - 15
P. O. Box 1000
Bakersfield, CA 93302
Local: (661) 868-8000
ACCESS—Toll-free: (800) 991-5272

Kings County Mental Health and Substance Abuse Services - 16
1393 Bailey Drive
Hanford, CA 93230
Local: (559) 582-4481 (Hanford)
ACCESS—Toll-free: (800) 655-2553

Lake County Mental Health Plan - 17
911 Parallel Drive
Lakeport, CA 95453
Local: (707) 263-8929
ACCESS—Toll-free: (800) 900-2075

Lassen County Mental Health Plan - 18
555 Hospital Lane
Susanville, CA 96130
Local: (530) 251-8108
ACCESS—Toll-free: (888) 289-5004

Los Angeles County Local Mental Health Plan - 19
550 South Vermont Avenue, 12th Floor
Los Angeles, CA 90020 ACCESS—
Toll-free: (800) 854-7771
Child Tx Authorizations: Paul McIver @ (213) 738-3940
Adult Tx Authorizations: (213) 738-2466

Madera County Behavioral Services - 20
14227 Road 28
Madera, CA 93638
Local: (559) 673-3508
ACCESS—Toll-free: (888) 275-9779

Marin Mental Health Plan - 21
Community Mental Health Services
250 Bon Air Road
Greenbrae, CA 94904
Local: (415) 499-4271
Providers (415) 499-7587
ACCESS—Toll-free: (888) 818-1115

Mariposa County – Mariposa Counseling Center - 22
Physical Address:
5037 Stroming Road Ste A
Mariposa, CA 95338
Local: (209) 966-2000
ACCESS—Toll-free: (800) 549-6741

Mailing Address:
P.O. Box 99
Mariposa, CA 95338

Mendocino County Mental Health Services - 23
860 North Bush Street
Ukiah, CA 95482
Local: (707) 463-4396
ACCESS—Toll-free: (800) 555-5906

Merced County Mental Health Department - 24
480 East 13th Street
Merced, CA 95340
Local: (209) 381-6800
ACCESS—Toll-free: (888) 334-0163
(209) 381-6868

Modoc County Mental Health Services - 25
441 N. Main St.
Alturas, CA 96101
Local: (530) 233-6312
ACCESS—Toll-free: (800) 699-4880

Mono County Mental Health - 26
P. O. Box 2619
Mammoth Lakes, CA 93546
Local: (760) 924-1740
ACCESS—Toll-free: (800) 687-1101
After hours—Toll free: (800) 700-3577

Monterey County Behavioral Health - 27
115 Cayuga Street
Salinas, CA 93901
Local: (831) 796-3066
ACCESS—Toll-free: (888) 258-6029

Napa County Mental Health Plan - 28
2261 Elm Street
Napa, CA 94559
Local: (707) 259-8151
ACCESS—Toll-free: (800) 648-8650

Nevada County Behavioral Health - 29
500 Crown Point Circle, Suite 120
Grass Valley, CA 95945
Local: (530) 265-1437
ACCESS—Toll-free: (888) 801-1437

Orange County - 30
Pacific Care Behavioral Health
P.O. Box 55307
Sherman Oaks, CA 91413 ACCESS—Toll-free: (800) 723-8641

Placer County Mental Health Services - 31
11716 Enterprise Avenue
Auburn, CA 95602
Local: (530) 886-5401
ACCESS—Toll-free: (888) 886-5401

Plumas County Mental Health Plan - 32
270 County Hospital Road, Suite 229
Quincy, CA 95971
Local: (530) 283-6307
ACCESS—Toll-free: (800) 757-7898

Riverside County Mental Health Plan - 33
P. O. Box 7549
Riverside, CA 92513
ACCESS—Toll-free: (800) 706-7500

Sacramento County Mental Health Plan - 34
3331 Power Inn Road Ste.170
Sacramento, CA 95826
Local: (916) 875-1055
ACCESS—Toll-free: (888) 881-4881

San Benito County Mental Health Plan - 35
1131 San Felipe Road, Suite 104
Hollister, CA 95023
Local: (831) 636-4020
ACCESS—Toll-free: (888) 636-4020

San Bernardino County Mental Health Plan - 36
303 East Vanderbilt Way
San Bernardino, CA 92415-0026
Local: (909) 386-8256 ACCESS—Toll-free: (888) 743-1478

San Diego County - 37
United Behavioral Health
3111 Camino Del Rio North, Suite 500
San Diego, CA 92108
Providers (800) 798-2254
ACCESS—Toll-free: (800) 479-3339

San Francisco Mental Health Plan - 38
1380 Howard Street, 5th Floor
San Francisco, CA 94103
Local: (415) 255-3737
ACCESS—Toll-free: (888) 246-3333

San Joaquin County Mental Health Plan - 39
1212 North California Street
Stockton, CA 95202
Local: (209) 468-9370
ACCESS—Toll-free: (888) 468-9370

San Luis Obispo County Mental Health Plan - 40
2178 Johnson Avenue
San Luis Obispo, CA 93401-4535
Local: (805) 781-4700
ACCESS—Toll-free: (800) 838-1381

San Mateo County Mental Health - 41
225 37th Avenue
San Mateo, CA 94403
Local: (650) 573-2544
ACCESS—Toll-free: (800) 686-0101

Santa Barbara County Alcohol,
Drug & Mental Health Services - 42
114 E. Haley St., Ste. P
Santa Barbara, CA 93101
Local: (805) 884-1650
ACCESS—Toll-free: (888) 868-1649

Santa Clara County Mental Health Department - 43
828 South Bascom Avenue Ste 200
San Jose, CA 95218
(408) 885-5770
ACCESS—Toll-free: (800) 704-0900

Santa Cruz County Mental Health Plan - 44
1400 Emeline Avenue
Santa Cruz, CA 95060
Local: (831) 454-4170
ACCESS—Toll-free: (800) 952-2335

Shasta County - 45
2640 Breslauer Way
Redding, CA 96001
Local: (530) 225-5200
ACCESS—Toll-free: (888) 385-5201

Sierra County Mental Health - 46
704 Mill Street
Loyalton, CA 96118
Local: (530) 993-6746
ACCESS—Accept Collect Calls

Siskiyou County Behavioral Health Services - 47
2060 Campus Dr.
Yreka, CA 96097
Local: (530) 841-4100
ACCESS—Toll-free: (800) 842-8979

Solano County Mental Health - 48
275 Beck Avenue
Fairfield, CA 94533
Local: (707) 784-8320
ACCESS—Toll-free: (800) 400-6001

Sonoma County Mental Health Plan - 49
Resource Team – 1221 Farmers Lane, Suite A
Santa Rosa, CA 95405
Local: (707) 565-6900
ACCESS—Toll-free: (800) 870-8786

Stanislaus County Behavioral Health Center - 50
800 Scenic Drive
Modesto, CA 95350
Local: (209) 558-4700
ACCESS—Toll-free: (800) 548-4673

Sutter – Yuba Bi-County Mental Health Plan - 51
1965 Live Oak Blvd.
Yuba City, CA 95991
Local: (530) 822-7200
ACCESS—Toll-free: (888) 923-3800

Tehama County Mental Health Plan - 52
1860 Walnut Street
Red Bluff, CA 96080
Local: (530) 527-5637
ACCESS—Toll-free: (800) 240-3208

Mailing Address:
P.O. Box 400
Redbluff, CA 96080

Trinity County Behavioral Health Services - 53
P. O. Box 1640
1 Industrial Park Way
Weaverville, CA 96093
Local: (530) 623-1362
ACCESS—Toll-free: (888) 624-5820

Tulare County Health and Human Services - 54
Mental Health Branch
5957 South Mooney Blvd.
Visalia, CA 93277
Local: (559) 737-4660
ACCESS—Toll-free: (800) 320-1616

Tuolumne County Behavioral Health - 55
197 Mono Way
Sonora, CA 95370
Local: (209) 588-9528
ACCESS—Toll-free: (800) 630-1130

Ventura County Mental Health Plan - 56
300 Hillmont Avenue
Ventura, CA 93003-1699
Local: (805) 652-6127
ACCESS—Toll-free: (800) 671-0887

Yolo County Mental Health Plan - 57
137 North Cottonwood Street, Suite 1530
Woodland, CA 95695
Local: (530) 666-8630
English: ACCESS—Toll-free: (888)965-6647
Spanish: ACCESS—Toll-free: (888)400-0022

Yuba County - 58
See Sutter-Yuba Bi-County Mental Health Plan

Appendix 2: Beneficiary Rights & Forms

Beneficiary Rights & Forms

All forms listed below can be found on the State Informing Materials page of the County of San Bernardino Department of Behavioral Health website at http://www.sbcounty.gov/dbh/ConsumerInformation/ConsumerInfo.asp#

These forms are subject to ongoing updating. To ensure you are using the most current form, please use the one posted on the website.

Form
Guide to Medi-Cal Mental Health Services (English) (Spanish) (Large Fonts)
Notice of Actions - A (English) (Spanish)
Notice of Actions - B (English) (Spanish)
Notice of Actions - C (English) (Spanish)
Notice of Actions - D (English) (Spanish)
Notice of Actions - E (English) (Spanish)
Notice of Actions - Back (English) (Spanish)
Grievance Process Poster (English / Spanish)
Grievance Forms (English) (Spanish)
Appeal Forms (English) (Spanish)
Second Opinion Forms (English) (Spanish)
Change of Provider Request - (English) (Spanish)
Advance Health Care Directive Brochure (English)(Spanish)
Notice of Privacy Practices (NOPP) (English) (Spanish)
EPSDT Brochure (English) (Spanish)

Appendix 3: Forms

Provider Forms

Please copy or print the forms listed in this section directly from this manual or some can also be uploaded in the Fee-For-Service Provider Network http://wp.sbcounty.gov/dbh/for-providers/ffs-provider-network/

Form
Initial Contact Log
Beneficiary Registration Sheet
Fee-For-Service –Outpatient Treatment Authorization Request (TAR) Form (includes Diagnosis Sheet & Client Plan)
Diagnosis Sheet
Change / Addition of Diagnosis
Discharge Summary
Consent for Outpatient Treatment (English / Spanish)
Authorization to Release Confidential Protected Health Information (PHI) (English / Spanish)
Alert Sheet
Advanced Directives Notice (English/Spanish)
Update Provider Information Form
FFS Provider Signature Authorization Form
Claims Certification and Program Integrity
Claims Inquiry Form

Psychiatric Forms

Please copy or print the forms listed in this section directly from this manual or some can also be uploaded in the Fee-For-Service Provider Network http://wp.sbcounty.gov/dbh/for-providers/ffs-provider-network/

Form
Outpatient Medication Record
Medication Consent Form (English / Spanish/Vietnamese)
Physical Assessment (English / Spanish)
Abnormal Involuntary Movement Scale (AIMS)

County Of San Bernardino
Department of Behavioral Health

INITIAL CONTACT LOG
TELEPHONE, WALK-IN AND WRITTEN REQUESTS FOR SERVICES

NAME OF CLINIC_____ **REPORTING MONTH/YEAR_____**

TITLE 9 REQUIRES THAT ALL INITIAL REQUESTS FOR SERVICES MUST BE LOGGED

	DATE AND TIME	** URGENT YES√ NO√	NAME OF CALLER AND RELATIONSHIP TO BENEFICIARY (Last Name, First Name)	NAME OF BENEFICIARY (Last Name, First Name)	INTERPRETER SERVICES OFFERED YES√ NO√ (LANGUAGE)	*** CALLER'S RESPONSE TO OFFER OF INTERPRETER SERVICES	REASON FOR CALL	INITIAL DISPOSITION	**RESPONSE TIME TO OBTAIN URGENT SERVICES	STAFF NAME
1		☐ ☐			☐ ☐					
2		☐ ☐			☐ ☐					
3		☐ ☐			☐ ☐					
4		☐ ☐			☐ ☐					
5		☐ ☐			☐ ☐					
6		☐ ☐			☐ ☐					
7		☐ ☐			☐ ☐					

MHP REQUIRES A MAXIMUM RESPONSE TIME OF 2 HOURS FOR ALL REQUESTS FOR URGENT SERVICES. * ENTER 1) ACCEPTED OR 2) REFUSED

BENEFICIARY REGISTRATION SHEET

Last Name	First Name	Middle Name

Beneficiary's Birth Name (if different from name listed above)

Sex	Birthdate	Social Security Number
☐M ☐F	/ /	

Ethnicity (Race) (Check 2 if appropriate)

White ☐	Laotian ☐	Samoan ☐
Black ☐	Cambodian ☐	Asian Indian ☐
Native American ☐	Japanese ☐	Hawaiian ☐
Mexican American/ Chicano ☐	Filipino ☐	Guamanian ☐
Latin American ☐	Other Asian ☐	Amerasian ☐
Other Spanish ☐	Other Non White ☐	Korean ☐
Chinese ☐	Unknown ☐	Vietnamese ☐
	Other Southeast Asian ☐	Multiple ☐

Primary Spoken Language (If Obtainable)

English ☐	Cantonese ☐	Polish ☐
Spanish ☐	Korean ☐	Russian ☐
Other Chinese ☐	Mandarin ☐	Portuguese ☐
Japanese ☐	Armenian ☐	Italian ☐
Filipino Dialect ☐	Ilacano ☐	Arabic ☐
Vietnamese ☐	Mien ☐	Samoan ☐
Laotian ☐	Hmong ☐	Thai ☐
Cambodia ☐	Turkish ☐	Farsi ☐
Sign Language ☐	Hebrew ☐	Other Sign ☐
Other ☐	French ☐	Unknown/not reported ☐

Home Address

City	CA	Zip

Mailing Address (if different than above)

City	CA	Zip

Home Phone	Work Phone
( ) -	( ) -

Marital Status: Never Married ☐ Now married/remarried/living together ☐ Separated ☐ Widowed ☐ Divorced/dissolved/annulled ☐ Unknown ☐

Please indicate where the beneficiary resides. (check all that apply)

Alone ☐	Single Room (hotel, motel) ☐	Board and Care Home ☐	Alternative to Hospitalization (<6 beds) ☐
Family ☐	Group Quarters ☐	Small Board & Care (<7) ☐	Alternative to Hospitalization (>6 beds) ☐
Group Home ☐	Homeless, no residence ☐	Large Board & Care (>6) ☐	SNF/1CF/Nursing home, for physical health reasons ☐
SNF ☐	Homeless, in Transit ☐	House or Apartment ☐	
IMD ☐	Chaparral Residential ☐	SNF/1CF, for Psychiatric Reasons ☐	Adult Res./Social Rehab ☐
Charlee ☐	Chaparral Intensive ☐	House or Apartment w. support ☐	House or Apartment w/supervision ☐
FFA ☐	Lives w/adopt Parent ☐	General Hospital ☐	Other: _____ ☐
Foster Family ☐			

Please indicate the beneficiary's Legal Status:

Voluntary ☐	72 Hour Hold for Minor ☐	Judicial Commitment DD ☐	Temporary Conservatorship ☐	Second 14 Day Hold ☐
72 Hour Hold ☐	First 14 Day Hold ☐	Commitment of Minor DD ☐	Permanent Conservatorship ☐	Unknown ☐

Medi-Cal Number	Education (Yrs)

First Name of Beneficiary's Mother	

Beneficiary's Place of Birth (County only if California)	County: State Country:

Name of Primary Care Physician	Primary Care Physician Phone Number ( ) -

Is Beneficiary on Conservatorship? Yes ☐ No ☐	Conservator Name

Conservator Address	Conservator Phone Number ( ) -

Name of Provider

Provider Phone Number	Provider Fax Number
( ) -	( ) -

Referral Source ☐ Self ☐ Family ☐ Friends ☐ Employer ☐ Other _____

When completed please retain in client record and fax to (909) 890-0353

or mail to: Access Unit, 303 E Vanderbilt Way., San Bernardino, CA 92410

REVISED 11/15

San Bernardino County Department of Behavioral Health

Fee-For-Service Provider- Outpatient Treatment Authorization Request (TAR)

All items must be addressed. Approval is based on documentation of Medical Necessity (Functional Impairments)

PART 1	**BENEFICIARY INFORMATION**				
Client Name			DOB		
Phone		SSN or Medi-Cal Number			
Address					
City			Zip Code		
Living Arrangement	☐ Independent ☐ Bio Family ☐ Foster Family ☐ Group Home ☐ SNF ☐ B&C				
Minor is under the jurisdiction of:	☐ DCS ☐ Court ☐ Probation ☐ Bio Family ☐ Other:				

PART 2	**PROVIDER INFORMATION**				
Provider Name					
Provider Service Site Address					
City			Zip Code		
Phone #		Fax #		Licensure	☐ Psychiatrist ☐ Psychologist ☐ LCS ☐ LMFT

PART 3	**TREATMENT AUTHORIZATION REQUESTED** *(check all that apply)*		
☐ Adult ☐ Minor	☐ Initial Authorization	☐ Re-Authorization *or* ☐ Changes to Authorization	**Received Date Stamp** *(County Use Only):*
CFS Active: ☐ Yes ☐ No	Assessment Date __-__-____ *(90791 or 90792 Claims)*		
Coordination of Care with	☐ PCP ☐ Psychiatrist ☐ Psychologist ☐ LCSW ☐ LMFT ☐ DCFS ☐ Other:		
Modality & Requested Units *(For Psychologist, LCSW, LMFT)*	☐ Individual __ ☐ Family __ ☐ Case Conference __ ☐ Group __ **** If this is a Change to Authorization, describe the Clinically Significant Event necessitating the additional session(s).*** ****Authorizations are for 6 month cycles.***		
Modality & Requested Units *(For Psychiatrist)*	☐ Pharmacological Management # Requested __ **** If this is a Change to Authorization, describe the Clinically Significant Event necessitating the additional session(s).*** ****Authorizations for minors are for 6 month cycles.*** ****Authorizations for adults are for 12 month cycles.***	***NOTE: Signed Medication Consent Form MUST be attached for Initial and/or Re-Authorization Requests.**	

PART 4	**Medical Necessity for Tier III Services is met:** ☐ **Yes** ☐ **No**						
Current Risk Assessments	**Suicidal Ideation**	☐ None	☐ Ideation	☐ Intent	☐ Plan	☐ Means	☐ History
		Describe:					
	Homicidal Ideation	☐ None	☐ Ideation	☐ Intent	☐ Plan	☐ Means	☐ History
		Describe:					

Inpatient Psychiatric Admissions	**Other Outpatient Mental Health Services**
☐ None *or* ☐ Yes *if yes,* Total #: __ # In Past Year: __ Date of 1st : __-__-____ Date of Last : __-__-____	☐ None ☐ Yes If yes, type of Service:

Client Name		DOB	

CURRENT DIAGNOSES	
ICD-10 Code	**Name** ***(Diagnosis name must match with the reported code)*** *****Must document Specific, Behavioral Examples of the Diagnostic Symptoms including Frequency and Severity:***

Describe or Indicate N/A	**You Must Provide behaviorally specific examples of the selected impairment(s):	
	Primary Support	☐ N/A
	Social Environment	☐ N/A
	Educational	☐ N/A
	Occupational	☐ N/A
	Housing	☐ N/A
	Economic	☐ N/A
	Legal	☐ N/A
	Access to Health Care Services	☐ N/A
	Other Psychosocial /Environmental	☐ N/A

REQUIRED ADDITIONAL INFORMATION FOR RE-AUTHORIZATIONS: ***Describe how treatment benefitted the client. Identify improvements or barriers in treatment. Be behaviorally and symptom specific:***

(Symptoms / Behaviors)	Severity (increased, decreased, or the same)	Frequency (/hr, /day, /wk, /mo)
(Symptoms / Behaviors)	Severity (increased, decreased, or the same)	Frequency (/hr, /day, /wk, /mo)
(Symptoms / Behaviors)	Severity (increased, decreased, or the same)	Frequency (/hr, /day, /wk, /mo)
(Symptoms / Behaviors)	Severity (increased, decreased, or the same)	Frequency (/hr, /day, /wk, /mo)

****If barriers are identified, please describe:**

Current Medical Conditions:	**Health Problems**	○ None Known ○ Yes / Describe:
	Sleep Problems	○ None Known ○ Yes / Describe:
	Appetite Problems/Changes	○ None Known ○ Yes / Describe:
	Adverse Response to Medications	○ None Known ○ Yes / Describe:

Client Name		DOB	

Required for Minors	**Height:**	Problems / Changes:
	Weight:	Problems / Changes:

Current Medications /Prescribed During This Visit:	Name	Dose	Frequency	Target Symptoms

Past Psychotropic Medications - ***including current medications if taken before this visit:***

***Tool for your Convenience - Sample (TAR) Documentation**

Initial TAR

Example: Dx: Depression Sx/Bx: depressed 7/10 with 10 the worst, crying spells whenever alone and sometimes while with others, isolates to bedroom daily, sleeps 3h/night and 10h/day, poor focus, energy and motivation, not socializing, sad, h/o cutting, thoughts of SI 2x/mo but no plan.

Re-Auth TAR

Example: Dx: ADHD; Sx/Bx: less impulsive and hyperactive, better able to sit still, calmer, focus is better, needs redirection now only 2x/day, able to stay on task better and more goals, school grades now Cs and Bs.

Reminder Tool

☐ **Did I attach the completed Medication Consent form with the 'Initial' and/or 'Re-Authorization' TAR?** *(Psychiatrists Only)*

☐ **Did I include the Initial Authorization Assessment Date with the 'Initial' TAR?**

☐ **Does the 'Provider Service Site Address' match the service site address given previously for this patient?**

☐ **Did I include current and correct patient identification information?**

PART 5	**PROVIDER NAME & SIGNATURE** I certify that the above information is accurate and all the eligibility documentation required are on file.			
Provider Name		Provider Signature		Date

FAX COMPLETED FORM TO COUNTY OF SAN BERNARDINO ACCESS UNIT AT (909) 890-0353.

Authorization requests are processed within 14 calendar days from date this completed TAR is received by the unit.

For urgent conditions, please call the Access Unit at: (888) 743-1478. If the condition is urgent, the TAR will be processed as an expedited TAR.

PART 6	**MHP ACTION: (COUNTY USE ONLY)**			
☐ **Unable to Process**	☐ Missing required information ☐ Unable to locate beneficiary ☐ Duplication of services ☐ Other: _____			
Action	☐ Approved (*Authorization letter sent*) ☐ 14 Days Extension Request Made. **Extension:** _____-_____-_____*=28 days from original stamp date*	☐ Modified ☐ Denied	☐ NOA-B Issued ___-___-___	☐ **Provider Notified**__-___-____ ☐ **Beneficiary Notified**__-___-____
Reason for 14 Days Extension or Comments				
Access Unit Reviewer Name		Signature		
Reviewer Title / License		Date		

DIAGNOSIS SHEET

Beneficiary Name _____

Date of Birth _____

SSN _____

Make all applicable diagnoses, including substance-related diagnoses. P before principal diagnosis if not listed first.

ICD-10 CM CODE	ICD-10 CM CODE NAME

Printed Provider Name _____

Provider Signature _____

Date _____

Any change in diagnosis requires complete re-write below. (See Progress Note for explanation and justification.) Please submit Change/ Addition of Diagnosis form to the Access Unit at (909)890-0353.

ICD-10 CM CODE	ICD-10 CM CODE NAME

Provider Signature _____

Printed Provider Name _____

Date _____

Print Form

CLIENT PLAN

HOST COUNTY: _____ **COUNTY OF ORIGIN:** _____
Mental Health Plan — Mental Health Plan

CHILD'S NAME **DOB:** **Age Today:**

_____ _____ _____ _____ _____
(First) (Middle) (Last) (mmddyyyy)

SSN: _____ Identification Number: _____
(111223333)

Other coordinated services/agencies involved (with contacts if known): ☐ None Known

1. _____ Contact _____
2. _____ Contact _____
3. _____ Contact _____

TREATMENT GOALS

Specific observable and/or quantifiable goals (include the current Baseline)	Modalities and Interventions	Within what time frame (Duration)

I participated in the development of this plan and was offered a copy.

_____ _____ _____ _____
Child/Youth Signature* Date Caregiver Signature Date

_____ _____ _____ _____
Provider Signature (Lic/Reg) Date LPHA (Lic/Reg) Co-Signature (if required) Date

_____ _____
Provider Phone Number Provider Phone Number

*Child/Youth refuses or is unavailable to sign. Please explain the refusal or unavailability here:

CHANGE/ADDITION OF DIAGNOSIS

Beneficiary Name _____

Date of Birth _____

SSN _____

FORMER

DATE	ICD-10 CM CODE	ICD-10 CM CODE NAME

PRESENT:

DATE	ICD-10 CM CODE	ICD-10 CM CODE NAME

Reason for Change: _____

Date of diagnosis change and/or addition: _____

Provider Signature _____

Printed Provider Name _____

Date _____

Guidelines found: W&I Code 5328

Revised 3.2016 NF ca

DISCHARGE SUMMARY

Client Name: _____
Date of Birth: _____
SSN: _____

Reason for Evaluation/Treatment: _____

_____

_____

Treatment Focus and Course of Treatment: _____

_____

_____

_____

_____

_____

Condition at Discharge/Status of Problems Treated: _____

_____

_____

_____

Discharge Diagnosis (please list code and description):

ICD 10 CM _____
ICD 10 CM _____
ICD 10 CM _____
ICD 10 CM _____
ICD 10 CM _____

Reason for Discharge (please check):

☐ Mutual Agreement/Treatment Goals Reached
☐ Mutual Agreement/Treatment Goals Partially Reached
☐ Mutual Agreement/Treatment Goals Not Reached
☐ Client Discharged/Program Unilateral Decision
☐ Client Withdrew: AWOL, AMA, No Improvement
☐ Client Moved Out of Service Area
☐ Discharge/Administrative Reasons
☐ Other (reason): _____

Discharge Recommendations/Arrangements/Appointments:

Discharge With: ☐ No Meds ☐ Meds _____

Discharge To: _____

Prognosis: ☐Excellent ☐ Good ☐ Favorable ☐ Guarded ☐ Poor

Admission Date: _____ Date of Last Service: _____

Provider: _____ Date: _____

San Bernardino County Department of Behavioral Health
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
Mental Health and Substance Use Disorder Treatment

Client Name: _____ Date of Birth: / / *(Month/Date/Year)*

Client Address: _____ Last 4 digits SSN: XXX / XX / _____

_____ Client Phone: ( )

Completion of this document authorizes the release and use of your health information. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____ **to release to:**
(Facility Name/Provider/Other)

Name (To Whom): _____
(Individual or Treating Provider or Third Party Payer or Non-treating Provider)

To:
(*SUD only*) _____
(Only completed if Non-treating Provider Entity/Non Third Party Payer Entity)

☐ Select if "*general designation*" if you are requesting an intermediary facilitate health information exchange, which allows a non-treating entity to obtain PHI and then disclose to multiple treating provider entities listed in the "To" section. A list of disclosures made by the non-treating entity through general designation must be maintained for any future disclosures by the non-treating entity.

Address: _____

City, State Zip: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

a. I specifically authorize release of the following information *(check as appropriate)*:

☐ **Mental Health** treatment information _____ *(client or legal representative's initials)*
☐ **Substance Use Disorder (SUD)** treatment information _____ *(client/legal representative's initials)*

b. I authorize release of:

☐ All my health information pertaining to my medical history, mental health condition, SUD treatment (must be accompanied with one other identifier); from_____ to_____ **OR**
☐ Only the following records or types of health information; from_____ to_____
☐ Assessment ☐ Client Plan ☐ Summary Letter ☐ Attendance ☐ Treatment Notes
☐ Discharge Summary ☐ Diagnosis ☐ Medication ☐ Other _____

c. If releasing **SUD** treatment information please select from the following recipient options:

☐ Individual *(name of intended recipient)*
☐ Treating Provider Entity *(name of entity which has a "treating provider relationship")*
☐ Third Party Payer *(name of entity with no treating provider relationship, but is a third party payer)*
☐ Non-Treating Provider Entity *(name of entity with no treating provider relationship and not a third party payer)*

Note: If "Non-Treating Provider Entity" is selected, <u>one</u> of the following additional identifiers must also be included on the "To" line above: 1) name of individual participant(s); 2) name of treating provider participants or entities with a treating provider relationship ***if*** general designation is selected and the non-treating entity in the "To Whom" section will be storing PHI to facilitate an exchange amongst treating providers after the initial disclosure.

PURPOSE

Purpose of requested use or disclosure: ☐ client request; **OR** ☐ other *(please list purpose)*:

Limitations, if any:

EXPIRATION (MENTAL HEALTH)

This Authorization expires *[insert exact date]*: _____

Note: California law requires you enter an exact date; otherwise, DBH cannot process this Authorization.

REVOCATION (MENTAL HEALTH)

I understand that I may cancel this Authorization at any time, but I must do so in writing by submitting my request for revocation to the health care facility that I authorized to release my health information. If I revoke this Authorization, I must submit to the following address: _____.

(Insert the address of the DBH Clinic authorized to disclose or use the client's health information)

My cancellation of this Authorization will take effect upon receipt by DBH and no further information will be released based on the cancellation. I understand that DBH may not be able to retrieve any information that has already been released prior to the revocation.

EXPIRATION (SUD)

Unless I revoke my consent earlier, this consent will expire automatically as follows:

_____.

(Describe date, event, or condition upon which consent will expire, which must not be longer than reasonably necessary to serve the purpose of this consent)

REVOCATION (SUD)

I understand that I may cancel this Authorization at any time, but I must do so in writing by submitting my request for revocation to the health care facility that I authorized to release my health information. If I revoke this Authorization, I must submit to the following address:

_____.

(Insert the address of the DBH Clinic authorized to disclose or use the client's health information)

My cancellation of this Authorization will take effect upon receipt by DBH and no further information will be released based on the cancellation. I understand that DBH may not be able to retrieve any information that has already been released prior to the revocation.

San Bernardino County Department of Behavioral Health
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
Mental Health and Substance Use Disorder Treatment

MY RIGHTS (MENTAL HEALTH)

- I may refuse to sign this Authorization. My refusal to sign will not affect my ability to get treatment, payment or eligibility for benefits.
- I have a right to receive a copy of this Authorization.
- To the extent permitted by law, I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I understand the health information I authorized for release could be re-disclosed by the person/entity I designated to receive the information. I understand DBH cannot prevent my information previously released by this Authorization from being re-released by whoever received it.
- I understand in some cases California law does not prohibit the re-release of my information and my information may no longer by protected by federal confidentiality law (HIPAA). However, I understand California law prohibits the person or entity receiving my health information from making additional disclosures unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

MY RIGHTS (SUD)

- I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA), 45 C.F.R. Sections 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
- I understand that I might be denied service if I refuse to consent to a disclosure for purpose of treatment, payment, or health care operations, if permitted by state law.
- I will not be denied services if I refuse to consent to a disclosure for other purposes.
- I understand that if the general designation option is used on this Authorization I must be provided, upon my request, with a list of entities to which my information has been disclosed pursuant to the general designation (the list of disclosures).
- I have been provided a copy of this form.
- If a "general designation" is selected to allow all my treating providers to receive specified information, I understand I have the right to obtain a list of disclosures if a request is made in writing (within two years of disclosure) 30 days from the date the written request is received; list of disclosure shall contain name of entity disclosure was made to, date of disclosure, and brief description of identifying information released.

SIGNATURE

Date: _____ Time: _____ ☐ am ☐ pm

Signature: _____

(DBH client shall sign, including minor age 12 and up, if having legal and mental capacity)

Signature: _____

(legal representative of client or parent/guardian for minors not having capacity to consent)

If signed by someone other than the client, state your name and legal relationship to the client:

_____

(Name and relation to client)

San Bernardino County Department of Behavioral Health
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
Mental Health and Substance Use Disorder Treatment

NOTICE PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

(This form must be given to every individual and/or entity provided with SUD treatment information)

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information in NOT sufficient for this purpose (see §2.31), The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided in §2.12 (c)(5) and 2.65.

LANGUAGE TAGLINES

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call *[1-888-743-1478]* (TTY: *[711]*).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *[1-888-743-1478]* (TTY: *[711]*).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số *[1-888-743-1478]* (TTY: *[711]*).

Tagalog (Tagalog– Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa *[1-888-743-1478]* (TTY: *[711]*).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. *[1-888-743-1478]* (TTY: *[711]*)번으로 전화해 주십시오.

繁體中文**(Chinese)**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 *[1-888-743-1478]* (TTY: *[711]*)。

Հայերեն **(Armenian)**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք *[1-888-743-1478]* (TTY (հեռատիպ)՝ *[711]*):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *[1-888-743-1478]* (телетайп: *[711]*).

فارسی **(Farsi)**
توجه: اگر به زبان فارسی گفتگو می‌شود، تسهیلات زبانی تی رایگان به صورت شما ارائه می‌شود. با *[1-888-743-1478]* (TTY: *[711]*) تماس بگیرید

日本語 **(Japanese)**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。*[1-888-743-1478]* (TTY: *[711]*) まで、お電話にてご連絡ください。

Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau *[1-888-743-1478]* (TTY: *[711]*).

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸ ੀਂ ਪੰਜਾਬ ਬੋਲਿ ਹੋ, ਤਾ ੀਂ ਭਾਸ਼ਾ ਧ ਿੱਚ ਸਹਾਇਤਾ ਸੇ ਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਿ ਹੈ। *[1-888-743-1478]* (TTY: *[711]*) 'ਤੇ ਕਾਲ ਕਰੋ।

الـ عربـ ية (Arabic)
بـ رقـ م اتـ صل .بـ الـ مجان لـ كـ تـ توافـ ر الـ لـغويـ ة الـ مـ ساعدة خدمات فـ إن الـ لـغة، اذكـ ر تـ تحدث كـ نت إذا :مـ لحوظة
[1-888-743-1478]
(م رقـ ف هلتـ صم الـ بـ كم الـ والـ :*[711]* .)

हिंदी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। *[1-888-743-1478]* (TTY: *[711]*) पर कॉल करें।

ภาษาไทย **(Thai)**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร *[1-888-743-1478]* (TTY: *[711]*).

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ រ ើសិនជាអ្នកនិយាយ ភាសាខ្ម , រសវាជំនួយមននកភាសា រោយមិនគិត្ថ្លៃ
គឺអាចមានសំរា ់ ំរ ើអ្នក។ ចូ ទូ ស័ព្ទ *[1-888-743-1478]* (TTY: *[711]*)។

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ,
ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ *[1-888-743-1478]* (TTY: *[711]*).

CONDADO DE SAN BERNARDINO
DEPARTAMENTO DE SALUD MENTAL Y COMPORTAMIENTO
CONSENTIMIENTO PARA EL TRATAMIENTO DE CONSUL TA EXTERNA

1. Los servicios de consulta externa pueden incluir asesoramiento ; diagn6stico; prueba de drogas y alcohol; intervenci6n de crisis; terapia personal, en grupo 6 de familia; medicamentos; servicios de tratamiento diurno; entrenamiento en la vida cotidiana y trato social; orientaci6n pre-profesional; y *Jo* servicios de manejo de casos. Consultas extemas son suministradas por miembros del grupo del departamento plan los cuales son profesionales titulados. (Listed podria ser responsable monetariamente por planificaciones de tratamiento y actividades de consulta que se lleven a cabo sin su presencia.)
2. Tratamientos de consulta externa podrian consistir en contacto entre profesionales y clientes, enfocandose en el problema expuesto y sensaciones asociadas, posibles causas del problema e intentos anteriores a adaptarse, y los posibles cursos alternativos de acci6n y sus consecuencias. La frecuencia y el tipo de tratamiento seran planeados por usted y el personal de tratamiento.
3. Se le info1111ara por medio de una hoja separada de consentimiento, sobre cualquier medicamento psicotr6pico que tenga que usar como parte del tratamiento.
4. Se espera que usted se beneficie de este tratamiento, aunque no hay garanfias de esto. Los beneficios maximos se obtienen al asistir frecuentemente, pero se podria sentir peor temporalmente mientras este entratamiento.
5. De ser posible, se espera que usted pague (6 autorice pago de) todo 6 parte del costo de tratamiento. La cantidad que usted pague depende de su capacidad de pago basado en sus ingresos y miembros de familia inmediata. Si se inicia acci6n legal para recaudar su cuenta, usted sera responsable en pagar todos los honorarios razonables de abogado y costos de corte ademas de cualquier fallo en su contra.
6. La falta de mantener sus citas 6 de seguir las recomendaciones de tratamiento, podria resultar en que se descontinue su tratamiento. Si no puede mantener su cita, se espera que usted de notificaci6n a la cllnica.
7. Toda la informaci6n y documentaci6n obtenida durante el transcurso del tratamiento son confidenciales, y no sera divulgada sin su consentimiento por escrfo, excepto bajo las siguientes condiciones:
   a. Como lo especifica las Practicas de Privacidad HIPAA, las cuales se le han entregado.
   b. Listed es un(a) menor no-emancipado(a), esta bajo tutela judicial de la corte, 6 esta bajo el cuidado legal LPS (en estos casos otras personas como sus padres, la corte o la persona encargada de usted legalmente, pueden obtener toda la info1111aci6n acerca de usted);
   c. Informaci6n acerca de todos los clientes se reporta al Departamento de Salud Mental del estado de California y al Departamento de Programas de Alcohol y Droga del estado de California, como es requerido por ellos con prop6sfos de investigaci6n y colecci6n de datos(lo cual incluye su nombre e informaci6n de identificaci6n);
   d. Bajo ciertas circunstancias como se ha establecido por el c6digo de bienestar publico e instituciones 5328, y las regulaciones federales HIPAA, las cuales puede pedirlas y leerlas en cualquier momento.

   Si las leyes de la confidencialidad el estado y las federales son diferentes, nosotros aplicamos la que le protege mas su informaci6n medica.
8. Listed tiene el derecho de aceptar, rechazar, 6 parar el tratamiento en cualquier momento.
9. Durante el transcurso del tratamiento, doy autorizaci6n al Departamento de Salud Mental y Comportamiento del Condado de San Bernardino a que solicitar y recibir pagos de beneficios medicos de cualquier plan de aseguranza de salud que me cubra, inclusive Medicare y programas relacionados con pago por asistencia publica.
10. Esta forma es para informar a las personas elegibles para Medi-Cal Oncluye padres 6 tutores de ninos 6 adolescentes con derecho a Medi-Cal) de lo siguiente:

    Mi Aceptaci6n y participaci6n en el sistema de salud conductual es voluntaria, y no es un requisito previo para tener acceso a otros servicios de la comunidad. Las personas mantienen el derecho de tener acceso a otros servicios de indemnizaci6n de Medi-Cal y tienen el derecho a pedir un cambio de proveedor, personal asistente, terapeuta, coordinador, y/o encargado(a) del caso hasta donde lo permite la ley.

11. Los servicios estan sujetos a la terminaci6n si usted posee un arma en las clinicas de DBH ya que es una violaci6n del c6digo penal 17b. Los servicios tambien son sujetos a la terminaci6n si usted amenaza o asalta a un empleado de DBH.

He leido lo anterior, y estoy de acuerdo en aceptar tratamiento, y ademas concuerdo con todas las condiciones indicadas aqui. Confirmo haber recibido una copia de este acuerdo.

Fi1111a del Cliente	Imprima el Nombre del Cliente	Fecha
Fi1111a del Testigo	Imprima el Nombre del Cliente	Fecha
Fi1111a del Padre/Tutor/Conservador:	Imprima el Nombre del Cliente	Fecha

CONDADO DE SAN BERNARDINO DEPARTAMENTO DE SALUD MENTAL
AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN MÉDICA PROTEGIDA (PHI)
Tratamiento de salud mental y trastornos por uso de sustancias

Nombre del cliente: _____ Fecha de nacimiento: / / *(Mes/Día/Año)*

Domicilio del cliente: _____ Número de Seguro Social XXX / XX / (solo los últimos 4 dígitos)

_____ Número telefónico: ( )

Al completar este documento usted autoriza la divulgación y el uso de su información médica. El no proporcionar toda la información solicitada, podría causar que esta autorización se considere inválida.

USO Y DIVULGACIÓN DE LA INFORMACIÓN MÉDICA

Autorizo a: _____ **para que divulgue a:**

(Nombre de la entidad/Proveedor/Otro)

Nombre (A quién): _____

(Persona/Organización que da el tratamiento o Tercero responsable de los pagos o Proveedor que no da el tratamiento)

A:
(Solo para *SUD*) _____

(Completar solo si es una entidad proveedora que no da el tratamiento/la entidad no es un tercero responsable de los pagos)

☐ Marque si es una "*designación general*" si usted está solicitando que un intermediario facilite el intercambio de la información médica que permite que una entidad que no da tratamiento obtenga la información médica protegida (PHI, por sus siglas en inglés) para después divulgarla a múltiples entidades que proporcionan tratamiento indicadas en la sección "A:". Para cualquier divulgación futura, la entidad que no da tratamiento deberá mantener una lista de las divulgaciones que haga a través de la designación general.

Dirección: Ciudad, Estado, Código postal: 11234 Anderson Street Loma Linda, CA 92354

Número telefónico: (909) 558-9500 Número de fax: ( )

a. Yo específicamente autorizo la divulgación de la siguiente información (marque el casillero apropiado)

☐ Información sobre tratamiento de **Salud Mental** _____ *(iniciales del cliente o representante legal)*

☐ Información sobre tratamiento de **trastorno por uso de sustancias (SUD, por sus siglas en inglés)** _____ *(iniciales del cliente o representante legal)*

b. Yo autorizo la divulgación de:

☐ Toda la información médica relacionada con mi historial médico, condición de salud mental y tratamiento de trastorno por uso de sustancias que he recibido (debe ir acompañada de un identificador adicional); de _____ a _____ ***O,***

☐ Solamente los siguientes expedientes o tipos de información médica; de_____ a_____

☐ Evaluación ☐ Plan del cliente ☐ Carta de resumen ☐ Asistencia ☐ Notas de tratamiento

☐ Resumen de alta del paciente ☐ Diagnóstico ☐ Medicación ☐ Otro _____

c. Si se está divulgando información del tratamiento por **SUD,** de las siguientes opciones seleccione el receptor:

☐ Individual *(nombre del receptor previsto)*

☐ Entidad que proporcionará el tratamiento *(nombre de la entidad que tiene una "relación de proveedor del tratamiento")*

☐ Tercero a cargo de pagos *(nombre de la entidad no proveedora del tratamiento, sino un tercero responsable de los pagos)*

☐ Entidad proveedora que no da tratamiento *(nombre de la entidad que no tiene relación de proveedora de tratamiento y que no es un tercero responsable de los pagos)*

Nota: Si selecciona "Entidad proveedora que no da tratamiento", también deberá incluir uno de los siguientes identificadores adicionales en la línea "A:" arriba: 1) nombre del(los) participante(s) individual(es); 2) nombre de los proveedores del tratamiento participantes o entidades que tienen una relación de proveedor del tratamiento, en el cual "*designación general*" fue seleccionada, y la entidad proveedora que no da tratamiento en la sección "A quién" estará guardando la PHI para facilitar un intercambio entre los proveedores del tratamiento después de la divulgación inicial.

PROPÓSITO

Propósito del uso o divulgación de la información solicitada: ☐ petición del cliente; **o,** ☐ otro *(indicar el propósito)*: _____

_____

_____

Proporcione alguna limitación, si la hay: _____

_____

_____

_____

VENCIMIENTO (SALUD MENTAL)

Esta Autorización vence el *[escriba la fecha exacta]*: _____

Nota: Las leyes de California requieren que usted ponga una fecha exacta; de otra manera, DBH no podrá procesar esta Autorización.

REVOCACIÓN (SALUD MENTAL)

Comprendo que puedo cancelar esta Autorización en cualquier momento, pero debo hacerlo por escrito presentando mi solicitud de revocación a la entidad de atención médica que yo autoricé para divulgar mi información médica. Si revoco esta Autorización, debo enviarla a la siguiente dirección:

_____

(Escriba la dirección de la clínica del DBH autorizada para divulgar o utilizar la información médica del cliente)

Mi cancelación de esta Autorización entrará en vigor tras la recepción por DBH y no se divulgará más información en base a la cancelación. Comprendo que DBH puede no ser capaz de recuperar información que ya haya sido divulgada antes de la revocación.

CONDADO DE SAN BERNARDINO DEPARTAMENTO DE SALUD MENTAL
AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN MÉDICA PROTEGIDA (PHI)
Tratamiento de salud mental y trastornos por uso de sustancias

VENCIMIENTO (SUD)

A menos que revoque mi consentimiento indicando una fecha anterior, este consentimiento vencerá automáticamente de la manera siguiente:

_____

(Describa la fecha, evento o condición según el cual vencerá el consentimiento, cuya fecha no será después de lo razonablemente necesario para el propósito de este consentimiento)

REVOCACIÓN (SUD)

Comprendo que puedo cancelar esta Autorización en cualquier momento, pero debo hacerlo por escrito presentando mi solicitud de revocación a la entidad de atención médica que yo autoricé para divulgar mi información médica. Si revoco esta autorización, debo enviarla a la dirección siguiente:

_____

(Escriba la dirección de la clínica del DBH autorizada para divulgar o utilizar la información médica del cliente)

Mi cancelación de esta Autorización entrará en vigor tras la recepción por el DBH y no se divulgará más información en base a la cancelación. Comprendo que DBH puede no ser capaz de recuperar información que ya haya sido divulgada antes de la revocación.

MIS DERECHOS (SALUD MENTAL)

- Puedo rehusarme a firmar esta Autorización. Esto no afectará mi capacidad de recibir tratamiento, pagos o mi elegibilidad para beneficios.
- Tengo derecho a recibir una copia de esta Autorización.
- Hasta donde lo permita la ley, puedo revisar u obtener una copia de la información médica que se me pide autorizar para divulgación.
- Comprendo que la información médica autorizada por esta divulgación puede volver a ser divulgada por la persona o entidad que yo designe para recibir la información. Comprendo que DBH no puede impedir que mi información anteriormente divulgada por medio de esta autorización sea divulgada por la persona que lo recibió.
- Comprendo que en algunos casos las leyes de California no prohíben volver a divulgar mi información y que mi información podría no estar protegida por las leyes federales de confidencialidad (HIPAA, por sus siglas en inglés). Sin embargo, comprendo que las leyes de California prohíben a la persona o entidad que recibe mi información médica hacer otra divulgación a menos que obtenga nueva autorización de mi parte o a menos que tal divulgación sea específicamente requerida o permitida por la ley.

MIS DERECHOS (SUD)

- Comprendo que mis expedientes de trastorno por el uso de sustancias están protegidos por las regulaciones federales que rigen la Confidencialidad de los Registros de Pacientes de Trastornos por el Uso de Sustancias, 42 C.F.R. Parte 2, y por la Ley de Transferibilidad y Responsabilidad del Seguro de Salud de 1996 ("HIPAA"), 45 C.F.R. Secciones 160 y 164, y no pueden ser divulgados sin mi consentimiento escrito, a menos que así lo estipulen las regulaciones.
- Comprendo que es posible que se me niegue el servicio si me rehúso a dar mi consentimiento para la divulgación con el propósito de tratamiento, pagos u operaciones relacionadas con la atención médica, si así lo permite la ley del Estado.
- No se me negarán los servicios si me rehúso a dar mi consentimiento para otros propósitos.
- Comprendo que si se utiliza la opción de designación general en esta Autorización, se me deberá proporcionar una lista de las entidades a las que se divulgue mi información de conformidad con la designación general (la lista de divulgaciones) bajo mi petición.
- Se me ha proporcionado una copia de este formulario.

- Si la opción "designación general" aparece marcada para permitir que todos mis proveedores de tratamiento reciban la información especificada, comprendo que tengo derecho a obtener una lista de las divulgaciones al solicitarla por escrito (dentro de dos años a partir de la divulgación) a los treinta (30) días de la fecha en que se haya recibido mi solicitud por escrito; la lista de divulgaciones deberá contener el nombre de la entidad a la que se le divulgó la información, la fecha en la que se divulgó y una breve descripción de la información de identificación divulgada.

FIRMA

Fecha: _____ Hora: _____ ☐ am ☐ pm

Firma: _____

(El cliente del DBH debe firmar, incluyendo los menores de 12 años y mayores, si tienen capacidad legal y mental)

Firma: _____

(El representante legal del cliente o padre/tutor de menores que no tengan capacidad de otorgar su consentimiento)

Si esta autorización es firmada por alguien que no sea el cliente, indique su nombre y relación legal con el cliente:

_____

(Nombre y relación con el cliente)

CONDADO DE SAN BERNARDINO DEPARTAMENTO DE SALUD MENTAL
AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN MÉDICA PROTEGIDA (PHI)
Tratamiento de salud mental y trastornos por uso de sustancias

AVISO SOBRE LA PROHIBICIÓN DE VOLVER A DIVULGAR INFORMACIÓN RELACIONADA CON EL TRASTORNO POR EL USO DE SUSTANCIAS (SUD, por sus siglas en inglés)

(Este formulario se deberá proporcionar a todas las personas y/o entidades a las que se proporcione información de tratamiento por SUD)

Esta información proporcionada a usted proviene de registros protegidos por las normas de confidencialidad contempladas en el Código de Reglamentos Federales (42 CFR Parte 2). Los reglamentos federales prohíben que usted vuelva a divulgar la información que aparece en este registro que identifique a un paciente que tenga o haya tenido algún trastorno por el uso de sustancias, ya sea de manera directa, al hacer referencia a información disponible públicamente, o a través de la verificación de dicha información por otra persona, a menos que dicha divulgación sea autorizada expresamente por escrito por la persona cuya información está siendo divulgada, o según lo permita el 42 CFR Parte 2. Una autorización general para la divulgación de información médica o de otra índole NO es suficiente para este propósito (consultar la sección §2.31), Los reglamentos federales restringen el uso de la información para la investigación o persecución por un delito cometido por pacientes con trastornos por el uso de sustancias, excepto lo previsto en las secciones §2.12 (c)(5) y 2.65.

LANGUAGE TAGLINES

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call *[1-888-743-1478]* (TTY: *[711]*).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *[1-888-743-1478]* (TTY: *[711]*).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số *[1-888-743-1478]* (TTY: *[711]*).

Tagalog (Tagalog–Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa *[1-888-743-1478]* (TTY: *[711]*).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. *[1-888-743-1478]* (TTY: *[711]*)번으로 전화해 주십시오.

繁體中文**(Chinese)**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 *[1-888-743-1478]* (TTY: *[711]*)。

Հայերեն **(Armenian)**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք *[1-888-743-1478]* (TTY (հեռատիպ)՝ *[711]*):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *[1-888-743-1478]* (телетайп: *[711]*).

فارسی **(Farsi)**
توجه: اگر به زبان فارسی گفتگو می‌شود، تسهیلات زبانی بصورت رایگان
شما برای راهنمایی با شماره *[1-888-743-1478]* (TTY: *[711]*) تماس بگیرید.

日本語 **(Japanese)**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。*[1-888-743-1478]* (TTY: *[711]*) まで、お電話にてご連絡ください。

Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau *[1-888-743-1478]* (TTY: *[711]*).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸ ੀਂ ਪੰਜਾਬ ਬੋਲਿ ਹੋ, ਤਾ ੀਂ ਭਾਸ਼ਾ ਧ ਿੱਚ ਸਹਾਇਤਾ ਸੇ ਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਿ ਹੈ। *[1-888-743-1478]* (TTY: *[711]*) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر تتوافر المساعدة اللغوية المساعدة خدمات فإن اللغة، *[1-888-743-1478]* برقم اتصل بالمجان لك ت
(والصم البكم هاتف رقم: *[711]* .)

हिंदी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। *[1-888-743-1478]* (TTY: *[711]*) पर कॉल करें।

ภาษาไทย **(Thai)**

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร *[1-888-743-1478]* (TTY: *[711]*).

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ រ ើសិនជាអ្នកនិយាយ ភាសាខ្ម , រសវាជំនួយមននកភាសា រោយមិនគិត្ឈ្នួល
គឺអាចមានសំរា ់ ំរ ើអ្នក។ ចូ ទូ សព្ទ *[1-888-743-1478]* (TTY: *[711]*)។

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ.
ໂທຣ *[1-888-743-1478]* (TTY: *[711]*).

ALLERGY ALERT SHEET

Please list Allergies, Adverse Reactions, and Physical Problems below:

ALLERGIES:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

ADVERSE REACTIONS:

1. _____

2. _____

3. _____

Primary Care Physician or Clinic: _____

Telephone Number _____ FAX Number _____

Date	Physical Problems	Comments	Initials

_____ _____ _____

Date Printed Name of Physician Physician's Signature

ALERT SHEET

San Bernardino County

Department of Behavioral Health

Confidential Patient Information
See W&I Code 5328

Name:

Chart No:

DOB:

Program:

Date:_____

_____ reports that he/she has not prepared an advance directive for healthcare.

Person receiving this information:_____

Client Signature:_____

Date:_____

All healthcare providers are advised that _____has prepared an advance directive for healthcare, which is attached or is available from (name, address, phone):

_____

_____

_____

_____

Person receiving this information:_____

Client Signature:_____

Date:_____

All healthcare providers are advised that _____has prepared an advance directive for healthcare, which is attached or is available from (name, address, phone):

_____

_____

_____

_____

Person receiving this information:_____

Client Signature:_____

Advance Health Care Directive
County of San Bernardino
DEPARTMENT OF BEHAVIORAL HEALTH
Confidential Patient Information
See W & I Code 5328

NAME:

CHART NO:

DOB:

PROGRAM:

LANGUAGE TAGLINES

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call *[1-888-743-1478]* (TTY: *[711]*).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *[1-888-743-1478]* (TTY: *[711]*).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số *[1-888-743-1478]* (TTY: *[711]*).

Tagalog (Tagalog– Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa *[1-888-743-1478]* (TTY: *[711]*).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. *[1-888-743-1478]* (TTY: *[711]*)번으로 전화해 주십시오.

繁體中文**(Chinese)**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 *[1-888-743-1478]* (TTY: *[711]*)。

Հայերեն **(Armenian)**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք *[1-888-743-1478]* (TTY (հեռատիպ)՝ *[711]*):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *[1-888-743-1478]* (телетайп: *[711]*).

فارسی **(Farsi)**
توجه: اگر به زبان فارسی گفتگو می‌شود، تسهیلات کمک زبانی رایگان به صورت شما ارائه می‌شود. با *[1-888-743-1478]* (TTY: *[711]*) تماس بگیرید.

LANGUAGE TAGLINES

日本語 **(Japanese)**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。*[1-888-743-1478]* (TTY: *[711]*) まで、お電話にてご連絡ください。

Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau *[1-888-743-1478]* (TTY: *[711]*).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸ ੀਂ ਪੰਜਾਬ ਬੋਲਿ ਹੋ, ਤਾ ੀਂ ਭਾਸ਼ਾ ਧ ਿੱਚ ਸਹਾਇਤਾ ਸੇ ਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਿ ਹੈ। *[1-888-743-1478]* (TTY: *[711]*) 'ਤੇ ਕਾਲ ਕਰੋ।

الـعربـيـة (Arabic)
ملحوظة: إذا كـنت تـتحدث تـواف ر الـ لـغوي ة الـم ساعدة خدمات ف إن الـ لـغة، اذكر ت بـ رق م اتـ صل بـ الـمجان لـ ك ت
[1-888-743-1478]
(والـ بـكم الـ صم هلتـ ف رق م: *[711]* .)

हिंदी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। *[1-888-743-1478]* (TTY: *[711]*) पर कॉल करें।

ภาษาไทย **(Thai)**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร *[1-888-743-1478]* (TTY: *[711]*).

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ រ ើសិនជាអ្នកនិយាយ ភាសាខ្ម , រសវាជំនួយមននកភាសា រោយមិនគិតុ្ឋលួ
គឺអាចមានសំវា ៈ ំរ ើអ្នក។ ចូ ទូ សព្ទ *[1-888-743-1478]* (TTY: *[711]*)។

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ,
ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ *[1-888-743-1478]* (TTY: *[711]*).

Fecha: _____

_____reporta que el/ella no ha preparado una directiva por anticipado para el cuidado de salud.

Persona recibiendo esta información: _____

_____
Firma de Cliente

Fecha: _____

A todo proveedor de cuidado de salud se le informa que_____ ha preparado una directiva por anticipado para el cuidado de salud, el cual esta adjunto o esta disponible de: (nombre, direccion, telefono):

_____

_____

_____

_____

Persona recibiendo esta información: _____

_____
Firma de Cliente

Fecha: _____

A todo proveedor de cuidado de salud se le informa que_____ ha preparado una directiva por anticipado para el cuidado de salud, el cual esta adjunto o esta disponible de: (nombre, direccion, telefono):

_____

_____

_____

_____

Persona recibiendo esta información: _____

_____
Firma de Cliente

Advance Health Care Directive
County of San Bernardino
DEPARTMENT OF BEHAVIORAL HEALTH
Confidential Patient Information
See W & I Code 5328

NAME:

CHART NO:

DOB:

PROGRAM:

303 East Vanderbilt Way, San Bernardino, CA 92415-0026 | Phone: 909.386.8256 Fax: 909.890.0353
www.SBCounty.gov

SAN BERNARDINO COUNTY

Behavioral Health
Update Provider Information Form

PROVIDER NAME: _____ **DATE:** _____

(Individual name and Business/Corporate name)

This is to notify the San Bernardino County Department of Behavioral Health that I have:

- ☐ Moved to a new office (complete #1 and #2)
- ☐ Added a new service location (complete #1)
- ☐ Changed Contact information, i.e., phone number/fax number/contact person (complete #3)
- ☐ 4) Closing service site location (complete #4):

1) The new address is:

_____ Phone Number: _____

_____ Fax Number: _____

_____ E-Mail Address:_____

This address is **effective** as of *(specify date)*: _____

- Fee for Service Site Certification Form must be submitted for each new location (form may be obtained by contacting Access Unit Provider Relations Representative).

This address replaces the current addresses I have on file for: *(check all that apply)*

- ☐ Mailing
- ☐ Billing
- ☐ Tax (*new W-9 form must be submitted)*
- ☐ No change of address(s) on file

---

2) The previous service site address to be taken off your profile (if applicable): **Inactive Date:** _____

_____

_____

---

3) Change of Contact Information:

Old Telephone number:_____ New Telephone number:_____

Old Fax number:_____ New Fax number:_____

Old Contact Person:_____ New Contact Person:_____

This change is **effective** as of *(specify date)*: _____

---

4) Address of Service Site location to be closed: Effective Date: _____

_____

_____

_____

Requirement to send a copy of:

Notification to Access Unit with eff. date (30 days in advance)

Notification that was sent to clients

Other changes: _____

_____

_____

Provider Signature ***(Required)***

303 E. Vanderbilt Way, San Bernardino • CA 92415-0026 | Phone: 1.888.743.1478 • Fax: 909.890.0353
www.SBCounty.gov

SAN BERNARDINO COUNTY

Access Unit – Provider Signature Authorization Form

Provider Name:			
Provider Address:			
Provider Phone #:			
Effective Date:			
Provider Signature:		**Date:**	
Authorized Signature (s)			
Designee Printed Name			
Designee Signature:		**Date:**	
Designee Printed Name			
Designee Signature:		**Date:**	
Designee Printed Name			
Designee Signature:		**Date:**	
Designee Printed Name			
Designee Signature:		**Date:**	

Medi-Cal regulations require that either the FFS Provider or their designee sign and date each Form 1500 claim form submitted. If a designee signs the Provider's name, it must be initialed by the designee next to the Provider's name in Box 31 of the Form 1500.

Claims that are submitted for payment need to have at least one of the authorized signatures above.

This form is to be completed and faxed to (909) 890-0353 or returned by mail to:

County of San Bernardino- DBH
Access Unit - Claims
303 E Vanderbilt Way
San Bernardino, CA 92415

MEDI-CAL ELIGIBLE

CLAIMS CERTIFICATION AND PROGRAM INTEGRITY

HEREBY CERTIFY under penalty of perjury to the following:

1. An assessment of the beneficiary was conducted in compliance with the requirements established in the San Bernardino County Department of Behavioral Health Provider Manual and your Provider Service Agreement with San Bernardino County Department of Behavioral Health.

2. The beneficiary was eligible to receive Medi-Cal services at the time the services were provided to the beneficiary.

3. The services included in the claim were actually provided to the beneficiary.

4. Medical necessity was established for the beneficiary as defined under Title 9, California Code of Regulations, Division 1, Chapter 11, for the service(s) provided, for the timeframe in which the service(s) were provided.

5. A client plan was developed and maintained for the beneficary that met all client plan requirements established in the San Bernardino County Department of Behavioral Health Provider Manual and your Provider Service Agreement with San Bernardino County Department of Behavioral Health.

6. For each beneficiary with day rehabilitation, day treatment intensive or EPSDT specialty mental health services included in the claim, all requirements for payment authorization for day rehabilitation, day treatment intensive and EPSDT supplemental speciality mental health services were met and any reviews for such service(s) were conducted prior to the initial authorization and any re-authorization periods as established in the Provider Manual and your Provider Service agreement with San Bernardino County Department of Behavioral Health.

_____ _____

Authorized Provider Name (print) Date

_____

Signature of Authorized Provider

303 E. Vanderbilt Way, San Bernardino • CA 92415-0026 | Phone: 1.888.743.1478 • Fax: 909.890.0353

www.SBCounty.gov

SAN BERNARDINO COUNTY

Access Unit – Provider Claims Inquiry Form

PROVIDER INFORMATION	
Name	
Address	
Phone	Fax

CLIENT INFORMATION
Date Submitted:
Client Name:
Client Medi-Cal #:
Date of Services:
Reason for inquire:

Requested by (please print)_____

Signature_____

Date _____

Date	MEDICATION — DOSAGE AND FREQUENCY	Route/Site of Entry	On Hand	New Amount	Physician Signature

Date	PATIENT ABLE TO HANDLE OWN MEDICATIONS? ☐ Yes ☐ No	☐ Family ☐ Conservator ☐ Care Provider	*Physician Signature*
Site Code	PO — per orem IM — intramuscular	RA — right arm LA — left arm	RUOQ — right upper outer quadrant LUOQ — left upper outer quadrant

OUTPATIENT MEDICATION RECORD

County of San Bernardino
DEPARTMENT OF BEHAVIORAL HEALTH

Confidential Patient Information
See W&I Code 5328

NAME:

CHART NO.:

DOB:

PROGRAM:

County of San Bernardino
Department of Behavioral Health

(Each physician responsible for this client's ongoing care must complete this form separately.)

INFORMATION RELEVANT TO CONSENT:
The undersigned physician for the client named below hereby certifies that he/she has supplied the following information regarding the administration of psychotropic medication to this client:

1. The nature of the client's medical condition;
2. The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff;
3. The reasonable alternative treatments available, if any;
4. The type, range of frequency and amount (including the use of PRN orders), method (oral or injection), and duration of taking the medication;
5. The probable side effects of these drugs known to commonly occur, and particular side effects likely to occur with this particular client;
6. The possible additional side effects that may occur to clients taking such medication beyond three months: the client shall be advised that such side effects may include persistent involuntary movement of the face or mouth and might, at times, include similar movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after the medications have been discontinued;
7. Printed information on medications given to client: ☐ YES ☐ NO If answer is NO, WHY NOT?

_____

_____

_____ _____
DATE SIGNATURE OF PHYSICIAN

DATE AND M.D. INITIALS FOR EACH ADDITIONAL CLIENT CONSENT SIGNATURE BELOW _____

CONSENT:
The client hereby acknowledges each time by signature below that:

1. I have participated to my satisfaction in the discussion and planning of my current medication services.
2. All the information above regarding the administration of psychotropic medications has been fully explained to me;
3. I understand this information and have no further questions at this time;
4. I understand that if I have questions after I have taken this medication, I will have an opportunity to discuss them with my physician;
5. I understand that nothing in this article prohibits a physician from taking appropriate action in an emergency;
6. I understand that I can withdraw this consent at any time by telling a member of the treating staff.

I DO CONSENT TO MY MEDICATION TREATMENT PLAN AND TO THE USE OF (list specific names of medications):

MEDICATIONS	DATE	SIGNATURE OF CLIENT

MEDICATIONS CONSENT FORM
San Bernardino County
DEPARTMENT OF BEHAVIORAL HEALTH
Confidential Patient Information
See W&I Code 5328

NAME:

CHART NO:

DOB:

PROGRAM:

LANGUAGE TAGLINES

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call *[1-888-743-1478]* (TTY: *[711]*).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *[1-888-743-1478]* (TTY: *[711]*).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số *[1-888-743-1478]* (TTY: *[711]*).

Tagalog (Tagalog– Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa *[1-888-743-1478]* (TTY: *[711]*).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. *[1-888-743-1478]* (TTY: *[711]*)번으로 전화해 주십시오.

繁體中文(Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 *[1-888-743-1478]* (TTY: *[711]*)。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք *[1-888-743-1478]* (TTY (հեռատիպ)՝ *[711]*):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *[1-888-743-1478]* (телетайп: *[711]*).

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با *[1-888-743-1478]* (TTY: *[711]*) تماس بگیری

LANGUAGE TAGLINES

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。*[1-888-743-1478]* (TTY: *[711]*) まで、お電話にてご連絡ください。

Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau *[1-888-743-1478]* (TTY: *[711]*).

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸ ੀਂ ਪੰਜਾਬ ਬੋਲਿ ਹੋ, ਤਾ ੀਂ ਭਾਸ਼ਾ ਧ ਿੱਚ ਸਹਾਇਤਾ ਸੇ ਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਿ ਹੈ। *[1-888-743-1478]* (TTY: *[711]*) 'ਤੇ ਕਾਲ ਕਰੋ।

(Arabic)العربية
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم *[1-888-743-1478]*
(:بكم والصم الف هلتق رقم *[711]* .)

हिंदी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। *[1-888-743-1478]* (TTY: *[711]*) पर कॉल करें।

ภาษาไทย (Thai)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร *[1-888-743-1478]* (TTY: *[711]*).

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ រ ើសិនជាអ្នកនិយាយ ភាសាខ្ម ែ , រសវាជំនួយមននកភាសា រោយមិនគិត្ឌួល គឺអាចមានសំរា ់ ំរ ើអ្នក។ ចូ ទូ សព្ទ *[1-888-743-1478]* (TTY: *[711]*)។

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ *[1-888-743-1478]* (TTY: *[711]*).

(Cada médico responsable por el cuidado continuo de su cliente, debe llenar este formulario por separado.)

INFORMACIÓN REFERENTE AL CONSENTIMIENTO:
El suscrito médico para el cliente mencionado abajo por este medio certifica que él / ella ha proporcionado la siguiente información con respecto a la suministración de medicamento psicotrópico para este cliente:

1. La naturaleza de la condición médica del cliente;
2. Las razones por tomar dicho medicamento, inclusive las probabilidades de mejorar o no mejorar sin dicho medicamento, y que el consentimiento, una vez concedido, puede ser retirado en cualquier momento al declarar dicha intención a cualesquiera de los miembros del personal tratante;
3. La disponibilidad de tratamientos alternos razonables, si existieren;
4. El tipo, rango de frecuencia y cantidad (incluyendo el uso de órdenes PRN), método (oral o inyección), y el tiempo que va a durar tomando el medicamento;
5. Los posibles efectos secundarios conocidos de ocurrencia común de estas drogas y los efectos secundarios particulares que probablemente puedan suceder con este cliente en particular;
6. Los posibles efectos secundarios adicionales que les puedan ocurrir a clientes que ingieran dichos medicamentos pasado de tres meses: se le debe advertir al cliente que dichos efectos secundarios pueden incluir movimiento involuntario persistente de la cara o boca y podría, en ocasiones, incluir movimiento similar de manos y pies, y que estos síntomas de discinesia tardía son potencialmente irreversibles y pueden presentarse después de haber descontinuado los medicamentos;
7. Se entregó información impresa de medicamentos al cliente: ☐ SÍ ☐ NO Si contestó NO, ¿POR QUÉ NO?

_____

_____

_____ _____
FECHA FIRMA DEL MÉDICO

COLOQUE FECHA E INICIALES DEL MÉDICO POR CADA FIRMA ADICIONAL DE CONSENTIMIENTO DEL CLIENTE ABAJO

CONSENTIMIENTO:
El suscrito cliente por este medio reconoce que:

1. He participado plenamente en la discusión y el planeamiento de mi tratamiento médico por medio de los medicamentos psicótropicos actualmente mencionados;
2. Toda la información de arriba referente a la suministración de medicamentos psicotrópicos me ha sido explicada plenamente;
3. Entiendo esta información y no tengo más preguntas que hacer en este momento;
4. Entiendo que si tengo preguntas después de haber ingerido este medicamento, tendré la oportunidad de discutirlas con mi médico;
5. Entiendo que nada en este artículo le prohíbe a un médico que tome acción adecuada en caso de emergencia;
6. Entiendo que puedo retirar este consentimiento en cualquier momento, diciéndole a un miembro del personal de tratamiento.

DOY MI CONSENTIMIENTO AL PLAN DE TRATAMIENTO DE MEDICAMENTO Y AL USO DE (dé nombres específicos de medicamentos):

MEDICAMENTOS	FECHA	FIRMA DEL CLIENTE

FORMA DE CONSENTIMIENTO DE MEDICAMENTOS
Condado de San Bernardino
DEPARTAMENTO DE SALUD DE LA CONDUCTA
Datos Confidenciales del Paciente
Ver Código 5328 de Bel

NOMBRE:

EXPEDIENTE CLÍNICO NÚM:

FECHA DE NAC:

PROGRAMA:

LANGUAGE TAGLINES

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call *[1-888-743-1478]* (TTY: *[711]*).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *[1-888-743-1478]* (TTY: *[711]*).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số *[1-888-743-1478]* (TTY: *[711]*).

Tagalog (Tagalog– Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa *[1-888-743-1478]* (TTY: *[711]*).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. *[1-888-743-1478]* (TTY: *[711]*)번으로 전화해 주십시오.

繁體中文**(Chinese)**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 *[1-888-743-1478]* (TTY: *[711]*)。

Հայերեն **(Armenian)**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք *[1-888-743-1478]* (TTY (հեռատիպ)՝ *[711]*):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *[1-888-743-1478]* (телетайп: *[711]*).

فارسی **(Farsi)**
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با *[1-888-743-1478]* (TTY: *[711]*) تماس بگیرید.

LANGUAGE TAGLINES

日本語 **(Japanese)**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。*[1-888-743-1478]* (TTY: *[711]*) まで、お電話にてご連絡ください。

Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau *[1-888-743-1478]* (TTY: *[711]*).

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸ ੀਂ ਪੰਜਾਬ ਬੋਲਿ ਹੋ, ਤਾ ੀਂ ਭਾਸ਼ਾ ਧ ਿੱਚ ਸਹਾਇਤਾ ਸੇ ਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਿ ਹੈ। *[1-888-743-1478]* (TTY: *[711]*) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة: إذا تحدث كنت تر غب في استخدام خدمات المساعدة اللغوية المجانية، فإن الخدمات متوافرة لك تتصل بالرقم *[1-888-743-1478]*
(TTY: *[711]*؛ الصم وضعاف السمع الرقم ف هاتف)

हिंदी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। *[1-888-743-1478]* (TTY: *[711]*) पर कॉल करें।

ภาษาไทย **(Thai)**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร *[1-888-743-1478]* (TTY: *[711]*).

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ រ ើសិនជាអ្នកនិយាយ ភាសាខ្ម ែ , រសវាជំនួយមននកភាសា រោយមិនគិតឧ្ម ួល
គឺអាចមានសំរា ំរ ើអ្នក។ ចូ ទូ សព្ទ *[1-888-743-1478]* (TTY: *[711]*)។

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ *[1-888-743-1478]* (TTY: *[711]*).

Physical Assessment

Dear Client:

Please be aware that in all cases in which medication is prescribed, especially psychotropic medications, it is essential that you be in good physical condition and/or that there are no contraindications for your taking the medication as prescribed.

If psychotropic medication is prescribed, and you have not had a physical examination and appropriate laboratory work within the last year, please schedule one as soon as possible. I will be glad to consult with your physician so that he/she may be made aware of what medication(s) are being considered or prescribed.

_____ Date: _____
Physician's Signature

_____
Physician (Print name)

_____ Date: _____
Client's Signature

PHYSICAL ASSESSMENT
County of San Bernardino
DEPARTMENT OF BEHAVIORAL HEALTH
Confidential Patient Information
See W & I Code 5328

NAME:

CHART NO:

DOB:

PROGRAM:

LANGUAGE TAGLINES

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call *[1-888-743-1478]* (TTY: *[711]*).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *[1-888-743-1478]* (TTY: *[711]*).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số *[1-888-743-1478]* (TTY: *[711]*).

Tagalog (Tagalog– Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa *[1-888-743-1478]* (TTY: *[711]*).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. *[1-888-743-1478]* (TTY: *[711]*)번으로 전화해 주십시오.

繁體中文**(Chinese)**
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 *[1-888-743-1478]* (TTY: *[711]*)。

Հայերեն **(Armenian)**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք *[1-888-743-1478]* (TTY (հեռատիպ)՝ *[711]*):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните *[1-888-743-1478]* (телетайп: *[711]*).

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می‌شود، تسهیلات زبانی تحت
شما برای راهنمایی به صورت
رایگان در دسترس می‌باشد با *[1-888-743-1478]* (TTY: *[711]*) تماس بگیرید.

LANGUAGE TAGLINES

日本語 **(Japanese)**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。*[1-888-743-1478]* (TTY: *[711]*) まで、お電話にてご連絡ください。

Hmoob (Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau *[1-888-743-1478]* (TTY: *[711]*).

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸ ੀਂ ਪੰਜਾਬ ਬੋਲਿ ਹੋ, ਤਾ ੀਂ ਭਾਸ਼ਾ ਧ ਿੱਚ ਸਹਾਇਤਾ ਸੇ ਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਿ ਹੈ। *[1-888-743-1478]* (TTY: *[711]*) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة: إذا تحدث كنت تر غب في المساعدة بالمجان لك تتوافر الخدمات المساعدة اللغوية، اذكر اتصل برقم *[1-888-743-1478]*
(والصم بكم الهاتف رقم: *[711]* .)

हिंदी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। *[1-888-743-1478]* (TTY: *[711]*) पर कॉल करें।

ภาษาไทย **(Thai)**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร *[1-888-743-1478]* (TTY: *[711]*).

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ រ ើសិនជាអ្នកនិយាយ ភាសាខ្ម , រសវាជំនួយមននកភាសា រោយមិនគិតឧ្ល គឺអាចមានសំរា ់ ំរ ើអ្នក។ ចូ ទូ សព្ទ *[1-888-743-1478]* (TTY: *[711]*)។

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ *[1-888-743-1478]* (TTY: *[711]*).

MOVEMENT RATINGS: Rate highest severity observed		CODE 0 - None 1 - Minimal (may be extreme normal) 2 - Mild 3 - Moderate 4 - Severe	
FACIAL AND ORAL MOVEMENTS	1.	Muscle of facial expression (e.g. movements of forehead, eyebrows, periorbital area, cheeks). Include frowning, blinking, smiling, grimacing.	
	2.	Lips and perioral area, (e.g. puckering, pouting, smacking)	
	3.	Jaw, (e.g. biting, clenching, chewing, mouth opening, lateral movements)	
	4.	Tongue (Rate only increase in movement both in and out of mouth, NOT inability to sustain movement.)	
EXTREMITY MOVEMENTS	5.	Upper (arms, wrists, fingers) Include choreic movements (i.e. rapid objectively purposeless, irregular, spontaneous), athetoid movements (i.e., slow, irregular, complex, serpentine). Do NOT include tremor (i.e., repetitive, regular, rhythmic).	
	6.	Lower (legs, knees, ankles, toes) (e.g. lateral knee movements, foot tapping, heel drooping, foot squirming, inversion and eversion of foot)	
TRUNK MOVEMENTS	7.	Neck, shoulders, hips, (e.g. cocking, twisting, squirming, pelvic gyrations)	
GLOBAL JUDGEMENTS	8.	Severity of abnormal movements	
	9.	Incapacitation due to abnormal movements	
	10.	Patient's awareness of abnormal movements (rate only patient's report) 0 No Awareness 1 Aware, No Distress 2 Aware, Mild Distress 3 Aware, Moderate Distress 4 Aware, Severe Distress	
DENTAL STATUS	11.	Current problems with teeth and/or denture	1 - Yes 2 - No 2
	12.	Does patient usually wear dentures?	1 - Yes 2 - No 2

M.D. SIGNATURE *PRINTED NAME* *DATE OF EVALUATION*

ABNORMAL INVOLUNTARY MOVEMENT SCALE

County of San Bernardino

Department of Behavioral Health

CONFIDENTIAL PATIENT INFORMATION
SEE W&I CODE 5238

NAME:

CHART NO.:

DOB:

PROGRAM:

Appendix 4: Useful Tools

Useful Tools

The Useful Tools listed below have been referenced within this manual.

Form
Medi-Cal Codes for California Counties
Frequently Used Provider Reimbursement Rates
Master Treatment Goals
Required Treatment Records
Instructions for Completing the CMS-1500 Form
Sample CMS-1500 Form
Title 9 of the California Code of Regulations, Section 1830.205
Title 9 of the California Code of Regulations, Section 1830.210
Title 9 of the California Code of Regulations, Section 1850.205

MEDI-CAL CODES FOR CALIFORNIA COUNTIES

County Code Listing

01	Alameda	**30**	Orange
02	Alpine	**31**	Placer
03	Amador	**32**	Plumas
04	Butte	**33**	Riverside
05	Calaveras	**34**	Sacramento
06	Colusa	**35**	San Benito
07	Contra Costa	**36**	**San Bernardino**
08	Del Norte	**37**	San Diego
09	El Dorado	**38**	San Francisco
10	Fresno	**39**	Sa Joaquin
11	Glenn	**40**	San Luis Obispo
12	Humboldt	**41**	San Mateo
13	Imperial	**42**	Santa Barbara
14	Inyo	**43**	Santa Clara
15	Kern	**44**	Santa Cruz
16	Kings	**45**	Shasta
17	Lake	**46**	Sierra
18	Lassen	**47**	Siskiyou
19	Los Angeles	**48**	Solano
20	Madera	**49**	Sonoma
21	Marin	**50**	Stanislaus
22	Mariposa	**51**	Sutter
23	Mendocino	**52**	Tehama
24	Merced	**53**	Trinity
25	Modoc	**54**	Tulare
26	Mono	**55**	Tuolumne
27	Monterey	**56**	Ventura
28	Napa	**57**	Yolo
29	Nevada	**58**	Yuba

Frequently Used CPT Codes With 2016 Rates

Dear MHP FFS Providers:

- The Department of Behavioral Health Mental Health Plan is increasing some of the rates for the frequently used CPT codes.
- The changes are effective February 1, 2016.
- The switch to the new rates is **based on the date of service**, not the date the claim is submitted. For dates of service prior to February 1, 2016, you will be paid the previous rate. For dates of service on or after February 1, 2016, you will be paid the new rate listed below.
- **Please note there is a new outpatient CPT code for Case Conference. The new CPT code, duration and rate are highlighted below.**

Effective February 1, 2016

Outpatient Codes for Psychiatrists (MD/DO)			
CPT Code	**Service Description**	**Duration**	**Rate**
90792	Psychiatric Diagnostic Eval (w/ Medical Svcs) (Board Certified, Eligible, or Child Psychiatrist)	60 min.	$124.31
99213	Individual Outpatient Tx with Med Eval (Board Certified, Eligible, or Child Psychiatrist)	15 min.	$65.81
99303	Nursing Facility Assessment	50 min	$84.76
99312	Nursing Facility Subsequent Care	25 min	$32.29

Outpatient Code for Psychologists (Psy.D./Ph.D.), Licensed Clinical Social Workers (LCSW) and Marriage and Family Therapists (LMFT)				
OLD CPT Code	**NEW CPT Code**	**Service Description**	**Duration**	**Rate**
90791		Psychiatric Diagnostic Eval (no Medical Svcs)	60 min.	$95.03
90834		Individual Psychotherapy	45 min.	$80.44
90847		Family Psychotherapy	60 min.	$80.44
X9544	99448	Case Conference	30 min.	$40.21

Inpatient Codes for Psychiatrists (MD, DO)			
CPT Code	**Service Description**	**Duration**	**Rate**
99221	Acute Hospital Inpatient Initial Care	30 min.	$53.82
99222	Acute Hospital Inpatient Initial Care	50 min.	$75.35
99231	Acute Hospital Inpatient Subsequent Care	15 min.	$26.91
99232	Acute Hospital Inpatient Subsequent Care	25 min.	$35.52
99233	Acute Hospital Inpatient Subsequent Care	35 min.	$43.06
99238	Discharge Inpatient care	30 min.	$21.53
99239	Discharge Inpatient care	50 min.	$30.75
99241	Office Consultation	15 min.	$28.78
99251	Initial Inpatient Consultation	20 min.	$37.00
99252	Initial Inpatient Consultation	40 min.	$47.97
99253	Initial Inpatient Consultation	55 min.	$67.16

Any Questions? Please contact Access Unit at 1(888)743-1478.

MASTER TREATMENT GOALS

Crisis Intervention

1. Reduction or elimination of the behavior(s) (specify and operationally define), attributable to the mental health condition, which precipitated or exacerbated crisis.

Prevent Harm to Self or Others

2. Client will not attempt suicide. Elimination of ideations/gestures from current baseline (specify) to a target of zero.
3. Client will not commit violence to others. Elimination of specific behaviors (specify and operationally define) from baseline (specify) to target of zero.
4. Client will not commit physical and/or sexual abuse. Elimination of specific behaviors from baseline (specify and operationally define), to target of zero.
5. Client will eliminate criminal activities (specify the activities and specify how activities are attributable to mental disorder), from current baseline (specify), to a target of zero.

Increase Access to Resources

6. Client will increase access to needed resources (housing, medical care, financial resources and conservatorship, etc.), currently impeded by impairments attributable to mental health condition (must describe how current access to resources is directly impeded by mental health condition).

Maintain Community Functioning and Avoid Higher Levels of Care

7. Client will reduce/eliminate behaviors (specify and operationally define), attributable to mental health condition, which have led to hospitalization or higher levels of care.
8. Client will reduce/eliminate behaviors (specify and operationally define), attributable to mental health condition, which have led to hospitalization, harm to self or others, becoming homeless, or jailed, etc.

Dysfunctional Behaviors

9. Client will reduce dysfunctional behaviors (specify and operationally define), attributable to mental health condition, which significantly impair community, social, occupational and /or familial functioning. These may include self-mutilation, disorders of eating, public disruptiveness, behaviors resulting in arrest, concentration difficulties, and disruptive obsessions, and/or compulsions.
10. Client will reduce dysfunctional behaviors (specify and operationally define), attributable to mental health condition, which significantly impair clients ability to care for self (i.e. access needed resources, perform basic care of self activities).

Child Maturation, Welfare and Family Environment

11. Client will reduce behaviors (specify and operationally define), attributable to mental health condition, which impair functioning at school or threaten school placement
12. Client will reduce behaviors (specify and operationally define), attributable to mental health condition, which impairs client's ability to remain with family (avoid placement)
13. Client will reduce behaviors (specify and operationally define), attributable to mental health condition, which impairs client to make normal progress toward maturation and self-support.

Social Functioning

14. Client will reduce behaviors (specify and operationally define), attributable to mental health condition, which impede ability to develop social support system and maintain it

Job Skills and Work

15. Client will reduce behaviors (specify and operationally define), attributable to mental health condition, which impede the ability to enter the job market and become self-supporting.
16. Client will reduce behaviors (specify and operationally define), attributable to mental health condition, which impede the ability to maintain employment.

REQUIRED TREATMENT RECORDS

The following documents must be included in the client's record. These records are subject to periodic audit.

- MHP Assessment Plan
- Diagnosis Sheet
- Client Plan
- Re-Authorization Request (ifapplicable)
- Annual Psychiatric Assessment Review
- DBH Consent for Outpatient Treatment (includes client authorization for providers and MHP to communicate about clinical and authorization aspects of treatment)
- Advance DirectivesNotice
- Medication Consent Form (only if medications are prescribed by the provider)
- Progress Notes for each assessment or treatment sessions (as outlined in the State of California DMH Documentation Standards)
- Medication Order Sheet (only if medications are prescribed by the provider)
- AIMS Scale (annually, only if medications are prescribed by the provider)
- Physical Assessment Notification (annually, only if medications are prescribed by the provider)
- Release of Information forms (asneeded)
- Discharge Summary (faxed to Access Unit following termination)

INSTRUCTIONS FOR COMPLETING THE CMS-1500 FORM

Box#

1. 1a. leave blank. 1b. enter either patient social security number or the Medi-Cal ID, starting with a "9", number from the Medi-Cal Card
2. Enter patient name (use same spelling/name as on Medi-Cal Card)
3. Enter patient birth date
4. Leave blank
5. Enter patient address, city, state, zip code and phone number
6. Leave blank
7. 7a, 7b leave all blank
8. Leave blank
9. 9a, 9b, 9c, 9d leave all blank
10. 10a, 10b, 10c leave all blank.
11. 11a, 11b, 11c, 11d leave all blank
12. Put either "Signature on File" or "SOF". You do not need to have the patient sign each HCFA form; however, you are required to have a signed release on file.
13. Put either "Signature on File" or "SOF". You do not need to have the patient sign each HCFA form; however, you are required to have a signed release on file.
14. Leave blank
15. Leave blank
16. Leave blank
17. 17a, 17b leave all blank
18. Leave blank
19. Leave blank
20. Leave blank
21. Enter diagnosis (must have at least AXIS I)
22. Leave blank
23. Leave blank
24. You must complete 24a, b, d, e, f, g, j (NPI number) - You do not need to complete 24c, h, i.
25. Enter provider SSN or EIN
26. Leave blank
27. Leave blank
28. Enter total charge
29. Enter amount paid ONLY if you have collected the Medi-Cal Share of Cost for the services provided. Note: this only applies to patients that have a Medi-Cal Share of Cost.
30. Enter balance due to provider
31. Must have original signature and date signed
32. Enter address where the service was provided, if different from billing address. Please include the individual provider's NPI number under 32a.
33. Enter provider name, mailing address and phone number. Please include the individual provider's NPI number again under 33a.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Title 9 of the California Code of Regulations, Section § 1830.205

§ 1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

(a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this Subchapter, except as specifically provided.
(b) The beneficiary must meet criteria outlined in Subsections (1)-(3) below to be eligible for services:

(1) Have one of the following diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IVE, Fourth Edition (1994), published by the American Psychiatric Association:
(A) Pervasive Developmental Disorders, except Autistic Disorders
(B) Disruptive Behavior and Attention Deficit Disorders
(C) Feeding and Eating Disorders of Infancy and Early Childhood
(D) Elimination Disorders
(E) Other Disorders of Infancy, Childhood, or Adolescence
(F) Schizophrenia and other Psychotic Disorders, except Psychotic Disorders due to a General Medical Condition
(G) Mood Disorders, except Mood Disorders due to a General Medical Condition
(H) Anxiety Disorders, except Anxiety Disorders due to a General Medical Condition
(I) Somatoform Disorders
(J) Factitious Disorders
(K) Dissociative Disorders
(L) Paraphilias
(M) Gender Identity Disorder
(N) Eating Disorders
(O) Impulse Control Disorders Not Elsewhere Classified
(P) Adjustment Disorders
(Q) Personality Disorders, excluding Antisocial Personality Disorder
(R) Medication-Induced Movement Disorders related to other included diagnoses.

(2) Have at least one of the following impairments as a result of the mental disorder(s) listed in Subsection (b)(1) above:
(A) A significant impairment in an important area of life functioning.
(B) A reasonable probability of significant deterioration in an important area of life functioning.
(C) Except as provided in Section 1830.210, a reasonable probability a child will not progress developmentally as individually appropriate. For the purpose of this Section, a child is a person under the age of 21 years.

(3) Meet each of the intervention criteria listed below:
(A) The focus of the proposed intervention is to address the condition identified in Subsection (b)(2) above.
(B) The expectation is that the proposed intervention will:
1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning, or
3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
4. For a child who meets the criteria of Section 1830.210(1), meet the criteria of Section 1830.210(b) and (c).
(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this Section or Section 1830.210 are met, beneficiaries shall receive specialty mental health services for a diagnosis included in Subsection (b)(1) even if a diagnosis that is not included in Subsection (b)(1) is also present.

Title 9 of the California Code of Regulations, Section § 1830.210

§ 1830.210. Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries Under 21 Years of Age.

(a) For beneficiaries under 21 years of age who are eligible for EPSDT supplemental specialty mental health services, and who do not meet the medical necessity requirements of Section 1830.205(b)(2)-(3), medical necessity criteria for specialty mental health services covered by this Subchapter shall be met when all of the following exist:

The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),

The beneficiary has a condition that would not be responsive to physical health care based treatment, and

The requirements of Title 22, Section 51340(e)(3)(A) are met with respect to the mental disorder; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22, Section 51340(e)(3)(A) with respect to the mental disorder and the requirements of Title 22, Section 51340(f) are met.

(b) The MHP shall not approve a request for an EPSDT supplemental specialty mental health service under this Section or Section 1830.205 if the MHP determines that the service to be provided is accessible and available in an appropriate and timely manner as another specialty mental health service covered by this Subchapter and the MHP provides or arranges and pays for such a specialty mental health service.

(c) The MHP shall not approve a request for specialty mental health services under this Section in home and community based settings if the MHP determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total cost to the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner, and the MHP provides or arranges and pays for the institutional level of care if the institutional level of care is covered by the MHP under Section 1810.345, or arranges for the institutional level of care, if the institutional level of care is not covered by the MHP under Section 1810.345. For the purpose of this Subsection, the determination of the availability of an appropriate institutional level of care shall be made in accordance with the stipulated settlement in T.L. v. Belshe.

Title 9 of the California Code of Regulations, Section § 1850.205

§ 1850.205. General Provisions.

(a) An MHP shall develop problem resolution processes that enable a beneficiary to resolve a problem or concern about any issue related to the MHP's performance of its duties under this Chapter, including the delivery of specialty mental health services.

(b) The MHP's beneficiary problem resolution processes shall include:

(1) A grievance process;

(2) An appeal process; and

(3) An expedited appeal process.

(c) For the grievance, appeal, and expedited appeal processes, found in Sections 1850.206, 1850.207 and 1850.208 respectively, the MHP shall ensure:

(1) That each beneficiary has adequate information about the MHP's processes by taking at least the following actions:

(A) Including information describing the grievance, appeal, and expedited appeal processes in the MHP's beneficiary booklet and providing the beneficiary booklet to beneficiaries as described in Section 1810.360.

(B) Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all MHP provider sites sufficient to ensure that the information is readily available to both beneficiaries and provider staff. The posted notice shall also explain the availability of fair hearings after the exhaustion of an appeal or expedited appeal process, including information that a fair hearing may be requested whether or not the beneficiary has received a notice of action pursuant to Section 1850.210. For the purposes of this Section, an MHP provider site means any office or facility owned or operated by the MHP or a provider contracting with the MHP at which beneficiaries may obtain specialty mental health services.

(C) Making forms that may be used to file grievances, appeals, and expedited appeals, and self addressed envelopes available for beneficiaries to pick up at all MHP provider sites without having to make a verbal or written request to anyone.

(2) That a beneficiary may authorize another person to act on the beneficiary's behalf. The beneficiary may select a provider as his or her representative in the appeal or expedited appeal process.

(3) That a beneficiary's legal representative may use the grievance, appeal, or expedited appeal processes on the beneficiary's behalf.

(4) That an MHP staff person or other individual is identified by the MHP as having responsibility for assisting a beneficiary, at the beneficiary's request, with these processes, including assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the MHP is the person providing specialty mental health services to the beneficiary requesting assistance, the MHP shall identify another individual to assist that beneficiary.

(5) That a beneficiary is not subject to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal.

(6) That procedures for the processes maintain the confidentiality of beneficiaries.

(7) That a procedure is included by which issues identified as a result of the grievance, appeal or expedited appeal processes are transmitted to the MHP's Quality Improvement Committee, the MHP's administration or another appropriate body within the MHP for consideration in the MHP's Quality Improvement Program as required by Section 1810.440(a)(5).

(8) That the individuals making the decision on the grievance, appeal, or expedited appeal were not involved in any previous review or decision-making on the issue presented in the respective problem resolution process.

(9) That the individual making the decision on the grievance, appeal, or expedited appeal has the appropriate clinical expertise as determined by the MHP to treat the beneficiary's condition, if the grievance is regarding the denial of a request for an expedited appeal or if the grievance, appeal, or expedited appeal is about clinical issues.

(d) For the grievance, appeal, and expedited appeal processes found in Sections 1850.206, 1850.207, and 1850.208, the MHP shall:

(1) Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance or appeal. The log entry shall include but not be limited to the name of the beneficiary, the date of receipt of the grievance, appeal, or expedited appeal, and the nature of the problem.

(2) Record in the grievance and appeal log or another central location determined by the MHP the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary, or document the reason(s) that there has not been final disposition of the grievance, appeal, or expedited appeal.

(3) Provide a staff person or other individual with responsibility to provide information on request by the beneficiary or an appropriate representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal.

(4) Acknowledge the receipt of each grievance, appeal, and expedited appeal to the beneficiary in writing.

(5) Identify the roles and responsibilities of the MHP, the provider, and the beneficiary.

(6) Notify those providers cited by the beneficiary or otherwise involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal.

(e) No provision of an MHP's beneficiary problem resolution processes shall be construed to replace or conflict with the duties of county patients' rights advocates as described in Welfare and Institutions Code, Section 5520.

Appendix 5: Research Policy & Application Process

Research Policy & Application Process

The Research Policy and Application Process can be found online in the County of San Bernardino Department of Behavioral Health Standards Practice Manual (SPM) at http://wp.sbcounty.gov/dbh/for-providers/admin/standard-practice-manual/.

Note: This policy is subject to ongoing updating. To ensure you are accessing the most current policy, please referencing the one posted on the website.