

State of California

MH 2180(1/07)

MEDI-CAL (M/C) CERTIFICATION AND TRANSMITTAL

Department of Mental Health

Part A: Provide the following information:

1619005576

NPI#

COUNTY SUBMITTING FORM: PLACER

COUNTY CODE: 31

TYPE OF TRANSACTION (Check all that apply)

If change, indicate one or more types:

- Activate
- Terminate
- Change
- Re-Cert
- Name
- Address
- Mode/SF
- Effective Date

PROVIDER NUMBER: 8159

PROVIDER NAME: Sierra Family Services Auburn

PROVIDER ADDRESS: 1225 Lincoln Way Auburn CA 95603

PROVIDER CITY: Auburn

PROVIDER ZIP CODE: 95603

M/C ACTIVATION DATE: _____

M/C TERMINATION DATE: _____

M/C RECERT DATE: 10/01/10

IF CHANGE, EFFECTIVE DATE OF CHANGE: _____

Per the MHP Contract, the M/C activation date cannot be earlier than the latest date of the following dates:

- 1) Date the site was operational: _____
- 2) Date of the fire clearance: 09/08/10
- 3) Date the provider requested certification: 09/17/10

In addition, the onsite review must be within six months of these dates. Date of onsite review: 09/28/10

Is the county submitting this form, the host county? yes no If no, name host county? _____

Indicate services Revenue/Procedure Code (CR/DC Mode, Service Function)

- | | | | | |
|---|--------------|--------------|---|---------------|
| <input type="checkbox"/> (07) General Hospital | 0100 (05/10) | 0101 (05/19) | <input type="checkbox"/> Non-Hospital PHF | H2013 (05/20) |
| <input type="checkbox"/> (08) Psych Hosp Age (< 21) | 0100 (05/10) | 0101 (05/19) | <input type="checkbox"/> Crisis Residential | H0018 (05/40) |
| <input type="checkbox"/> (09) Psych Hosp Age (> 64) | 0100 (05/10) | 0101 (05/19) | <input type="checkbox"/> Adult Residential | H0019 (05/65) |
- For Residential - How many beds? _____

Check only one Mode (either 12 or 18).

(12) Hospital Outpatient

(18) Non-Hospital Outpatient

Indicate services Procedure Code (CR/DC Mode, Service Function)

- | | | | |
|--|---------------|---|--|
| <input type="checkbox"/> Crisis Stabilization ER | S0404 (10/20) | <input type="checkbox"/> Crisis Stabilization UC | S9484 (10/25) |
| <input type="checkbox"/> Day TX Intensive Half Day | H2012 (10/81) | <input type="checkbox"/> Day TX Intensive Full Day | H2012 (10/85) |
| <input type="checkbox"/> Day Rehab. Half Day | H2012 (10/91) | <input type="checkbox"/> Day Rehab. Full Day | H2012 (10/95) |
| <input checked="" type="checkbox"/> Case Manage./Brokerage | T1017 (15/01) | <input checked="" type="checkbox"/> MHS H2015 (15/30) | <input type="checkbox"/> TBS H2019 (15/58) |
| <input type="checkbox"/> Medication Support | H2010 (15/60) | <input checked="" type="checkbox"/> Crisis Intervention H2011 (15/70) | |

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

Michelle Johnson, MSW, MPA

Print name of person completing form.

County Fax: (530) 886-5499

Authorized Signature: _____

Phone: (530) 886-5440

Date: 10/01/10

Check below to indicate person signing.

- County Mental Health Director or Designee
- Medi-Cal Oversight

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

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

Medi-Cal Oversight

Date: 11/08/10

RECEIVED