

PROVIDER AGENCY CERTIFICATION FORM
BEHAVIORAL HEALTH OVERLAY SERVICES –
CHILD WELFARE

Provider Agency Name: _____ Medicaid No. _____

Provider Agency Address: _____

City: _____ Zip Code _____ Phone No.: () _____

County: _____ District: _____ Area: _____

Name and Address of Site: _____

_____ Zip Code _____

Surveyed By: _____ Date of Survey: _____

This is to certify that the above named provider agency and site meet the following qualifications and certification criteria as specified Chapter 2, Section 7 of this handbook:

1. Is an enrolled Medicaid Community Mental Health Services provider.
2. Is licensed by the Department of Children and Families under Chapter 65C-14, F.A.C. as a child caring agency and is under contract with the Child Welfare and Community Based Care office or provider to provide group shelter care or residential group care.
3. Has the primary mission in this program to provide an alternative living situation to children who have been removed from the home due to abuse or neglect or adjudicated dependent;
4. Is designated by the Department of Children and Families as an essential behavioral health care provider.
5. Received an on-site survey by the district Substance Abuse and Mental Health and Child Welfare offices for Behavioral Health Overlay Services provider agency certification and was found to be in compliance with the provisions for provider qualifications and certification criteria. These certification criteria include:

- | | |
|--|---|
| • Services to be provided | • Qualifications and responsibilities |
| • Provider capacity | • Clinical supervision |
| • Intensity of services | • Behavioral health overlay services design |
| • Quality assurance program | • Recipient eligibility |
| • Required policies and procedures | • Recipient certification and re-certification |
| • Organizational chart and staff credentials | • Medical record and documentation requirements |
| • Clinical staffing requirements, including staff ratios | |

I certify that statements made in this document are accurate and correct to the best of my knowledge, information, and belief.

District SAMH Designated Representative or Representative

District or Regional Child Welfare

Date: _____

Date: _____

continued

APPENDIX O, continued

**PROVIDER AGENCY CERTIFICATION FORM
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This certification has been reviewed by:

AHCA Representative

Date

The above named site is in compliance with and adheres to Medicaid policies and procedures as put forth in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook and with the specific standards for Behavioral Health Overlay Services –Child Welfare.

Provider's CEO Signature

Date

Original to provider, copies to district or regional Child Welfare, SAMH and area Medicaid offices.