

PROVIDER AGENCY CERTIFICATION FORM
BEHAVIORAL HEALTH OVERLAY SERVICES –
DEPARTMENT OF JUVENILE JUSTICE

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 presented in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, Chapter 2, Section 4.

1. Is an enrolled Medicaid Community Behavioral Health Services provider.
2. Is under contract with the Department of Juvenile Justice as a residential group care provider.
3. Has the primary mission in this program to provide an alternative living situation to children who have been adjudicated delinquent.
4. Is designated by the Department of Juvenile Justice as an essential behavioral health care provider.
5. Received an on-site survey by the district Substance Abuse and Mental Health (SAMH) program office, local Mental Health authority 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
- Provider capacity
- Intensity of services
- Quality assurance program
- Required policies and procedures
- Organizational chart and staff credentials
- Clinical staffing requirements, including staff ratios
- Qualifications and responsibilities
- Clinical supervision
- Behavioral health overlay services design
- Recipient eligibility
- Recipient certification and re-certification
- Medical record and documentation requirements

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

District Substance Abuse and Mental Health Representative

Date

This certification has been reviewed by:

AHCA Representative

Date

continued

APPENDIX H, continued

PROVIDER AGENCY CERTIFICATION FORM, BEHAVIORAL HEALTH OVERLAY SERVICES

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 in Section 4.

Provider's CEO signature

Date

Original to provider, copies to District SAMH and Area Medicaid Office