PROVIDER AGENCY SELF 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: _____

This is to certify that the above named provider agency has conducted a self-survey of the above named site and determined that the provider and site are in compliance with the certification criteria, presented in the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, Chapter 2, Section 4, as required to be a Behavioral Health Overlay Services Provider, including the following:

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; and
5. Will cooperate with an on-site survey by the district Substance Abuse and Mental Health program office or AHCA Utilization Management organization, local Mental Health authority for Behavioral Health Overlay Services Provider Agency Certification within six months of this self-certification and agrees to adhere to 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
- Staffing 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 the above named site is in compliance with 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. I further certify that statements made in this document are accurate and correct to the best of my knowledge.

_____ _____

Executive Director's Signature Date

Executive Director's Name (please print) _____

Send original form to:
AHCA, Medicaid Services
Behavioral Health Unit-DJJ/Overlay
2727 Mahan Drive, MS 20
Tallahassee, FL 32308

Provider should maintain a copy.