

PROVIDER AGENCY SELF-STUDY FORM THERAPEUTIC GROUP HOME SERVICES

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-study of the above named site and determined that the provider and site are in compliance with the certification criteria for the provision of Therapeutic Group Care Services included in Section 6 of the Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook, including the following:

- Be designated by the Department of Children and Families, District Substance Abuse and Mental Health (SAMH) Program Office as a Therapeutic Group Care Services provider;
- Be properly licensed in accordance with Chapter 409.175, F. S., and Chapter 64C-13, F. A. C., or 65C-14, F. A. C., by the district Family Safety Program office. The program must become licensed by AHCA as required under Chapter 65E-9, F.A.C., when it is promulgated.
- Will cooperate with an on-site survey by the district Substance Abuse and Mental Health and the Family Safety Program Offices for the purpose of Provider Agency Certification prior to initiation of billing, within six months of initial certification and annually thereafter, and agrees to adhere to the provisions for provider qualifications and certification criteria.

These certification criteria include:

- Required Capabilities for Therapeutic Group Care Providers
- Quality Assurance Program Requirements
- Services to be Provided
- Staff Qualifications and Training
- Required Policies And Procedures

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 Therapeutic Group Home Services and 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, Long Term Care and Behavioral Health Unit, 2727 Mahan Drive, MS 20, Tallahassee FL 32308. Provider should maintain a copy.