DRUG MEDI-CAL

DHCS FORM 6001(Rev. 10/13) APPLICATION GUIDE

The application process to become a Drug Medi-Cal (DMC) Provider can be a daunting task. The purpose of this guide is assist you in the process and help you to be successful, not only in the application process but also as a provider of Drug Medi-Cal services. **In addition to completing the DMC Applicaton (Form DHCS 6001, rev. 10/13) and supplying supporting information, applicants must also complete and submit the Medi-Cal Disclosure Statement (Form DHCS 6207, rev. 7/14).**

Re-certification is required following relocation of a clinic or satellite site, to add services or funding and/or to apply for DMC certification following a change of ownership

Before attempting to fill out the application(s) it is advised to complete several preliminary tasks and organize some of the required documents. These tasks include:

☐ Ensure you have an executed contract between you and either the county in which services are provided or the State. You cannot bill for Drug Medi-Cal (DMC) reimbursement without a contract.

☐ Review the "Preparing to be a Drug Medi-Cal Provider" guidelines and ensure your agency is prepared to successfully complete the application and certification process.

COMPLETING THE INITIAL APPLICATION- **DHCS Form 6001**

This guide addresses completing all elements of the Application which applies for "**Original Applications**" (A substance abuse clinic or satellite site applying for initial DMC certification) and for **Recertification. Programs are also required to complete and submit an application when they**:

1) add additional services;
2) add a satellite site;
3) change site status due to relocation or expansion; or,
4) change ownership

Instructions for which sections must be completed for these applications are found on pages 2-5 of the application. It is advised applicants thoroughly read through these instructions before entering information onto the application form. The instructions are clear about which areas of the application need to be completed depending on the type of DMC certification action you are requesting—they will not be repeated here.

DO NOT USE: Correction tape, white out, or highlighter pen or ink of a similar type to the form. If you must make corrections line through, date and initial in ink (blue preferred).

DO NOT: Staple or bind your application form or any attachments

Section I **Identifying Information for Substance Abuse Clinic** (Page 6 of 12)	
☐	a. **Legal Entity Name** (and address): This is the name of the "legal entity" in control of the clinic (as listed with the IRS). Note that while the form only asks for the "name" the instructions ask for both "name" and "address." Both the name and address you enter should match the following; **i.** ☐ If applicant is a corporation, enter the **name and address as it appears on the Articles of Incorporation** **ii.** ☐ If applicant is a partnership, enter **name and address as it appears on the partnership agreement** **iii.** ☐ If applicant is a county, indicate **the name (address if included) as it appears on the county charter** iv. ☐ If the applicant is a sole proprietor, the name and address of the sole proprietor must be listed. **(*Note: Sole proprietor's must also complete the Application Supplement for Sole Proprietors*—**See DHCS website for Form DHCS 5111)

☐	*b.* **Program/Clinic Name**: This is the name of the Program or Clinic which is the site requesting certification action and where services will be provided. *This is the name that is used "publically" (in advertising, brochures, etc.) and may not be the same as the legal entity name.* For Example: Your Legal Name may be "XYZ Community Services" but your clinic is called "The Good Treatment Clinic". Put the name, "Good Treatment Clinic" in this space. NOTE: If this is a fictitious business name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the recorded/stamped Permit to the application.
☐	c. **School Name:** If you are certifying at a school site, enter the schools name here.
☐	d. **Street Addresss; City, State, Zip Code:** This is the address (street, city, State, and zip) for the site named in 'b' above (NO P.O. Box numbers). Be sure to include any building numbers or suite numbers to clearly identify the site **(Note: This must be consistent with all other supporting documents such as the National Provider Identifier (NPI) documents, lease, fire clearance, and use permit)**
☐	**e.** **Mailing Address**; City, State, Zip Code: Enter where mail, especially information about your application should be sent. If this is the same address as the "site" do not write, "See Above." **Even if it is the same, enter the information completely.**
☐	f. **Website Address:** Enter the agency or Program's website if there is one.
☐	g. **Lease Information**: If the clinic is leased or rented, enter completely the "Full Name" of the owner and their address including City, State, and Zip Code. **Note that a copy of the lease/rental agreement must be included as an attachment.** o **If you are a school site or ANY SPACE that is donated, you will have to include a letter (official, on letterhead and signed by a titled and recognized authority such as the principal OR county official) describing the space and conditions for use.** **NOTE: This is a good time to start a "Table of Contents" for your attachments and label each one.** This makes the review process smoother and better ensures that materials you include to support your application don't get lost or missed.
☐	h. **Medi-Cal Provider Number**: If you currently have a Medi-Cal Provider Number, enter it here.
☐	i. **CalOMS Number:** Be sure and check the box "yes" if you currently have a CalOMS reporting number; check "no" if you do not. If you do have a CaOMS number, also enter that number in the space provided.
☐	j. **Program Telephone Number:** Enter the telephone number for the site you are certifying
☐	**k.** **Type of Location:** Residential or outpatient clinic is common—See CCR §51341.1 for other types
☐	**l.** **NPI Number:** You must have and enter your National Provider Identification number. If you do not have one, see instructions above on how to obtain one. **Important,** verify the name and address on the NPI information (National web site) is the same as the name and location of the site you are certifying. Attach a copy of the CMS/National Plan and Provider Enumeration System (NPPES) confirmation for each NPI listed in your application package.
☐	m. **Federal Employer Identification Number (FEIN)**: This is required for sole proprietors
☐	n. **County of program operation:** List the county in which your program operates

Section II: **Administration** (Page 6 of 12)	
☐	**Clinical Director**: DMC Standards (IV.B) identify the clinical director as the individual who supervises both the professional and non-professional clinical staff. Enter all information including the individual's NPI number if any (This would be the individual's **Type-1 NPI** number, not the programs NPI number)
☐	**Executive Director:** The person responsible for representing the legal entity for the operation of the Clinic. As with the clinical director enter all information including NPI (Type-1) number, if any.

NOTE: Enter complete information on both the Clinical Director and Executive Director even if they are the same person—**do not write "same as above".**

Section III: **Type of Legal Agency or Entity** (Page 6 of 12)	
☐	**Check the box which correctly identifies what type of governance controls the clinic—**Be sure to also attach the appropriate documents (Articles of Incorporation, etc.) which support your status: -If ☐ Sole Proprietorship, then attach ☐ Copy of fictitious business name permit/statement -If ☐ Partnership, then attach ☐ Copy of partnership agreement -If ☐ Not for Profit Corporation, then attach ☐ Copy of Articles of Incorporation (stamped by Sec. of State) -If ☐ Other Corporation, then attach ☐ Copy of Articles of Incorporation (stamped by Sec. of State) -If ☐ Government or Other, check box and include a copy of organizational chart reflecting program's placement within the government agency These attachments should be labled and entered on your Table of Contents for attachments. **Also recheck to ensure the name on your documentation matches the name and address you entered for Legal Entity in Section 1 above)**

Section IV: **Funding Sources**	
☐	Identify funding sources for operations. Include all sources of revenue for your program. This should match revenue identified in your current year budget. In addition to writing/typing in the revenue sources (grants; contract; third-party payments; insurance; Medi-Cal; client fees; etc.) be sure to: ☐ Attach a copy of your current years budget—this is a **line item budget** to include revenue and expenses.

Section V: **Type of Application**	
☐	Check all that apply (This identifies the reason you are applying for certification)—one of the boxes must be checked. Read pages 1-2 of the application for explanations of the categories): ☐ Original Application adding (Use this if this is your initial application and you are certifying a substance abuse clinic providing services over 20 hours per week (see DMC Stds,II.A). ☐ Satellite Site (Use this if you are trying to certify a clinic based at a specific building, place, or premises that is at a separate location from a DMC certified substance abuse clinic and provides **no more than 20 hours a week of substance abuse services**, and the director or substance abuse professional is on-site a minimum of 4 hours a week (see DMC Stds, II.C) ☐ Adding services and/or Program Types (List these in the space provided) ☐ Relocating (includes: o where you are moving from in the space provided; o list the date of your move; and check the appropriate box indicating if your entire program is moving or just the DMC component ☐ Change of ownership (List previous ownership name in space provided) ☐ Other (Indicate why—recertification is a common reason)

Section VI: **Services Modality(ies)**	
☐	In this section be sure an **mark all services to be provided by the DMC clinic.** This will include existing services and additional ones being requested by this application. Note that perinatal residential services require a residential AOD license issued by DHCS: Narcotic Treatment Programs [NTP] requires a license issued by DHCS. Information on licensing Is available on the DHCS website (www.dhcs.ca.gov). Be clear if you are marking "Non-perinatal" "perinatal"—to provide and bill DMC for the enhanced perintal rate you must be perinatal certified; if you are not going to provide that service, request "non-perinatal" in the modality you wish to be certified to provide. MARK ALL MODALITIES AND SERIVCES YOU WISH TO BE CERTIFIED TO PROVIDE AT THIS SITE.

Section VII: **Hours of Service Provision**	
☐	Check the box which describes the hours the clinic will be open to provide services. Remember a satellite site provides no more than 20 hours a week of substance abuse services, and the director or substance abuse professional is on-site a minimum of 4 hours a week. Even if your site provides less that 20 hours of DMC groups at week, but is open to provide substance abuse services more than 20 hours, mark the box "More than 20 hours per week."

Section VIII: **Drug Protocol**	
☐	Attach a Drug Protocol for EACH SERVICE MODALITY being request in Section VI. This important element documents how your program complies with DMC regulations and standards. As an attachment it is highly recommended that you organize this document with a table of contents and section tabs. REFER TO THE PROTOCOL GUIDES FOR DETAILED INFORMATION ON COMPLETING THIS SECTION.

Section IX: **Federally Qualified Health Center (FQHC)**	
☐ Complete ☐ N/A	**Check the appropriate box** indicating if your facility is either: o An existing FQHC or in the process of applying for FQHC status o A Federally Certified Rural Health Clinic (FHC) or in the process of applying for RHC designation If neither of these designations apply, leave this section blank.

Section X: **Residential Substance Abuse Applicants**	
☐ Complete ☐ N/A	1) Check to indicate if your facility is separately licensed by DHCS: o If yes, enter your license number o If no, you must first obtain a license before applying for DMC Certification 2) List the number of treatment beds (Programs cannot exceed 16 treatment beds) 3) Indicate if food, shelter, and AOD services are all provided at the licensed facility. If all services are not provided at the licensed facility (for example, food and shelter are provided at the licens facility but treatment/recovery services are provided at another location) complete the Table provided listing all onsite and offsite services. Be sure and list the service (onsite or offsite), the provider's name (legal entity), and the address where the service is provided) If you are not a Residential Substance Abuse Applicant, leave this section blank

Section XI: **Staff**

Medical Director- ***All Programs must designate a Medical Director and complete the following:***

☐ Enter the name of your Medical Director (as it appears on her/his Medical License)
☐ Enter the Medical License number
☐ Enter the Medical Director's NPI Number (Type-1)

☐ **Submit: Current and legible copy of the medical director's license**
- **If Medical Director is not employed as agency staff, include a copy of the MOU or Contract for services)**

Program Staff- Complete all of the following information for staff (**paid and volunteer**) that will "provide direct treatment services" at the site your are certifying (NOTE: Information in Personnel files must match the information provided in this section)

☐ Enter total number of staff (total direct service staff at the site to be certified)
☐ Enter total number of staff who perform alcohol/drug counseling duties (at site to be certified)
☐ Enter total number of staff who are **currently** licensed, certified, or registered counselors)

Note: Counseling staff listed must be certified or registered by an "Approved Certifying Organization" (Breining Institute has been de-certified and does not qualify) or appropriately licensed as indicated on Page 9 (of 12) of the application. At least 30% of the counseling staff must be currently licensed or certified, remaining counseling staff must be at least registed.

Section XI: **Staff (Continued)**

☐ Enter information on each staff person (from your Total number of Staff) on the "Employee Information" Form (Pages 10-11)—Must be complete and match Personnel Files!
- **Column 1**: Include Staff persons name (Place a "V" after their name if they are a volunteer, Job Title, and Schedules Hours of work per week
- **Column 2**: Date Hired or started as a volunteer
- **Column 3**: AOD Treatment Experience (in years)
- **Column 4**: Date of last TB Test
- **Columns 5 and 6:** Dates of First Aid and CPR Training (Only required for Residential Programs)
- **Column 7:** Licensing Status, yes or no.
- **Column 8:** Certification Status, yes or no
- **Column 9:** Registration Status

(Note: 30% of counseling staff must be licensed and/or Certified; all other counseling staff must be registered for licensing or certification)
- **Column 10 and 11:** Certification/License Number, organization, and dates enacted/expiration

Section XII: **Fire Clearance**

☐ **Submit: Copy of Valid Fire Clearance** from the State Fire Marshal or local fire authority—must be issued no more than 12 months prior to the date of the application for certification. Form is available online as follows:
-Outpatient Fire Clearance: www.dhcs.ca.gov/formsandpubs/forms/Forms/SUDCD/DHCS 5104.pdf.
-Residential Fire Clearance: www.documents.dgs.ca.gov/osp/pdf/std850.pdf

Clearance must list complete address where services will be provided including room or suite number(s).
- **Residential programs** must be currently licensed and have a current fire clearance
- **School-Based** programs **Submit a letter from School/District or a copy of the Memorandum of Understanding (MOU)** between the school and the program (program services are being provided on school grounds and **Facility meets Fire Standards**)

Section XIII: **Local Zoning Approval Document**	
☐	**Check the box which applies to your certification site and include a copy of the required documentation as clearly outlined in application form.** **Note:** If your site is not required to obtain zoning approval, you must SUBMIT A LETTER from the local agency responsible for issuing zoning approval stating that approval is not required—this must be on local agency letterhead.

☐	**Section XIV: Signing the Application:** ☐ If a sole proprietorship, application shall be signed by the sole proprietor (put individual's Social Security Number in the F.E.I.N. section of the application- Attach a copy of the individual's (proprietor) social security card and Applicant Supplement for Sole Proprietors ☐ If a partnership, application shall be signed by each partner ☐ If a firm, association, corporation or governmental entity, application is signed by the chief executive officer or individual legally responsible for representing the entity o *Attach a copy of the Resolution or Board Minutes authorizing the individual to sign the application* o *Signature/Name must match exactly the name on the Resolution*

Other Attachments highly recommended:

☐ If you have a Tax Identification Number (TIN), include copy of the IRS form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification)

☐ A legible and current copy of you Professional liability insurance (for all licensed or certified providers, as applicable)

☐ A legible and current copy of liability (commercial/general) insurance for the location where Services are rendered. Providers who deliver services exclusively in the licensed facility identified in the application are exempted.

☐ If applicable, copies of local permits and/or business licenses required for the type of business