***INSTRUCTIONS:***

1. *Use this form to request changes in**program location, hours, program mergers, and type of service modalities (described as (B) in the Process for provider and Program Changes).* ***BHCS contractors must receive approval prior to implementation of any changes that fall within these categories.***
2. *Complete the form by checking the boxes below that correspond to your requested change and providing the additional requested information.**You may need to submit multiple forms for multiple changes.*
3. *The blue-shaded boxes should not be completed by requestor of changes, and are for the sole use of BHCS Operational Leads (OL).*
4. *Completed forms should be sent to:*
   * *Assigned Program Contract Manager (PCM) via email or fax to 510.567.8290 for requested changes to contracted programs.*
   * *Assigned System of Care Director via email or fax for requested changes to County-Run Programs.*

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| **Date of Request\*** |  | Requester Name\* |  |
| Organization Name\* |  | | |
| **Organization Contact Person\*** |  | **Organizational Contact Title\*** |  |
| **Organization Contact Phone\*** |  | **Organization Contact Email\*** |  |

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| **Program Name\*** |  | | | **Existing RU #** |  |
| **Contract Type\***  *(If submitting requested changes for both MH and AOD, please use a separate from for each.)* | Mental Health  Alcohol and Other Drug | **Requested Effective Date** |  | | |

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| **Request to move entire program to new site address**\*\* | **Existing site address**  **(incl. +4 zip)** |  | **New site address**  **(incl. +4 zip)** | |  | **Approved**  **Not approved**  **BHCS OL initial\_\_\_\_\_\_\_** |
| **Request to add new site location to existing program (while still maintaining existing program at existing site)\*\*** | **Existing site address**  **(incl. +4 zip)** |  | Additional site address **(incl. +4 zip)** | |  | **Approved**  **Not approved**  **BHCS OL initial\_\_\_\_\_\_\_** |
| **Request to close existing site location** | **Existing site address** |  | | | | **Approved**  **Not approved**  **BHCS OL initial\_\_\_\_\_\_\_** |
| **Request to change program service delivery days/hours** | **Existing service delivery days/hours** |  | **Requested service delivery days/hours** |  | | **Approved**  **Not approved**  **BHCS OL initial\_\_\_\_\_\_\_** |

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| **For Mental Health Only: Request to add new service modality to existing program *(Check Requested modalities below)*** | | | | | | |
| ***Check type requesting to add/close*** | **BHCS OL: Check if approving request** | MH Service Modality | ***Check type requesting to add/close*** | **BHCS OL: Check if approving request** | MH Service Modality | |
| ***Residential Mode 05*** | | | | | | |
|  |  | Adult Crisis Residential (40) | | | | |
| Day Treatment Mode 10 | | | | | | |
|  |  | Crisis Stabilization Urgent Care (25) |  |  | Crisis Stabilization ER Room (20) | |
|  |  | Day Treatment Intensive: Half-day (81) |  |  | Day Rehabilitation: Half day (91) | |
|  |  | Day Treatment Intensive: Full day (85) |  |  | Day Rehabilitation: Full day (95) | |
| ***Outpatient Mode 15*** | | | | | | |
|  |  | Brokerage/Case Management (01) |  |  | MH Services (30) Check boxes below: | |
|  |  | Medication Support (60) | Assessment  Evaluation  Plan Development  Collateral  Family Engagement | Group Rehab  Group Therapy  Indiv. Rehab  Indiv. Therapy  Psych. Testing |
|  |  | Therapeutic Behavioral Services (58) |
|  |  | Crisis Intervention (70) |
| **For Mental Health Only: Request to close service modality to existing program *(Check Requested modalities below)*** | | | | | | |
| ***Check type requesting to add/close*** | **BHCS OL: Check if approving request** | MH Service Modality | ***Check type requesting to add/close*** | **BHCS OL: Check if approving request** | MH Service Modality | |
| ***Residential Mode 05*** | | | | | | |
|  |  | Adult Crisis Residential (40) | | | | |
| Day Treatment Mode 10 | | | | | | |
|  |  | Crisis Stabilization Urgent Care (25) |  |  | Crisis Stabilization ER Room (20) | |
|  |  | Day Treatment Intensive: Half-day (81) |  |  | Day Rehabilitation: Half day (91) | |
|  |  | Day Treatment Intensive: Full day (85) |  |  | Day Rehabilitation: Full day (95) | |
| ***Outpatient Mode 15*** | | | | | | |
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| ***FOR BHCS USE ONLY*** | | | | | |
| **System of Care Director or Designated Operational Lead** |  | Signature |  | Date |  |
| *I have received this completed form, signed by the Operational Lead, and take responsibility for next steps to be completed according to established Network Office procedures. Next steps include:*   * *Confirmation of receipt to provider and submitting signed form to Administrative Point Person (Nicole) - Program Contract Manager* * *Scanning and distribution of the signed form\*\*\* - Administrative Point Person* * *Report back to the provider around approval of their request – Fiscal/Program Contract Managers*   *May also include these additional steps:*   * *Site certification (Program Contract Manager and QA M/Cal Cert Staff)* * *RU changes (Fiscal Contract Manager), and/or a contract amendment – Fiscal/Program Contract Managers* | | | | | |
| Program Contract Manager |  | Signature |  | Date |  |
| **Fiscal Contract Manager(s)** |  | Signature |  | Date |  |
| **Administrative Point Person** |  | Signature |  | Date |  |
| Notes (for any special circumstances) |  | | | | |