***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*** |
| [ ]  | [ ]  | 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)  |

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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)  |  |