RESET FORM

Submit completed form to: Office of Provider Services
Email: bhrecredentialing@cchealth.org - or - Fax: (925) 608-6794

CONTRA COSTA HEALTH

Contra Costa County Behavioral Health

FACILITY CHANGE FORM

This form is used to request changes to a provider's facility and program authorizations. *Note: This form is only for active providers and should not be used for providers that have been inactivated, termed, or away from CCMHP for 30 days or more.*

Note: To add a facility for multiple providers, you can use the Facility/Program Assignment Form (Form MHA22e).

Section I: Provider Information

Provider Name: _____ _____ _____
Last *First* *Middle*

ShareCare ID: _____ NPI Number: _____

Section II: Facility Changes Requested

☐ **Contracted CBO** *(Community Based Organization)*
Agency Name: _____

- OR -

☐ **County Owned & Operated Facility**

Add or Remove? *(Check one)*	**Facility ID**	**Facility Name**	**Programs at the specified facility** (please list program number and program name)	**Effective Date**
☐ Add ☐ Remove			ID: _____ Name: _____ ID: _____ Name: _____	
☐ Add ☐ Remove			ID: _____ Name: _____ ID: _____ Name: _____	
☐ Add ☐ Remove			ID: _____ Name: _____ ID: _____ Name: _____	

Section III: Signatures

SUPERVISOR APPROVAL IS REQUIRED FOR FACILITY ADDS & CHANGES:

Supervisor Name: _____ Signature: _____ Date: _____

Section IV: Requester Information

Requester/Contact Person: _____ Email: _____

Section V: For Provider Services Use Only

Credential Type: _____

☐ Update ShareCare
☐ Add to Tracking Sheet
☐ Notify Requester/Contact Person
☐ Update Provider Directory

Date Received: _____ Completed by: _____ Date: _____

Contra Costa County Behavioral Health

274 Report Provider Information

This form must be completed for <u>each</u> facility where the provider will be available to provide services.

Contra Costa County Mental Health Services must submit the 274 Report to DHCS to demonstrate that it complies with the network adequacy requirements. This form provides us with some of the provider information that is included in our monthly 274 Report submission. Please complete a copy of this form for each facility where the provider will be available to provide services. Additional copies of the form are available here: https://cchealth.org/mentalhealth/provider/

Section I: Provider and Facility Information

This form must be completed for each facility where the provider will be available to provide services.

Provider Name: _____ ShareCare ID *(if known)*: _____

Facility Name: _____ Facility ID: _____

Section II: Contact Information

This form should be completed by the 274 Report Contact Person for the organization/clinic.

Please list the person we can contact for questions regarding the information you list in this form:

Name: _____ Phone: _____ Email: _____

Section III: Inclusion in 274 Report

Will the person listed in Section I be providing outpatient mental health services, targeted case management, crisis intervention, medication support services, intensive care coordination, or intensive home-based services on a regular basis at the facility listed in Section I?

Please select one:

☐ **<u>Yes</u>**- Provider will be available to provide direct services to beneficiaries on a regular basis at the facility above.
Please complete the remainder of this form and return to the Provider Services Unit.

☐ **<u>No</u>**- The person listed in Section 1 is an Administrative Staff Member, Supervisor, and/or member of leadership and will not have the capacity to serve clients on a regular and on-going basis at this facility.
You can stop here and return form to Provider Service Unit. You do not need to complete the remainder of the form.

☐ **<u>No</u>**- The person listed in Section 1 is <u>only</u> providing inpatient, hospital, and/or residential services at this facility.
You can stop here and return form to Provider Service Unit. You do not need to complete the remainder of the form.

☐ **<u>No</u>**- The person listed in Section 1 is <u>ONLY</u> providing substance use disorder services and is not providing outpatient mental health services at this facility.
You can stop here and return form to Provider Service Unit. You do not need to complete the remainder of the form.

☐ **<u>No</u>**- For a reason other than those listed above, the person should be excluded on the 274 Report (please specify reason): _____
You can stop here and return form to Provider Service Unit. You do not need to complete the remainder of the form.

Print

Provider Name: _____

Contra Costa County Behavioral Health

274 Report Provider Information

Section IV: Area of Expertise

Select all Areas of Expertise

- ☐ Child/Adolescent (ages 0-20)
- ☐ Adult (ages 21+)
- ☐ Geriatric
- ☐ Substance Abuse

Section V: Service Types

Select up to 5 Service Types the provider is qualified to provide

- ☐ **Mental Health Services-** assessment, evaluation, plan development, rehabilitation, individual psychotherapy, group psychotherapy, group rehab, or collateral.
- ☐ **Targeted Case Management-** placement, linkage, or case management plan development.
- ☐ **Crisis Intervention-** crisis intervention.
- ☐ **Medication Support-** evaluation/RX, RN/LPT injection, education, medication plan development, or medication group.
- ☐ **Intensive Care Coordination-** Check this box if this facility is approved to provide Katie-A services and the services are within the provider's scope of practice.
- ☐ **Intensive Home-Based Services-** Check this box if this facility is approved to provide Katie-A services and the services are within the provider's scope of practice.

Section VI: Practice Focus

Select up to 5 Practice Focus Areas

- ☐ Disorders usually first diagnosed in infancy, childhood, or adolescence (1D)
- ☐ Delirium, Dementia, and Amnestic and other Cognitive Disorders (CD)
- ☐ Mental Disorders Due to a General Medical Condition Not Elsewhere Categorized (GM)
- ☐ Substance-Related Disorders (SR)
- ☐ Schizophrenia and Other Psychotic Disorders (PS)
- ☐ Depressive Disorders (DS)
- ☐ Bi-Polar Disorders (BP)
- ☐ Mood Disorders (MD)
- ☐ Anxiety Disorders (AD)
- ☐ Somatoform Disorders (SD)
- ☐ Factitious Disorders (FD)
- ☐ Dissociative Disorders (DD)
- ☐ Sexual and Gender Identity Disorders (SG)
- ☐ Eating Disorders (ED)
- ☐ Sleep Disorders (SL)
- ☐ Impulse-Control Disorders not otherwise elsewhere categorized (IC)
- ☐ Adjustment Disorders (AJ)
- ☐ Personality Disorders (PD)

Section VII: FTE

FTE is dedicated time available to serve the Medi-Cal beneficiaries (including assessment, plan development, treatment, documentation, chart review, etc). For Administrative Staff, do not include percent of time spent on administrative functions. For example, if a Program Manager is needed for administrative functions 90% of the time, they can only be included in the 274 Report at a maximum of 10% FTE.

100% = 40 hours/week
87% = 35 hours/week
80% = 32 hours/week
75% = 30 hours/week
62% = 25 hours/week
50% = 20 hours/week
40% = 16 hours/week
37% = 15 hours/week
25% = 10 hours/week
20% = 8 hours/week

FTE % Children's Services (0-20): _____% **FTE % Adult Services (21+): _____%**

Total FTE at all facilities for an individual provider should not exceed 100% (40 hours/week).

Section VIII: Caseload

Enter the Maximum & Current Caseload for each age group. Or, enter "N/A" if the provider does not work with the specified age group.

For providers that do not carry a caseload (such as nursing staff and staff at mobile crisis units and transitional teams), estimate the Max Caseload based on the maximum number of beneficiaries the provider could serve during the amount of time specified in the FTE section above. Estimate the Current Caseload based on average/range of encounters per month.

Current Caseload (Children 0-20): _____ **Maximum Caseload (Children 0-20): _____**

Current Caseload (Adult 21+): _____ **Maximum Caseload (Adult 21+): _____**

Section IX: Telehealth

How are the services provided for this provider at this facility?

- ☐ Services provided through telehealth only
- ☐ Services provided both in-person & through telehealth
- ☐ Services provided in-person only

Section X: Field Based Services

Does provider travel to beneficiaries' home and/or community settings to deliver services?

- ☐ Yes - Maximum miles provider will travel: _____
- ☐ No

Section XI: Cultural Competency Training

Has the provider completed Cultural Competency Training in the past 12 months?

- ☐ Yes- Total Training Hours in Last 12 Months: _____
- ☐ No

Prov. Serv. Unit Use Only: Provider Start Date: _____ ☐ S.P. 274 Record Created ☐ S.P. 274 Monthly Record Created Date Complete: _____