PROVIDER AGENCY SELF-CERTIFICATION

Provider Agency Name: _____ Medicaid No.: _____

Provider Agency Address: _____

City: _____ Zip Code: _____ Phone No.: _____

County: _____ Circuit: _____ Area: _____

Name and Address of Site: _____

_____ Zip Code: _____

This is to certify that the above named provider agency has conducted a self-survey of the above named site and determined that the provider and site are in compliance with the certification criteria, presented in the Florida Medicaid Behavioral Overlay Health Services Coverage and Limitations Handbook, including the following:

1. Is an enrolled Medicaid community behavioral health services provider.
2. Is licensed by the Department of Children and Families under Chapter 65C-14, F.A.C.
3. Is under contract with the Department of Children and Families, Child Welfare and Community-Based Care organization.
4. Is able to comply with policy standards in the following areas:

    - Services to be provided
    - Crisis intervention and support
    - Quality assurance program
    - Required policies and procedures
    - Clinical record and documentation requirement

I certify that the above named provider and site is in compliance with Medicaid policies and procedures as put forth in the Florida Medicaid Behavioral Overlay Health Services Coverage and Limitations Handbook. I further certify that statements made in this document are accurate and correct to the best of my knowledge.

Executive Director's Name
(please print) _____

Executive Director's
Signature _____ Date _____

Send original form to:
AHCA, Medicaid Services
Behavioral Health Unit
2727 Mahan Drive, MS 20
Tallahassee, FL 32308

Provider should maintain a copy.

AHCA Form 5000-3523, Revised March 2014 (incorporated by reference in Rule 59G-4.027, F.A.C.)