



**Behavioral Health and Recovery Services
Department of Health and Human Services**

Date:	[Date]
To:	Cody Milner / cmilner@marincounty.org
From:	[Agency Name and Name of Staff Submitting]
Site:	[Site/Program Name] – <i>Note: A separate attestation shall be sent for each certified/licensed service site</i>
Re:	Monthly Attestation of Compliance with Reporting Requirements – [Month/Year]

Please indicate whether your agency is current in compliance with the reporting and notification requirements referenced below. If you are not currently in compliance, please describe why and your plans and timeframe to achieve compliance. Please also indicate any technical assistance needs from the County.

Submitted to BHRS (and DHCS as applicable)			
	In Compliance	Explanation (If Not in Compliance)	
DATAR <i>Due by the 10th of the month</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Billing <i>Due by the 10th of the month</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
CalOMS <i>Timelines in MHSUS-ADP-16</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Monthly Excluded Provider Check <i>Exhibit I</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Address Open Admissions <i>Referenced Attachments</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Notified BHRS (and DHCS as applicable)			
	Any Occurrences	If Yes, Compliant with Notification	If any occurrences, describe the occurrence(s)
Staff Changes <i>MHSUS-ADP-08</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Interim Services <i>MHSUS-ADP-07</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Unusual Occurrence or Incident	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Timely Access <i>MHSUS-ADP-18</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Reduction in Services, Changes in Location, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Facility/Program Closure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
Corrective Action Plan/Notice of Deficiency Received or Addressed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

By signing below, I attest that to the best of my knowledge, the above information is true and correct. I further attest that I am authorized to sign on behalf of my agency.

(Executive Director/Authorized Designee)

(Printed Name)

(Date)

Please complete, sign and return this form by the 10th of the month (or the next business day if the 10th falls on a weekend or holiday) to Cody Milner / cmilner@marincounty.org or 415-223-9921 (fax).