

**DEPARTMENT OF SOCIAL SERVICES**

744 P Street, Sacramento, CA 95814



February 28, 2003

FOSTER CARE AUDITS AND RATES LETTER (FCARL) NO. 2003-01

TO: ALL GROUP HOME PROVIDERS

SUBJECT: CHANGES TO DOCUMENTATION OF MENTAL HEALTH TREATMENT SERVICES

REFERENCE: Foster Care Audits Letter (FCAL) No. 2000-03

The California Department of Social Services (CDSS) previously issued a form for provider use in documenting mental health treatment services. However, we have found that there have been some problems concerning identification of the mental health professionals who are actually providing the services. Consequently, we have revised the Verification of Mental Health Treatment Services form (SR 2C MHV) to include a line for information concerning interns or other mental health professionals who work under the licenses and supervision of licensed mental health professionals.

The revised form is enclosed for your immediate use. You may wish to copy the form onto your group home letterhead for official use. Parts II and III of the form should be completed and signed by the mental health professional. Foster Care group home auditors will accept this form as proof of paid-awake mental health treatment hours, **provided that the completed and signed form is in the group home files.**

If you have any questions concerning the use of this form, you may contact Ms. Judi Queirolo, Manager, Audits Policy and Support Unit, at (916) 274-0445.

Sincerely,

CORA DIXON, Acting Chief  
Foster Care Audits and Rates Branch

Enclosures

c: County Welfare Directors' Association  
Foster Care Alliance  
African American Foster Parent and Group Home Association  
Community Residential Care Association of California  
Residential Care Providers Association of Los Angeles County  
Association of Minority Adolescents in Residential Care Homes of Los Angeles County  
California Alliance of Child & Family Services  
Association of Minority Adolescents in Residential Care Homes (AMARCH)  
North Valley Children and Family Services, Inc.  
Association of Community Services Agencies

**VERIFICATION OF MENTAL HEALTH TREATMENT SERVICES***Please print in ink or type the requested data***PART I - CHILD INFORMATION**

CHILD'S NAME:	FIRST	MIDDLE INITIAL	LAST	CHILD'S SOCIAL SECURITY NUMBER:

**PART II - MENTAL HEALTH PROFESSIONAL INFORMATION**

CLINIC NAME:	MENTAL HEALTH PROFESSIONAL'S NAME:
MENTAL HEALTH PROFESSIONAL'S LICENSE OR REGISTRATION NUMBER:	LICENSE EXPIRATION DATE:

**Please check your professional level:**

- Psychiatrist   
 Psychologist   
 Licensed Clinical Social Worker  
 Marriage and Family Therapist   
 Intern   
 Other (*Specify*): \_\_\_\_\_

**Are you providing services under another individual's license number?**     **Yes**     **No**

If Yes, please provide the name and license number of the mental health professional: \_\_\_\_\_

**PART III - MENTAL HEALTH SERVICES INFORMATION**

DATE(S) OF SERVICE:	TOTAL HOURS OF SERVICE:

**TYPE OF SERVICE PROVIDED: (CHECK APPLICABLE SERVICES PROVIDED)**

- Individual Therapy   
 Group Therapy   
 Family Therapy  
 Psychological Testing   
 Diagnostic Interview   
 Medication Evaluation

***I certify by my signature that I provided the services listed herein.***

MENTAL HEALTH PROFESSIONAL SIGNATURE AND TITLE	DATE