

## NM SBHC CERTIFICATION / RECERTIFICATION SITE REVIEW TOOL-SUMMARY

### Part 1: *INFORMATION FORM*

Date of Review	
Sponsoring Organization	
Address Phone E-mail	
Affiliated SBHCs	
Review Location	
<b>Reviewer/s</b> (Name, Affiliation, Phone & Email)	<b>1.</b>
<b>Sponsor Representatives</b> (Name, Ph, Email)	<b>1.</b> <b>2.</b> <b>3.</b>
<b>SBHC Representatives</b> (Name, Ph, Email)	<b>1.</b> <b>2.</b> <b>3.</b>

<p><b>Additional Information</b> (Phone calls, date Self-Assessment sent out, etc.)</p>	
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### Part 2: *Electronic Assessment Tool* – Attached Excel Form

# SBHC EAT Summary

Sponsoring Organization: \_

Date of Review:

**Part 3: REVIEW SUMMARY:** Refer to the Electronic Assessment Tool

The SBHC Site Review Tool and any other documentation from the site visit will be submitted to HSD for review. If the score on the Electronic Assessment Tool is 90% or above, HSD will issue a Letter of Medicaid Eligibility to the SBHC and the sponsoring entity. If any score on the Electronic Assessment Tool is below 90%, HSD will send a letter to the sponsoring entity requiring a Corrective Action Plan (CAP).

**Mark the appropriate box:**

<input type="checkbox"/>	The score on the Electronic Assessment Tool was <b>90% or above.</b>
<i>Comments, observations, concerns, plans:</i>	

<input type="checkbox"/>	The score on the Electronic Assessment Tool <b>was below 90%</b> and requires a CAP.
<i>Comments, observations, concerns, plans:</i>	

The findings of this Site Visit and Review have been discussed with the SBHC and/or representatives from the sponsoring entity. Time was allowed for questions and answers.

<b>REVIEWER:</b> Name / Signature	Date
<b>REVIEWER:</b> Name / Signature	Date

<b>SPONSOR:</b> Name / Signature	Date
<b>SPONSOR:</b> Name / Signature	Date
<b>SPONSOR/SBHC COMMENTS</b>	