EXHIBIT 278

MODEL DENIAL LETTER FOR CMHC APPLICANTS

STATE RESTRICTIONS ON SCREENING

(**Date**)

Community Mental Health Center Name
Address
City, State, ZIP Code

Dear _____:

RE: Provider Number (**Provider Number**)

This is to inform you of the Centers for Medicare & Medicaid Services' initial determination (see 42 CFR Part 498.3) that your facility does not meet the requirements for certification to participate in the Medicare program as a community mental health center (CMHC) providing partial hospitalization services.

In order to be certified as a CMHC providing partial hospitalization services in the Medicare program, an entity must meet the statutory requirements for a CMHC. These requirements are found at §1861(ff)(3) of the Social Security Act, which requires that a CMHC provide the services described in §1916(c)(4) (now found at §1913(c)(1) of the Public Health Service (PHS) Act) and meet applicable licensing or certification requirements for a CMHC in the State in which it is located.

The services listed in the PHS Act that an entity must provide in order to be approved as a CMHC are as follows: outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of service areas of the centers who have been discharged from inpatient treatment at a mental health facility; 24 hour-a-day emergency care services; and screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission.

After a careful review, CMS has determined that you do not meet the statutory requirements for a CMHC. This is because, as discussed in the attached statement of findings, you do not provide screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission, one of the services listed in §1913(c)(1) of the PHS Act, and required by §1861(ff)(3)(B) of the Social Security Act. Our review indicates that pertinent requirements (see attachment) for the State of (**State)** place restrictions on who may perform screening, and specifically preclude your facility from providing this service.

If you believe that this initial determination is not correct, you may request that it be reconsidered. The request must be submitted in writing to (**name and address**) within 60 days of the date you receive this notice in accordance with 42 CFR Part 498.22. The date of receipt will be presumed to be 5 days after the date on the notice unless there is a showing that it was, in fact, received earlier or later. The request should state the legal and factual reasons why you consider the decision to be incorrect and should include any documentation supporting these legal and factual conclusions.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)