EXHIBIT 282

MODEL LETTER PARTICIPATION IN MEDICARE AS A COMMUNITY MENTAL HEALTH CENTER PROVIDING PARTIAL HOSPITALIZATION SERVICES (INCLUDING THRESHOLD AND SERVICE REQUIREMENTS)

(**Date**)

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

Dear _____:

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

In order to be certified as a CMHC for the purpose of 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) 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; day treatment or other partial hospitalization services; or psychosocial rehabilitation services; and screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission.

The statute requests that an applicant CMHC be providing the core services at the time of certification, not at some future point in time. Accordingly, CMS will look for evidence that the applicant is already providing the core services as a pre-condition for certification. For example, CMS will look to see that the applicant:

- Is fully operational for a sufficient period of time that enables us to be reasonably assured of the facility's compliance with program requirements. We believe one business quarter would provide us with the information we need to assess compliance;

- Has served, as evidenced by complete, onsite medical record documentation from within 3 months of the date of the initial Medicare application for new applicants or the date of sale for a change of ownership, a sufficient number of persons to enable us to be reasonably assured that the facility is, in fact, complying with basic program requirements. We believe, that to achieve this objective, a facility should have served at least 10 non-Medicare patients, including:

    - A minimum of three patients for which medical records demonstrate that the CMHC has:

        - The legal capacity under State law to provide screening services for admission to State mental health facilities;

        - The capability and clinical expertise to provide such screening services; and

        - Provided screening services the specific purpose (e.g. reason for referral) of which is to assess the patient's need for admission to a State mental health facility. Where there are State requirements for the completion of required forms, court documents or any other required documentation in response to the screening request, these documents would be evidence of providing the service. Otherwise, evidence in the screening assessment must include a clinical decision regarding the appropriate level of care and follow-up placement.

    - A minimum of 3-day treatment or partial hospitalization or psychosocial rehabilitation patients (this is group treatment and three patients is the smallest number the CMHC could justify as a group); and

    - At least one patient from each of the four outpatient categories:

        - Children;

        - Elderly;

        - Chronically mentally ill; and

        - Residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility.

At this time, there are no **prior service requirements** regarding the following core service:

24 hour a day emergency care services.

However, please be aware that your CMHC must be able to demonstrate that it can provide 24-hour emergency care services.

NOTE: If you are approved for Medicare participation, you are expected to continue to provide the non-Medicare services. Providing these services is ongoing and not a one-time qualifying event for Medicare participation.

The address shown in your provider agreement is where CMS requires records of services, provided either directly or under an arrangement, be available, because the CMHC is responsible for all services.

A CMHC may provide one or more core services under arrangement with another individual, group, or entity only when the following criteria are met:

- Service Authorized by State Law -- In no case may a CMHC provide a service under arrangement when the CMHC has not been given authority to provide the service itself directly under State statute, licensure, certification, or regulation.

- Full Legal Responsibility -- A CMHC that provides a core service under arrangement with another entity remains the legally responsible authority through which comprehensive mental health services are provided. It is not sufficient for the arrangement to be a referral process where the CMHC does not assume overall management responsibility for the provision of core services by a separate individual, group, or entity. The CMHC must retain complete accountability for the services provided under the arrangement. The CMHC must retain legal, professional, and administrative responsibility to coordinate care, supervise and evaluate the services, and ensure the delivery of high quality mental health treatment.

- Written Agreement -- If a CMHC provides services under arrangement, there must be a written agreement or contract between the two parties that specifies the services to be rendered and the manner in which the CMHC exercises its professional and administrative responsibility. Furthermore, for the agreement to serve as the vehicle through which the CMHC meets the requirement to provide

one or more of the core services, the terms of the agreement must be adhered to in practice. In order to verify the nature of the relationship between the CMHC and the other party, the agreement must be accessible to CMS or its agents, and the documentation for all services rendered under arrangement must be maintained by the CMHC at the site identified in the provider agreement.

We will also assign each CMHC a provider identification number .

Those facilities that are denied approval to participate in the Medicare program will be notified and given the reason(s) for the denial.

You are required to notify the CMS RO at the time you are planning a transfer, deletion, addition, or relocation of a service area. If operation of the entire facility is later transferred to another owner, ownership group, or to a lessee, the CMHC identification number will be automatically assigned to the successor, following notification.

Each proposed CMHC must enroll with Medicare by completing a Form CMS-855 and independently meet the Federal requirements for CMHCs, sign a separate CMHC provider agreement and receive a separate identification number. The facility must also conform to the provisions of §1866 of the Social Security Act and all Medicare regulations applicable to CMHCs.

In addition, your application must contain at least the following:

- The name and address of the facility;
- The name of the responsible agent, including the address and telephone number;
- The facility. s Medicare provider number, if the facility is already participating in the Medicare program as another type of provider;
- The Medicare provider number of the entity, if the facility is operated as part of and under control of another entity that is participating in the Medicare program;
- The identification of the community your CMHC intends to serve, because in accordance with §1913(c)(1), CMHCs are required to provide mental health services to individuals who reside in a distinct and definable community. If a CMHC intends to operate an alternative site outside its community, the site must have a separate provider agreement/number because this would be a different

community. CMS must approve all alternative sites. If a CMHC operates a CMS-approved alternative site, the site is not required to provide all of the core PHSA services. However, a patient must be able to access and receive the services he/she needs at the approved primary site, or at an alternative site that is within the distinct and definable community served by the CMHC;

- The type of ownership or control (i.e, nonprofit, government);
- The services provided with the number of full-time equivalent employees; and
- A signed Attestation Statement indicating that the facility complies with all of the Federal requirements in §1861(ff)(3)(B) of the Social Security Act.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)