Community Health Worker Supervising Provider Entity Onboarding Packet

Thank you for your interest in joining the CenCal Health provider network. We greatly value your partnership in better serving our community. CenCal Health credentials all CHW Supervising Provider Entities who provide services to our members. Enclosed is a credentialing application and additional documents required to begin the onboarding process. Please complete the packet in its entirety.

The following must accompany your application:

- □ Copy of all applicable required state and local facility licensure and permits
- □ Copy of most recent Accreditation certificate (if applicable)
- □ Copy of California Medicaid (Medi-Cal) participation approval
- □ Copy of Policy & Procedures or Program Description outlining how the Supervising Entity will vet, monitor, and oversee CHWs
- □ Proof of facility Commercial General Liability coverage
- □ Proof of facility Professional Liability coverage (if applicable)
- □ Signed and dated Supervising Provider Attestation
- □ New Provider Training Orientation Attestation

Medi-Cal Enrollment is Separate and Required
Beginning January 1, 2018, federal law requires that all non-exempt providers of services to Medi-Cal recipients must be screened and enrolled as Medi-Cal providers by the Department of Health Care Services (DHCS). This is a requirement in addition to CenCal Health's onboarding and credentialing process. Please find more information about the Medi-Cal enrollment process on our website here.

All provider credentialing applications are reviewed by the CenCal Health Credentials and Peer Review Committee or a Medical Director. To ensure timely processing of your application, please complete and return all documents listed above as soon as possible. Forms may be submitted in the following ways:

Mail: CenCal Health, Attn: Provider Services Department
4050 Calle Real, Santa Barbara, CA 93110
Email: provideronboarding@cencalhealth.org
Fax: (805) 681-3033

We appreciate your cooperation during the onboarding process. If you have any questions, please contact us at the above email.

Thank You,

CenCal Health – Provider Services Department

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Community Health Worker Supervising Provider Entity Provider Application

☐ INITIAL CREDENTIALING ☐ RE-CREDENTIALING

IDENTIFICATION

CORPORATE IDENTIFICATION INFORMATION

Legal Business Name: (As reported to the IRS)	Federal Tax Identification Number (TIN):
Doing Business As (DBA) Name: (If applicable)	National Provider Identifier (NPI) for entity being credentialed: (Application **cannot** be processed without a valid 10-digit NPI)
Corporate Address: _____ _____	Hospital or Health System Affiliation: List Hospital or Health System Affiliation below: _____ ☐ Not affiliated with any hospital/health system
Date of Incorporation: _____/_____/_____	Length of time in business with this Name and Tax ID: _____ Years _____ Months _____

☐ Is entity owned in whole or in part or managed by a hospital or health care system/organization?

☐ Yes, owned in whole or in part by _____

☐ Yes, managed by _____

☐ Not affiliated with a hospital or health care system/organization

ENTITY INFORMATION

Address must be a street address, not a Post Office box.

Entity Name:			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	County:
Entity Phone:	Fax:	Website:	
Credentialing Contact Name:		Contact Title:	
Phone:	Fax:	Email:	
Entity Administrator:		Email:	

Clinic Office Hours

[redacted]	Mon	Tue	Wed	Thu	Fri	Sat	Sun
A.M.							
P.M.							

MAILING/CORRESPONDENCE ADDRESS

Must be an address where provider can be contacted directly. ***PAYMENTS WILL BE MAILED TO THIS ADDRESS.***

☐ Check here if all correspondence can be directed to the facility location above.
If not, complete the section below.

Name:

Mailing Address Line 1:

Mailing Address Line 2:

City:	State:	Zip:	Phone:

ENTITY TYPE

Check ONE box only per Application.

☐ Licensed Provider
☐ Hospital
☐ Outpatient Clinic
☐ Local Health Jurisdiction
☐ Community-Based Organization
☐ Other

_____

HEALTH CARE LICENSURE

Attach a copy of each license for this entity (if applicable). Use a separate sheet if necessary. All licenses must be unrestricted/unconditional.
Do not submit practitioner licenses

License Number	State or City	Licensing Agency	Initial Issue Date	Renewal Date	Expiration Date
			___/___/___	___/___/___	___/___/___
			___/___/___	___/___/___	___/___/___

MEDICAID & MEDICARE STATUS

1. Is this entity participating in the Medicare program? ☐ Yes ☐ No ☐ Pending
   Medicare number:_____ Date of initial Certification:_____/_____/_____
2. ☐ Check here if facility is not eligible for Medicare certification.
3. HOSPITALS ONLY: Is hospital designated by CMS as a Sole Community Provider? ☐ Yes ☐ No
   If YES, attach copy of documentation from CMS specifying Sole Community Provider designation.
4. Is this entity participating in California Medicaid (Medi-Cal) program?
   ☐ Yes ☐ No ☐ Pending
5. NPI number:_____ Date of initial Certification:_____/_____/_____
   If YES, attach copy of documentation from California Medicaid (Medi-Cal) showing participation.

ACCREDITED FACILITIES

Complete this section and attach copy of current Accreditation certificate or letter. Certificate/letter should list this entity location as being included in the accreditation.

AAAASF - American Association for Accreditation of Ambulatory Surgery Facilities
AAAHC - Accreditation Association for Ambulatory Health Care
ACHC - Accreditation Commission for Health Care
CARF - Commission on Accreditation of Rehabilitation Facilities
CCAC - Continuing Care Accreditation Commission
CHAP - Community Health Accreditation Program
DNV (NIAHO) - Det Norske Veritas (National Integrated Accreditation for Healthcare Organizations)
TJC – The Joint Commission (Formerly known as JCAHO)
IMQ – Institute for Medical Quality

1. Date of last full survey:_____/_____/ _____
2. Effective dates of accreditation:_____/_____/_____through_____/_____/_____

NON ACCREDITED ENTITIES

Complete this section and attach copy of most recent onsite government agency survey along with your Corrective Action Plan (CAP), if deficiencies were cited, OR attach letter from government agency stating facility is in substantial compliance with most recent survey standards.

Has this entity had an onsite licensing/certification survey by the Department of Health or CMS within the past 36 months?

☐ Yes – Date of most recent onsite survey:_____, _____, _____***See instructions above.***

☐ No - Contact CenCal Health.

INSURANCE

Complete this section and attach a copy of the entity's insurance certificate(s) that includes:

- ***Insurer(s) Affording Coverage***
- ***Policy Number***
- ***Effective Date and Expiration Date***
- ***Amounts of Coverage***
- ***This entity listed as covered by the policy***
- ***Name and Phone Number of Agency issuing policy***

Entities that are covered by Government insurance - and a certificate was not issued - should attach a letter detailing coverage.

1. Is this entity covered by Commercial General Liability insurance in the amount of $1 million per occurrence and $3 million aggregate? (Excess liability/Umbrella coverage can be counted toward the $3 million aggregate amount.)

☐ Yes
☐ No - ***Please obtain the above amount of required coverage before submitting application.***
☐ Entity is covered by Government insurance.

2. Is entity covered by Professional liability insurance in the amount of $1 million per occurrence and $3 million aggregate? Must be a entity/organizational policy, not Individual-only, policy. (Excess liability/Umbrella coverage can be counted toward the $3 million aggregate amount.)

☐ Yes
☐ No - ***Please obtain the above amount of required coverage before submitting application.***
☐ Entity is covered by Government insurance.

3. Has this entity's Commercial General or Professional liability insurance ever, for any reason, been denied, cancelled, non-renewed, or initially refused upon application?

☐ Yes – *Explain fully below.*
☐ No

ATTESTATION

Answer every question YES or NO.
Provide a detailed explanation, including dates below for all for any question(s) answered YES.
Use a separate sheet if necessary.
Be sure to Sign and date Attestation.

☐ Yes ☐ No	1. Has this entity ever had or currently have pending any legal actions against it?
☐ Yes ☐ No	2. Has this entity ever been convicted of a crime, excluding misdemeanors?
☐ Yes ☐ No	3. Has any government agency ever investigated, suspended, revoked, or taken other action against this entity/organization's license to conduct business?
☐ Yes ☐ No	4. At any time has any license or certification been revoked, denied, or suspended by others or voluntarily given up by the entity, or are any actions which may lead to such conclusions now underway?
☐ Yes ☐ No	5. At any time, has this entity/organization been assessed a penalty or fined by a government agency or is the entity currently under investigation by the Medicaid or Medicare programs or any other government agency?
☐ Yes ☐ No	6. At any time, has any third party payor ever revoked, reduced, denied, or suspended this entity's network participation due to inappropriate utilization management, quality of care issue , or for any other reason?
☐ Yes ☐ No	7. Has any managing employee or person with an ownership or controlling interest in this facility/organization been excluded from participation in any government health care program?
☐ Yes ☐ No	8. Has this entity, under any current former name or business identity, ever had its accreditation revoked or suspended?

Explanation for question(s) answered YES:

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire Application are true, accurate, and complete to the best of my knowledge. I fully understand that any falsification of information or omissions from this Application may be grounds for denial of this Application as a Health Plan participating provider or cause for summary dismissal from the Health Plan.

I further understand, as an authorized agent of the applicant, that I and the organization have the burden of producing adequate information for the proper evaluation of the organization's competence, character, and ethics in resolving doubts about such qualifications.

I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

_____ Printed Name of Authorized Representative

_____ Authorized Representative's Title

_____ Signature of Authorized Representative

_____/_____/_____ Date Signed

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Supervising Provider Attestation for Community Health Workers

CenCal Health requires all Supervising Providers that supervise Community Health Workers (CHWs) to submit an attestation as a part of the credentialing process.

I, _____, agree to the follow the protocols establish by APL 22-016 and CenCal Health in my oversight of CHWs. I agree to and understand the following:

1. The Supervising Provider must be enrolled in Medi-Cal if there is a state-level enrollment pathway for them to do so.
   a. When there is no state-level Medi-Cal enrollment pathway, CenCal Health will vet the qualifications of the Provider or Provider organization to ensure they can meet the standards and capabilities required to be a Supervising Provider.
2. The Supervising Provider ensures that CHWs meet the qualifications as listed in APL 22-016, oversees CHWs and the services delivered to Medi-Cal members, and submits claims for services provided by CHWs.
3. The Supervising Providers must provide direct or indirect oversight to CHWs.
   a. Direct oversight includes, but is not limited to, guiding CHWs in providing services, developing a care plan, and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements.
   b. Indirect oversight includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements.
4. The Supervising Provider must maintain evidence of CHWs' qualifications including:
   a. Lived experience
   b. CHW's minimum qualifications as evidenced through at least one of the following pathways (as determined by the Supervising Provider):
      1) CHW Certificate
      2) Violence Prevention Professional (VPP) Certificate
      3) Work Experience Pathway
   c. CHW's required completion of the minimum annual six hours of additional training.
      1) Supervising providers may provide and/or require additional training, as identified by the supervising provider training.
5. The Supervising Provider must be a licensed provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO).
6. The Supervising Provider must carry professional liability coverage in the amount per the provider contract.
7. The Supervising Provider must have a business license that meets industry standards.
8. The Supervising Provider is responsible for ensuring the provision of CHW services complies with all applicable requirements as listed in APL 22-016.
9. The Supervising Provider must assess CHWs for sufficient experience to provide services.
10. The Supervising Provider must have the ability to submit claims or encounters to CenCal Health using standardized protocols.
11. The Supervising Provider must share a list of CHWs with NPI as appropriate, when requested by CenCal Health.
12. The Supervising Provider agrees to submit to an audit of any records related to services provided to CenCal Health Members if requested by CenCal Health.
13. CenCal Health may conduct an annual audit to ensure the Supervising Provider maintains evidence of the CHW qualifications and ongoing training per APL 22-016.

This agreement is effective until amended in writing or terminated by the Supervising Provider and shall automatically terminate if Supervising Provider is no longer contracted or credentialed with CenCal Health.

Effective Date: _____

_____ _____

Supervising Provider Name/NPI Signature

New Provider Training Attestation Form

Organizational Practice Name: _____

By signing below, I am acknowledging having received the below information as part of CenCal Health's new provider orientation. I understand that this information is always available to me within the **CenCal Health Provider Manual Operations Guide**, online at **cencalhealth.org/providers/welcome-to-the-network**, and through the Provider Relations Department.

A. Overview of CenCal Health

- Summary of Managed Care
- CenCal Health Programs
- Acronyms
- Provider Communication

B. Standard Training Material

- Member Eligibility
- Covered Services and Carved Out Services
- Member Access (including appointment waiting time standards and ensuring telephone translation and language access)
- Required Preventive Services [including Early, Periodic Screening, Diagnosis and Testing (EPSDT)] services for Members less than 21 years of age
- Coordination of Care and Referrals (including non-covered services)
- Radiology Benefit Manager (RBM)
- Medical Record Documentation and Coding Requirements
- Prior Authorization and Utilization Management (including policies and procedures for clinical protocols governing Referral Authorization Forms (RAFs) & Treatment Authorization Requests (TARs)
- Mental Health & Behavioral Health Therapy Benefit [includes Specialty Mental Health Services (SMHS) and Non-Specialty Mental Health Services (NSMHS), Substance Use Disorder (SUD) and Intellectual and Developmental Disabilities (IDD)], and children with special health care needs
- California Children's Services (CCS) and Whole Child Model (WCM)
- Regional Centers (including Tri-Counties Regional Center)
- Child Health and Disability Prevention Program (CHDP)
- Seniors and Persons with Disabilities (SPD)
- Members with chronic conditions
- Cultural Linguistics, Interpreter Services, Alternative Format Selection and Language Requirements
- Pharmacy
- Grievance and Appeals Policies and Procedures
- Member Rights and Responsibilities
- Diversity, Equity, and Inclusion (DEI) Training
- Quality Improvement and Health Equity Transformation Program
- Population Health Management Program
- Health Education Resources
- Provider and Member Incentive Programs, as applicable

C. Information/Data Sharing, Data Collection, and Reporting Requirements

- Secure Data Sharing Methods
- Member and Member Care Team Contact Information

D. Website Demonstration

- Online Provider Directory
- Contracted Provider List (PDF)
- Provider Manual
- Transaction Services
- Provider Portal

In addition to the above topics, CenCal Health provides additional information to Primary Care Providers (PCPs), including:

- Facility Site Review
- Incentive Programs
- Reports available for Primary Care Providers

Training Acknowledgment & Attestation

Signature _____ Date _____

Print First & Last Name _____ Group Billing NPI# _____

Title _____ Practitioner NPI# (if applicable) _____

○ Our practice, including Practitioners and Medical Staff, acknowledges and confirm(s) to have received all CenCal Health Provider Regulatory Training resources.

Please provide a list all Rendering Practitioners within your organization who have completed these training resources. This applies to newly joining physicians to your organization, and/or being re-credentialed with CenCal Health. If you are using a Roster, please leave this section blank.

Print First & Last Name _____ Date _____

Practitioner NPI# _____

(continue to next page)

Print First & Last Name

Date

Practitioner NPI#

Print First & Last Name

Date

Practitioner NPI#

Print First & Last Name

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