Community Supports (CS) Organization Provider Credentialing Application

Dear Provider,

Thank you for your interest in joining the CenCal Health provider network. We greatly value your partnership in better serving our community.

Enclosed is Community Support (CS) Provider credentialing application and supplemental requiredforms.

In addition to this fully completed application, please also include the following:

- A copy of general/professional liability coverage
- A copy of applicable state licenses and/or a copy of current business license,

If any of the following apply to your organization, please include with this application:

- Disclosure of any history of liability claims in the past 7 years (if applicable, not required)
- A copy of current state (Center for Medicare Services) site review (if applicable, not required)
- A copy of accreditation/certification (if applicable, not required)

DHCS Medi-Cal Provider Screening and Enrollment

Federal law requires that all CenCal Health-contracted providers are screened and enrolled in the Department of Health Care Services (DHCS) Medi-Cal Fee-for-Service Program, if applicable.

All CS Providers for whom a DHCS state-level enrollment pathway exists must enroll in Medi-Cal via the DHCS Provider Enrollment Division portal at pave.dhcs.ca.gov/sso/login.do. To create an account, click on the "Sign Up" button at the top right corner ofthe page.

A CS Provider may be a non-traditional provider type for whom there is no established credentialing pathway. In these instances, CenCal Health will verify the CS Provider's credentials through credentialing in addition to requiring any or all the following documents: applicable business or professional license, IRS Form 990, nonprofit status, and/or other documentation demonstrating official established business and/or individual entity.

Thank You,

Provider Services Credentialing Department

CenCal Health

Community Supports (CS) Organization Provider Credentialing Application

Organization – Community Support Service Type (Please check all that apply):

☐ Housing Transition Navigation Services	☐ Recuperative Care (Medical Respite)	☐ Sobering Centers	☐ Meals/Medically Tailored Meals
☐ Housing Deposits	☐ Respite Services	☐ Housing Tenancy and Sustaining Services	☐ Personal Care/Homemaker Services (Beyond IHSS)
☐ Short-Term Post Hospitalization	☐ Nursing Facility Transition/Diversion Assisted Living Facilities	☐ Environmental Accessibility Adaption (Home Modifications)	☐ Asthma Remediation Services

Other (Please List):

General Information

Office Manager or Admin Staff Name:			
Doing Business as (DBA), if Different than name:			
Telephone Number:		Fax Number:	
Business Address:		City/State/Zip:	
Email Address:		Website Address:	
Office Contact Name:			
Phone:	☐ ☐	Email:	
Are you enrolled in Medi-Cal?	Yes or No ☐ ☐	Are you enrolled in Medicare?	Yes or No ☐ ☐
Do you have a National Provider Identifier **(NPI)?**	Yes or No ☐ ☐	If yes, please provide your NPI#:	

Credentialing Contract
Name:
Email Address:
Phone:

Facility License Information – State Issued, Business License, Accreditations (Accreditations not required), and/or Non-Profit Status

California License Number	Type:
Issue Date:	Expiration Date:
Additional Licensure (Business or other):	Type:
Issue Date:	Expiration Date:
Additional Licensure (Business or other):	Type:

Community Supports (CS) Organization Provider Credentialing Application

Insurance Information			
Name of General Liability Insurance Company:		Insurance Policy Number:	
Date Policy Issued:		Expiration Date:	
Policy Amount Per Occurrence	$	Policy Amount Aggregate:	$

Community Supports (CS) Organization Provider Credentialing Application

Offices/Sites where Members will be served (if additional, please add to end of application)			
Office/Site #1 Name:			
Address:		City/State/Zip:	
Phone:		Fax:	
Email:		Website:	
Location Hours:			
Office/Site #2 Name:			
Address:		City/State/Zip:	
Phone:		Fax:	
Email:		Website:	
Location Hours:			
Office/Site #3 Name:			
Address:		City/State/Zip:	
Phone:		Fax:	
Email:		**Website**	
Location Hours:			

Disclosure of any history of liability claims in the last 7 years:

Does your organization have any liability claims within the last 7 years?

- ☐ No
- ☐ Yes, please provide with your completed credentialing application, a copy of any liability claimsagainst your organization within the last 7 years.

Community Supports (CS) Organization Provider Credentialing Application

Declaration of Authority and Applicable Staff Screening

I declare that I have the authority to legally bind the applicant or provider pursuant to Title 22, CCR section51000.30(a)(2)(B). I hereby affirm that the information submitted to CenCal Health and any addenda thereto is true, current, and complete to the best of my knowledge and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my Services Agreement.

Applicable Staff:

Will your organization be utilizing medically licensed provider staff to provide Community Supports?

- ☐ **No:** Our CS Organization does not employ any of the below licensed staff for this CommunitySupport.
- ☐ **Yes*:** Our CS Organization does employ the below licensed staff. Check all applicable boxes.
  - **Physician Providers:** Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of PodiatricMedicine (DPM), Doctor of Dental Surgery (DDS/DMD), Psychiatrist (MD),
  - **Mental Health Provider:** Psychologist, Licensed Clinical Social Worker, or Board-CertifiedBehavior Analyst
  - **Non-Physician Medical Practitioner:** Physician Assistant (PA), Nurse Practitioner (NP),Certified Nurse Midwife,
  - **Allied Providers:** Doctor of Chiropractic (DC), Physical Therapist (PT), Occupational Therapist(OT), Speech and Language Therapist (SLP), Acupuncturist, Licensed Midwife, Optometrist (OD),

I attest that background screening has been performed on all CS staff.

I certify that no CS Staff employed by my organization:

- ☐ Currently are excluded by a State Medicaid agency;
- ☐ Currently are excluded from any other Federal health care program;
- ☐ Currently are debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement program or activity in accordance with the Federal Acquisition Streamlining Act implementing regulations and the Department of Health and Human Services non-procurement common rule at 45 CFR part 76; and
- ☐ History of fraud, waste, and/or abuse; and
- ☐ Recent history of criminal activity, including a history of criminal activities that endanger Membersand/or their families.

For any boxes you are unable to check, please provide a detailed explanation on a separate sheet.

Signature:_____ Title:_____

Date: _____

*Licensed Staff as listed above are required to submit additional credentialing application requirements asoutlined in PS-CR01 Provider Enrollment and Screening, PS-CR03 Provider Credentialing and Peer Review Policy and PS-CR11 Credentialing of Organizational Providers.

Please notify your Provider Services Credentialing Representative if you employ any of the listed licensed staff.

Community Supports (CS) Organization Provider Credentialing Application

The form below is a requirement of our Medi-Cal contract with the State. Please review and sign below whereindicated.

LETTER OF AUTHORIZATION PROCEDURES
RELEASE/ACCESS OF DHS COMPUTER FILES FOR THE
MEDI-CAL PROGRAM DECLARATION OF
CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized / maintained by the Department of Health Services, I,_____, agree
(Provider/Organization name)

not to divulge any information obtained in the course of my assignment to unauthorized persons and agree not topublish or otherwise make public any information regarding persons receiving Medi-Cal services such thatthe persons who receive such services are identifiable.

Access to such data shall be limited to the Plan, myself, my employees, fiscal agents, State and federal personnel who require the information in the performance of their duties, and to such others as may be authorized by the Department of Health Services.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____
Signature of Provider/Organization

_____
Date

ATTESTATION QUESTIONS
Please answer the following questions "yes" or "no." ***If your answer to questions A through K is "yes," or if your answer to N is "no," please provide full details on separate sheet.***
A. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service? Yes ☐ No ☐
B. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service? Yes ☐ No ☐
C. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to the interference with or obstruction of any investigation into any criminal offense described in Title 42 - Code of Federal Regulations Section 1001.1001 or 1001.201? Yes ☐ No ☐
D. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? Yes ☐ No ☐
E. Has the facility ever had the State license involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or has the facility voluntarily relinquished the State license in anticipation of any of these actions; or are any of these actions pending with respect to the State license? Yes ☐ No ☐
F. Has the facility ever been charged, suspended, fined, disciplined, or otherwise sanctioned, submitted to probationary conditions, restricted or excluded, or has the facility voluntarily relinquished eligibility to provide services or accepted conditions on its eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending? Yes ☐ No ☐
G. Has the facility had its membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? Yes ☐ No ☐
H. Has the facility ever had any other regulatory agency (OSHA, etc.) deny, revoke, suspend, not renew, place under probation, subject to disciplinary action or otherwise limited or curtail operations; or are any actions pending from any other regulatory agency? Yes ☐ No ☐
I. Has the facility ever had accreditation by an organization (CLIA, JCAHO, etc.) involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or has the facility voluntarily relinquished the accreditation in anticipation of any of these actions; or are any of these actions pending with respect to any such accreditation? Yes ☐ No ☐
J. Has the facility ever been placed under temporary government ordered management? Yes ☐ No ☐
K. Has the facility ever permitted the appointment of a receiver for its business or its assets? Yes ☐ No ☐
L. Do you understand that subject to proper confidentiality restrictions and authorizations, medical records might be subject to on site review by CenCal Health representatives for peer review, utilization review, and quality assurance purposes? Yes ☐ No ☐
M. Does the facility currently participate or have you ever participated as a provider in the Medi-cal program or in another state's Medicaid program? Yes ☐ No ☐
N. Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? Yes ☐ No ☐

I hereby affirm that the information submitted to CenCal Health and any addenda thereto is true, current, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of the Services Agreement.

Print Name: _____

Signature: _____ **Date:** _____

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to the credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any re-credentialing application regarding applicant organization. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of applicant organization qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to applicant organization participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq, if applicable.

I understand and agree that as an applicant, the applicant organization has the burden of producing adequate information for proper evaluation of professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediatelyin writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or non-renewal of license to practice medicine in California; (ii) any cancellation or non-renewal of professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against applicant organization by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting license to practice medicine; or (ii) any adverse action against applicant organization by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) any material reduction in professional liability insurance coverage; or (iv) receipt of written notice of any legal action against applicant organization, including, without limitation, any filed and served malpractice suit or arbitration action; or (v) receipt of written notice of any adverse action against applicant organization under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denialof the application or termination of the Services Agreement. A photocopy of this document shall be as effective as the original; however, original signatures and current dates are required on all pages.

Print Name Here: _____ **Organization Name:** _____

Signature _____ **Date:** _____

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Addendum D: Provider Application

Provider Name: _____ **Provider NPI:** _____

Provider Email: _____

Position (ie MD, DO, Psychiatrist, Physician Assistant, MFT, LCSW, Psychologist): _____ **Date:** _____

Are you accepting New Patients? ☐ YES ☐ NO **Exclude from Directory?** ☐ YES ☐ NO

Do you provide: ☐ In Person & Telehealth Appointments ☐ Telehealth Only ☐ In Person Only

What is the age range you are willing to accept? Min _____ Max _____

Gender Affirmation Services? ☐ Yes ☐ No

How many hours a week do you work? ☐ 40 hrs OR ☐ ____ hrs/week

Please list the languages you speak (other than English) and what level of fluency per language:

Language: _____ Fluency: ☐ Certified Fluent ☐ Good ☐ Fair ☐ Poor

Language: _____ Fluency: ☐ Certified Fluent ☐ Good ☐ Fair ☐ Poor

Language: _____ Fluency: ☐ Certified Fluent ☐ Good ☐ Fair ☐ Poor

Please list your primary race:

White ☐	Japanese ☐	Alaskan Native or American Indian ☐
Hispanic ☐	Hawaiian ☐	Korean ☐
Black ☐	Cambodian ☐	Vietnamese ☐
Filipino ☐	Samoan ☐	Chinese ☐
Asian or Pacific Islander ☐	Laotian ☐	Other ☐
Asian Indian ☐	Guamanian ☐	Decline to state ☐

Please list your primary ethnicity (see list on page 3):

☐
Other (not on list) ☐
Decline to state ☐

Please list your gender:

Male ☐	Female ☐	Genderqueer – neither male or female ☐	Transgender male – trans man/female-to male (FTM) ☐
Decline to state ☐	Other ☐		Transgender female – trans woman/male-to female (MTF) ☐

Program/Specialty Participation:	**Yes**	**No**	**Effective Date**
Child Health and Disability Prevention Program (CHDP)	☐	☐	
California Children Services (CCS)	☐	☐	
Medi-Cal Certified	☐	☐	
HIV Specialist	☐	☐	

For Mental Health Providers Only – please see page 2.

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For Mental Health Providers ONLY:

Put a check in the box next to the following areas in which you specialize with your patients as well as the treatment modalities. For those areas with an asterisk, please provide a copy of any certificates obtained in this area.

Area of expertise (check all that apply): □ Child/Adolescent □ Adult □ Geriatric □ Substance Abuse

Mental Health Practice Focus

ADHD (1D)	
Anxiety (AD)	
Autism Spectrum Disorder (1D)*	*
Bipolar Disorder (BP)	
Borderline Personality Disorder (PD)	
Dementia (CD)	
Depression (MD)	
Dissociative Disorders (DD)	
Eating Disorder (ED)*	*
Families with Children with Serious Illnesses (AJ)	
Gambling (IC)	
Gender Dysphoria/LGBTQI (SG)	
Grief (AJ)	
Hoarding (AD)	
Illness Anxiety/Somatic Symptom Disorder (SD)	
Narcolepsy (SL)	
OCD (AD)*	*
Phobias (AD)*	*
Perinatal Mental Health (MD)* including	*
PTSD/Trauma (AD)	
Schizophrenia/Schizo-affective Disorder (PS)	
Separation Anxiety (ID)	
Sexual Dysfunctions (SG)	
Skin-picking/Trichotillomania (IC)	
Substance Abuse (SR)	
Traumatic Brain Injury (GM)	

Treatment Modalities

Child-parent Psychotherapy (CPP)	
Cognitive Behavioral Therapy (CBT)	
Couples Counseling	
Dialectical Behavior Therapy (DBT)	
Eye Movement Desensitization and Reprocessing (EMDR)	
Family Therapy (FMTPY)	
Group Therapy (GRTPY)	
Hypnotherapy	
Mindfulness Practices and Integrative (MPI)	
Parent-Child Interaction Therapy (PCIT)	
Play Therapy (PLTPY)	
Positive Parenting Program (Triple P)	
Trauma-focused Cognitive Behavioral Therapy (TF-CBT)	
Spravato/Ketamine Treatment	
PSYCHOLOGISTS ONLY – Psychological testing	
PSYCHOLOGISTS ONLY – Neuro-psych testing	

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Afghanistani	Chinese	Korean	Pohnpeian
African	Chuukese	Kosraean	Polish
African American	Colombian	Kurdish	Polynesian
Alaska Native	Costa Rican	La Raza	Portuguese
American Indian	Criollo	Laotian	Puerto Rican
Andalusian	Cuban	Latin American	Punjabi (India)
Arab	Dominica Islander	Lebanese	Russian
Argentinean	Dominican	Maldivian	Saipanese
Armenian	Ecuadorian	Mariana Islander	Salvadoran
Asian Indian	Egyptian	Marshallese	Samoan
Assyrian	English	Melanesian	Scottish
Asturian	Ethiopian	Mexican	Singaporean
Bahamian	European	Mexican American	Solomon Islander
Bangladeshi	Fijian	Mexican American Indian	South American
Barbadian	Filipino	Mexicano	South American Indian
Belearic Islander	French	Micronesian	Spaniard
Bengalese (India)	Gallego	Middle Eastern or North African	Spanish Basque
Bhutanese	German	Mixtec (Mexican Indian	Sri Lankan
Black	Guamanian	Namibian	Syrian
Bolivian	Guamanian or Chamorro	Native Hawaiian	Tahitian
Bosnian	Guatemalan	Nepalese	Taiwanese
Botswanan	Haitian	New Hebrides	Thai
Brazilian	Hindu	Nicaraguan	Tobagoan
Burmese	Hmong	Nigerian	Tokelauan
Cambodian	Honduran	Okinawan	Tongan
Canal Zone	Indonesian	Other Hispanic	Trinidadian
Canarian	Iranian	Other Latino	Uruguayan
Carolinian	Iraqi	Pakistani	Valencian
Castilian	Irish	Palauan	Venezuelan
Catalonian	Israeli	Palestinian	Vietnamese
Central American	Italian	Panamanian	West Indian
Central American Indian	Iwo Jiman	Papua New Guinean	Yao (Mien)
Chamorro	Jamaican	Paraguayan	Yapese
Chicano	Japanese	Peruvian	Zairean
Chilean	Kiribati		

Addendum E: ECM and CS Data Collection

CenCal HEALTH
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Provider Name: _____ Provider NPI: _____ Effective Date: _____

Enhanced Care Management Program Descriptions (ECM):

Please enter the Youth and Adult Outreach Capacity Numbers next to the Population of Focus (POF) that your organization is participating in. If your program is not live with services, input "0" under outreach capacity and "NO" under the Live Service column. Indicate the County (or both) where services will be provided. Note: CalAIM defines Youth Members as those ages 0 to 20 and Adult Members as those ages 21 to 999.

ECM Program Descriptions	County	Youth (Age 0 to 20) Outreach Capacity *Current/Updated*	Adult (Age 21 & Up) Outreach Capacity *Current/Updated*	Direct referrals from CenCal Health *(Yes/No)*	Live Service *(Yes/No)*
ECM - Homelessness (POF1): Individuals Experiencing Homelessness	SB				
	SLO				
ECM - High Utilizers (POF2): Individuals At Risk for Avoidable Hospital or ED Utilization	SB				
	SLO				
ECM - SMI/SUD (POF3): Individuals Serious Mental Health and Substance Abuse Disorder	SB				
	SLO				
ECM - Justice Involved (POF4): Adult Transitioning from Incarceration	SB	◯ Pre____ ◯ Post ____ ◯ Both _____	◯ Pre____ ◯ Post ____ ◯ Both _____		
	SLO	◯ Pre____ ◯ Post ____ ◯ Both _____	◯ Pre____ ◯ Post ____ ◯ Both _____		
ECM - Inst/Long Term Care (POF5): Adults Living in the Community Who are at Risk of LTC Institutionalization	SB				
	SLO				
ECM - SNF/Community (POF6): Nursing Facility Residents Transitioning to the Community	SB				
	SLO				
ECM - Enrolled in CCS/WCM (POF7): Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition	SB				
	SLO				
ECM - Child Welfare (POF8): Children and Youth Involved in Child Welfare	SB				
	SLO				
ECM – Birth Equity (POF9): Pregnant and postpartum individuals at risk for adverse perinatal outcomes	SB				
	SLO				

Community Supports Program Descriptions (CS)

Enter Outreach Capacity Numbers for all the Community Supports Programs your organization is contracted to provide. If your program is not live with services, input "0" under outreach capacity and "NO" under the Live with Service column. Indicate the County (or both) where services will be provided. For programs that do not serve all age ranges (0–999), specify your preferred age ranges in the Notes column.

CS Program	County	Outreach Capacity *Current/Updated*	Direct referrals from CenCal Health *(Yes/No)*	Live Service *(Yes/No)*	Notes *(Age ranges/ Comments)*
Asthma Remediation	SB				
	SLO				
Community Transition Services/ Nursing Facility Transition to a Home	SB				
	SLO				
Day Habilitation Programs	SB				
	SLO				
Environmental Accessibility Adaptations	SB				
	SLO				
Housing Deposits	SB				
	SLO				
Housing Tenancy and Sustaining Services	SB				
	SLO				
Housing Transition Navigation Services	SB				
	SLO				

Community Supports Program Descriptions (CS) (cont.)					
CS Program	**County**	**Outreach Capacity** *Current/Updated*	**Direct referrals from CenCal Health** *(Yes/No)*	**Live Service** *(Yes/No)*	**Notes** *(Age ranges/ Comments)*
Medically Tailored Meals	SB				
	SLO				
Nursing Facility Transition/Diversion to Assisted Living Facilities	SB				
	SLO				
Personal Care and Homemaker Services	SB				
	SLO				
Recuperative Care	SB				
	SLO				
Respite Services	SB				
	SLO				
Short-Term Post-Hospitalization Housing	SB				
	SLO				
Sobering Centers	SB				
	SLO				

CalAIM Community Supports and Enhanced Care Management Contacts

Please enter any contact information for the Community Supports Programs and Enhanced Care Management Populations of Focus.

ECM / CS Program Name	Program Contact Person	Phone Number	Email Address

Zip Code Reference Table

Santa Barbara County	Santa Barbara County Zip Codes	San Luis Obispo County	SLO County Zip Codes
Buellton	93427	Arroyo Grande	93420
Carpinteria	93103	Atascadero	93422
Goleta	93117	Avila Beach	93424
Guadalupe	93434	Bradley	93426
Lompoc	93436	Cambria	93428
Lompoc	93437	Cayucos	93430
Maricopa	93252	Creston	93432
New Cuyama	93254	Grover Beach	93433
Santa Barbara	93101	Los Osos	93402
Santa Barbara	93103	Morro Bay	93442
Santa Barbara	93105	Nipomo	93444
Santa Barbara	93108	Oceano	93445
Santa Barbara	93109	Paso Robles	93446
Santa Barbara	93110	Paso Robles	93447
Santa Barbara	93111	Pismo Beach	93449
Santa Maria	93454	San Luis Obispo	93401
Santa Maria	93455	San Luis Obispo	93405
Santa Maria	93458	San Luis Obispo	93406
Santa Ynez	93460	San Luis Obispo	93407
Solvang	93463	San Miguel	93451
		San Simeon	93452
		Santa Margarita	93453
		Shandon	93461
		Templeton	93465

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

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