CenCal HEALTH
Local. Quality. Healthcare.

Organizational Provider 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 Organizations 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 CMS certification to provide partial hospitalization services (if applicable)
- □ Proof of facility Commercial General Liability coverage
- □ Proof of facility Professional Liability coverage (if applicable)
- □ 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

ORGANIZATIONAL 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 facility 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 facility 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

FACILITY INFORMATION

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

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

Clinic Office Hours

	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:

FACILITY TYPE

Check ONE box only per Application.

- ☐ Free-Standing Surgical Centers – Free standing only
- ☐ Skilled Nursing, Acute Rehabilitation, Intermediate Care or Sub-Acute Facilities
- ☐ Sleep Center
- ☐ Hospital - All types
- ☐ Kidney Dialysis Center
- ☐ Extended Care facilities or Nursing Home
- ☐ Hospice
- ☐ Laboratories
- ☐ Transportation Providers
- ☐ Other _____

HEALTH CARE LICENSURE

Attach a copy of each license for this facility. 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 facility 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 facility 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 facility 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 FACILITIES

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 facility 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.

STAFFING

Does this facility validate, for each licensed practitioner employed or contracted at the facility, the credentials necessary to perform health care services? ☐ Yes ☐ No

- If YES, indicate how the facility conducts the credentialing process for each practitioner:
  - ☐ Credentialing procedures are performed internally.
  - ☐ Credentialing procedures are outsourced/delegated to _____
  - ☐ Other, specify: _____
- If NO, explain: _____

INSURANCE

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

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

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

1. Is this facility 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.***
☐ Facility is covered by Government insurance.

2. Is facility covered by Professional liability insurance in the amount of $1 million per occurrence and $3 million aggregate? Must be a facility/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.***
☐ Facility is covered by Government insurance.

3. Has this facility'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 facility ever had or currently have pending any legal actions against it?
☐ Yes ☐ No	2. Has this facility 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 facility/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 facility, or are any actions which may lead to such conclusions now underway?
☐ Yes ☐ No	5. At any time, has this facility/organization been assessed a penalty or fined by a government agency or is the facility 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 facility'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 facility, 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

HHA MEDICARE CERTIFICATION EXCEPTION FORM

Only Non Medicare certified Home Care agencies should complete this form.
All questions must be answered. Completion of this form doesn't guarantee acceptance to plan.

Home Care Agency Name: _____

1. Indicate the number of hours and days per week the agency is available to serve clients.

   Hours per day:_____Days per week: _____

2. List all states and years this agency has been in business.

   State:_____Year(s):_____-_____

   State:_____Year(s):_____-_____

   State:_____Year(s):_____-_____

3. Indicate the number of clients you have served:

   This year: _____

   Last year: _____

   Two years ago: _____

4. Indicate the number of agency employees in each category.

   Registered Nurses (RN): _____
   Licensed Practical Nurses (LPN): _____
   Personal Care Assistants (PCA): _____
   Other_____: _____

5. Indicate percentage of your clients, in the past year through present, who primarily received **personal care assistant (PCA)** or **home health aide** services rather than skilled nursing services.

   _____%

6. Give reason(s) this home care agency has not pursued/been granted Medicare (CMS) certification.

ORGANIZATIONAL PROVIDER APPLICATION

LANGUAGES

- ***Please check all languages spoken by facility staff fluently enough to treat patients/clients who speak only that language.***
- ***If none of these languages are spoken at your facility, check "None of These."***
- ***Indicate if Sign Language and/or an Interpreter Service is available at your facility.***

☐	AFRIKAANS	☐	HILIGAYNON	☐	OROMO
☐	AKAN	☐	HINDI	☐	PAKASTANI
☐	AMHARIC	☐	HINDU	☐	PERSIAN
☐	ARABIC	☐	HMONG	☐	POLISH
☐	ARABIC NORTH LEVAN	☐	HUNGARIAN	☐	PORTUGUESE
☐	ARMENIAN	☐	IBO OF NIGERIA	☐	PUNJABI
☐	ASSAMESE	☐	ICELANDIC	☐	ROMANIAN
☐	BENGA	☐	INDONESIAN	☐	RUSSIAN
☐	BENGALI	☐	ILOCANO	☐	SERBIAN
☐	BOSNIAN	☐	ITALIAN	☐	SINDHI
☐	BULGARIAN	☐	KANNADA	☐	SINHALA
☐	BURMESE	☐	KAREN	☐	SLAVIC
☐	CAMBODIAN	☐	KASHMIRI	☐	SLOVENIAN
☐	CANTONESE	☐	KISII	☐	SOMALI
☐	CHILEAN	☐	KISW AHILI	☐	SPANISH
☐	CHINESE	☐	KONKANI	☐	SW AHILI
☐	CHINESE MANDARIN	☐	KOREAN	☐	SW EDISH
☐	CROATIAN	☐	KUNIAN	☐	TAGALOG
☐	CZECH	☐	KURDISH	☐	TAIWANESE
☐	DANISH	☐	LATIAN	☐	TAMIL
☐	DUTCH	☐	LAOTIAN	☐	TELUGU
☐	EGYPTIAN	☐	LATVIAN	☐	THAI
☐	ESAN	☐	LIINGALA	☐	TIGRIGNA
☐	ESTONIAN	☐	LITHUANIAN	☐	TSWANA
☐	FARSI	☐	LUGANDA	☐	TURKISH
☐	FILIPINO	☐	LUO	☐	TURKMEN
☐	FINNISH	☐	MALAY	☐	UKRANIAN
☐	FLEMISH	☐	MALAYALAM	☐	URDU
☐	FRENCH	☐	MANDARI	☐	VIETNAMESE
☐	GERMAN	☐	MANDINKA	☐	WELSH
☐	GREEK	☐	MARATHI	☐	WOLOF
☐	GUJARATI	☐	NEPALI	☐	YIDDISH
☐	HAITIAN CREOLE FRENCH	☐	NORWEGIAN	☐	YORUBA
☐	HEBREW	☐	OJIBWE	☐	**NONE OF THESE**

☐ **AMERICAN SIGN LANGUAGE** ☐ **INTERPRETER SERVICE UTILIZED BY FACILITY**

Facility Name:_____ **TIN:** _____

ATTESTATION AND RELEASE OF INFORMATION FORM

Modifications Will Not Be Accepted

RELEASE OF INFORMATION:
As part of the application process and for the purpose of verifying any information provided on this application, I, the undersigned authorized agent of the applicant facility/organization, grant the Managed Care Organization permission to contact any individual, institution, facility, or agency identified on, or relative to, this application. Further, I hereby consent and authorize the Managed Care Organization to request, receive and inspect any and all records pertinent to consideration of this application.

As a health organizational facility/organization applicant, I, the undersigned authorized agent, acknowledge that I am required to supply the Managed Care Organization with verification of current professional liability and/or general liability coverage and any additional documentation necessary and relevant to the review of this application.

SITE REVIEW AUTHORIZATION:
I hereby grant permission for the Managed Care Organization to conduct on-site and medical record reviews as necessary if applicable. I further agree that this facility will participate in and support the Managed Care Organizations quality improvement and utilization review programs.

ATTESTATION:
I certify the information on this entire application is complete, accurate and current. I acknowledge that any misstatements in or omissions from this application constitute grounds for denial or summary dismissal. A copy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

I acknowledge that a decision about participation for the organization on this application will be delayed until all required information is received and/or verified. I acknowledge that acceptance of this application does not constitute approval or acceptance or participating status with the Managed Care Organization and does not grant this facility any rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this facility by the Managed Care Organization. All services rendered to its Members must be individually authorized until a written notice of participation and conditions of participation is issued by the Managed Care Organization.

This facility complies with all federal, state, and local handicapped access requirements as well as the standards required by the 1992 federal Americans with Disabilities Act.

I certify that the appropriate state license or certification source is checked for all new employees or contracted service providers prior to the first provision of service. I certify that the appropriate state license or certification source is checked at least annually for existing and contracted service providers to ensure that every licensed individual providing services as a representative of the applicant holds a current license or certification to provide services. I certify that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service. I certify that the applicant does not employ or contract with any individual convicted of a felony for a healthcare-related crime, including, but not limited to, healthcare fraud, patient abuse and the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

I certify that the on-line exclusion lists for the Department of Health and Human Services Office of Inspector General **(https://exclusions.oig.hhs.gov/)** and System for Award Management **(https://sam.gov/)** are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthly basis to ensure that no state or federally excluded individuals perform any function related to any state or federal healthcare program. I certify that I will remove any employee or contracted service provider found on one of the above referenced federal exclusion lists from any functions related to a state or federal healthcare program.

The individual executing this Attestation is duly authorized and has the proper authority and proper authorization to execute this Attestation and does so with the intent to fully bind Facility to the truthfulness of its answers.

Authorized Signer: _____ Date: _____

Printed Name of Signer: _____ Authorized Signer Title: _____

Signer's Email Address: _____

Printed Facility Name: _____

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

Date

Practitioner NPI#

Print First & Last Name

Date

Practitioner NPI#

Print First & Last Name

Date

Practitioner NPI#

Print First & Last Name

Date

Practitioner NPI#