California Child Health and Disability Prevention (CHDP) Program
CHDP HEALTH ASSESSMENT PROVIDER APPLICATION

IMPORTANT:

- Refer to attached instructions to complete this form.
- Type or print legibly.
- Laboratories please use the CHDP Laboratory Provider Application (DHS 4502).
- Return completed form and required attachments to your local CHDP Program. Addresses may be found at http://www.dhs.ca.gov/pcfh/cms/chdp/directory.htm

For Local CHDP Program Use Only			
CHDP Program			
Address *(number, street)*			
City	County	State CA	ZIP code

Application for participation as *(check one)*:

(Please see instructions for description.)

☐ Comprehensive Care Provider

☐ Health Assessment Only Provider

Provider type *(check one)*:

☐ Solo practice ☐ Government

☐ Group practice ☐ Teaching institution

☐ Clinic *(please specify type)* ____________

☐ Other *(please specify)* ____________

1. Legal name of Provider Applicant as listed with the IRS

2. Business name if different from legal name

Is this a fictitious business name?	If yes, list the Fictitious Business Name Statement/Permit number	Effective date
☐ Yes ☐ No	*(Attach a legible copy of the Fictitious Business Name Statement/Permit.)*	

3. Business address (office/site of practice)

Number, street	City	County	State	ZIP code

4. Business telephone number ( )	5. Fax number ( )	6. E-mail address

7. Pay-to name *(last)* *(first)* *(middle initial)*	8. Social security number (SSN) *(Required if not using a FEIN) (attach a copy)*	9. Federal Employer ID Number (FEIN) *(attach a copy)*

10. Pay-to address

Number, street	City	State	ZIP code

11. Type of business *(check one)*:

☐ Sole proprietor ☐ Corporation ☐ Partnership ☐ Limited liability corporation ☐ Other ____________ *(please specify)*

Principal owners

12. Active Medi-Cal provider number(s) for business address listed in number 3 *(see instructions)*

13. Vaccines for Children (VFC) provider number

14. Active provider in *(check all that apply)*

☐ Medi-Cal Managed Care plans *(please specify)* ____________

☐ Healthy Families plan *(please specify)* ____________

☐ California Children's Services

☐ Other children's health insurance program (please specify)

____

15. History of providing CHDP services *(attach additional sheets if needed)*

	Name	Current Provider Yes	Current Provider No	Former Provider Yes	Former Provider No	(If yes, specify from/to dates)
California County(ies)		☐	☐	☐	☐	From ________ To ________
Other State(s)		☐	☐	☐	☐	From ________ To ________

For LOCAL CHDP PROGRAM Use Only

Reviewed by CHDP Director *(print name)*	Signature	Date signed	Date CHDP Provider Data Sheet (PM 177) sent to State

16. Clinical Laboratory Improvement Amendment (CLIA) *(check one)*:

	Certificate number	Waiver or certificate expiration date
☐ CLIA waiver *(attach a copy)* ☐ CLIA certificate *(attach a copy)*		

17. List of clinicians providing CHDP services in the office location *(business address listed in number 3)* pertaining to this application:
Please attach a copy of license and curriculum vitae for ***each*** clinician that includes relevant certification and/or pediatric experience in the past three years.

Name and Title (e.g., M.D., PNP)	Professional License Number	Specialty	CHDP Experience

(If more space is needed, attach additional information.)

18. Describe how you provide 24-hour on-call services. Please attach detailed description and names of clinicians providing these services.

19. Describe your provisions for any necessary hospitalizations and the name of those hospital(s). If more space is needed, attach additional information.

20. If you are completing this application to be a Health Assessment Only Provider, please attach a detailed description of your procedures for referral to diagnostic, treatment, and follow-up services for conditions identified during the health assessment.

21. Name of physician responsible for quality/oversight of clinical practice	22. Telephone number	23. E-mail address
	( )	

The Provider Applicant hereby affirms that all CHDP Clinicians meet the minimum qualification requirements as specified in the CHDP Provider Manual and have agreed to abide by the regulatory requirements and policies of the CHDP Program. The information submitted on this application and any attachments is true, accurate, and complete to the best of the Provider Applicant's knowledge and belief and are furnished in good faith. The Provider Applicant understands that failure to comply with the requirements of the CHDP Program may result in disenrollment.

24. Printed name and title of Provider Applicant *(first)* *(middle initial)* *(last)* *(title)*

25. Provider Applicant signature ***IN BLUE INK ONLY***	Date

Privacy Statement (as required by Civil Code, Section 1798 et seq.)

All information requested by the application is required by the California Department of Health Services (CDHS) by the authority of Title 17, Section 6860. The consequences of not supplying the requested information are denial of enrollment as a CHDP provider and no issuance of the provider number to obtain reimbursement from the CHDP Program. Any information provided will be used to verify eligibility to participate as a provider in the CHDP Program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare fiscal intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, and Medicaid and licensing programs in other states. For more information or access to records containing your personal information maintained by CDHS, contact the Provider Services Unit, Children's Medical Services Branch, MS 8105, P.O. Box 997413, Sacramento, CA 95899-7413, (916) 322-8702.

INSTRUCTIONS FOR COMPLETION OF THE CHDP HEALTH ASSESSMENT PROVIDER APPLICATION

For assistance in completing this application, please call your local CHDP Program. Phone numbers can be found at http://www.dhs.ca.gov/pcfh/cms/chdp/directory.htm.

Health care providers wishing to enroll as a provider with the CHDP Program must complete an application and be approved by the local CHDP Program in order to bill the CHDP Program for CHDP services. Laboratories must use the CHDP Laboratory Provider Application (DHS 4502).

Omission of any information or documentation on this application or the failure to sign this application may result in delays in processing or inability to process this application. Provider Applicants may be contacted orally or in writing if additional information and documentation are needed. A separate application must be completed if you wish to apply for participation in the CHDP Program in more than one location. Upon review and approval of the complete application and an on-site facility and medical record review, the Provider Applicant will be assigned a provider number to use when billing the CHDP program.

Who can apply: Pediatricians, Family Practitioners, and Internists (for youth 14 years of age and older) or Independent Certified Family or Pediatric Nurse Practitioners, and clinics/agencies employing the preceding types of professionals, may be considered for status as a Comprehensive Care or Health Assessment Only Provider.

Application for participation as:
A Comprehensive Care Provider means that the Provider:

- Provides all preventive health assessment services as outlined in the CHDP Program Health Assessment Guidelines;
- Is responsible for the overall follow-up and medical case management for a child initially evaluated through the CHDP Program by initiating diagnosis, treatment, and follow-up for discovered or suspected conditions identified during the health assessment and referring to specialty care when appropriate;
- Provides families and/or patient with written summary of findings;
- Is available as the source for primary medical care, serving as a medical home, on an ongoing basis for medical services;
- Assures the availability of medical services after usual and customary office hours;
- Maintains records for each child receiving a CHDP health assessment.

A Health Assessment Only Provider means that the Provider:

- Provides all preventive health assessment services as outlined in the CHDP Program Health Assessment Guidelines;
- Documents in the child's record the referral for all children with discovered or suspected conditions identified during the health assessment needing definitive diagnosis, treatment, and follow-up services;
- Provides families and/or patient with written summary of findings;
- Provides referral/follow-up report form to families and/or patient to be given to the provider(s) to whom the child has been referred for follow-up care showing the reason for referral;
- Maintains records for each child receiving a CHDP health assessment.

Different fee schedules have been established for Comprehensive Care Providers because of their ability to provide ongoing coordinated care to CHDP-eligible children as described above.

Provider type: Each provider type must meet specific license and registration requirements. Check the appropriate box that describes your profession or business for which you are applying to obtain a CHDP provider number in order to bill the CHDP Program. Check the "clinic" box if your type is a Hospital Outpatient Clinic, Rural Health Clinic, Community Health Clinic, Indian Health Clinic, etc., and specify what type of clinic. Identify the type of practice if the selection is "Other," such as schools. Call the office listed above if assistance is needed in determining your provider type. A separate application must be completed if you wish to apply for participation in the CHDP Program in more than one location.

1. Legal name of Provider Applicant means the name under which the Provider Applicant is applying for a CHDP provider number in the CHDP Program and listed with the Internal Revenue Service (IRS).
2. Business name means the name of the Provider Applicant if different from that listed in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the record/stamped Fictitious Business Name Statement/Permit to the application.
3. Business address (office/site of practice) means the office or location where the Provider Applicant is providing services, including the street name and number, room or suite number or letter, city, county, state, and 5-digit ZIP code. A post office box or commercial box is ***not*** acceptable. **NOTE**: Provider Applicants with multiple business addresses where CHDP services will be provided must complete a separate application for ***each*** business address.
4. Business telephone number means the primary business telephone number used at the Provider Applicant's business address. A beeper number, answering service, answering machine, pager, facsimile machine, or cellular phone is ***not*** acceptable as the business telephone number.
5. Fax number means the facsimile number used at the business address in number 3 on this application.
6. E-mail address means the address to which electronic communications may be sent.

7. Pay-to name means the name of the person or business to which ***payment should be issued*** by the CHDP Program for CHDP services provided by the eligible clinicians employed by the CHDP Provider. The pay-to name may be the legal name indicated in number 1, or another person or business chosen by the Provider Applicant. **NOTE:** See number 10.
8. Provide the social security number of the Provider Applicant named in number 1. The social security number is not required if the Provider Applicant is using their Federal Employer Identification Number (FEIN) requested in number 9. Attach a clearly legible copy of the social security card if this number is being provided.
9. Enter the Federal Employer Identification Number (FEIN) issued by the IRS under the legal name of the Provider Applicant. Attach a legible copy of IRS Form 941, Form 8109-C, Form 147-C, Form SS-4 (Confirmation Notification), or Form 2363. If the business is a Sole Proprietorship not using a FEIN, provide the social security number or Individual Taxpayer Identification Number (ITIN) of the Sole Proprietor. Attach a legible copy of the ITIN, if applicable.
10. The pay-to address means the location to which payment should be sent. Include the post office box number, street number and name, room or suite number or letter, city, state, and 5-digit ZIP code.
11. Indicate the type of business that applies to your business structure. Provide the names of the principal owners.
12. Provide all active Medi-Cal provider numbers for the address in number 3. If applicable, include the name, address, and Medi-Cal provider number of each satellite center on a separate sheet and submit with this form. Enter **"New Applicant with L&C"** if the Provider Type is a clinic not yet licensed.
13. Provide the Vaccines for Children (VFC) provider number.
14. Identify all health care plans in which the Provider Applicant is an active provider, e.g., Medi-Cal Managed Care health plan, Healthy Families Program, or other children's health insurance programs.
15. Indicate your history of providing CHDP services in California and other states by providing the name of the county(ies) and other state(s), if you are a current or former provider, and from/to dates.
16. Check the appropriate box to indicate whether your business address has a CLIA waiver or certificate. Provide the certificate number if the business address has a CLIA certificate and the expiration date of the CLIA waiver or certificate. Attach a legible copy of the waiver or certificate.
17. Provide the names, titles, professional license numbers, specialty, and location and length of time clinicians at the business address provided on this application delivered CHDP services to children and youth up to age 21 years. Attach a copy of each clinician's professional license and curriculum vitae.
18. Describe how your practice provides 24-hour on-call services to the clients seen at the business address on this application. Include the names of the clinicians providing these services.
19. Describe how you arrange for hospitalizations of clients needing admission and the names of those hospitals.
20. If you are applying to be a Health Assessment Only Provider, describe your procedures for referral for diagnosis and treatment and follow-up of conditions identified during the health assessment.
21. Name the physician responsible for oversight of the quality of clinical practice at the business address.
22. Provide the telephone number for the person named in number 21.
23. Provide the e-mail address for the person named in number 21.
24. Print the first name, middle initial, last name, and title of the Provider Applicant indicated in number 1.
25. Provider Applicant signature means the first name, middle initial, and last name of the Provider Applicant indicated in number 1. An original signature ***IN BLUE INK ONLY*** is required. Indicate the date this application is signed. **NOTE:** Provider Applicant signature on the CHDP Health Assessment Provider Program Agreement (DHS 4491) means the name and title of the Provider Applicant indicated in number 1 of the CHDP Health Assessment Provider Application (DHS 4490). An original signature is required. Indicate the date the program agreement is signed.

Did you remember to enclose (as applicable):

- ☐ The original, signed CHDP Health Assessment Program Provider Agreement (DHS 4491)
- ☐ Copy of FEIN or ITIN verification, or social security card, if applicable
- ☐ Copy of Fictitious Business Name Statement/Permit, if applicable
- ☐ Copy of CLIA waiver or certificate
- ☐ Copy of professional licenses, relevant certifications, and curriculum vitae for all clinicians providing CHDP services
- ☐ Description of 24-hour coverage arrangements
- ☐ Description of arrangements for hospitalizations, if applicable
- ☐ Description of referral procedures for diagnosis and treatment, if applicable
- ☐ Other, if applicable

Send completed form to your local CHDP Program. If not indicated on page 1 of this application, mailing addresses may be found at http://www.dhs.ca.gov/pcfh/cms/chdp/directory.htm.