Dear Sir or Madam:

Thank you for your interest in joining the Central California Alliance for Health (the Alliance) provider network. We greatly value your partnership in better serving our community. The Alliance credentials all non-physician medical practitioners (NPMP) who provide care to our members. In accordance with State regulations, NPMPs must be appropriately supervised by a physician who is credentialed and contracted with the Alliance, with the exception of CRNAs. Enclosed is a NPMP Application and additional documents required to begin the credentialing process. Please complete the application packet and all accompanying documents in its entirety.

The following document copies ***must* accompany your application:**

- Addendum A, B and C (form enclosed)
- NPMP Agreement (form enclosed)
  - For Licensed Midwives, please contact credentialing@thealliance.health for Licensed Midwife specific consulting agreement.
- Language Verification Form (form enclosed)
- Declaration of Confidentiality (form enclosed)
- Certificate Regarding Debarment (form enclosed)
- Taxpayer Identification Form (W-9) (form enclosed)
- Copy of current Professional License
- Copy of current NPI number
- Copy of current DEA license (if applicable)
- Copy of completion of certification program (if applicable)
- Copy of professional liability coverage with limits of $1,000,000/claim and $3,000,000/aggregate
- Curriculum vitae (with dates in MM/YYYY format)

Medi-Cal Certification is required

Beginning January 1, 2018, federal law requires that all Alliance-contracted providers are screened and enrolled in the Department of Health Care Services (DHCS) Medi-Cal Fee-for-Service Program. Providers have the right to be screened and enrolled directly through DHCS, but still need to complete the Alliance credentialing process which is separate from DHCS screening and enrollment. See the next page for additional information.

All provider applications are reviewed by the Alliance Peer Review and Credentialing Committee or a Medical Director. To ensure timely processing of your application, we require that you complete and return all documents listed above as soon as possible. Forms may be submitted in the following ways:

Mail: 1600 Green Hills Road, Scotts Valley, CA 95066 Attn: Credentialing
Email: credentialing@thealliance.health
Fax: 831-430-5528

We appreciate your cooperation in the credentialing process and if you have any questions, please contact us at the email above.

Sincerely,
CCAH - Credentialing Department

DHCS Medi-Cal Provider Screening and Enrollment Requirement

Beginning January 1, 2018, federal law requires that all Alliance-contracted providers are screened and enrolled in the Department of Health Care Services (DHCS) Medi-Cal Fee-for-Service Program. If you are already screened and enrolled through DHCS, you have successfully met this requirement.

Alliance providers have two options for enrolling with the Medi-Cal Fee-for-Service Program. Providers may enroll through (1) DHCS; or (2) through a Managed Care Plan that has a screening and enrollment process substantially equivalent to that of the Department of Health Care Services (DHCS).

- If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal Fee for Service (FFS) beneficiaries and contract with the Alliance.
- If the provider enrolls through a Managed Care Plan, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.
- The Alliance is working to implement a screening and enrollment process, which we anticipate will go live no later than 2019. Until such time as the Alliance screening and enrollment process is implemented, providers contracted with the Alliance are required to enroll directly with DHCS.

Enrollment through DHCS

- Providers will use the DHCS standardized application form(s) when applying for participation in the DHCS Medi-Cal Program. The application forms are available on the DHCS website at www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx. DHCS also has a new online portal for enrollment, available at pave.dhcs.ca.gov/sso/login.do. To create an account, click on the "Sign Up" button at the top right corner of the page.

Upon successful enrollment through DHCS, providers will have satisfied the Alliance screening and enrollment requirement. Please note that absent successful screening and enrollment through DHCS, a contracted provider's status with the Alliance may change after January 1, 2018.

If you have questions about these new requirements, please contact Alliance Provider Services at 800-700-3874 ext. 5504.

Non-Physician Medical Practitioner (NPMP) Application

This application is submitted to: **Central California Alliance for Health**, herein, this Healthcare Organization[1]

I. INSTRUCTIONS

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. Current copies of the following documents must be submitted with this application:

u Copy of State Medical License(s) u Copy of DEA Certificate u Face Sheet of Professional Liability Policy or Certification u Curriculum Vitae u Certification (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:	
Is there any other name under which you have been known? Name(s):			
Home Mailing Address:	City:	State:	Zip:
Home Telephone Number:	E-Mail Address:		
Home Fax Number:	Pager Number: ( )		
Birth Date:	Citizenship (If not a United States citizen, please include copy of Alien Registration Card.)		
Birth Place (City/State/Country):			
Social Security #:	Gender	Male	Female
Specialty (primary):	Specialty (secondary):		

Professional Type: Certified Nurse Midwife (CNM) Nurse Practitioner (NP) Licensed Midwife (LM)

Physician Assistant (PA) Certified Registered Nurse Anesthetist (CRNA)

III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (If Hospital Based):	
Primary Practice Street Address:	City:	
	State:	Zip:
Telephone Number:	Fax Number:	
Office Manager/Administrator:	Telephone Number:	
E-Mail Address:	Fax Number:	
Number of Hours Worked Per Week:	Federal Tax ID Number:	
Supervising Physician Name, Title:	Medical License Number:	
	NPI:	Specialty:
Secondary Practice Name & Address:	City:	
	State:	Zip:
Office Manager/Administrator:	Telephone Number:	
E-Mail Address:	Fax Number:	
Number of Hours Worked Per Week:	Federal Tax ID Number:	
Supervising Physician Name, Title:	Medical License Number:	
	NPI:	Specialty:

1 As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above

IV. POSTGRADUATE EDUCATION (Attach additional sheets if necessary. Reference this section number and title)

College or University Name:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:
College or University Name:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:

V. PROFESSIONAL CERTIFICATIONS

Include certifications by organizations which are duly organized and recognized:

Name of Issuing Organization:	Specialty:	Date Certified/Recertified:	Expiration Date (if any):

Have you applied for certification other than those indicated above?		Yes		No

If so, list date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification on separate sheet.

VI. MEDICAL LICENSURE/REGISTRATIONS (Remember to attach copies of documents)

California State License Number:	Type:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA) Registration #:		Issue Date:	Expiration Date:
National Provider Identifier (NPI):			Expiration Date:
Taxonomy:		MediCal/Medicaid Number:	

VII. PROFESSIONAL LIABILITY (Remember to attach copy of professional liability policy or certification face sheet)

Current Insurance Carrier:	Policy Number:	Eff date:
Per Claim Amount:	Aggregate Amount:	Expiration Date:

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference this section number and title.

Mailing Address:	City:	
	State:	ZIP:

VIII. CURRENT HOSPITAL & OTHER INSTITUTIONAL AFFILIATIONS

A. CURRENT AFFILIATION (Attach additional sheets if necessary. Reference this section number and title)

Name and Mailing Address of Primary Hospital:	City:	
	State:	ZIP:
Department/Status (active, provisional, courtesy, etc.):	Appointment Date:	

If you do not have hospital privileges, please leave this section blank

IX. WORK HISTORY (Attach additional sheets if necessary. Reference this section number and title)

Chronologically list the last 5 years of work history activities since completion of postgraduate training (use extra sheets if necessary). Please explain any gaps exceeding 6 months in professional work history on a separate page.

Current Practice Name:		Telephone Number:	
Contact Name:		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy):	Present	
Practice Name:		Telephone Number:	
Contact Name:		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy):		
Practice Name:		Telephone Number:	
Contact Name:		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy):		

X. BILLING INFORMATION

Billing Company:		
Street Address:	City:	
	State:	ZIP:
Contact:	Telephone Number:	
Name Affiliated with Tax ID:	Federal Tax ID:	

XI. 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 L is "no," please please provide full details on separate sheet.
A. Has your license to practice in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you been fined or received a letter of reprimand or is such action pending? Yes ☐ No ☐
B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your 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 action pending? Yes ☐ No ☐
C. Have your clinical privileges, 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 program, medical society, professional association, medical school faculty position or other health delivery entity or systems), 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 ☐
D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned form any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health deliver entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract or in return for such an investigation not being conducted, or is any such action pending? Yes ☐ No ☐
E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any fellowship, preceptorship, or other clinical education program? Yes ☐ No ☐
F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending? Yes ☐ No ☐
G. Have you been denied certification/recertification by a specialty group, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)? Yes ☐ No ☐
H. Have you ever been convicted of any crime (other than a minor traffic violation)? Yes ☐ No ☐
I. Do you presently use any drugs illegally? Yes ☐ No ☐
J. Have any judgments been entered against you, or settlements been agreed to by you within the last (7) years, in professional liability cases, or are there any filed and serviced professional liability lawsuits/arbitrations against you pending? Yes ☐ No ☐
K. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier proved you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? Yes ☐ No ☐
L. Are you able to perform all the services required by your agreement with, or the professional staff by laws 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 in this Section XI, Attestation Questions, 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 denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: _____

Signature: _____ Date: _____

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my 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 (IPA's), health plans, health maintenance organizations (HMO's), preferred provider organizations (PPO's), other health deliver systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claim history), licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. 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 state3 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 my 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 my 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 I, as an applicant, have the burden of producing adequate information for proper evaluation of my 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 immediately in writing of the occurrence of any of the following (i) the unstated suspension, revocation or nonrenewal of my license in California; (ii) any suspension revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than (14) calendar days from the occurrence of any of the following (i) receipt of written notice of any adverse action against me 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 my license to the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and serviced malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me 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 (including my curriculum vitae if attached) 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 denial of my application or termination of my privileges, employment or physician assistant/nurse practitioner participation agreement. A photocopy of this document shall be as effective as the original.

Print Name Here: _____

Signature: _____ Date: _____

3 The intent of this release is to apply at a minimum, protections comparable to those available in California to any action, regardless of where such action is brought.

Addenda Submitting (Please check the following)

☐ Addendum B- Professional Liability Action Explanation

This application and Addenda A and B were created and are endorsed by:

- American Medical Group Association (310/ 430-1191X223)
- California Association of Health Plans (916-552-2910)
- California Healthcare Association (916/ 552-7574)
- California Medical Association (415/882-5166)
- National IPA Coalition (510/267-1999)
- The Medical Quality Commission (310/936-1100 x 230)

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.
The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of the application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address:_____ City:_____ State:_____ Zip:_____

APPLICANT SIGNATURE (Stamp is Not Acceptable): _____
PRINTED NAME: _____
DATE: _____

California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to _____ herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise conclude professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

☐ *Please check here if there are no pending/ settled claims to report (and sign below to attest).*

I. Practitioner Identifying Information

Last Name: _____ First Name: _____ Middle: _____

II. Case Information

Patient's Name: _____ Patient Gender ◯ Male ◯ Female Patient DOB: _____

City, County, State where lawsuit filed: _____

Court Case number, if known: _____

Date of alleged incident serving as basis for the lawsuit/ arbitration: _____

Date suit filed: _____

Location of incident:
☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center ☐ Other (specify) _____

Relationship to patient (Attending physician, Surgeon, Assistant, Consultant, etc.) _____

Allegation

_____

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ◯ Yes ◯ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization.

_____

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name: _____ Telephone Number: _____ Fax Number: _____

III. Status of Lawsuit/Arbitration (check one)

☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: $

☐ Judgment rendered and I was found not liable.

☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: $

☐ Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:
1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

APPLICANT SIGNATURE (Stamp is Not Acceptable) **PRINTED NAME** **DATE**

Addendum C to Non-Physician Medical Practitioner (NPMP) Application

1. Credentialing Contact Information:

Name: _____

Phone: _____ Fax: _____

Address: _____

Address 2: _____

Email: _____

2.

Program / Specialty Participation:	Yes	No	Effective Date
Comprehensive Perinatal Services Provider (CPSP)	☐	☐	
Child Health and Disability Prevention Program (CHDP)	☐	☐	
California Children's Services (CCS)	☐	☐	
Medi-Cal Certified	☐	☐	

Addendum F
Behavioral 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.

Mental Health Practice Clinical Specialty - Focus	
Addiction*	
Anxiety	
Attention Deficit Hyperactivity Disorder	
Autism	
Bipolar Disorder	
Depression	
Developmental Disorders	
Dissociative Disorders	
Eating Disorders *	
Families with Children with Serious Illnesses	
Grief	
Insomnia/ Sleep Issues	
Learning Disability	
Life Transitions	
Medication Management – PSYCHIATRISTS AND MDs ONLY	
Men's Issues	
Military and Veterans	
Neuro-psych testing – PSYCHOLOGISTS ONLY	
Obsessive-Compulsive	
Parenting	
Perinatal and Post Partum	
Personality Disorder	
Phobias	
Psychiatric evaluation – PSYCHIATRISTS, PSYCHOLOGISTS ONLY	
Psychological testing – PSYCHOLOGISTS ONLY	
Psychopharmacology – PSYCHIATRISTS (MD) and PSYCHIATRIC RN ONLY	
Psychosis	
Racism	

Relational/Separation/Divorce	
Schizophrenia	
School Issues	
Self-Esteem	
Self-Harm	
Sexual Abuse	
Sexual Issues	
Spirituality/Religion	
Substance Misuse	
Suicidal Ideation	
Trauma and PTSD	
Women's Issues	

Treatment Modalities & Populations Served	
Addiction	
Adolescents	
Anger Management	
Bariatric Counseling	
Behavior Modification	
Brief Therapy	
Child Therapy	
Chronic /Terminal Illness	
Chronic Pain	
Cognitive Behavioral Therapy (CBT)	
Conduct Disorder	
Couple's Counseling	
Dementia	
Dialectical Behavior Therapy (DBT)	
Domestic Violence	
LGBTQIA	
Eye Movement Desensitization and Reprocessing (EMDR)	
Family Therapy	
Foster/ Adoption	
Geriatric Therapy	
Group Therapy	
HIV/AIDS	
Hoarding	
Hypnotherapy	
Parent-Child Interaction Therapy (PCIT)	
Positive Parenting Program	

Sex and Intimacy	
LGBTQIA	
Solution Focused	
Stress Management	
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	
Adolescents	
Couples	
Domestic Violence	
Pediatrics	
Play Therapy (Pediatrics)	
Motivational Interviewing	

New Provider Training

As a new provider joining the Alliance, you are required to complete the Alliance new provider training.

After reviewing the information in the New Provider Training, please sign below to acknowledge that you have received these training materials and the date of your review.

New Provider Training Non-PCP

I have completed my review of the new provider training materials from the Central California Alliance for Health.

_____

Signature of Provider

_____

Date

SUMMARY OF NON-PHYSICIAN MEDICAL PRACTITIONERS REQUIREMENTS

Non-physician medical practitioners (NPMP) are defined as nurse practitioners, physician assistants and nurse midwives. When providing services under the supervision of a physician, nurse practitioners should be supervised according to California Code of Regulations, the Nurse Practice Act, and the California Business and Professions Code. Physician assistants may provide medical services under a Delegation of Services Agreement (DSA) entered into with the supervising physician, in accordance with the California Code of Regulations and the California Business and Professions Code.

Central California Alliance for Health will perform credentialing and ongoing monitoring activities for all NPMPs who operate under a supervisory agreement with a contracted, credentialed supervising physician.

Each physician/NPMP team will sign an agreement, and keep it on file, stating that the NPMP will follow the protocols developed for practice by the supervising physician. The protocols may be revised with the approval of the supervising physician and a new agreement should then be signed. A sample agreement is attached.

NON-PHYSICIAN MEDICAL PRACTITIONER (NPMP) AGREEMENT*

The following is an agreement between _____ and _____.
NPMP Name Supervising Physician

I agree to follow the protocols established by _____ for NPMPs.
Name of Practice or Group

I agree to consult with my supervising physician for all cases as outlined in the protocol and for any case that I am unsure about the diagnosis or management.

I understand that a physician will be available either on-site or by electronic communication at all times.

I understand that I am expected to stabilize clients during life-threatening emergencies and to contact a physician as soon as possible and/or arrange for emergency transport to the nearest hospital.

I understand that my charts will be reviewed by the supervising physician who will discuss cases with me on a regular basis.

I understand that medications must be ordered as per California Business and Professional Codes relating to the practice of NPMPs.

This agreement is effective until the supervising physician(s), or the NPMP requests a change in writing.

I understand that failure to follow these protocols may result in disciplinary action.

Non-Physician Medical Practitioner	Supervising Physician
_____	_____
Signature	Signature
_____	_____
Type or Print Name	Type or Print Name
_____	_____
Date	Date

***This document may be substituted with a standard written agreement if one already exists.**

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

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 not to divulge
(Provider name)

any information obtained in the course of my assignment to unauthorized persons, and agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the 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

_____
Date

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION - LOWER TIERED COVERED TRANSACTIONS

Instructions for Certification

1. By signing and submitting this certification as part of this proposal, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances, including but not limited to suspension, debarment, or exclusion from participation in any federally-funded health care program following its
previous certification.

4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion-Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to check the List of Parties Excluded from Federal Procurement and No procurement Programs.

8. Nothing contained in the foregoing shall be construed to require establishment of a system or records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

(1) The prospective lower tier participant certifies, by submitting this proposal and signing below, that neither it or its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency, or is excluded as the result of state or federal action from participation in any federally-funded health care program.

(2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

_____

Signature

_____

Printed Name

_____

Date

Provider Language Verification Form

Provider Office/Clinic Name:_____

Address:_____

Telephone:_____Fax:_____Email:_____

In order to comply with State of California requirements and to meet the needs of Limited English Proficient (LEP) members, the Alliance assesses the language capabilities of our provider network on an annual basis. The information submitted on this form will be reflected in our Provider Directory. Please call the Provider Services Department at 831-430-5504 if you have any questions.

If additional space is needed, please copy this form before completion

List all providers (MD, DO, NP, PA) who are <u>fluent</u>* in any language *other than English*	**Language(s) spoken fluently by provider *other than English***
1	
2	
3	
4	
5	
6	
7	
8	

Are there **other medical staff** (RN, LVN, MA) who are fluent in a language other than English?

☐ **No** ☐ **Yes - Check box and list all languages below** *(not necessary to list staff names)*

Language(s):_____

Are there **non-medical staff** (Receptionist, Scheduler) who are fluent in a language other than English?

☐ **No** ☐ **Yes - Check box and list all languages below** *(not necessary to list staff names)*

Language(s):_____

Physician/Administrator Signature:_____Date:_____

**Fluent: Able to speak and understand a language easily and accurately on all levels related to patient care; able to understand and participate in any conversation within the range of one's experience with a high degree of precision; able to fully comprehend a language, unaffected by rate of speech.*

Please Fax Completed Form to Provider Services at 831-430-5857

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ _____
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,