



## Organizational Provider Onboarding Packet

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**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](mailto: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 <b>cannot</b> be processed without a valid 10-digit NPI)			
Corporate Address: ----- -----				Hospital or Health System Affiliation: List Hospital or Health System Affiliation below:  <input type="checkbox"/> Not affiliated with any hospital/health system			
Date of Incorporation: _____ / _____ / _____				Length of time in business with this Name and Tax ID: _____ Years _____ Months _____			
<input type="checkbox"/> Is facility owned in whole or in part or managed by a hospital or health care system/organization? <input type="checkbox"/> Yes, owned in whole or in part by _____ <input type="checkbox"/> Yes, managed by _____ <input type="checkbox"/> 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**

- Is this facility participating in the Medicare program?  Yes  No  Pending  
Medicare number: \_\_\_\_\_ Date of initial Certification: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
- Check here if facility is not eligible for Medicare certification.
- HOSPITAL 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.*
- Is this facility participating in California Medicaid (Medi-Cal) program?  
 Yes  No  Pending
- 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
- AAAHHC** - 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

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## 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.

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Has this facility ever had or currently have pending any legal actions against it?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Has this facility ever been convicted of a crime, excluding misdemeanors?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Has any government agency ever investigated, suspended, revoked, or taken other action against this facility/organization's license to conduct business?
<input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> 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

# HHH 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.*

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

**AMERICAN SIGN LANGUAGE**

**INTERPRETER SERVICE UTILIZED BY FACILITY**

Facility Name: \_\_\_\_\_ TIN: \_\_\_\_\_



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](#), via the New Provider Orientation training videos located online at [www.cencalhealth.org/providers/welcome-to-the-network](http://www.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) (including sensitivity, diversity, communication skills, cultural competency, health needs for various populations, Social Drivers of Health and disparity impacts on Member's health care) – *Coming Soon!*
- ✓ 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**

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

**D. Data Collection and Reporting Requirements**

**E. 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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print First & Last Name

\_\_\_\_\_  
Group Billing NPI#

\_\_\_\_\_  
Title

Our practice, including Practitioners and Medical Staff, acknowledges and confirm(s) to have received Cultural Competency, Health Literacy & Linguistics training and Seniors and Persons with Disabilities (SPD) Sensitivity training resources located online at [cencalhealth.org/providers/cultural-linguistic-resources/cultural-competency-and-health-literacy/](http://cencalhealth.org/providers/cultural-linguistic-resources/cultural-competency-and-health-literacy/)

**Please list all Rendering Practitioners within your organization that received these training resources below. This applies to newly joining physicians to your organization, and/or being re-credentialed with CenCal Health.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print First & Last Name

\_\_\_\_\_  
Practitioner NPI#

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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Print First & Last Name

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Practitioner NPI#

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