

APPLICATION TO PARTICIPATE IN THE FAMILY PACT (PLANNING, ACCESS, CARE, AND TREATMENT) PROGRAM (Section 24005, Welfare and Institutions Code)

IMPORTANT:

- Must be a current Medi-Cal provider.
- Read all attached materials before completing.
- Type or print clearly in ink.
- Signature of individual provider or individual is required (see page 4).
- *Return completed form to:*

California Department of Public Health
MCAH/OFPP Branch
Family PACT Provider Enrollment
1615 Capitol Avenue, MS 8307
P.O. Box 997420
Sacramento, CA 95899-7420
(916) 650-0285

FOR STATE USE ONLY

Date received: _____
Date approved: _____
Date returned: _____

Enrollment Action Requested:

New enrollment

Additional site address

Current Medi-Cal provider number: _____ and/or National Provider Identifier (NPI): _____

Family PACT Provider Type:

Sole proprietor

Group provider

Government entity

Licensed Community/Free Clinic

Federally Qualified Health Center (FQHC); Rural Health Center (RHC); Indian Health Center (IHC)

1.a. Legal name of applicant (must be same name as used for current Medi-Cal provider number)

1.b. Contact person for this application ()	1.c. Contact person's telephone number ()	1.d. Contact person's fax number ()
2.a. Primary service site telephone number ()	2.b. FAX number ()	2.c. E-mail address

3. Primary service site

4. Primary service site address (number, street)	City	County	State	Nine-digit ZIP code
5. Pay to address (number, street)	City	County	State	Nine-digit ZIP code
6. Mailing address (number, street)	City	County	State	Nine-digit ZIP code

7.a. Fictitious Business Name Statement number (attach copy), if applicable	7.b. Effective date	8. Date of birth	9. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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10. Provider type (see Attachment A, Title 22 CCR, Section 51051)	10.a. Board-certified specialty	11. Current Medi-Cal provider number	12.a. License to Provide Health Services effective date (attach copy)	12.b. Expiration date
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13. Federal Employer Identification Number (A copy of IRS Form 941, Form 8109-C, Form SS-4 [Confirmation Notification], or Form 2363 must be submitted with the application) _____	14. Social security number (If Sole Proprietor not using a Tax Identification number, you must disclose this number and attach a copy of the ITIN verification, if _____ Name of Sole Proprietor (last, first, middle) _____
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15. NPI	16. Driver's license number or state-issued identification number (attach legible copy)
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17. List below all service sites, other than the one listed in question 4, at which Family PACT services will be provided. Identify the Medi-Cal provider number and NPI for each site. **List all provider numbers, service sites, and addresses that are applicable under this application.** Please attach a separate sheet of paper for any additional sites and Medi-Cal provider numbers not listed below.

Service site name	Medi-Cal provider number for this site		NPI	
Address (number, street)	City	State	ZIP code	Telephone number ()
Service site name	Medi-Cal provider number for this site		NPI	
Address (number, street)	City	State	ZIP code	Telephone number ()
Service site name	Medi-Cal provider number for this site		NPI	
Address (number, street)	City	State	ZIP code	Telephone number ()
Service site name	Medi-Cal provider number for this site		NPI	
Address (number, street)	City	State	ZIP code	Telephone number ()
Service site name	Medi-Cal provider number for this site		NPI	
Address (number, street)	City	State	ZIP code	Telephone number ()
Service site name	Medi-Cal provider number for this site		NPI	
Address (number, street)	City	State	ZIP code	Telephone number ()
Service site name	Medi-Cal provider number for this site		NPI	
Address (number, street)	City	State	ZIP code	Telephone number ()
Service site name	Medi-Cal provider number for this site		NPI	
Address (number, street)	City	State	ZIP code	Telephone number ()
Service site name	Medi-Cal provider number for this site		NPI	
Address (number, street)	City	State	ZIP code	Telephone number ()

18. Practitioners

Please identify all practitioners (medical doctors, certified nurse midwives, nurse practitioners, physician assistants) who will be providing clinical family planning services under the Family PACT program. You may attach a list with the following information if it is easier than using the format provided below.

SERVICE SITE/ PRACTITIONER'S NAME	PROVIDER TYPE (e.g., M.D., CNM, NP, PA)	CALIFORNIA LICENSE NUMBER	INDIVIDUAL MEDI-CAL PROVIDER NUMBER (IF APPLICABLE)	INDIVIDUAL NPI
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Orientation and Training Session

Applicants are required to attend a Provider Orientation session mandated by the legislation implementing Family PACT before they can participate in the Family PACT program. The original copy of the certificate of attendance must be attached to this Family PACT Application.

I have received, and have on file, a completed Practitioner Agreement from each practitioner identified in the Application. I am duly authorized to commit all service sites, provider numbers, and practitioners specified in this application. I understand that providers who do not provide services consistent with the "Family PACT Standards" for Administrative Practices and Clinical Reproductive Health Services may be permanently disenrolled as a provider from the Family PACT program. I understand that incorrect or inaccurate information may affect my eligibility to participate in the Family PACT program and receive Medi-Cal reimbursement and that I must report changes to the above information to the California Department of Health Care Services, Medi-Cal Provider Enrollment Branch (DHCS-PEB). This includes any change of location or practitioner which must be reported to DHCS-PEB within 35 days of the change. Failure to comply may result in permanent disenrollment from the Family PACT program.

Provider agrees: (a) that compliance with the provisions of this application is a condition precedent to payment to the provider. The parties agree that this application is a legal and binding document and is fully enforceable in a court of competent jurisdiction. The individual provider signing this application or the individual signing the application on behalf of a group understands it and is authorized to execute it; (b) to certify clients for eligibility for the Family PACT program, and recertify on an annual basis, according to certification instructions issued by the California Department of Public Health (CDPH); (c) to cooperate with and participate in the evaluation effort of the Family PACT program determined by CDPH; (d) to make administrative files and billing and medical records pertaining to the Family PACT program available at reasonable times for inspection, auditing, monitoring, or evaluation by state auditors/quality improvement staff for a period of four years from the end of the fiscal year in which the client encounter took place.

I declare under penalty of perjury under the laws of the State of California that the foregoing Application (CDPH 4468), Provider Agreement (CDPH 4469), Practitioner Agreement (CDPH 4470), and Disclosure Statement (CDPH 4471) information is true, accurate, and complete to the best of my knowledge and belief.

19. Type or print name of individual provider signing the application or individual signing the application on behalf of a group	Title of individual signing the application
20. Signature (original blue ink only)	Date

INSTRUCTIONS FOR COMPLETION OF APPLICATION TO PARTICIPATE IN THE FAMILY PACT PROGRAM

1. Legal name means the name under which the applicant or provider is applying for enrollment or continued enrollment. Contact person who is familiar with the application and can be contacted for questions. Contact's telephone number and fax number.
2. Primary service site telephone means the primary business telephone number used at the business location. A beeper number, answering service, pager, facsimile machine, cellular phone, or answering machine is not acceptable. Also include fax number and e-mail address, if available.
3. Primary service site means, if the provider has multiple sites, the site considered the main or headquarters site.
4. Primary service site address means the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code where Family PACT services are determined. A post office box or commercial box is not acceptable.
5. Pay to address means the address to which the applicant wishes to receive payment. The Pay to Address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
6. Mailing address is where the applicant or provider wishes to receive general Family PACT correspondence. General Family PACT correspondence includes Medi-Cal Bulletin Updates and Family PACT Policies, Procedures, and Billing Instructions (P.P.B.I.) updates. Provide, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
7. If the name in number 2 is a Fictitious Business Name, provide the Fictitious Business Name Statement number. Attach a clearly legible recorded-stamped copy of the Fictitious Business Name Statement with the application. If nonapplicable, write "N/A." Provide the effective date of the Fictitious Business Name Statement or Fictitious Name Permit.
8. List the date of birth of the applicant if an individual owner.
9. List the gender of the applicant if an individual owner.
10. Indicate the provider type (see Attachment A list from Title 22, California Code of Regulations, Section 51051).
11. List current Medi-Cal provider number.
12. If individual provider or licensed community clinic, provide the license/certificate number, or other approval to provide health care, of the applicant or provider. Attach a clear legible copy of the license, certification, or approval. List the effective date and expiration date of the license/certificate number, or other approval listed in number 12. If a governmental agency, write "exempt."
13. List the Federal Employer Identification Number issued by the Internal Revenue Service (IRS) under the name of the applicant or provider. Attach a clearly legible copy of the IRS Form 941, Form 8109-C, Form SS-4 (confirmation notification), or Form 2363.
14. If the business is a sole proprietorship not using an Employer Identification Number, provide the social security number of the Sole Proprietor. List the Sole Proprietor's name. Provide a clearly legible copy of the social security card.
15. List National Provider Identifier (NPI).
16. Provide the driver's license or state-issued identification number and state of issuance of the applicant or provider. Attach a clearly legible copy with the application.
17. List all additional service sites at which Family PACT services will be provided.
18. List all practitioners and the service site where they will be providing Family PACT clinical family planning services.
19. Name and title of individual provider signing the application or individual signing on behalf of a group means the first, middle, and last name of individual who is applying to the Department for enrollment or continued enrollment as a provider in the Family PACT program (typed or printed).
20. An original signature, in blue ink, of the individual listed in number 19 is required. Also provide the title of the person signing the application. Include the city, state, and date where and when the application was signed.
21. Complete Attachment B, Identification Card Request Form, and include with mailed application. Failure to complete and mail this form with the application will severely delay receipt of HAP cards.

! Remember to enclose a copy of the following, **if applicable**:

- Driver's license or identification card
- Social security card
- Tax identification number verification
- License, certificate, or other approval
- Fictitious Business Name Statement
- Identification Card Request Form (Attachment B)

Title 22, California Code of Regulations
§ 51051. Provider.

(a) "Provider" means any individual, partnership, provider group association, corporation, institution, or entity, and the officers, director employees, or agents thereof, that provides services, goods, supplies, merchandise, directly or indirectly, to a Medi-Cal beneficiary, that meet the Standards for Participation specified in Article 3 (commencing with Section 51200), and that has been enrolled in the Medi-Cal program.

(b) Providers include, but are not limited to:

Acupuncturists
 Assistive Device and Sick Room Supply Dealers
 Audiologist
 Blood Banks
 Child Health and Disability Prevention Providers
 Chiropractors
 Christian Science Facilities
 Christian Science Practitioners
 Clinical Laboratories or Laboratories
 Comprehensive Perinatal Providers
 Dental School Clinics
 Dentists
 Dispensing Opticians
 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Providers
 EPSDT Supplemental Services Providers
 Fabricating Optical Laboratory
 Hearing Aid Dispensers
 Home Health Agencies Hospices
 Hospital Outpatient Departments
 Hospitals
 Incontinence Medical Supply Dealers
 Intermediate Care Facilities
 Intermediate Care Facilities for the Developmentally Disabled
 Local Educational Agency Providers
 Nurse Anesthetists
 Nurse Midwives
 Nurse Practitioners
 Nurse Facilities
 Occupational Therapists
 Ocularists Optometrists
 Orthotists
 Organized Outpatient Clinics
 Outpatient Heroin Detoxification Providers
 Personal Care Service Providers
 Pharmacies/Pharmacists
 Physical Therapists
 Physicians
 Podiatrists
 Portable X-ray Services
 Prosthetists
 Providers of Medical Transportation
 Psychologists Rehabilitation
 Centers Renal Dialysis Centers and Community Hemodialysis Units
 Respiratory Care Practitioners
 Rural Health Clinics
 Short-Doyle Medi-Cal Providers
 Skilled Nursing Facilities
 Speech Therapists
 Targeted Case Management Providers

FAMILY PACT PROGRAM

HEALTH ACCESS PROGRAMS (HAP)
IDENTIFICATION CARD REQUEST FORM

Under the Family PACT (Planning, Access, Care and Treatment) Program, client eligibility will be determined by the medical provider based upon the information provided by the client under self-certification. The provider will issue a **Health Access Program** (HAP) identification card to the client. The client will use this card for access to other medical providers as well as pharmacies and laboratories.

Individual sites listed on the *Application and Agreement* must order their own cards after the application has been approved. Sites are not allowed to share cards.

This form is for a one-time only order for the first quantity of cards you estimate you will need. For a first time INITIAL ORDER ONLY, please complete the information below and return this form with your *Application and Agreement*. HAP enrollment cards will be issued in blocks of 100. For this initial order, please ONLY order the quantity expected to be used for a six-month period.

Provider name

Street address

City

State

Zip

Medi-Cal provider number

NPI

Provider telephone number

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Number of Health Access Program (HAP) identification cards needed: _____
(Order a six-month supply in blocks of 100.)

Please allow eight weeks for receipt of your order.

**FOR ALL FUTURE ORDERS, CALL THE HEALTH ACCESS
PROGRAMS HOTLINE AT 1-800- 541-5555**

July 2007