SAN FRANCISCO HEALTH PLAN
Here for you

ORGANIZATIONAL PROVIDER CREDENTIALING APPLICATION

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. Accompany this application with the documents listed in the cover letter. **This application must be completed in its entirety, signed and dated; incomplete applications may be returned or nullified.**

SERVICE TYPE		
☐ Primary Care	☐ Specialty Clinic, please specify: _____	
☐ Acupuncture ☐ Ambulatory Surgery Center ☐ CBAS ☐ Dialysis Center ☐ DME and Medical Supplies ☐ Family Planning	☐ Home Health Agency and Hospice Care ☐ Home Infusion ☐ Hospice Care ☐ Laboratory ☐ Medical Imaging / Radiology	☐ Skilled Nursing Facility ☐ Non-Emergency Medical Transportation ☐ Other, please specify _____

CLINIC INFORMATION (Parent Organization / Primary Location)			
Clinic Name		**Year Opened**	
Clinic Address			
Billing Address			
Organization Type	☐ Non-profit Corporation ☐ Professional Corporation ☐ Government entity	☐ Limited Liability Corporation (LLC) ☐ Subsidiary ☐ Other:	
Doing Business As (DBA) If different		Is this a fictitious business name? ☐ Yes ☐ No	
Telephone		**Fax**	
Email		**Web address**	

CLAIMS INFORMATION				
Mode of Claims Submission	☐ 837 / 5010 Direct ☐ Paper (CMS 1500 / UB 04) ☐ 837 / 5010 Via Clearinghouse. Name: _____			
Claims Submitter Contact	Name			
	Phone		Fax	
	Email			

FACILITY LICENSURE INFORMATION

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Type	Number	Expiration Date
NPI		n/a
TIN		
CA State License		
Business License		
DEA		
CMS Certification		

Other Certifications and Accreditations (provide a copy of certification letter)

☐ AAAASF	☐ ACHC	☐ CCAC	☐ COLA	☐ HFAP
☐ AAAHC	☐ AOA	☐ CHAP	☐ DNVNIAHO	☐ IHS
☐ AADE	☐ CARF	☐ CLIA	☐ FDA	☐ TJC

SITE VISIT

1. In the past 36 months, has the facility had an onsite visit by a government agency (e.g. CMS or DHCS)
   ☐ Yes; Date of the visit _____ (answer questions 2)
   ☐ No
2. Were there any deficiencies found during the last full scope survey?
   ☐ Yes (answer questions 2) ☐ No
3. Have all the deficiencies corrected?
   ☐ Yes (answer questions 2)
   ☐ No, please explain:

NOTE: Attach a copy of the most recent onsite survey; if citations were issued, include a copy of the Corrective Action Plan.

ACCESSIBILTY, HOURS OF OPERATION, LANGUAGE

Accessible by Public Transportation	☐ Yes ☐ No		**Block to Nearest Bus Stop**				
Hours of Operation	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**
Open							
Close							
Language Capability	☐ English ☐ Spanish ☐ Chinese ☐ Other ☐ TTY/TDD						

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CLINIC KEY CONTACTS			
Role	**Name and Title**	**Phone**	**Email Address**
CEO			
COO			
Medical Director			
Clinic Manager			
Billing			
Credentialing			
Compliance			

I hereby affirm that the information submitted to San Francisco Health Plan and any addenda hereto is true and complete to the best of my knowledge and furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my Service Agreement.

Signature (Stamp Is Not Acceptable)	**Printed Name and Title**	**Date**

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. Accompany this application with the documents listed in the cover letter. **This application must be completed in its entirety, signed and dated; incomplete applications may be returned or nullified.**

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Complete a separate application for each location for which your organization is contracting.

ADDITIONAL LOCATION			
Clinic Name		**Year Opened**	
Clinic Address			
Telephone		**Fax**	
Email		**Web address**	

Type	Number (if different from primary location)	Expiration Date
NPI		n/a
TIN		
CA State License		
Business License		
DEA		
CMS Certification		

SITE VISIT

4. In the past 36 months, has the facility had an onsite visit by a government agency (e.g. CMS or DHCS)
   ☐ Yes; Date of the visit _____ (answer questions 2)
   ☐ No
5. Were there any deficiencies found during the last full scope survey?
   ☐ Yes (answer questions 2) ☐ No
6. Have all the deficiencies corrected?
   ☐ Yes (answer questions 2)
   ☐ No, please explain:

NOTE: Attach a copy of the most recent onsite survey; if citations were issued, include a copy of the Corrective Action Plan.

ACCESSIBILTY, HOURS OF OPERATION, LANGUAGE

Accessible by Public Transportation	☐ Yes ☐ No	**Block to Nearest Bus Stop**					
Hours of Operation	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**
Open							
Close							
Language Capability	☐ English ☐ Spanish ☐ Chinese ☐ Other ☐ TTY/TDD						

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ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to questions A through K is "yes," or your answer to question N is "no," please provide full details in a separate sheet.

A.	Has any owner or managing employee of this organization, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law related to: (a) the delivery of an item or service under Medicare or State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service?	☐ Yes ☐ No
B.	Has any owner or managing employee of this organization, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law related to the interference with or obstruction of any investigation into any criminal offense described in Title 42 Code of Federal Regulations Section 1001.1001 or 1001.201?	☐ Yes ☐ No
C.	Has any owner or managing employee of this organization, under any current or former name or business identity ever had any felony or misdemeanor convictions, under Federal or State law relating to the unlawful manufacture, distribution, prescription, or dispending of a controlled substance?	☐ Yes ☐ No
D.	For conduct at site(s) submitted in this application, has this organization ever been charged, suspended, fined, disciplined, or otherwise sanctioned, submitted to probationary conditions, restricted or excluded, or has the facility voluntarily relinquished eligibility to provide services or accepted conditions on its 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 any public program, or is any such action pending?	☐ Yes ☐ No
E.	For site(s) submitted in this application, has this organization ever had any other regulatory agency (OSHA, etc.) deny, revoke, suspend, not renew, place under probation, subject to disciplinary action or otherwise limited or curtail operations; or are any actions pending from any other regulatory agency?	☐ Yes ☐ No
F.	Has the facility ever had accreditation by an organization (CLIA, TJC, etc.) involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or has the facility voluntarily relinquished the accreditation in anticipation of any of these actions; or are any of these actions pending with respect to any such accreditation?	☐ Yes ☐ No
G.	Has this organization ever been placed under temporary government-ordered management?	☐ Yes ☐ No
H.	Has this organization ever permitted the appointment of a receiver for its business or its assets?	☐ Yes ☐ No
I.	Do you understand that subject to proper confidentiality restrictions and authorizations, medical records might be subject to on-site review by SFHP representatives for peer review, utilization review, and quality assurance purposes?	☐ Yes ☐ No

I hereby affirm that the information submitted to San Francisco Health Plan and any addenda hereto are true, current, and complete to the best of my knowledge and beliefs, and it is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of the Service Agreement.

Applicant Signature (Stamp Is Not Acceptable)	**Printed Name**	**Date**

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INFORMATION RELEASE / ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and 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 (IPAs), health care service plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims 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 peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state 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 unstayed suspension, revocation or nonrenewal of my license to practice medicine 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, within fourteen (14) 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 practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board 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 served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding any 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 pledge to provide continuous care for my patients.

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 participation agreement.

Photocopy of this document shall be as effective as the original.

Applicant Signature (Stamp Is Not Acceptable)	**Printed Name**	**Date**

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PROVIDER RIGHTS

Right to Review

The provider has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that provider'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 provider 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

Providers may request to be informed of the status of their credentialing/recredentialing application. The provider 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

Providers 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. Providers 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 provider believes that erroneous information has been supplied to Healthcare Organization by primary sources, the provider may correct such information by submitting written notification to the Credentialing Department. Providers 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 provider of a discrepancy or within 24 hours of a provider's review of his/her credentials file.

Upon receipt of notification from the provider, 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 provider's credentials file. The provider 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 provider via certified letter. The provider 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.

Applicant Signature (Stamp Is Not Acceptable)	**Printed Name**	**Date**

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EMPLOYEE LANGUAGE SKILLS SELF-ASSESSMENT TOOL

This self-assessment is intended for clinical and non-clinical employees who are bilingual and communicate with a patient in a language other than English.

Employee Name: _____ Department/Job Title_____

Directions: 1) Write any/all languages or dialects you know. 2) Indicate how fluently you speak, read and/or write each language. (See key below) 3) Specify if you currently use the language regularly as part of your job responsibilities.

Language	Dialect, Region, and/or Country	Fluency (See key attached). Circle			As part of your job do you use this language to speak with patients?	As part of your job do you read this language?	As part of your job do you write this language?
		Speaking	Reading	Writing			
1.		N/A	N/A	N/A	Yes ◯ No ◉	Yes ◯ No ◉	Yes ◯ No ◉
2.		N/A	N/A	N/A	Yes ◯ No ◉	Yes ◯ No ◉	Yes ◯ No ◉
3.		N/A	N/A	N/A	Yes ◯ No ◉	Yes ◯ No ◉	Yes ◯ No ◉
4.		N/A	N/A	N/A	Yes ◯ No ◉	Yes ◯ No ◉	Yes ◯ No ◉

Please check off additional qualifications/credentials that support language proficiency level, and attach them to this form. Note: Per state guideline, bilingual providers and staff who communicate with patients in a language other than English must identify and maintain qualifications of their bilingual capabilities on file.

- ☐ Formal language assessment by qualified agency
- ☐ Native speaker with a higher education in language, which demonstrates sufficient accuracy and vocabulary in health care setting.
- ☐ Documentation of successful completion of a specific type of interpreter training
- ☐ Documentation of years employed as an interpreter and/or translator
- ☐ Other (Please specify):

Individuals, who rate themselves with speaking, reading, or writing capabilities below level 3 as defined on the Employee Skills Self-Assessment Key, should not use their bilingual skills or serve as interpreters and/or translators. For assistance, please contact the patient's contracted health plan for immediate telephonic interpreter assistance.

TO BE SIGNED BY THE PERSON COMPLETING THIS FORM

I, _____, attest that the information provided above is accurate.

Date: _____

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Employee Language Skills Self-Assessment Key

Key	Spoken Language
1	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry-level questions. May require slow speech and repetition.
2	Meets basic conversational needs. Able to understand and respond to simple questions casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.
3	Able to speak the language with sufficient accuracy and vocabulary to have effective for informal conversations on most familiar topics related to health care.
4	Able to use the language fluently and accurately on all levels related to health care work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.
5	Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language, including health care topics, such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural preferences. Usually has received formal education in target language.

Key	Reading
1	No functional ability to read. Able to understand and read only a few key words.
2	Limited to simple vocabulary and sentence structure.
3	Understands conventional topics, non-technical terms and heath care terms.
4	Understands materials that contain idioms and specialized health care terminology; understands a broad range of literature.
5	Understands sophisticated materials, including those related to academic, medical and technical vocabulary.

Key	Writing
1	No functional ability to write the language and is only able to write single elementary words.
2	Able to write simple sentences. Requires major editing.
3	Writes on conventional and simple health care topics with few errors in spelling and structure.
4	Writes on academic, technical, and most health care and medical topics with few errors in structure and spelling.
5	Writes proficiently equivalent to that of an educated native speaker/writer. Writes with idiomatic ease of expression and feeling for the style of language. Proficient in medical, healthcare, academic and technical vocabulary.

Interpretation VS. Translation	**Interpretation:** Involves spoken communication between two parties, such as between a patient and a pharmacist, or between a family member and doctor. **Translation:** Involves very different skills from interpretation. A translator takes a written document in one language and changes it into a document in another language, preserving the tone and meaning of the original. *Source: University of Washington Center*

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Managed Care Provider Enrollment Disclosure

Background

Beginning January 1, 2018, federal law requires that all managed care network providers must enroll in the Medi-Cal Program if they wish to provide services to Medi-Cal managed care beneficiaries. Managed care providers have two options for enrolling with the Medi-Cal Program. Providers may enroll through (A) a Managed Care Plan (MCP); or (B) DHCS. If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with MCPs. If the provider enrolls through an MCP, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to fee-for-service (FFS) providers will also apply to the enrollment process for managed care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements - the "Plan Provider Agreement" and the "DHCS Provider Enrollment Agreement." The Plan Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The DHCS Provider Enrollment Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. Enrollment through an MCP. The following provides an overview of the MCP enrollment process:

- The provider will submit a provider enrollment application to the MCP using a process developed by the MCP.
- As part of the application process, the provider will be required to agree that DHCS and the MCP may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The MCP will be responsible for gathering all necessary documents and information associated with the MCP application.
- The provider should direct any questions it has regarding its MCP application to the MCP.
- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with the MCP.
- While the MCP enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment application may differ. In addition, MCPs will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.
- Providers will not have the right to appeal an MCP's decision to cease the enrollment process.
- The MCP will complete the enrollment process within 120 days of the provider's submission of its application. During this time, the provider may participate in the MCP's network for up to 120 days, pending approval from the MCP.
- Once the enrolling MCP places a provider on the Enrolled Provider List, the provider is eligible to contract with all MCPs. However, an MCP is not required to contract with an enrolled provider.
- Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.

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- Accordingly, if the MCP receives any information that impacts the provider's enrollment, the MCP will suspend processing the provider's enrollment application and refer the provider to DHCS' FFS Provider Enrollment Division (PED) for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

B. Enrollment through DHCS.

- The provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program. (See http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx)
- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for managed care providers.
- Upon successful enrollment through DHCS, the provider will be eligible to contract with MCPs and provide services to FFS beneficiaries.

There may be other important aspects of the enrollment process that are not set forth in this information bulletin. Please check the DHCS website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.