RESOLUTION No. 19-048

OF THE BOARD OF SUPERVISORS OF THE COUNTY OF NEVADA

RESOLUTION AUTHORIZING THE COUNTY PUBLIC HEALTH DIRECTOR TO SIGN AND SUBMIT THE FAMILY PACT PROVIDER APPLICATION TO THE STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY TO ALLOW CONTINUED PARTICPATION IN THE FAMILY PACT PROGRAM

WHEREAS, The Department of Health Care Services (DHCS), Office of Family Planning (OFP) is recertifying providers for continued participation in the Family Planning, Access, Care and Treatment (Family PACT) Program; and

WHEREAS, The Nevada County Department of Public Health desires to continue to participate as a Family Pact Program Provider; and

WHEREAS, to continue as an eligible Family PACT Program Provider, the County Department of Public Health must submit a completed Family PACT Provider recertification Application.

NOW, THEREFORE, BE IT HEREBY RESOLVED by the Board of Supervisors of the County of Nevada, State of California, that Jill Blake on behalf of the Public Health Department, be and hereby is authorized to sign and submit the Family PACT Provider Application, including any amendments thereto, or other documents that may be required to complete the application and enrollment in the Family PACT Program.

PASSED AND ADOPTED by the Board of Supervisors of the County of Nevada at a regular meeting of said Board, held on the 12th day of February, 2019, by the following vote of said Board:

Ayes: Supervisors Heidi Hall, Edward Scofield, Dan Miller, Susan K. Hoek and Richard Anderson

Noes: None.

Absent: None.

Abstain: None.

ATTEST:

JULIE PATTERSON HUNTER
Clerk of the Board of Supervisors

By:

Richard Anderson, Chair

2/12/19 cc: PH*
AC*

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

January 4, 2019

OFP ID# 250.97

COUNTY OF NEVADA
500 CRWON POINT CIR CTE 110
GRASS VALLEY, CA 95945

Subject: FAMILY PACT RECERTIFICATION
COUNTY OF NEVADA
500 CRWON POINT CIR CTE 110
GRASS VALLEY, CA 95945
NPI: 1700959863

Dear Family PACT Provider:

This letter provides written notice that the Department of Health Care Services (DHCS), Office of Family Planning (OFP) is certifying providers for continued participation in the Family Planning, Access, Care and Treatment (Family PACT) Program. For continued participation in the Family PACT Program, the provider must apply for recertification by submitting a completed Family PACT Provider Application (DHCS 4468, revised 12/18) within 30 days of the date of this notice.

Beginning February 1, 2018, each provider site is assigned a unique OFP ID for identification purposes. The above-noted Family PACT service site's OFP ID is 250.97. This number should be used for all Family PACT inquiries.

Family PACT providers applying for recertification will be provisionally certified for re-enrollment in the Family PACT Program until an eligible representative completes the legislatively mandated Provider Orientation per *Welfare and Institutions Code* (W&I Code), Section (§) 24005(k). Providers must complete all required trainings within six months from the recertification approval date for the provisional certification to be lifted. Failure to complete the Provider Orientation trainings within six months will result in disenrollment. The required Family PACT Provider Orientation trainings can be found online at: http://www.familypact.org/Providers/provider-training-page.

Nevada County Public Health

JAN 07 2019

RECEIVED

The Family PACT Provider Application packet can be found online at: www.FamilyPACT.org. Please submit a completed Family PACT Provider Application packet and **return within 30 days** of this notice to the address below.

Email: ProviderServices@dhcs.ca.gov

Mail: Department of Health Care Services
Office of Family Planning
P.O. Box 997413, MS 8400
Sacramento, CA 95899-7413

If you have any questions or require additional information, please contact the Office of Family Planning at (916) 650-0414 ext. 3.

Sincerely,

Office of Family Planning

Nevada County Public Health

JAN 07 2019

RECEIVED

INSTRUCTIONS FOR COMPLETING OF THE FAMILY PACT PROVIDER APPLICATION (DHCS 4468)

DO NOT USE staples on this form or on any attachments.

DO NOT USE correction tape, white out, or highlighter pen on this form. If you must make corrections, please line through, date, and initial in ink.

DO NOT LEAVE any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Omission of any information or documentation on this form or failure to sign any of the required documents may result in a denial of the provider's application.

Submit one application packet for each service site.

The information on the application forms must match the information on file with the DHCSPED.

Original signatures are required. Please use blue ink only.

This form is part of an application for enrollment or continued enrollment as a provider in the Family PACT Program. Applicants may be subject to an on-site inspection and to unannounced visits prior to enrollment or approval for continued enrollment in the program. In addition to this form and requested documentation, a Family PACT Provider Agreement (DHCS 4469) and Family PACT Practitioner Participation Agreement (DHCS 4470) must also be completed for enrollment or continued enrollment. The DHCS 4470 is not required to be completed by an APCC, nonprofit community clinic or PCC, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Services (IHS). Additional information can be found on the Family PACT website (www.familypact.org) by clicking the "Providers" tab, followed by "Provider Enrollment".

Important:

Read all instructions and gather the following documents to submit with the application. Please remember to include a legible copy of the following with your application packet.

- IRS issued Taxpayer Identification Number (TIN)
- License to provide health services
- Fictitious Business Name Statement, if applicable
- Driver's license or state issued identification card of individual signing the application
- Additional documentation requested by DHCS.

National Provider Identifier (NPI)—enter the NPI of the primary service site.

Date – enter the date you are completing the application.

Enrollment Action Requested—check all actions that apply.

"New Provider"—check if the provider is not currently enrolled in the Family PACT Program as a provider with an active provider number.

"Recertification"— Do not check this box unless you have received notification from the Department to apply for continued enrollment in the Family PACT Program.

"Change of service site address"—check if the provider is currently enrolled in the Family PACT Program and is requesting to relocate to a new business address and vacate the old location.

"New Taxpayer ID number"—check if a new Taxpayer Identification Number (TIN) was issued by the IRS. Indicate new TIN number and attach a legible copy of the IRS form 941, Form 8109-c, Letter 147-C, Form 2363, Form SS-4 or Exempt Form 1023.

"Change of ownership"—check if there is a change of ownership as defined in CCR, Title 22, Section 51000.6. Indicate the effective date in the space provided.

"Previous Family PACT Provider"-Were you previously enrolled into the Family PACT Program? If yes, provide your NPI.

"Medi-Cal Enrollment Status"—check if the site is currently enrolled in the Medi-Cal program. Indicate the application enrollment status, as applicable.

"Type of entity"—check the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, you must attach a legible copy of the partnership agreement. If you check "other", list the type of legal entity.

1. **"Service Site Legal Name"** the service site name listed with the Internal Revenue Service (IRS).
2. **"Service Site Business Name"** the service site business name (i.e. fictitious name if applicable).
3. **"Service Site Telephone Number"** is the primary service site telephone number used at the service location. A cell phone, answering service, facsimile machine, biller or billing service, or answering machine shall not be used as the primary service site telephone number.
4. **"Service Site Email Address"** is the primary service site email used at the service location.
5. **"Service Site Fax Number"** is the primary service site fax used at the primary service location.
6. **"Fictitious Business Name"**— check if the business name is fictitious. If this is a fictitious business name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit to the application. If non-applicable, write "N/A".
7. **"Service Site Address"** is the address, including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code where services are rendered. A post office or commercial box is not acceptable. The address must match the address submitted to Medi-Cal for enrollment.
8. **"Pay-to-Address"** is the address at which the provider 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. The address must match the address submitted to Medi-Cal for enrollment.
9. **"Mailing Address"** is the address at which the provider wishes to receive general DHCS correspondence. The mailing 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. The address must match the address submitted to Medi-Cal for enrollment.
10. "**License Number"** enter the license/certificate number, or other approval to provide health care services at the service site. If you are a licensed clinic, attach a legible copy of the license or certificate, issued by California Department of Public Health. If you are a physician, attach a legible copy of the license or certificate issues by the California Department of Consumers Affairs/Medical Board of California. Enter the effective date and the expiration date of the license/certificate number. If you are a government entity, write "Exempt".

11. "**Taxpayer Identification Number (TIN)**"enter the TIN issued by the IRS. Attach a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, Form 2363, Form SS-4, or Exemption Form 1023..
12. "**Social Security Number (SSN)**" if the business is a sole proprietorship not using a TIN, provide the social security number of the sole proprietor.
13. **"Ownership Interest and/or Managing Control Information (Entities)"**— list all corporations, unincorporated associations, partnerships, or similar entities having 5% or more (direct or indirect) ownership or control interest, or **any** partnership interest, in the applicant/provider identified in number 1.
14. **"Site Certifier"** – each service site location must designate one eligible representative to be a site certifier. The site certifier is responsible for overseeing family planning services at the location to be enrolled. A Medical Director, MD, CNP, or CNM is eligible to certify a site. The site certifier cannot certify multiple sites.
15. **"Sublease"** – if applicant subleases the location where services are being rendered or provided, attach a copy of all sublease agreements. Agreements must include sublessor and sublessee name, address, telephone number, and terms and conditions.
16. **"Practitioners"** are MDs, CNP, CNM, and Non-Physician Medical Practitioners who are enrolled in Medi-Cal and will provide clinical family planning services under the Family PACT Program. Enter the practitioner name, professional license number, individual NPI and indicate whether or not the person is trained in providing Long Acting Reversible Contraceptives (LARC).

Information about the individual signing this application.

17. **"Print Name of Person Signing the Application"**—print the last, first, and middle name of the person who is signing the application. The application must be signed by a person who is authorized to legally bind the provider.
18. "**Driver's License**" - enter the driver's license or state-issued identification number and state of issuance of the individual named in number 17. Attach a legible copy to the application.
19. **"Date of Birth"** - enter the date of birth of the individual named in number 17.
20. **"Social Security Number"** - enter the social security number of the individual named in number 17.
21. **"Penalty of Perjury"** - an original signature and title of the individual named in number 17 is required. Include the city, state, and the date where the application was signed.
22. **"Contact Person's Information"** - enter the last, first, and middle name, title, e-mail address, and telephone number of the individual who can be contacted by DHCS to answer questions regarding the application package. Failure to include this information may result in the application package being returned deficient for item(s) that a provider can readily provide by email, fax or telephone.

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

This information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your application being delayed or not processed.

FOR STATE USE ONLY

OFP ID#: ___________

FAMILY PACT PROVIDER APPLICATION

Please indicate if this is a new application or corrections to a previously submitted application.

NEW APPLICATION ■ CORRECTED APPLICATION ☐

National Provider Identifier (NPI) [ ] Date [ ]

Enrollment action requested **(check all that apply)**

☐ New provider
☐ Recertification
☐ Change of service site address
☐ New Tax Payer ID number (TIN)
☐ Change of ownership
Indicate effective date [ ]

Have you ever been a Family PACT Provider? Yes ■ No ☐

If yes, what was your previous NPI? [ ]

Medi-Cal Enrollment Status

☐ I am currently enrolled in the Medi-Cal program at this service site address under this legal name.
☐ I am not currently enrolled in the Medi-Cal program.
■ I have a pending Medi-Cal application. **Date Application sent:** [ ]

Type of Entity (check one)

■ Sole Proprietor
☐ Group Provider
☐ Rural Health Clinic (RHC)
Other [ ]
☐ Government entity
☐ Licensed Community/Free Clinic
☐ Federally Qualified Health Center (FQHC)

1. Service Site Legal Name (as listed with the IRS)

[ ]

2. Service Site Business Name	3. Service Site Telephone Number
4. Service Site Email Address	**5. Service Site FAX Number**

6. Is this a fictitious business name? ☒ Yes ☐ No	If yes, list the fictitious business name statement/permit number (attach legible copy)		Permit Effective Date
	Fictitious name	Permit number	

7. Service Site Address (number, street)	City	County	State	Nine-digit ZIP code

8. Pay to Address (number, street, P.O. Box number)	City	County	State	Nine-digit ZIP code

9. Mailing Address (number, street, P.O. Box number)	City	County	State	Nine-digit ZIP code

10. License number to provide health care services (attach a legible copy)	License effective date	License expiration date

11. Taxpayer Identification Number (TIN issued by the IRS (attach a legible copy of the IRS form)	12. Social Security Number (SSN). If sole proprietor not using TIN, you must disclose this number.

13. Ownership Interest and/or Managing Control Information (Entity)

If this section does not apply, draw a line through all fields or N/A.

Entity Legal Business Name	Percentage of Ownership or Control	NPI Number (If Applicable)
	0%	

Entity Legal Business Name	Percentage of Ownership or Control	NPI Number (If Applicable)
	0%	

14. Site Certifier: Each service site location must designate one eligible representative to be a site certifier. The site certifier is responsible for overseeing family planning services at the location to be enrolled. A Medical Director, MD, CNP, or CNM is eligible to certify a site. The site certifier cannot certify multiple sites.

Site Certifier Name	Site Certifier Individual NPI	Professional License Number

15. Does the provider sublease the service site where services are rendered? ■ Yes ☐ No
If yes, include a copy of all sublease agreements. Agreements must include sublessor and sublessee name, address, telephone number, terms of sublease and amount of sublease.

16. Practitioners: MDs, CNPs, CNM, and NMPs who are enrolled in Medi-Cal and will provide clinical family planning services under the Family PACT Program. Enter the practitioner name, professional license number, individual NPI and indicate whether the person is trained in providing Long-Acting Reversible Contraception (LARC). Effective June 1, 2019, each provider site enrolling into the Family PACT Program must identify, at a minimum, one practitioner trained to provide LARC services on-site. Please attach a separate legible sheet of paper listing any additional practitioners not reported below.

Practitioner Name	Individual NPI	Professional License Number	LARC Trained
			■ Yes ☐ No
Practitioner Name	Individual NPI	Professional License Number	LARC Trained
			■ Yes ☐ No
Practitioner Name	Individual NPI	Professional License Number	LARC Trained
			■ Yes ☐ No
Practitioner Name	Individual NPI	Professional License Number	LARC Trained
			■ Yes ☐ No

Information about the Individual Signing this Application

17. Print name of person signing the application on behalf of the provider, who is authorized to legally bind the provider.

Last ______ **First** ______ **Middle** ______

18. Driver's license or state-issued identification number and state of issuance, of individual named in number 17. (attach legible copy)	19. Date of Birth of individual named in number 17.	20. Social Security Number of individual named in number 17.

21. **I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider pursuant to CCR, Title 22, Section 51000.30(a)(2)(B).**

Signature of person signing the application on behalf of the provider. Signature of the individual named in number 17.	Title of individual named in number 17.

Executed at: ______ (City) ______ (State) on ______ (Date)

22 Contact Person's Information:

Enter the last, first, and middle name/initial, title, e-mail address and telephone number of the individual who can be contacted by DHCS to answer questions regarding the application packet. Failure to include this information may result in the application packet being returned deficient for item(s) that a provider may be able to provide by email, fax or telephone.

Last Name	First Name	Middle Name/Initial
Title/Position	E-mail address	Telephone number

If you need assistance with completing this application, please contact the Family PACT program at (916) 650-0414 or by email at ProviderServices@dhcs.ca.gov.