## MATERNAL AND CHILD HEALTH BRANCH

# APPLICATION FOR CERTIFICATION AS A COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP) PROVIDER

***For Official Use Only***

Local Agency Control Number__________________ Date Received ____________

State Control Number ________________________ Date Received ____________

Please read all the attached materials thoroughly before completing this form and retain a copy for your records. Please type or print in black ink. When completed, the original application form should be mailed with one copy to your local Comprehensive Perinatal Services Program Coordinator.

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|---|---|---|---|---|---|
| 1. **Name of Applicant** (Name must be the same name used for current Medi-Cal provider number.) | | | | Telephone Number<br>( ) | |
| **Other Name** (if any used for provider services) | | | | Fax Number<br>( ) | |
| **Service Address** (number/street) | | | **Billing Address** (number/street) | | |
| City | State | ZIP Code | City | State | ZIP Code |
| **Contact Person** | Telephone Number<br>( ) | | **Contact Person** | Telephone Number<br>( ) | |
| **E-mail Address** | | | **E-mail Address** | | |

2. **Please check provider type which applies to this application. The CPSP provider must be a:**

- ❒ General practice physician
- ❒ Family practice physician
- ❒ Family nurse practitioner
- ❒ Obstetrician/gynecologist
- ❒ Pediatric nurse practitioner
- ❒ Pediatrician
- ❒ Preferred provider organization
- ❒ Clinic
- ❒ Hospital
- ❒ Alternative birthing center
- ❒ Certified nurse midwife
- ❒ Group (any one of whose members is general or family practice, OB/GYN, or pediatrician)

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| 3. **Are you a current Medi-Cal provider?**<br>❒ Yes ❒ No **If no, do not complete the rest of this form. Contact your local CPSP coordinator.** | Current Medi-Cal provider number for application* |

* Current Medi-Cal provider number to be used by the applicant at the service address. Separate applications must be completed for each site that has a separate Medi-Cal provider number. If you are applying as an alternative birthing center, please contact your local CPSP coordinator for special instructions.

4. **Comprehensive Perinatal Services Practitioners:**

*** Practitioner Types**

| | | | |
|---|---|---|---|
| Physician | (MD) | Marriage and Family Therapist | (MFT) |
| Certified Nurse Midwife | (CNM) | Health Educator | (HE) |
| Registered Nurse | (RN) | Childbirth Educator | (CE) |
| Nurse Practitioner | (NP) | Dietitian/Registered | (RD) |
| Physician Assistant | (PA) | Comprehensive Perinatal Health Worker | (CPHW) |
| Social Worker | (SW) | Licensed Vocational Nurse | (LVN) |

**** Years of Experience**

For MD, CNM, RN, NP, PA, SW, MFCC, HE, LVN—Years of experience in Maternal and Child Health.
For CE, CPHW—Years of experience in perinatal care.
For RD/RDE—Years of experience in perinatal nutrition.

Please identify all program practitioners who will be providing Comprehensive Perinatal Services (Obstetric and Support Services).
If any services are provided at site(s) different from service address specified on page 1, please indicate location and services.

**Practitioners:**

| Last Name / Location | First | Middle Initial | *Type or Specialty | CA License, Certificate, Registration Number | Expr. Date of Lic., Cert., or Reg. No. MM/DD/YY | Year Graduated Degree and Institution/Univ. | Medi-Cal Rendering Provider Number | **Years of Experience | Obstetrics (applies to Physician, CNM, NP, PA) | Supervision | Back-up | Client Orientation | Health Education | Nutrition | Psychosocial | Case Coordination | Consultant | Protocol Approval |
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If additional space is required to list all program practitioners, please duplicate and use this page.

5. **Please indicate to what extent the applicant or staff have received state-approved training in the provision of the Comprehensive Peritatal Services Program:**

Staff person(s): ____________________ Date: ____________________ Location of training: ____________________

If you have not yet participated in such training, indicate whom and when you **intend** to: ____________________

____________________

6. **Please attach and label the following requested documents in the order they are described:**

   I. **Prenatal Medical Record form(s):** Attach a blank sample prenatal medical records form(s).

   II. **Individualized Care Plan:** Includes obstetric, nutrition, psychosocial, and health education components.

   III. **Nutrition, Psychosocial, and Health Education Assessment Tools:** Nutrition, psychosocial, and health education documents for initial assessment, trimester, reassessments, and postpartum assessments.

   IV. **General Description of Practice:** A description as to how the practice, clinic, and/or organization will provide CPSP services for the obstetric, nutrition, psychosocial, and health education components.

   V. **Delivery Hospitals:** The name(s) and address(es) of the hospital(s) at which deliveries are planned to take place.

   VI. **Referral Services:** The names and addresses of the persons and agencies to whom you will refer for OB and non-OB care; well-child pediatric care (e.g., CHDP); family planning services, Supplemental Nutrition Program for Women, Infants, and Children (WIC) services; genetic services; and dental services.

   VII. **Antepartum/Intrapartum/Postpartum Agreements:** If a person or entity other than the applicant will be responsible for performing and for billing, antepartum and/or intrapartum and/or postpartum obstetrical care, the applicant must attach a written agreement(s) to this application. The agreement(s) must describe the relationship and specific responsibilities of the applicant and the obstetric care provider(s), including the flow of patient services and patient information between all providers. It should include, as well, the name(s) of the delivery hospital(s) where obstetric provider has privileges, how emergency services will be provided, and billing responsibilities.

7. **Please give approximate number of total deliveries ____________ and Medi-Cal deliveries ____________ by the applicant for the last 12 months.**
Please furnish any other information that you feel would help evaluate your application to become approved as a Comprehensive Perinatal Service Program provider in the Department of Health Services' Medi-Cal program.

____________________

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I certify under penalty of perjury that the above information is true, accurate, and complete to the best of my knowledge. I understand that incorrect or inaccurate information may affect my eligibililty to receive Medi-Cal reimbursement and that I must report changes to the above information to the local CPSP coordinator.

____________________
Authorized agent's name (please print or type)

____________________
Title (please print or type)

➤ ____________________
Authorized agent's original signature

____________________
Date

*All information submitted with this application will be part of a file that is open for public inspection pursuant to the California Public Records Act, Government Code, Section 6250 ET SEQ.*

## *FOR OFFICIAL USE ONLY*

**Actions taken on application:**

- ❒ Returned for additional information ________ Initial ________ Date
- ❒ Application resubmitted ________ Initial ________ Date
- ❒ Returned for additional information ________ Initial ________ Date
- ❒ Application resubmitted ________ Initial ________ Date

**Recommended disposition to DHS:**

❒ To approve ❒ Not to approve

Signature: ➤ ____________________ Date: ____________

Title: ____________________

Local agency: ____________________

❒ Attach Local Agency Review Checklist (CPP 3)