

**COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)  
APPLICATION REVIEW CHECKLIST  
PSC to Submit with Application to Participate in CPSP (CDPH 4448)**

Date: \_\_\_\_\_

Local Agency Reviewer: \_\_\_\_\_

Local Agency Name: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

Doing Business As (DBA): \_\_\_\_\_

NPI: \_\_\_\_\_

- \* Use the checklist below to ensure that all sections of the CDPH 4448 are completed.
- \* Keep the original application and all attachments at the LHJ.
- \* For guidance, refer to the [MCAH Policies and Procedures](http://www.cdph.ca.gov/cpsp) manual on the CPSP website at [www.cdph.ca.gov/cpsp](http://www.cdph.ca.gov/cpsp).

YES	NO	SECTIONS 1-3: MEDICAL PROVIDER TYPE; PROVIDER INFORMATION; SUPERVISION
		One category has been checked for provider type
		Name and DBA of applicant have been verified with Provider Master File (PMF) database
		NPI listed for applicant (name associated with NPI matches legal name of applicant)
		Service, Pay-To, and Mailing addresses identified and match PMF
		Contact person name, phone number and email address
		Supervising physician, email, and license number entered
YES	NO	SECTION 4: CPSP PRACTITIONERS
		<ul style="list-style-type: none"> <li>• The type of practitioner/specialty is identified and is limited to those listed on the application (use only abbreviations listed)</li> </ul>
		<ul style="list-style-type: none"> <li>• Physician listed for protocol approval</li> </ul>
		<ul style="list-style-type: none"> <li>• A license, registration, or certificate number is entered for all MD, CNM, NP, PA, LVN, RD, RN (or other licensed practitioners)</li> </ul>
		<ul style="list-style-type: none"> <li>• Licenses or certificates for all practitioners (as applicable) are verified and current; License/certificate expiration does not precede the date of the application</li> </ul>
		<ul style="list-style-type: none"> <li>• School, degree, and year of graduation are identified for each practitioner and corresponds to practitioner type listed</li> </ul>
		<ul style="list-style-type: none"> <li>• High school name and year of graduation is listed for each Comprehensive Perinatal Health Worker (CPHW)</li> </ul>
		<ul style="list-style-type: none"> <li>• Each program function listed in #4(D) must have at least one box checked: OB, Backup*, Client Orientation, Health Education, Nutrition, Psychosocial, Case Coordination, Consultation**, and Protocol Approval. * Not required if using a hospitalist or laborist ** Not required if using previously approved protocols</li> </ul>
		<ul style="list-style-type: none"> <li>• CPHWs are not providing obstetrical or consultation services</li> </ul>
		<ul style="list-style-type: none"> <li>• Years of experience meet minimum requirements</li> </ul>

YES	NO	SECTION 5: PROTOCOLS
		<ul style="list-style-type: none"> <li>Only if developing new protocols: qualified individuals are identified to approve nutrition, psychosocial, and health education protocols</li> </ul>
		<ul style="list-style-type: none"> <li>Only if using previously approved template protocols:</li> </ul>
		1. Protocols ≤ 5 years old
		2. Name of protocol (county/clinic) and year developed or most recent update
		3. Name of person responsible for customizing protocols
YES	NO	SECTION 6: CPSP PROVIDER OVERVIEW TRAINING
		<ul style="list-style-type: none"> <li>Applicant has completed CPSP Provider Overview training, or has indicated they will participate in a future training</li> </ul>
YES	NO	SECTION 7: ATTACHMENTS
		<ul style="list-style-type: none"> <li>Prenatal Medical Record Form</li> </ul>
		<ul style="list-style-type: none"> <li>Nutrition, Psychosocial and Health Education assessment tools that are approved and reflect requirements (see the MCAH Policies and Procedures, CPSP section)</li> </ul>
		<ul style="list-style-type: none"> <li>Individualized Care Plan (ICP) - strengths, risk conditions, prioritization of needs, proposed interventions including methods, timeframes, and outcome objectives, proposed referrals, and staff persons' respective responsibilities based on the results of assessments</li> </ul>
		<ul style="list-style-type: none"> <li>General Description of Practice- description of how the practice, clinic, and/or organization will provide CPSP services for the obstetric, nutrition, psychosocial, and health education components as well as high-risk patient and emergency care</li> </ul>
		<ul style="list-style-type: none"> <li>Delivery Hospital(s) - The name(s) and address(es) of the hospital(s) at which deliveries are planned to take place; delivery physician(s) have privileges.</li> </ul>
		<ul style="list-style-type: none"> <li>Referral Services – Include names, addresses, and phone numbers</li> </ul>
		➤ OB care
		➤ Non-OB care
		➤ Well-child pediatric care (e.g. CHDP)
		➤ Family planning services (e.g. Family PACT)
		➤ WIC
		➤ Genetic services
		➤ Dental services
		<ul style="list-style-type: none"> <li>If applicable, the Intrapartum Agreement meets guidelines (as described in the Policies and Procedures Manual)</li> </ul>
		<ul style="list-style-type: none"> <li>If applicable, the Antepartum/Postpartum Agreement meets guidelines (as described in the Policies and Procedures Manual)</li> </ul>
		<ul style="list-style-type: none"> <li>If applicable, the Dual Provider Agreement meets guidelines (as described in the Policies and Procedures Manual)</li> </ul>
		<ul style="list-style-type: none"> <li>Application signed and dated by authorized agent</li> </ul>
		<ul style="list-style-type: none"> <li>Before the application is forwarded to the state, the coordinator signs, dates and makes a recommendation for disposition</li> </ul>
YES	NO	SECTION 8: DELIVERIES
		<ul style="list-style-type: none"> <li>Total number of deliveries and Medi-Cal deliveries in the past 12 months</li> </ul>
YES	NO	SECTION 9: AUTHORIZATION
		<ul style="list-style-type: none"> <li>Application signed by applicant or appropriate authorized agent</li> </ul>