



Maternal, Child and Adolescent Health Division

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

<i>For Official Use only</i>	
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 form should be mailed with one copy to your local CPSP Perinatal Services Coordinator (PSC).

1. Name of Applicant (Legal name must be the same name used for Federal Internal Revenue Service Tax Identification):			Telephone Number: ()		
Other Name (Business name used for provider services):			Fax Number: ()		
Service Address (Number/Street):			Billing Address (Number/Street):		
City:	State:	9 digit Zip Code:	City:	State:	9 digit Zip Code:
Contact Person:		Telephone Number: ()	Contact Person:		Telephone Number: ()
E-mail Address :			E-mail Address:		

2. Please check applicant's provider type below. The CPSP provider must be a:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Obstetrician/Gynecologist (OB/GYN) | <input type="checkbox"/> Family Nurse Practitioner | <input type="checkbox"/> Preferred Provider Organization | <input type="checkbox"/> Alternative Birthing Center |
| <input type="checkbox"/> Family Practice Physician | <input type="checkbox"/> Certified Nurse Midwife | <input type="checkbox"/> Clinic | <input type="checkbox"/> Group (At least one is: Family Practice, OB/GYN or Pediatrician) |
| <input type="checkbox"/> General Practice Physician | <input type="checkbox"/> Pediatrician | <input type="checkbox"/> Hospital | <input type="checkbox"/> Pediatric Nurse Practitioner |

3. Are You A Current Medi-Cal Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, do not complete the rest of this form. Contact your local CPSP coordinator.	National Provider Identifier (NPI)*
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5. Please indicate if the provider or staff has received state-sponsored Provider Overview and Steps to Take training in the provision of CPSP services:

Name: _____ Completion Date: _____

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

*Use additional pages as necessary for each person.

6. Please attach and label the following requested documents in the order they are described (Please note: all documents below will be kept on file at the local Perinatal Services Coordinator's office):

- I. Prenatal Medical Record Form(s):** Attach a 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. In your description, please include high risk and emergency patient care.
- V. List of Delivery Hospitals:** The name(s) and address(es) of the hospital(s) at which deliveries are planned to take place.
- VI. List of 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 providing and billing services for antepartum, 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 providers(s), including the flow of patient services and patient information between all providers. It should include 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 by the applicant in the last 12 months; of the total, how many were Medi-Cal deliveries.

Please furnish any other information that you feel would help evaluate your application to become approved as a CPSP provider.

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 eligibility to receive enhanced Medi-Cal reimbursement for CPSP services and that I must report changes to the above information to the local CPSP coordinator.

_____ Applicant or authorized agent's name (please print or type)	_____ Title (please print or type)
> _____ Applicant or 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.

Actions taken on application:

<input type="checkbox"/> Returned for additional information	_____	_____
	Initial	Date
<input type="checkbox"/> Application resubmitted	_____	_____
	Initial	Date
<input type="checkbox"/> Returned for additional information	_____	_____
	Initial	Date
<input type="checkbox"/> Application resubmitted	_____	_____
	Initial	Date

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CPSP PSC's recommendation to CDPH:

Approve Not approve

Signature: > _____ Date: _____

Title: _____

Local agency: _____

Attach Local Agency Review Checklist (CPP 3)