APPLICATION TO PARTICIPATE IN THE FAMILY PACT (FAMILY PLANNING, ACCESS, CARE AND TREATMENT) PROGRAM (§ 24005, Welfare and Institutions Code)

IMPORTANT:

- Applicant must be an enrolled Medi-Cal provider in good standing.
- Read all attached materials before completing.
- Type or print clearly in ink.
- An original signature in any color other than black is required on page 4.

Return completed form to: Department of Health Care Services
Office of Family Planning
Family PACT Provider Enrollment
1615 Capitol Avenue, MS 8400
P.O. Box 997413
Sacramento, CA 95899-7413

Enrollment Action Requested:

☐ Initial Application
☐ Additional site address
☐ Update Current National Provider Identifier (NPI): _____

Family PACT Provider Type:

☐ Sole proprietor ☐ Group provider ☐ Government entity
☐ Licensed Community/Free Clinic
☐ Federally Qualified Health Center (FQHC); Rural Health Center (RHC); Indian Health Center (IHC)

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1. Name of applicant (the person responsible for Family Planning services at this site) _____

1.a. Applicant's telephone number with area code _____

1.b. Applicant's email address _____

2. Primary service site name on file with Medi-Cal _____

3. Primary service site telephone number with area code _____

3.a. Primary service site FAX number with area code _____

3.b. Primary service site email address _____

4. Primary service site address (number, street) _____
City _____ County _____ State ____ Nine-digit ZIP code _____

5. Pay to address (number, street) _____
City _____ County _____ State ____ Nine-digit ZIP code _____

6. Mailing address (number, street) _____
City _____ County _____ State ____ Nine-digit ZIP code _____

7. Name of sole proprietor Last _____ First _____ Middle _____
Sole proprietor's NPI _____

8. Driver's license number or state-issued identification number (attach legible copy)

9. Fictitious business name statement number, if applicable

   Effective date

10. Provider type (see Title 22 CCR, § 51051)

    Board-certified specialty

11. License to provide health services effective date (attach copy)

    Expiration date

12. Federal Employer Identification Number (A copy of IRS Form 941, Form 8109-c, Form SS-4 [Confirmation Notification], or Form 2363 must be submitted with the application)

13. Social security number (If sole proprietor not using a Tax Identification number, you must disclose this number and attach a copy of the ITIN verification, if applicable)

14. List below all service sites, other than the one listed in question 4, at which Family PACT services will be provided. Identify the Medi-Cal NPI for each site. **List all NPIs, service sites, and addresses that are applicable under this application.** Please attach a separate sheet of paper for any additional sites and NPIs not listed below.

Service site name			NPI	
Address (number, street)	City	State	Zip code	Telephone number
Service site name			NPI	
Address (number, street)	City	State	Zip code	Telephone number
Service site name			NPI	
Address (number, street)	City	State	Zip code	Telephone number
Service site name			NPI	
Address (number, street)	City	State	Zip code	Telephone number
Service site name			NPI	
Address (number, street)	City	State	Zip code	Telephone number

15. Practitioners

Please identify all practitioners (medical doctors, certified nurse midwives, nurse practitioners, physician assistants) who will be providing clinical family planning services under the Family PACT program. You may attach a list with the following information if it is easier than using the format provided below.

	SERVICE SITE/ PRACTITIONER'S NAME	PROVIDER TYPE (e.g., M.D., CNM, NP, PA)	CALIFORNIA LICENSE NUMBER	INDIVIDUAL NPI
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Provider Orientation

New Family PACT provider applicants and/or new provider locations will be provisionally certified for enrollment in Family PACT after the provider is enrolled in Medi-Cal and until an eligible representative attends a legislatively mandated provider orientation as determined by DHCS. A provider must attend an orientation within six (6) months of the date of initial Family PACT enrollment in order for the provisional certification to be lifted. If a provider and/or provider location's provisional certification is not lifted within six (6) months of the date of initial Family PACT enrollment, that provider and/or provider location will be disenrolled from Family PACT.

Information about comprehensive family planning, program benefits and services, client eligibility, and provider responsibilities is provided at the orientation. Applicants who are enrolled in Medi-Cal, in good standing, or are pending Medi-Cal enrollment, and who have submitted a Family PACT application package may register for a provider orientation to certify a site for enrollment.

AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE FAMILY PACT PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON FAMILY PACT PROGRAM PROVIDER AGREEMENT (DHCS 4469), WHICH IS INCORPORATED HEREIN BY REFERENCE:

I am duly authorized to commit all service sites, provider numbers, and practitioners specified in this application. I understand that providers who do not provide services consistent with the "Family PACT Standards" for Administrative Practices and Clinical Reproductive Health Services may be permanently disenrolled as a provider from the Family PACT program. I understand that incorrect or inaccurate information may affect my eligibility to participate in the Family PACT program and receive Medi-Cal reimbursement and that I must report any changes in previously submitted information to the DHCS, Medi-Cal Provider Enrollment Division (DHCS-PED) and the Office of Family Planning (DHCS-OFP). This includes any change of location which must be reported to DHCS-PED and DHCS – OFP within 35 days of the change. Failure to comply may result in permanent disenrollment from the Family PACT program.

Provider agrees: (a) that compliance with the provisions of this application is a condition precedent to payment to the provider. The parties agree that this application is a legal and binding document and is fully enforceable in a court of competent jurisdiction. The individual provider signing this application or the individual signing the application on behalf of a group understands it and is authorized to execute it; (b) to certify clients for eligibility for the Family PACT program, and recertify on an annual basis, according to certification instructions issued by the DHCS; (c) to cooperate with and participate in the evaluation effort of the Family PACT program determined by DHCS; (d) to make administrative files and billing and medical records pertaining to the Family PACT program available at reasonable times for inspection, auditing, monitoring, or evaluation by state auditors/quality improvement staff for a period of three years from the end of the fiscal year in which the client encounter took place.

I declare under penalty of perjury under the laws of the State of California that the foregoing Application (DHCS 4468), information is true, accurate, and complete to the best of my knowledge and belief.

Privacy Statement (Civil Code § 1798 et seq.)

The 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 request being delayed or not be processed.

16. Type or print name of individual provider signing the application or individual signing the application on behalf of a group	16.a. Title of individual signing the application
17. Signature **(no black ink)**	17.a. Date

INSTRUCTIONS FOR COMPLETION OF APPLICATION TO PARTICIPATE IN THE FAMILY PACT PROGRAM

1. Name of applicant is the Medical Director, physician, or nurse practitioner responsible for overseeing the family planning services to be rendered at the site to be enrolled. The applicant's phone number and email are required for additional communication and documentation.
2. Primary service site name is what is on file in the Provider Master File (PMF) with Medi-Cal. Primary service site means, if the provider has multiple sites, the site considered the main or headquarters site.
3. Primary service site telephone means the primary business telephone number used at the business location. A beeper number, answering service, pager, facsimile machine, cellular phone, or answering machine is not acceptable.
4. Primary service site address means the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code where Family PACT services are provided. A post office box or commercial box is not acceptable.
5. Pay to address means the address to which the applicant 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.
6. Mailing address is where the applicant or provider wishes to receive general Family PACT correspondence. Provide, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
7. If the business is a sole proprietorship, list the Sole Proprietor's name and National Provider Identifier (NPI).
8. Provide the driver's license or state-issued identification number and state of issuance of the applicant or provider. Attach a clearly legible copy with the application.
9. If the name in number 2 is a Fictitious Business Name, provide the Fictitious Business Name Statement number. If nonapplicable, write "N/A." Provide the effective date of the Fictitious Business Name Statement or Fictitious Name Permit.
10. Indicate the provider type
11. If individual provider or licensed community clinic, provide the license/certificate number, or other approval to provide health care, of the applicant or provider. Attach a clear legible copy of the license, certification, or approval. List the effective date and expiration date of the license/certificate number, or other approval listed in number 11b. If a governmental agency, write "exempt."
12. List the Federal Employer Identification Number issued by the Internal Revenue Service (IRS) under the name of the applicant or provider. Attach a clearly legible copy of the IRS Form 941, Form 8109-C, Form SS-4 (confirmation notification), or Form 2363.
13. If the business is a sole proprietorship not using an Employer Identification Number, provide the social security number of the Sole Proprietor. List the Sole Proprietor's name. Provide a clearly legible copy of the social security card.
14. List all additional service sites at which Family PACT services will be provided. List all NPIs, service sites, and addresses that are applicable under this application.
15. Identify all practitioners (medical doctors, certified nurse midwives, nurse practitioners, physician assistants) who will be providing clinical family planning services under the Family PACT program and the service site(s) where Family PACT services will be provided to all sites that are applicable under this application.
16. Name and title of individual provider signing the application or individual signing on behalf of a group means the first, middle, and last name of individual who is applying to the Department for enrollment or continued enrollment as a provider in the Family PACT program (typed or printed)
17. An original signature, in any color other than black, of the individual listed in number 16 is required. Include the date the application was signed.

! **REMEMBER** to enclose a copy of the following, **if applicable:**

- Driver's license or identification card
- Social security card
- Tax identification number verification