



JENNIFER KENT  
DIRECTOR

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



EDMUND G. BROWN JR.  
GOVERNOR

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Please complete the enclosed Medi-Cal provider enrollment application package and return it to the Department of Health Care Services, Provider Enrollment Division, MS 4704, P.O. Box 997412, Sacramento, California, 95899-7412. Please read all the instructions included in the application package carefully and complete each item requested. Incomplete application packages will be returned.

**PLEASE NOTE:** Applicants and providers are required to submit their National Provider Identifier (NPI) with each Medi-Cal provider application package. Applicants are required to attach a copy of the CMS/National Plan and Provider Enumeration System (NPPES) confirmation for each NPI listed in the application package. If providers are not eligible to receive an NPI, they should instead enter the word "atypical" in any NPI fields. These "atypical providers" will receive a unique Medi-Cal provider number once the application is approved.

Applicants and providers may be required to submit an application fee or proof of payment for enrollment with Medicare or other state Medicaid programs. Effective January 1, 2013, the Department of Health Care Services (DHCS) requires certain applicants and providers to submit an application fee when requesting an enrollment action. The application fee collected is used to offset the cost of conducting the required screening as specified in Title 42 Code of Federal Regulation 455 Subpart E. Please reference the Medi-Cal Regulatory Provider Bulletin, "Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460," for further information.

It is your responsibility to report to the DHCS any modifications to information previously submitted within 35 days from the date of the change. Most changes may be reported on a Medi-Cal Supplemental Changes form, DHCS 6209. However, you must complete a new application package if you are reporting a change of ownership of 50 percent or more, a change of business address, or one of the other changes identified in California Code of Regulations (CCR), Title 22, Section 51000.30, subsections (a) through (b).

If you are planning to sell your business or buy an existing business, you may find it helpful to refer to the Medi-Cal Provider Enrollment page at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov). The Provider Enrollment page contains information about enrollment options available to you whenever there is a sale or purchase of a Medi-Cal enrolled provider or business, including the option to submit a "Successor Liability with Joint and Several Liability" agreement.

Enrollment forms are available at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov). For more information about the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our Website at [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov) and click the "Provider Enrollment" link.

If you have any additional enrollment questions, please contact the Provider Enrollment Message Center at (916) 323-1945, or via email at [DHCSDMCRecert@dhcs.ca.gov](mailto:DHCSDMCRecert@dhcs.ca.gov).

Provider Enrollment Division  
Enclosures 12/14

## INSTRUCTIONS FOR COMPLETION OF THE DRUG MEDI-CAL SUBSTANCE USE DISORDER CLINIC APPLICATION

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

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

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

This form is part of an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers must also provide additional information and documentation. Applicants and providers may be subject to an on-site inspection and to unannounced visits prior to enrollment or approval for continued enrollment in a program. In addition to this form and requested documentation, a MEDI-CAL DISCLOSURE STATEMENT (DHCS 6207) and a DRUG MEDI-CAL PROVIDER AGREEMENT (DHCS 6009) must also be completed for enrollment or continued enrollment. Additional information can be found on the Medi-Cal Web site ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)) by clicking the "Provider Enrollment" link.

**Omission of any information or documentation on this form or failure to sign any of these documents may result in any of the denial actions identified in California Code of Regulations (CCR), Title 22, Section 51000.50.**

"Provider Number (NPI)" – enter the NPI for the business address indicated in item 5.

"Date" – enter the date you are completing the application.

"Enrollment action requested" - check all that apply.

"New provider" - check if the applicant is not currently enrolled in the Medi-Cal program as a provider with an active provider number (NPI).

"Change of business address"—check if the applicant is currently enrolled in the Medi-Cal program and is requesting to relocate to a new business address and vacate the old location. Indicate the business address the applicant is moving from.

"Additional business address"—check if the applicant is currently enrolled in the Medi-Cal program and is requesting enrollment for an additional business location.

"New taxpayer ID"—check if a new Taxpayer Identification Number (TIN) has been issued by the IRS.

"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.

"Acceptance of "Successor Liability with Joint and Several Liability"" – check this box only if you are submitting this application pursuant to CCR, Title 22, Section 51000.32 and have already submitted or have enclosed a letter that meets the requirements of Section 51000.32(a)(1).

"Cumulative change of 50 percent or more in person(s) with ownership or control interest"—check if there is a cumulative change of 50 percent or more in the person(s) with ownership or control interest, as defined in CCR, Title 22, Section 51000.15, since the information provided in the last complete application package that was approved for enrollment. Indicate the effective date in the space provided.

"Sale or transfer of assets (50 percent or more)"—check if 50 percent or more of the assets owned by the corporation, at the location for which a provider number has been issued, are sold or transferred. Indicate the effective date in the space provided.

"Continued Enrollment"—check if the applicant is currently enrolled as a Medi-Cal provider and has been requested by the Department to apply for continued enrollment in the Medi-Cal program. Do not check this box unless you have received notification from the Department, pursuant to CCR, Title 22, Section 51000.55. List current provider number(s)(NPIs) in the space provided.

Check the box labeled "I intend to use my current . . ." if you intend to use your current provider number to bill for services delivered at this location while this application request is pending. This action places the provider on provisional provider status, pursuant to CCR, Title 22, Section 51000.51.

**Medi-Cal Application Fee** – check all that apply.

Check the box labeled "I am currently enrolled in the Medicare program..." if you are currently enrolled in the Medicare program at the business address indicated on page 6, item 5 of the application, and under the legal name listed on page 6, item 1 of the application. Provider locations are exempt from paying the fee if currently enrolled in Medicare pursuant to W&I Code Section

14043.25(d) and the provider bulletin, "Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460," January 2013. Verification is required: provide an official notice from the enrolling agency that specifies the applicant's/provider's legal name and physical business address as identified on this application.

Check the box labeled "I am currently enrolled in another State's..." if you are currently enrolled in another State's Medicaid or Children's Health Insurance Program (CHIP) at the business address indicated on page 6, item 5 of the application, and under the legal name listed on page 6, item 1 of the application. Provider locations are exempt from paying the fee if currently enrolled in another State's Medicaid or CHIP pursuant to W&I Code Section 14043.25(d) and the provider bulletin, "Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460," January 2013. Verification is required: provide an official notice from the enrolling agency that specifies the applicant's/provider's legal name and physical business address as identified on this application.

Check the box labeled "I have paid the application fee..." if you have paid the application fee to a Medicare contractor or another State's Medicaid or CHIP for the enrollment of the business address indicated on page 6, item 5 of the application, and under the legal name listed on page 6, item 1 of the application. Providers are exempt from paying the fee if they have already paid the fee to a Medicare contractor or another State's Medicaid or CHIP for the same business address pursuant to W&I Code Section 14043.25(d) and the provider bulletin, "Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460," January 2013. Verification is required: provide official proof of payment that specifies the applicant's/provider's legal name and physical business address as identified on this application.

Check the box labeled "I have included an application fee..." if you included with the application either an application fee cashier's check, fee waiver request, or both. Providers that do not meet the exemptions specified in the above boxes are required to pay the fee pursuant to W&I Code Section 14043.25(d) and the provider bulletin, "Medi-Cal Application Fee Requirements for Compliance with 42 Code of Federal Regulations Section 455.460," January 2013. **DHCS can only accept a cashier's check as payment of the application fee – made payable to the State of California, Department of Health Care Services.**

## I. Applicant Information

"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 it is incorporated. If a partnership, you must attach a legible copy of the partnership agreement.

1. "Provider legal name" is the name listed with the Internal Revenue Service (IRS).
2. "Business name" is the name of the applicant or provider if different from that listed in number 1. 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.
3. "Type of location" is the type of location the applicant is providing services at. Ex: "clinic", "doctor's office", "residential", etc.
4. "Business telephone number" is the primary business telephone number used at the business address. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service phone, or answering machine shall not be used as the primary business telephone.
5. "Business address" is the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit zip code. A post office or commercial box is not acceptable.
6. "Mailing address" is the address at which the applicant or provider wishes to receive general Medi-Cal correspondence.
7. "Previous business address" is the address where the applicant or provider was previously enrolled. If the applicant or provider is not submitting an application for a change of location, enter N/A.
8. Enter the taxpayer identification number (TIN) issued by the IRS under the name of the provider or applicant; or enter social security number (see Privacy Statement on page 9). Attach a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification).
9. Enter the 6-digit CalOMS number, if one has been assigned.
10. Enter any local business license or permit numbers for any city and/or county where you conduct your business and attach copies to the application. If this does not apply to you, enter N/A and provide an exemption from your county.
11. List your current Drug Medi-Cal provider number if one has already been assigned.
12. Enter each taxonomy code(s) associated with your NPI. Attach additional sheets if necessary.
13. Enter the requested information. Attach to this application a legible copy(ies) of applicant's current Certificate of Insurance for Liability Insurance that covers premises and operation for the business address listed in item 5.

14. Check the appropriate box to indicate whether you have workers' compensation insurance as required by state law.

## II. Service Modalities

15. Enter all services to be provided by the substance use disorder clinic, including existing services and additional services or program types being requested by this application. Note – DMC residential services require a residential alcoholism or drug use recovery or treatment facility license issued by DHCS. A Narcotic Treatment Program (NTP) license issued by DHCS is required to provide NTP services. Facility licensing and NTP information and application are available online at [www.dhcs.ca.gov/provgovpart/Pages/SUD-ProvPartners.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/SUD-ProvPartners.aspx)

## III. Residential Substance Use Disorder Services

**Note:** Applicants for residential services must first obtain a residential license issued by DHCS, or another governmental agency, prior to application submission for DMC residential services. Department of Social Services may be contacted at <http://www.cdss.ca.gov/cdssweb/PG69.htm> for all licensing requirements and procedures.

- 16.
- Indicate whether the applicant/provider provides residential services at the business address.
  - If you answered "yes" to item a., indicate if the facility is licensed by the DHCS, or another governmental agency, and provide the residential license number and a valid copy. If not applicable, check no and provide an explanation.
  - Indicate whether there are any other entities that provide residential services at the business address.

## IV. Substance Use Disorder Treatment Professionals, Licensed Substance Use Disorder Treatment Professionals, and Substance Use Disorder Non-physician Medical Practitioners

17. List the name, provider number (NPI), license/certification/registration information for all substance use disorder treatment professionals, licensed substance use disorder treatment professionals, and substance use disorder non-physician medical practitioners providing services at the business address identified in item 5. Attach additional sheets, if necessary.

## V. Substance Use Disorder Medical Director Information

18. "Legal name"—print the last, first, and middle name of the substance use disorder medical director designated for the business address identified in item 5.

19. Enter the substance use disorder medical director's medical license number(s). Attach a legible copy.

20. Enter the substance use disorder medical director's provider number (NPI).

## VI. Information About Authorized Individual Signing This Application

21. Print the name of the individual signing the application on behalf of the applicant/provider.

22. Check the gender of the individual identified in item 21.

23. Enter the driver's license or state-issued identification card number and state of issuance of the individual identified in number 21. Attach a legible copy to the application. The driver's license or state-issued identification card number must have been issued within the 50 United States or the District of Columbia.

24. Enter the date of birth of the individual identified in item 21.

25. Enter the social security number of the individual identified in item 21. Provision of the social security number is mandatory.

26. An original signature of the individual identified in item 21 is required. Also provide the title of the person signing the application. Include the city, state, and the date where and when the application was signed. **See CCR, Title 22, Section 51000.30(a)(2)(B) to determine whether you have the authority to sign this application.**

27. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If it must be notarized, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

28. Enter contact information for the applicant or provider or other authorized person designated for Provider Enrollment staff to contact for clarification. Failure to include this information may result in the application package being returned deficient for item(s) that an applicant can readily provide by fax or telephone.

**Attach a legible copy of each of the following items, if applicable:**

- National Provider Identifier (NPI) verification (CMS/NPPES verification)
- Proof of application fee payment to a Medicare contractor or another State's Medicaid/CHIP (if applicable)
- TIN verification
- Fictitious business name statement or fictitious name permit
- Applicable certifications for all listed substance use disorder treatment professionals
- Driver's license or state-issued identification card of individual signing the application
- Business licensure or evidence from your local government that one is not needed
- Certificate of Comprehensive Liability Insurance
- Medical license for the substance use disorder medical director
- Proof of worker's compensation Insurance
- Medicare enrollment verification
- Successor Liability Agreement (if applicable)
- Residential License issued by the DHCS or authorized governmental agency (if applicable)
- Signed Medi-Cal Disclosure Statement (6207)
- Signed Drug Medi-Cal Provider Agreement (6009)

**Approved counselor certifying organizations:**

1. California Consortium of Addiction Programs & Professionals (CCAPP)
2. California Association of Alcohol/Drug Educators (CAADE)
3. California Association of Drinking Driver Treatment Programs (CADDTP)
4. American Academy of Health Care Providers in the Addictive Disorder (AAHCPAD)



## DRUG MEDI-CAL SUBSTANCE USE DISORDER CLINIC APPLICATION

**FOR STATE USE ONLY**

**Important:**

- Read all instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- For Medi-Cal return completed forms to:  
 Department of Health Care Services  
 Provider Enrollment Division  
 MS 4704  
 P.O. Box 997412  
 Sacramento, CA 95899-7412  
 (916) 323-1945
- **Do not use staples on this form or on any attachments.**
- **Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you**

Provider number (NPI): \_\_\_\_\_

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

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

- New provider
- Change of business address
- Additional business address
- New taxpayer ID
- \*Change of ownership (per CCR, Title 22, Section 51000.6)
- \*Acceptance of "Successor Liability with Joint and Several Liability" (per CCR, Title 22, Sections 51000.24.1, 51000.32)
- \*Cumulative change of 50 percent or more in person(s) with ownership or control interest (per CCR, Title 22, Section 51000.15)
- \*Sale or transfer of assets (50 percent or more) (per CCR, Title 22, Section 51000.30)

- Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to CCR, Title 22, Section 51000.55.)
- I intend to use my current provider number to bill for services delivered at this location while this application request is pending. I understand that I will be on provisional provider status during this time, pursuant to CCR, Title 22, Section 51000.51.  
**\*A provider agreement may not be transferred or assigned to another. However, an applicant may be joined to the provider agreement by strict compliance with the provisions of CCR, Title 22, Section 51000.32 entitled "Requirements for Successor Liability with Joint & Several Liability."**

**For items above marked with \* indicate effective date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Indicate the change of ownership effective date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Medi-Cal Application Fee (check all that apply)

- I am currently enrolled in the Medicare program at this business address and under this legal name. (Attach verification)
- I am currently enrolled in another State's Medicaid or Children's Health Insurance Program (CHIP) at this business address under this legal name. (Attach verification)
- I have paid the application fee to a Medicare contractor or another State's Medicaid or CHIP for this business address under this legal name. (Attach proof of payment)
- I have included an application fee check and/or an application fee waiver request with this application.

**I. Applicant Information**

Type of entity (check one)

- Sole proprietorship
- Partnership
- Government entity
- Corporation:  
Corporate number: \_\_\_\_\_  
State incorporated: \_\_\_\_\_
- Limited Liability Company:  
LLC number: \_\_\_\_\_  
State registered/FILED: \_\_\_\_\_
- Nonprofit Corporation:  
Type of nonprofit: \_\_\_\_\_  
 Other: \_\_\_\_\_

1. Provider legal name (as listed with the IRS)					
2. Business name, if different			3. Type of location (clinic, doctor's office, residential, etc.)		
Is this a fictitious business name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list the Fictitious Business Name Statement/Permit number and effective date		4. Business telephone number		
(Attach a legible copy of the recorded/ stamped Fictitious Business Name Statement)					
5. Business address (suite and/or room number, street)		City	County	State	ZIP code (nine-digit)
6. Mailing address (number, street, P.O. Box number)		City	State	ZIP code (nine-digit)	
7. Previous business address (if changing business address; number, street)		City	County	State	ZIP code (nine-digit)
8. Taxpayer identification number (TIN) (attach legible copy of the IRS form) or social security number		9. 6-digit CalOMS number (if applicable)		10. Any local business license/permit numbers (attach legible copy)	
11. Current Drug Medi-Cal provider number (if applicable)		12. Taxonomy code		Taxonomy code	

**13. Proof of Liability Insurance – Applicant must attach a copy of their certificate of insurance for the business address.**

Name of insurance company

Insurance policy number	Date policy issued (mm/dd/yyyy)	Expiration date of policy (mm/dd/yyyy)
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Insurance agent's name – (first, middle, last, Jr., Sr., etc.)

Telephone number	Fax number	E-mail address
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14. Does the applicant have **workers' compensation insurance** as required by state law?  Yes  No  NA  
 If applicable, attach proof of maintenance of Workers' Compensation insurance. If not applicable, check N/A, or No, and provide an explanation:

**II. Service Modalities**

15. Identify the service modality(ies) and treatment component (non-perinatal or perinatal) requested for the site. If the site is currently certified, include service modality(ies) and treatment component(s) that the provider applicant wishes to continue as well as those to be added.

**Applicants for residential services must first obtain a residential license issued by the DHCS, or another governmental agency, prior to application submission for DMC residential services.**

**A Narcotic Treatment Program (NTP) license issued by DHCS is required to provide NTP services.**

Type of Services	Current and/or requested Treatment Component	
Narcotic Treatment Program (NTP) License #:	<input type="checkbox"/> Non-perinatal	<input type="checkbox"/> Perinatal
Intensive Outpatient Treatment (IOT)	<input type="checkbox"/> Non-perinatal	<input type="checkbox"/> Perinatal
Outpatient Drug Free (ODF)	<input type="checkbox"/> Non-perinatal	<input type="checkbox"/> Perinatal
Residential License #:	<input type="checkbox"/> Non-perinatal	<input type="checkbox"/> Perinatal
Naltrexone	<input type="checkbox"/> Non-perinatal	<input type="checkbox"/> Perinatal

**III. Residential Substance Use Disorder Services**

16. (a) Does the applicant/provider provide residential services at the business address in item 5?.....  Yes  No

(b) If you marked "yes" to item a., please indicate whether the applicant/provider is separately licensed by the DHCS or another governmental agency.....  Yes  No

If not applicable, check no, and provide an explanation: \_\_\_\_\_

If yes, please provide the license number and attach a legible copy: \_\_\_\_\_

(c) Does any other entity at the business address in item 5 provide residential services? .....  Yes  No

**Note:** You must first obtain a residential license, if you provide residential substance use disorder treatment services, prior to application submission for DMC residential services.



**VI. Information About Authorized Individual Signing This Application**

21. Printed name of the Individual Signing (last, first, middle)		22. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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23. Driver's license or state-issued ID card number and state of issuance (attach a legible copy)	24. Date of birth	25. Social security number
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**26. I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the Medi-Cal Disclosure Statement (DHCS 6207), and Drug Medi-Cal Provider Agreement (DHCS 6009) 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 authorized individual in item 21	Title
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Executed at: \_\_\_\_\_, \_\_\_\_\_ on \_\_\_\_\_  
 (City) (State) (Date)

27. Notary Public – Please see instructions under number 27 for who must have their application signed by a Notary Public in the form specified by Section 1189 of the Civil Code.

**28. Contact Person's Information**

Check here if you are the same person identified in item 21. If you checked the box, provide only the e-mail address and telephone number below.

Contact person's name (last, first, middle)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Title/Position	E-mail address	Telephone number
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**PRIVACY STATEMENT (Civil Code Section 1798 et seq.)**

All information requested on the application, the disclosure statement, and the provider agreement is mandatory. This information is required by the Department of Health Care Services, Provider Enrollment Division, by the authority of Welfare and Institutions Code, Section 14043.2(a) and Title 22, California Code of Regulations, Section 51536. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by DHCS, contact the Provider Enrollment Division at (916) 323-1945.