Intermediate Care Facility for Developmentally Disabled Credentialing Attestation

ICF/DD HOME INFORMATION

ICF/DD Home Name: _____

County of ICF/DD Home: _____

Primary Contact Name: _____

Primary Contact Email Address: _____

Primary Contact Phone: _____

Tax ID: _____

Regional Center Vendor Number: _____

Certificates of Insurance Numbers: _____

Business License Number: _____

As an authorized representative of the above named ICF/DD Home, I certify, under penalty of perjury, that the following credentialing requirements are satisfied:

- Completion of the Medi-Cal Managed Care Plan's specific Provider Training within the last two (2) years
- Facility Site Audit from State Agency
- No Change in 5% Ownership Disclosure since the last submission to MCP
- Possess an active CDPH License and CMS Certification
- In good standing as a Regional Center Vendor

[ ] I hereby certify under penalty of perjury that all information provided in this Attestation is true and accurate to the best of my knowledge and that this Attestation has been completed based on a good faith understanding of the requirements set forth in APL 23-023 ICF/DD – Long Term Care Benefit Standardization and Transition of Members to Managed Care or any superseding APL.

This Attestation will be accepted as compliant until such time that the above named ICF/DD Home provides an updated version of this Attestation.

Print Name of Authorized Representative: _____

Title of Authorized Representative: _____

_____

Signature of Authorized Representative **Date**