DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Michelle Baass | Director

Congregate Living Health Facility (CLHF) Application Requirements

- Application Fee: Cashier's Check in the amount of $709.00 made payable to the Department of Health Care Services
- The following Medi-Cal forms must be notarized:
    - Medi-Cal Provider Application (DHCS 6204)
    - Medi-Cal Disclosure Statement (DHCS 6207)
    - Medi-Cal Provider Agreement (DHCS 6208)
- Legal Name and Business Name
- Contact Person's Name, E-mail Address, and Telephone Number
- Proof of National Provider Identifier (NPI): NPPES NPI Registry Confirmation
- Proof of Federal Taxpayer Identification Number (TIN): IRS Letter SS-4, IRS Form 941, Form 8109-C, or Letter 147-C
- City Business License or Exemption Letter
- Facility license issued by Department of Public Health
- Valid State Issued ID or Driver's License (include copies for all individuals listed on the Medi-Cal forms)
- Doing Business As (DBA) or Fictitious Business Name Statement (required only if business is operating under a name different than the existing corporate name)
- General Liability Insurance
- Workers' Compensation Insurance
- Surety Bond or Exemption Letter
- Secretary of State Confirmation
- Articles of Incorporation or Articles of Organization

Submit complete application package to:

Department of Health Care Services
Integrated Systems of Care Division
Provider Enrollment Unit
1501 Capitol Avenue, MS 4502
P.O. Box 997437
Sacramento, CA 95899-7437

PLEASE NOTE: SEND PACKAGE TO THE PROVIDER ENROLLMENT UNIT
DO NOT SEND ANY DOCUMENTS TO THE PROVIDER ENROLLMENT DIVISION

If you have questions regarding the application requirements,
call 916-552-9105, option 5, then option 2.
Email inquiries can be sent to WaiveProEnroll@dhcs.ca.gov.