Care Coordination Agency (CCA)
Application Requirements

- **Application Fee:** Cashier’s Check or Money Order for $595.00 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 Printout
- Proof of Federal Taxpayer Identification Number: IRS Letter SS-4, IRS Form 941, Form 8109-C, or Letter 147-C
- City Business License (If applicable, provide Exemption Letter)
- Valid State Issued ID or Driver’s License (include copies for all individuals who have a percentage in ownership/control)
- 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
  **Requirement per CCR, Title 22. Division 3, Section 51000.60**
- Workman’s Compensation Insurance
  **Requirement per CCR, Title 22. Division 3, Section 51000.60**
- Secretary of State Confirmation (If applicable, provide Articles of Incorporation for a Corporation or LLC)
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.