Maternal, Child and Adolescent Health Division

APPLICATION FOR CERTIFICATION AS A COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP) PROVIDER

For Official Use only

Local Agency Control Number_____ Date Received_____

State Control Number_____ Date Received_____

Please read all the attached materials thoroughly before completing this form and retain a copy for your records. Please type or print in black ink. When completed, the original form should be mailed with one copy to your local CPSP Perinatal Services Coordinator (PSC).

1. **Name of Applicant** (Legal name must be the same name used for Federal Internal Revenue Service Tax Identification):					**Telephone Number:** ( )
Other Name (Business name used for provider services):					**Fax Number:** ( )
Service Address (Number/Street):			**Billing Address** (Number/Street):		
City:	**State:**	**9 digit Zip Code:**	**City:**	**State:**	**9 digit Zip Code:**
Contact Person:	**Telephone Number:** ( )		**Contact Person:**	**Telephone Number:** ( )	
E-mail Address :			**E-mail Address:**		

2. Please check applicant's provider type below. The CPSP provider must be a:

- ☐ **Obstetrician/Gynecologist (OB/GYN)**
- ☐ **Family Practice Physician**
- ☐ **General Practice Physician**
- ☐ **Family Nurse Practitioner**
- ☐ **Certified Nurse Midwife**
- ☐ **Pediatrician**
- ☐ **Preferred Provider Organization**
- ☐ **Clinic**
- ☐ **Hospital**
- ☐ **Alternative Birthing Center**
- ☐ **Group (At least one is: Family Practice, OB/GYN or Pediatrician)**
- ☐ **Pediatric Nurse Practitioner**

3. Are You A Current Medi-Cal Provider? ☐ Yes ☐ No **If No, do not complete the rest of this form. Contact your local CPSP coordinator.**	**National Provider Identifier** (NPI)*

4. Comprehensive Perinatal Services Practitioners:

Please identify all program practitioners who will be providing Comprehensive Perinatal Services (Obstetric and Support Services, which include: nutrition, psychosocial and health education) and their years of service.
If any services are provided at site(s) different from service address specified on page 1, please indicate location and services.

***Type of Practitioner/Specialty**

Physician	(MD)	Marriage and Family Therapist	(MFT)
Certified Nurse Midwife	(CNM)	Health Education	(HE)
Registered Nurse	(RN)	Childbirth Educator	(CE)
Nurse Practitioner	(NP)	Registered Dietician	(RD)
Physician Assistant	(PA)	Comprehensive Perinatal Health Worker	(CPHW)
Social Worker	(SW)	Licensed Vocational Nurse	(LVN)
Psychologist	(PSY)		

****Years of Experience**

For MD, CNM, RN, NP, PA, SW, MFT, HE, LVN, PSY –Years of experience in Maternal and Child Health
For CE, CPHW-Years of experience in perinatal care.
For RD-Years of experience in perinatal nutrition

Last Name First Middle Initial Location	***Type of Practitioner /Specialty**	**CA License, Certificate, Registration Number**	**Expr. Date of Lic., Cert., or Reg. No. MM/DD/YY**	**Year Graduated HS Diploma/Degree and Institution/Univ.**	**National Provider Identifier (NPI)**	****Years of Experience**	**Obstetric (applied to Physician, CNM, NP, PA)**	**Supervision**	**Backup**	**Client Orientation**	**Health Education**	**Nutrition**	**Psychosocial**	**Case Coordination**	**Consultation**	**Protocol Approval**

Last Name First Middle Initial Location	*Type of Practitioner /Specialty	CA License, Certificate, Registration Number	Expr. Date of Lic., Cert., or Reg. No. MM/DD/YY	Year Graduated HS Diploma/Degree and Institution/Univ.	National Provider Identifier (NPI)	**Years of Experience	Obstetric (applied to Physician, CNM, NP, PA)	Supervision	Backup	Client Orientation	Health Education	Nutrition	Psychosocial	Case Coordination	Consultation	Protocol Approval

If additional space is required to list all program practitioners, please duplicate and use this page.

5. Please indicate if the provider or staff has received state-sponsored Provider Overview and Steps to Take training in the provision of CPSP services:

Name: _____ Completion Date: _____

If you have not yet participated in such training, indicate when you intend to*:_____

_____

*Use additional pages as necessary for each person.

6. Please attach and label the following requested documents in the order they are described (Please note: all documents below will be kept on file at the local Perinatal Services Coordinator's office):

I. **Prenatal Medical Record Form(s):** Attach a sample prenatal medical records form(s).

II. **Individualized Care Plan:** Includes obstetric, nutrition, psychosocial, and health education components.

III. **Nutrition, Psychosocial, and Health Education Assessment Tools:** Nutrition, psychosocial, and health education documents for initial assessment, trimester reassessments, and postpartum assessments.

IV. **General Description of Practice:** A description as to how the practice, clinic, and/or organization will provide CPSP services for the obstetric, nutrition, psychosocial, and health education components. In your description, please include high risk and emergency patient care.

V. **List of Delivery Hospitals:** The name(s) and address(es) of the hospital(s) at which deliveries are planned to take place.

VI. **List of Referral Services:** The names and addresses of the persons and agencies to whom you will refer for OB and non-OB care, well-child pediatric care (e.g., CHDP), family planning services, Supplemental Nutrition Program for Women, Infants, and Children (WIC) services, genetic services, and dental services**.**

VII. **Antepartum/Intrapartum/Postpartum Agreements:** If a person or entity other than the applicant will be responsible for providing and billing services for antepartum, intrapartum, and/or postpartum obstetrical care, the applicant must attach a written agreement(s) to this application. The agreement(s) must describe the relationship and specific responsibilities of the applicant and the obstetric care providers(s), including the flow of patient services and patient information between all providers. It should include the name(s) of the delivery hospital(s) where obstetric provider has privileges, how emergency services will be provided, and billing responsibilities.

7 Please give approximate number of total deliveries by the applicant in the last 12 months; of the total, how many were Medi-Cal deliveries.
Please furnish any other information that you feel would help evaluate your application to become approved as a CPSP provider.

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_____

I certify under penalty of perjury that the above information is true, accurate, and complete to the best of my knowledge. I understand that incorrect or inaccurate information may affect my eligibility to receive enhanced Medi-Cal reimbursement for CPSP services and that I must report changes to the above information to the local CPSP coordinator.

_____ _____
Applicant or authorized agent's name (please print or type) Title (please print or type)

➤ _____ _____
Applicant or authorized agent's original signature Date

All information submitted with this application will be part of a file that is open for public inspection pursuant to the California Public Records Act, Government code, Section 6250 ET SEQ.

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Actions taken on application:

	Initial	Date
☐ Returned for additional information	_____	_____
☐ Application resubmitted	_____	_____
☐ Returned for additional information	_____	_____
☐ Application resubmitted	_____	_____

CPSP PSC's recommendation to CDPH:

☐ Approve ☐ Not approve

Signature: ➤ _____ Date: _____

Title: _____

Local agency: _____

☐ Attach Local Agency Review Checklist (CPP 3)