KERN HEALTH SYSTEMS
ORGANIZATIONAL PROVIDER APPLICATION

☐ **Initial Application** ☐ **Recredentialing**

FACILITY TYPE - *If your facility type is not listed below, contact Provider Relations Department.*

Check ONE box only per Application.

☐ Hospital - All types
☐ Skilled Nursing, Acute Rehabilitation, Intermediate Care or Sub-Acute Facilities
☐ Ambulatory Surgical Centers – Free standing only
☐ Extended Care facilities or Nursing Home (Congregate Living Facility)
☐ Ambulance ☐Transportation Providers
☐ Home Health
☐ Hospice ☐ Palliative Care Services
☐ Kidney Dialysis Center
☐ Laboratories
☐ Radiology Clinic/Center
☐ Physical Therapy Clinic/Center ☐ Occupational Therapy ☐ Speech Therapy
☐ Prosthetics & Orthotics
☐ DMEPOS Supplier ☐ Type: ________________________
☐ Sleep Center
☐ Urgent Care

CORPORATE IDENTIFICATION INFORMATION

Legal Business Name: (As reported to the IRS)	Federal Tax Identification Number (TIN):
Doing Business As (DBA) Name: (If applicable)	National Provider Identifier (NPI) for facility being credentialed:
Corporate Address:	Length of time in business with this Name and Tax ID: _____ Years _____ Months

Is facility owned in whole or in part or managed by a hospital or health care system/organization?
☐ Yes, owned in whole or in part by:
☐ Yes, managed by:
☐ Not affiliated with a hospital or health care system/organization.

FACILITY INFORMATION

Address must be a street address, not a Post Office box.

Facility Name:
Address Line 1:
Address Line 2:

City:	State:	Zip:	County:

Facility Phone:	Fax:	Website:

Facility Administrator:
Email:

Hours of Operation:

Mon	Tue	Wed	Thu	Fri	Sat	Sun

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CREDENTIALING CONTACT / CORRESPONDENCE ADDRESS

Credentialing Contact Name:
Mailing Address Line 1:
Mailing Address Line 2:

City:	State:	Zip:	Phone:
Fax:		Email:	

HEALTH CARE LICENSURE

Attach a copy of each license for this facility. All licenses must be unrestricted/unconditional.
****Hospitals & SNFs must include OSHPD ID Number***

License Number	State or City	Licensing Agency	Initial Issue Date	Renewal Date	Expiration Date

MEDI-CAL & MEDICARE STATUS

Kern Health Systems requires all providers to be enrolled with the Department of Health Care Services Medi-Cal Fee-For-Service Program. Each location will be verified for current enrollment status by location in order to participate in the KHS Network.

1. Is this facility participating in the Medi-Cal program?	☐ Yes	☐ No
NPI Number:	Date of initial Certification:	

☐ Check here if facility type is not eligible for Medi-Cal certification

If No, has your facility applied to Medi-Cal? ☐ Yes ☐ No (Attach copy of DHCS receipt of application submission)

If Yes, Attach copy of letter from California Medi-Cal FFS showing participation (Initial Application Only)

2. Is this facility participating in the Medicare program?	☐ Yes	☐ No
Medicare Number:	Date of initial Certification:	

☐ Check here if facility is not eligible for Medicare certification.

INSURANCE

Complete this section and attach a copy of the facility's insurance certificate(s).

1. Is this facility covered by General Liability insurance in the amount of $1 million per occurrence and $1 million aggregate?
   ☐ **Yes** ☐ **No** - ***Above amount is required before submitting application.***

☐ Facility is covered by Government insurance **–** ***Please attach detail letter of coverage***

2. Is facility covered by Professional liability insurance in the amount of $1 million per occurrence and $3 million aggregate? ***Must be a facility/organizational policy, not Individual-only policy.**
   ☐ **Yes** ☐ **No** - ***Above amount is required before submitting application.***

☐ Facility is covered by Government insurance **–** ***Please attach detail letter of coverage***

MEDICAL FACILITIES LISTED BELOW MUST BE ACCREDITED

- Hospital – ALL TYPES
- Free-Standing Surgical Center
- Home Health Care Agency
- Hospice
- Acute Rehabilitation Facilities
- Laboratories

ACCREDITATION

Complete this section and attach copy of current Accreditation certificate or letter. Certificate/letter should list this facility location as being included in the accreditation.

- ☐ **AAAASF** - American Association for Accreditation of Ambulatory Surgery Facilities
- ☐ **AAAHC** - Accreditation Association for Ambulatory Health Care
- ☐ **ABCOP** – American Board for Certification in Orthotics & Prosthetics
- ☐ **ACHC** - Accreditation Commission for Health Care
- ☐ **BOC** – Board of Certification/Accreditation International (O&P or DMEPOS)
- ☐ **CAP** – College of American Pathologists
- ☐ **CARF** - Commission on Accreditation of Rehabilitation Facilities
- ☐ **CCAC** - Continuing Care Accreditation Commission
- ☐ **CHAP** - Community Health Accreditation Program
- ☐ **COLA** – Laboratory Accreditation Program
- ☐ **DNV (NIAHO) -** Det Norske Veritas (National Integrated Accreditation for Healthcare Organizations)
- ☐ **HFAP** – Healthcare Facilities Accreditation Program (AOA)
- ☐ **TJC** – The Joint Commission (Formerly known as JCAHO)
- ☐ **IMQ** – Institute for Medical Quality

Date of last full survey:	
Effective dates of accreditation:	

NON-ACCREDITED FACILITIES

Complete this section and attach copy of most recent onsite government agency survey along with your Corrective Action Plan (CAP), if deficiencies were cited, OR attach letter from government agency stating facility is in substantial compliance with most recent survey standards.

Has this facility had an onsite licensing/certification survey by the Department of Health or CMS within the past 36 months?

☐ Yes	Date of most recent onsite survey:
☐ No	***Required before submitting application or provide explanation:***

STAFFING ATTESTATION

Does the facility have a method to verify the identity, license, certification, and criminal background of the individuals rendering services for your organization?

☐ Yes	Indicate how the facility conducts the credentialing process for each practitioner: ☐ Credentialing procedures are performed internally. ☐ Credentialing procedures are outsourced/delegated to: ☐ Other, specify:
☐ No	***Explain:***

ATTACHMENTS:

Check all documents that are included with this application. Failure to include required copies will delay the processing of the application.

- ☐ Copy of all State and local licenses required to operate as a health care facility
- ☐ Copy of facility's Commercial General Liability insurance certificate
- ☐ Copy of facility's Professional liability insurance certificate covering all facility employees
- ☐ Copy of Accreditation certificate or letter
- ☐ Copy of California Medi-Cal facility approval letter
- ☐ Copy of most recent onsite governmental licensing agency survey including facility's corrective action plan if deficiencies were cited, OR cover letter/email from licensing agency stating facility is in substantial compliance with licensing standards from most recent survey
- ☐ Facility Specific Checklist – Additional items specific to facility type

Disclosure/Attestation

Please provider written explanation for any questions answered "Yes",
****Except #10 - #8 & #9 provide copies of certificate of insurance coverage.***

1.	Has your facility/organization ever been disciplined by any state licensing or other authorizing agency, or has the organization or its branch locations ever voluntarily surrendered any license or certification while under investigation, or are there any actions or investigations currently under way which would lead to one of these outcomes?	☐ Yes	☐ No
2.	Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned, assessed a penalty/fine or otherwise restricted from participating in any private or public program, including but not limited to, Medicare, Medicaid/Medi-Cal, military, and State Department of Health Programs?	☐ Yes	☐ No
3.	Has this facility/organization, under current, former name, or business identity, ever had it accreditation revoked or suspended?	☐ Yes	☐ No
4.	Does your organization or any of its authorized representatives currently have any pending or settled legal actions?	☐ Yes	☐ No
5.	At any time, has any third party payer ever revoked, reduced, denied, or suspended your organization's participation due to inappropriate utilization management, quality of concerns, or any other reason?	☐ Yes	☐ No
6.	Has any managing employee or person with an ownership or controlling interest in this facility/organization been excluded, sanction or debarred from participation in any government health care program?	☐ Yes	☐ No
7.	Has your facility/organization's liability insurance coverage, for any reason, been denied, cancelled, restricted/limited, not renewed, or initially refused upon application?	☐ Yes	☐ No
8.	Is your facility/organization covered by Commercial General Liability insurance in the amount of $1million per occurrence? (*Provide copy)	☐ Yes	☐ No
9.	Is your facility/organization covered by Professional Liability insurance in the amount of $1million per occurrence and $3million aggregate as a covered facility/organizational policy (not individual-only policy)? (*Provide copy)	☐ Yes	☐ No
10.	Does your facility comply with State and Federal handicap access standards?	☐ Yes	☐ No

LANGUAGES

- ***Please check all languages spoken by facility staff fluently enough to treat patients/clients who speak only that language.***
- ***If none of these languages are spoken at your facility, check "None of These."***
- ***Indicate if Sign Language and/or an Interpreter Service is available at your facility.***

	AFAR		FARSI		PERSIAN
	ABKHAZIAN		FIJIAN		POLISH
	AFRIKAANS		FILIPINO		PORTUGUESE
	AKAN		FINNISH		PUNJABI
	ALBANIAN		FRENCH		ROMANIAN
	ARABIC		GERMAN		RUNDI
	ARMENIAN		GREEK		RUSSIAN
	BASQUE		GUJARATI		SANGO
	BENGALI		HAITIAN CREOLE FRENCH		SANSKRIT
	BOSNIAN		HEBREW		SLOVAK
	BULGARIAN		HINDI		SLOVENIAN
	BURMESE		HMONG		SPANISH
	CAMBODIAN		HUNGARIAN		SWEDISH
	CANTONESE		IGBO		TAGALOG
	CATALANN; VALENCIAN		INDONESIAN		TAIWANESE
	CEBUANO		IOLOCANO		TAMIL
	CHINESE		ITALIAN		TELUGU
	CHINESE MANDARIN		JAPANESE		THAI
	CROATIAN		KANNADA		TURKISH
	CZECH		KOREAN		UKRANIAN
	DANISH		LAO		URDU
	DUTCH		LITHUANIAN		VIETNAMESE
	GERMAN		MALAY		
	GREEK; MODERN		MALAYALAM		
	EGYPTIAN		NORWEGIAN		
	ESTONIAN		OROMO		

☐ None of these languages (English Only)

☐ American Sign Language

☐ Interpreter Services Utilized by Facility

Release of Information

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Release of Information:

As part of the application process and for the purpose of verifying any information provided on this application, I the undersigned, authorized agent of the facility/organization listed below, grant Kern Health Systems permission to contact any individual, institution, facility or agency identified on, or relative, to the evaluation of this application for the purposes of credentialing or recredentialing.

I, further understand, as an authorized agent of the facility/organization, that I and the facility/ organization have the burden of producing adequate information for the proper evaluation of the organization's competence, character, and ethics in resolving doubts about such qualifications.

I hereby grant permission for Kern Health System Representatives to conduct on-site and medical record reviews as necessary. I agree that this facility/organization will participate in and support Kern Health System's quality improvement and utilization review programs.

Release from Liability:

I, the undersigned, a duly authorized agent of the facility/organization, hereby release from any and all liability Kern Health Systems (KHS or Health Plan name: Kern Family Health Care), its respective agents and employees, for acts performed in good faith in connection with evaluating this facility/organization's credentialing and recredentialing applications. I also release from any and all liability all individuals and organizations who in good faith, at any time, provider KHS with information concerning this application.

I also herby attests to the correctness and completeness of this application and agree to notify KHS of any changes to information provided herein in accordance with timely notification as outlined in the contractual agreement.

Attestation:

I understand and hereby attest, and certify, that all information submitted on this application is true, accurate, and complete to the best of my belief and knowledge. I fully understand that any falsifications, misstatements in or omissions from the application, whether intentional or not, may constitute cause for denial from participation from the KHS Health Plan.

Signature: ____ Date: ____________________

Print Name: ____ Title: ____________________