

KERN HEALTH SYSTEMS ORGANIZATIONAL PROVIDER APPLICATION

Initial Application Recredentialing

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

Relations Department.

Check ONE box only per Application.

- Hospital - All types
- Skilled Nursing, Long-Term Care, Acute Rehabilitation, Intermediate or Sub-Acute
- Intermediate Care Facilities – Developmental Disabled #of Beds: _____
- Ambulatory Surgical Centers – Free standing only *Must be Accredited
- Ambulance Transportation Providers
- Cancer Center
- CBAS-Community Based Adult Services
- DMEPOS Supplier Prosthetics & Orthotics Hearing Aid Dispenser
- Home Health
- Hospice Palliative Care Services
- Kidney Dialysis Center
- Laboratories
- Radiology Clinic/Center Portable/Mobile X-Ray
- Physical Therapy Clinic/Center Occupational Therapy Speech Therapy
- Sleep Center
- Urgent Care Other:

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?	
<input type="checkbox"/> Yes, owned in whole or in part by: <input type="checkbox"/> Yes, managed by: <input type="checkbox"/> 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:						
City:	State:	Zip:	County:			
Facility Phone:	Fax:	Website:				
Facility Administrator:						
Admin 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 Type	State Agency	State/City	Number	Issued Date	Exp Date
State License					
State Registration					
DEA					
CLIA					
Other:					

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

Medi-Cal Number:

Date of initial Certification:

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*

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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

Select the method(s) the facility uses to verify the identity, license, certification, and criminal background of the individuals rendering services for your organization?

- Credentialing procedures are performed internally.
- Credentialing procedures are outsourced/delegated to:
- On-line directory with the appropriate state and/or federal licensure or certification board
- Background check agency, contracted organization or vendor

No process please explain

Explanation:

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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 cover letter stating the facility is in substantial compliance, or copy of survey including facility's corrective action plan if deficiencies were cited
- Facility Specific Checklist – Additional items as specified 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Has this facility/organization, under current, former name, or business identity, ever had it accreditation revoked or suspended?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Does your organization or any of its authorized representatives currently have any pending or settled legal actions?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Is your facility/organization covered by Commercial General Liability insurance in the amount of \$1million per occurrence? (*Required - Provide copy)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)? (*Required Provide copy)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Does your facility comply with State and Federal handicap access standards, if applicable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	Does your facility verify on-line exclusion lists for the Department of Health and Human Services Office of Inspector General (https://exclusions.oig.hhs.gov/) and System for Award Management (https://sam.gov/) are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthly basis to ensure that no state or federally excluded individuals perform any function related to any state or federal healthcare program and further certify removal of any employee or contracted service provider that is found on one of the above referenced federal exclusion lists?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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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.

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

- None of these languages (English Only)
- American Sign Language
- Interpreter Services Utilized by Facility

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Release of Information

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 hereby 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: _____