KERN HEALTH SYSTEMS

PLEASE RETURN THIS CHECK-LIST WITH YOUR APPLICATION

Asthma Preventive Services (APS) Provider
APS PROVIDER APPLICATION CHECK-LIST

1. ☐ Section I. Personal Information

2. ☐ Section II. Education

3. ☐ Section III. Current Employment or Volunteer Work

4. ☐ Section IV
   - ☐ Certificate from CDPH Asthma Management Academy; OR
   - ☐ Certificate demonstrating completion of a training program consistent with the guidelines of the National Institutes of Health's Guidelines for the Diagnosis and Management of Asthma with core competences

   Attachments:
   - ☐ Documentation 16-hours face to face client contact in asthma management
   - ☐ Documentation 4-hours annually of continuing education on asthma

5. ☐ Section V. Attestation

6. ☐ Section VI. Application Signature & Date

7. ☐ Section VII. Supervising Provider Signature & date

NOTIFICATIONS:

- ***KEEP A COPY OF ALL MATERIALS SUBMITTED FOR YOUR RECORDS AS THE SUPERVISING PROVIDER MUST MAINTAIN EVIDENCE OF EXPERIENCE, MINIMUM QUALIFICATIONS, AND RELEVANT ANNUAL TRAINING.***
- ***APS EMPLOYERS ARE RESPONSIBLE FOR VERIFICATION OF APPLICANTS' PERSONAL OR BACKGROUND INFORMATION.***
- ***YOU HAVE THE RIGHT TO REQUEST AND BE INFORMED ABOUT INFORMATION THAT KHS COLLECTS ABOUT YOU OTHER THAN PROTECTED BY PEER REVIEW LAWS. YOU ARE ENTITLED TO CORRECT ERRONEOUS INFORMATION UPON REQUEST. YOU ALSO HAVE THE RIGHT TO ASK THE STATUS OF YOUR APPLICATION.***

Mail, email or fax complete application to:

Mail to: Kern Health Systems Attn: PNM-Credentialing 2900 Buck Owens Blvd Bakersfield CA 93309	**Email to:** credentialing@khs-net.com **Fax to:** 661-716-9619

Section I. Personal Information
(Please *Print* or *Type* all information in ink)

Last Name | First Name | Middle Name

Home Address (Street Address) | Apt.# | City | State | Zip Code | County

Social Security Number | Mobile/Cell Phone

Date of Birth (Month/Day/Year) | **Gender:** ☐ **Female** ☐ **Male**

Email address | NPI Number

Race/Ethnicity **(Optional for Directory Purposes Only to help members make informed choice and to ensure our network is adequate to meet the needs of our members)** ☐ **Decline to Disclose**

☐ **American Indian/Alaskan** ☐ **Asian** ☐ **Black/African American** ☐ **Hispanic/Latino** ☐ **White**

☐ **Native Hawaiian/Other Pacific Islander** ☐ **Other (Specify)**

Language(s) used

English:	☐ **Speak**	☐ **Read**	☐ **Write**	**Preferred Language for Correspondence:**	☐ **English**	☐ **Spanish**
Spanish:	☐ **Speak**	☐ **Read**	☐ **Write**	**(Specify Other Language)**		
Other:	☐ **Speak**	☐ **Read**	☐ **Write**			

Section II. Education
Highest Level of Education Completed (Check One)

☐ Elementary–12th Grade or General Education(GED) ☐ Some College/Jr College or Technical Degree

☐ College/University Degree ☐ Advanced Degree such as Master's or Doctoral

College/Univ. Name: Degree Type:

Section III. Current Employment or Volunteer Work

Name of Organization (Volunteer or Employment)

Address (Street address) | City | State | Zip Code | Phone #

Current Job Title | Work Start Date

Work Status: ☐ Full-Time ☐ Part-Time ☐ Volunteer

Section IV. Application based on Certificate from CDPH

☐ I completed the California Department of Public Health Asthma Management Academy.

Date training completed (MO / DY / YEAR)	☐ Certificate Attached
Sponsoring Organization / Training Program	Instructor
Training Location (City)	☐ **On-Site Program** ☐ **Distance Learning (REMOTE)**

OR Skip to Next Section if completing application based on Training Program

Section IV. Application Based on Training Program

☐ I completed a certificate demonstrating completion of a training program consistent with the guidelines of the National Institutes of Health's Guidelines for the diagnosis and management of asthma with core competencies in the following areas:

- Basic facts of asthma's impact on the human body, including asthma control
- Roles of medications
- Environmental control measures
- Teaching individuals about asthma self-monitoring
- Implementation of a plan of care
- Effective communication strategies including at a minimum cultural and linguistic competency and motivational interviewing
- Roles of a care team and community referrals

Date training completed (MO / DY / YEAR)	☐ Certificate Attached
Sponsoring Organization / Training Program	Instructor
Training Location (City)	☐ **On-Site Program** ☐ **Distance Learning (REMOTE)**

Section V. APS Provider Attestation

Please read the following statements carefully. Sign or type your name below to indicate your understanding and acceptance of this attestation and acknowledgement statements in the space provide below.

Asthma Preventive Service Providers
Asthma prevention services may be provided by licensed providers such as Physicians, NP's and PA's. These services may also be provided by unlicensed providers such as community health workers (CHW), promotores, or community health representatives who meet the qualifications of an asthma preventive service provider as stated below.
For more information, refer to the Community Health Worker (CHW) Preventive Services section in Part 2 of the DHCS Provider Manual.

Asthma Education and Home Assessments for Environmental Triggers
CHWs who have not met the qualifications listed in Section IV may not provide asthma education or in-home environmental trigger assessments, but they may provide CHW services for health education and navigation, as defined in the Provider Manual for CHWs, to individuals with asthma. Unlicensed asthma preventive service providers must be supervised by either a physician, physician assistant, nurse practitioner, clinic, hospital, local health jurisdiction, or community-based organization.

Completed:

- Completed a minimum of 16 hours of face-to-face client contact focused on asthma management and prevention.
- Four hours annually of continuing education on asthma.

Section VI. APS Provider Application Signature

- I certify that all the information provided by me in connection with this application is true and complete. I understand providing false or misleading information, material omissions or misrepresentations which is used in determining my qualifications may result in the voiding of the application and failure to be granted APS network participation.
- I agree to abide by Kern Health Systems (KHS) Policy and Procedures, KHS provider service agreement, the Department of Health Care Services All Plan Letter 22-016, 42 CFR 440.130(c) and any subsequent updates, related to Community Health Worker Service Benefit and/or DHCS Provider Manual for Asthma Preventive Service Providers.
- I further give KHS permission to verify any information, work or volunteer experience, which are important in determining my qualifications.
- I understand the application and supporting documentation submitted become the property of KHS and are non-returnable.
- I shall advise KHS PNM-Credentialing Department of my current address immediately, but no later than 10-days, of any changes of address or within 1-day of other significant changes in my work, volunteer status and/or certification.
- I understand my employer is responsible for verification of my personal or background information.

I acknowledge that this application is not a contract between me and Kern Health Systems and does not make me an employee, agent, contractor, or representative of Kern Health Systems.

APS Provider Signature **(Electronic or Digital Signatures Accepted / Stamped or Changed Font Signatures are NOT ACCEPTABLE)**	**Date**

Section VII. Supervising Provider / Attestation & Acknowledgement

TO BE COMPLETED BY SUPERVISOR(S) LISTED IN SECTION III
Form must be submitted with Application

- I attest that as the Supervising Provider, I meet the qualification as a licensed provider, or other acceptable supervising provider designated within a hospital, outpatient clinic, local health jurisdiction (LHJ) or a community-based organization (CBO), employing or otherwise overseeing the APS Provider, with which Kern Health Systems (KHS) contracts.
- I agree to ensure that the APS Provider meets the qualification listed in the KHS Policy and Procedures, KHS provider service agreement, and the DHCS Provider Manual for Asthma Preventive Service Providers.
- I agree to oversee the APS Provider and the services delivered to KHS beneficiaries, and submit claims for services provided by the APS Provider.
- I understand as the Supervising Provider, I must maintain evidence of the APS Provider's education, minimum qualifications, training, and additional relevant training annually and will provide, upon request, to KHS Staff or DHCS Staff.
- I acknowledge responsibility for ensuring the provision of Asthma Preventive services complies with all applicable requirements and will provide direct or indirect oversight to the APS Provider including but not limited to; guiding APS Provider in providing services, participating in the development of a plan of care, and following up on the progression of APS services to ensure that services are provided in compliance with all applicable requirements. Indirect oversight includes, but is not limited to, ensuring connectivity of APS Providers with the ordering entity and ensuring appropriate services are provided in compliance with all applicable regulations.
- I understand employers of the APS Provider are responsible for verification of applicants' personal or background information.
- I understand it is my responsibility to submit to KHS PNM-Credentialing Department all APS Provider Applications prior to initiating services to a KFHC Members; claims will be denied if services are rendered prior to receiving approval of the APS Provider or prior to receiving an official approval letter and effective date. I further understand my responsibility to notify KHS PNM Department of any changes to my practice, including changes to the APS Provider providing services in my office including those who are no longer active, or who have significant changes in their work, volunteer status and/or certification immediately, but no later than 10-days of any changes.

Business Name:		**Business Tax ID:**	
APS Provider Name:		**APS Provider NPI:**	
Supervising Provider Name:		**Supervising Provider NPI:**	
Supervising Provider's Signature **(Electronic or Digital Signatures Accepted / Stamped or Changed Font Signatures are NOT ACCEPTABLE)**		**Date**	