MATERNAL, CHILD AND ADOLESCENT HEALTH DIVISION
APPLICATION TO PARTICIPATE IN THE
COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

Complete and submit this application form to your local CPSP Perinatal Services Coordinator (PSC) as listed at CPSP website (www.cdph.ca.gov/CPSP)

IMPORTANT: Please read all the attached materials thoroughly before completing this form and retain a copy for your records.

For State Use only

Date Received:_____

Effective Date:_____

1. GENERAL INFORMATION

Legal Name of Applicant *(must be the same name used for Federal Internal Revenue Service Tax Identification)* | Telephone Number: ( )

AKA (optional)

Service Address:			Mailing Address *(if different from services address)*		
City	State	Zip Code	City	State	Zip Code

Contact Person	Contact's Telephone Number	E-mail Address

2. PROVIDER DETAILS

National Provider Identifier (NPI) *(must match the legal name of the applicant)*

Provider Name (Primary Supervising): | License Number

Please check the CPSP applicant's Medi-Cal Provider type:

☐ FQHC/RHC/IHC ☐ Alternative Birthing Center ☐ Clinic ☐ Group ☐ Solo Provider ☐ Hospital

Is provider a Certified Nurse Midwife (CNM)? ☐ Yes ☐ No *(if "No", skip this section)*

Physician's Name (to *whom high risk clients are referred*):_____

Physician's License Number:_____

3. LIST OF PRACTITIONERS PROVIDING CPSP SERVICES

#	(a) Practitioner Name	(b) Practitioner Type *(e.g., MD, NP, CNM, RD, CPHW)*	(c) Licensed and Non-Licensed Staff	(d) Type of Service Provided *								(e) Years of Exp.
				OB	*B*	*CO*	*Edu*	*N*	*Psy*	*CC*	*CON*	
1			License or Certification:_____ Institute:_____ Degree:_____ Year:_____	☐	☐	☐	☐	☐	☐	☐	☐	___
2			License or Certification:_____ Institute:_____ Degree:_____ Year:_____	☐	☐	☐	☐	☐	☐	☐	☐	___
3			License or Certification:_____ Institute:_____ Degree:_____ Year:_____	☐	☐	☐	☐	☐	☐	☐	☐	___

#	(a) Practitioner Name	(b) Practitioner Type *(e.g., MD, NP, CNM, RD, CPHW)*	(c) Licensed and Non-Licensed Staff	(d) Type of Service Provided *								(e) Years of Exp.
				OB	*B*	*CO*	*Edu*	*N*	*Psy*	*CC*	*CON*	
4			License or Certification: Institute: Degree: Year:	☐	☐	☐	☐	☐	☐	☐	☐	___
5			License or Certification: Institute: Degree: Year:	☐	☐	☐	☐	☐	☐	☐	☐	___
6			License or Certification: Institute: Degree: Year:	☐	☐	☐	☐	☐	☐	☐	☐	___
7			License or Certification: Institute: Degree: Year:	☐	☐	☐	☐	☐	☐	☐	☐	___
8			License or Certification: Institute: Degree: Year:	☐	☐	☐	☐	☐	☐	☐	☐	___
9			License or Certification: Institute: Degree: Year:	☐	☐	☐	☐	☐	☐	☐	☐	___
10			License or Certification: Institute: Degree: Year:	☐	☐	☐	☐	☐	☐	☐	☐	___

** OB = OB/GYN services* *B = Backup physician* *C0 = Client Orientation* *Edu = Health Education*
N = Nutrition *Psy = Psychosocial* *CC = Case Coordination* *Con = Consultation*

☐ **Additional Practitioners (Complete CDPH 4448A)**

4. DISCIPLINE-SPECIFIC PROTOCOLS

Name (Health Education Consultant)

Name (Nutrition Consultant)

Name (Psychosocial Consultant)

Is provider using previously approved protocols? ☐ Yes ☐ No *(if "No", skip this section)*

Identify which protocols you will be using (*e.g., XXX County protocols*): _____

Please identify the responsible party ensuring that protocols are tailored to the provider site: _____

5. STATE-SPONSORED PROVIDER OVERVIEW TRAINING

#	Staff Name	Title	Training Date *(attended)*	Training Date *(will attend)*
1				
2				
3				
4				

#	Staff Name	Title	Training Date *(attended)*	Training Date *(will attend)*
5				
6				
7				
8				
9				
10				

6. ATTACHMENTS (ATTACH AND LABEL THE FOLLOWING REQUIRED 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. **Nutrition, Psychosocial, and Health Education Assessment Tools:** Nutrition, psychosocial, and health education documents for initial assessment, trimester reassessments, and postpartum assessments.

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

IV. **General Description of Practice:** A description of 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 name(s) and address(es) of the person(s) and agency(ies) 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 and Dual Provider Model 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 provider(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. DELIVERIES

a. Please indicate the approximate number of deliveries in the last 12 months: _____

Of the total deliveries, please list the approximate number of Medi-Cal deliveries: _____

8. AUTHORIZATION

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	Title (print or type)	Applicant or authorized agent's original signature	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.

FOR LOCAL HEALTH JURISDICTION (LHJ) USE ONLY

ACTIONS TAKEN ON APPLICATION

Date	Action	Initial
	PSC received Application	
	Returned for additional information	
	Application resubmitted	
	Returned for additional information	
	Application resubmitted	

CPSP PSC'S RECOMMENDATION TO CDPH

☐ Deferred ☐ Recommended → **Provider Effective Date**:_____

Local Agency Name

Perinatal Service Coordinator Name *(print or type)*	Title
PSC Signature ➤	Signature Date ➤

INSTRUCTIONS - *For completing the application to participate in the Comprehensive Perinatal Services Program*

- Type or print form in black ink.
- It is recommended that you review Title 22, California Code of Regulations (CCR) for CPSP, Sections 51001 through 51504.1, before submitting this application. The CCR pertaining to CPSP providers can be found at California Code of Regulations website (http://ccr.oal.ca.gov).
- A separate application must be submitted for each service site.
- Submit the completed application form to your local Perinatal Services Coordinator (PSC). A listing of PSCs can be found at the CPSP website (www.cdph.ca.gov/CPSP).

FORM ENTRIES

1) GENERAL INFORMATION – Identify your legal name ("AKA" is optional). The legal name must match your Federal Internal Revenue Service Tax Identification number. Include:

- Service address
- Mailing address (if different from service address)
- City, state, zip code
- Telephone number
- E-mail address

2) PROVIDER DETAILS –

National Provider Identifier (NPI): The number under which you will bill Medi-Cal for CPSP services. The NPI must match the legal name of the applicant.

Primary CPSP supervising provider:

Medi-Cal provider type:

- Alternative Birthing Center
- Clinic
- FQHC/RHC/IHC
- Group Hospital
- Solo Provider

Certified Nurse Midwives (CNM): If the provider is a CNM, identify the physician to whom high risk clients are referred *and their license number*

3) LIST OF PRACTITIONERS PROVIDING CPSP SERVICES –

Complete the table identifying the practitioners providing CPSP services and which services each staff person will be providing to patients. Each provider will state in their site specific protocols that all CPSP services are provided by or under the personal supervision of a physician." (See CCR, Section 51179 and 51179.5.)

Complete CDPH 4448A, if listing more than 10 practitioners.

(a) Practitioner Name:

(b) Practitioner Type: *(choose one)*

- MD=Physician in OB/GYN, family practice, general practice, pediatrician
- CNM = Certified Nurse Midwife
- Phys. Asst. = Physician's Assistant
- RN's
- LVN's
- NP
- Social Worker
- Psychologist = Psychologist/MFT
- RD
- Health Educators
- CCE = Certified Childbirth Educators
- CPHW = Comprehensive Perinatal Health Workers

(c) Licensed and Non-Licensed Staff:

(d) Service Type: *(choose all that apply)*

OB = OB/GYN services
B = Backup physician (if attending physician is not available)
CO = Client Orientation
Edu = Health Education
N = Nutrition
Psy = Psychosocial
CC = Case Coordination
Con = Consultation for those patients identified as high risk

(e) Years of Service Experience: Number of years performing services as indicated 3(e). (One year experience in maternal and child health).

4) DISCIPLINE-SPECIFIC PROTOCOLS –

Identify consultants who will be signing the CPSP discipline specific protocols and/or providing consultation

- The provider must implement approved protocols within six months of being approved as a CPSP provider. Protocols must align with the assessment form used.
- Protocols are "written procedures for providing psychosocial, nutrition, and health education services and related case coordination" and must be approved by the provider and the consultants listed in this section.
- List the consultants who will approve the protocols for the health education, nutrition, and psychosocial CPSP services. New providers who use previously approved template protocols, tailored to their practice do not need to have them signed by a health educator, dietician or social worker. However, include a statement on the application such as "Using 2009 XXX County Protocols."
- Regardless of whether newly developed or previously approved protocols are used, providers must identify their health education, nutrition and psychosocial consultants on the application who are available for consultation for each discipline.
- Identify the responsible party ensuring that protocols are tailored to the provider site.

5) STATE-SPONSORED PROVIDER OVERVIEW TRAINING - Please indicate the staff that have attended a state-sponsored Provider Overview (in-person or online) and Steps to Take training in the provision of CPSP services. If you have not attended training and you need information on scheduled state-sponsored trainings, contact your local CPSP PSC or visit http://cdph.ca.gov/cpsp.

6) ATTACHMENTS - Attach and label with sequential numbers the required documents in the order they are described:

Attachment I: Prenatal Medical Record Form(s)/screenshot of EHR

Attachment II: Nutrition, Psychosocial, and Health Education Assessment Tools

Attachment III: The Individualized Care Plan

Attachment IV: General Description of Practice

Attachment V: List of Delivery Hospitals

Attachment VI: List of Mandated Referral Services - List the names and addresses of the persons and agencies that you refer clients to:

- Medical Care (OB and non-OB)
- Well-Child Care (e.g., CHDP)
- Family Planning
- Supplemental Food Program for Women, Infants and Children (WIC)
- Genetic Services
- Dental Services

If you need information on the services above, contact your local CPSP PSC.

Attachment VII: Antepartum/Intrapartum/Postpartum and Dual Provider Model Agreements

7) SERVICE DELIVERIES - a. Provide the approximate number of total deliveries. b. Of the total deliveries, list the number of Medi-Cal deliveries in the last 12 months.

8) LEGALLY AUTHORIZED –

Signature: The application should be signed by the CPSP applicant or an agent of the organization.

Date: This should be the date the completed application is submitted to the local PSC.

CPSP Provider Application Checklist

Please use this checklist in preparing your CPSP Provider Application prior to submitting it to your local CPSP PSC.

- ☐ Carefully read over the *Instructions for Completing the Provider Application* and review the *CPSP Regulations*.
- ☐ Complete the *Application for Certification as a Comprehensive Perinatal Services Program Provider* (CDPH 4448).
- ☐ Attach the *Perinatal Medical Record Form(s)* (Attachment I to CDPH 4448).
- ☐ Attach the *Nutrition, Psychosocial, and Health Education Assessment Tools* (Attachment II to CDPH 4448).
- ☐ Attach the *Individualized Care Plan Form* if separate from the assessment tool (Attachment III to CDPH 4448).
- ☐ Attach the *General Description of the Practice* (Attachment IV to CDPH 4448).
- ☐ Attach the list of *Delivery Hospitals* (Attachment V to CDPH 4448).
- ☐ Attach the list of *Referral Services* (Attachment VI to CDPH 4448).
- ☐ Attach the *Antepartum/Intrapartum/Postpartum Agreement(s)* (if applicable) (Attachment VII to CDPH 4448).
- ☐ Sign and date the application.
- ☐ Submit the completed application to your local CPSP PSC.