Dear Applicant:

To enroll as a Family, Planning, Access, Care and Treatment (Family PACT) provider, please complete the enclosed Family PACT provider enrollment application package and return it by email or mail to:

email: ProviderServices@dhcs.ca.gov
Mail: Department of Health Care Services
Office of Family Planning
MS 8400
P.O. Box 997413
Sacramento, California, 95899-7413

Please read all the instructions included in the application package carefully and complete each item requested. **Incomplete application packages will be returned.**

Eligible Providers. Per California Welfare and Institutions Code (W&I Code), Section 24005(b) and (c), eligible providers are licensed medical personnel with family planning skills, competency and knowledge, who will provide the full range of services covered in the program, as long as these services are within the provider's scope of licensure and practice. Clinical providers electing to participate in the Family PACT program must be enrolled Medi-Cal providers in good standing.

Solo providers, group providers or primary care clinics are eligible to apply for enrollment in the Family PACT program if they currently have a National Provider Identifier (NPI) and are enrolled in Medi-Cal in good standing. An affiliate primary care clinic's enrollment in the Family PACT program is dictated by W&I Code, Section 24005(t)(1) through (2). Intermittent clinics, as defined by Health and Safety Code (H&S Code), Section 1206(h) and mobile clinics, as defined by H&S Code, Sections 1765, 120, 1765.150 and 1765.155, must apply for enrollment in the Family PACT program using their organizational NPI. The organizational NPI must be enrolled in Medi-Cal in good standing.

Providers are required to submit their NPI with each application package. Providers are required to attach a copy of the CMS/National Plan and Provider Enumeration System (NPPES) confirmation for each NPI listed in the application package.

Service Location. A provider's service location is certified for enrollment in the Family PACT program when the provider meets all the Family PACT provider enrollment requirements set forth in the Family PACT Policies, Procedures and Billing Instructions (PPBI) Manual. **All Family PACT services shall be rendered at the enrolled service location(s) only.** All information on the application must match the information on file in the Medi-Cal's Provider Master File database.

Non-Physician Medical Practitioners. Non-Physician Medical Practitioners (NMPs) employed by a Medi-Cal provider who is applying to enroll in the Family PACT program and who will be delivering Family PACT services must be identified.

Provider Orientation. New Family PACT providers and/or new provider locations will be provisionally certified for enrollment into the Family PACT program after the provider is enrolled in Medi-Cal and until an eligible representative attends a legislatively mandated provider orientation as determined by DHCS. A provider must attend an orientation within six (6) months of the date of initial Family PACT enrollment for the provisional certification to be lifted. If a provider does not attend an orientation within six (6) months of the date of initial Family PACT enrollment, that provider and/or provider location will be disenrolled from the Family PACT program.

Providers who are enrolled in Medi-Cal, in good standing, or are pending Medi-Cal enrollment, and who have submitted a Family PACT application may register for a provider orientation to certify a site for enrollment.

The medical director, physician, nurse practitioner, or certified nurse midwife responsible for overseeing the family planning services to be rendered at the site establishing enrollment is eligible to certify the site. Site certifiers shall sign a statement of affirming responsibility. Provider Orientation details and registration information are posted on the Family PACT website at www.familypact.org.

Records Retention. Providers must maintain legible copies of all initial and updated applications (DHCS 4468) and initial and updated provider agreements (DHCS 4469) at the provider site.

Reporting a Change of Information. Providers are responsible for notifying the DHCS Provider Enrollment Division within 35 days of any change in previously submitted information. When submitting changes to a Medi-Cal record (for example, changes to a service address, NPI, FEIN, legal name or business name), providers are required to submit a completed Application to Participate in the Family PACT Program (DHCS 4468) to Family PACT Provider Enrollment.

If adding a new or additional service site, submitting a change of provider type, or a change of ownership, a provider must re-apply for enrollment in the Family PACT Program.

Provider Disenrollment. Providers may terminate their participation in the Family PACT Program at any time by providing written notification of voluntary termination to Family PACT Provider Enrollment. The letter should be on provider or clinic letterhead and must include the NPI, the service site address, effective date of disenrollment and the provider-owner's signature.

Providers are subject to disenrollment for failure to adhere to program policies and administrative practices. On-site visits and attempts at corrective action may be made prior to disenrollment. Failure to notify DHCS Provider Enrollment Division and the Office of Family Planning/Family PACT Program of any changes to previously submitted information (for example, a change of service location) may result in disenrollment from the Family PACT Program.

DHCS may restrict the participation of a provider in Medi-Cal through suspension or determine that a provider is ineligible to participate in the Medi-Cal program. If a provider is suspended from the Medi-Cal program, enrollment in the Family PACT Program is terminated effective the date of the Medi-Cal suspension and Family PACT services are no longer reimbursable.

If you have any additional enrollment questions, please contact the Family PACT program at (916) 650-0414 or by email at ProviderServices@dhcs.ca.gov.

Family PACT Program

Enclosure(s)

INSTRUCTIONS FOR COMPLETING OF THE FAMILY PACT PROVIDER APPLICATION (DHCS 4468)

DO NOT USE staples on this form or on any attachments.

DO NOT USE correction tape, white out, or highlighter pen on this form. If you must make corrections, please line through, date, and initial in ink.

DO NOT LEAVE any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

This form is part of an application for enrollment or continued enrollment as a provider in the Family PACT program. Providers must also provide additional information and documentation. Applicants may be subject to an on-site inspection and to unannounced visits prior to enrollment or approval for continued enrollment in the program. In addition to this form and requested documentation a Family PACT Provider Agreement (DHCS 4469) must also be completed for enrollment or continued enrollment. Additional information can be found on the Family PACT website (www.familypact.org) by clicking the “Providers” tab, followed by “Provider Enrollment”.

Omission of any information or documentation on this form or failure to sign any of the required documents may result in a denial of the provider's application.

National Provider Identifier (NPI)—enter the NPI of the provider.

Enrollment Action Requested—check the action requested. Enter the date you are completing the application.

“New Provider”—check if the provider is not currently enrolled in the Family PACT program as a provider with an active provider number. Include the NPI for the business address indicated in item 6.

“Change of business address”—check if the provider is currently enrolled in the Family PACT program and is requesting to relocate to a new business address and vacate the old location. Indicate the new business address provider under Type of Entity number 1 through number 13.

“Additional business address”—check if the provider is currently enrolled in the Family PACT program and is requesting enrollment for an additional business location.

“New Taxpayer ID number”—check if a new Taxpayer Identification Number (TIN) was issued by the IRS.

“Change of ownership”—check if there is a change of ownership as defined in CCR, Title 22, Section 51000.6. Indicate the effective date in the space provided.

“Continued Enrollment”—check if the provider is currently enrolled as a Family PACT provider and has been requested by the Department to apply for continued enrollment in the Family PACT program. Do not check this box unless you have received notification from the Department.

“Medi-Cal Enrollment Status”—check if the provider is currently enrolled in the Medi-Cal program. Indicate the application process status, as applicable. Attach verification if applicable.

"Type of entity"—check the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, you must attach a legible copy of the partnership agreement. If you check "other", list the type of legal entity.

1. **"Legal Name"** is the name listed with the Internal Revenue Service (IRS).
2. **"Business Name"** is the name of the provider if different from that listed in number 1.
3. **"Business Telephone Number"** is the primary business telephone number used at the business address. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the primary business telephone.
4. **"Business Email Address"** is the primary business email used at the business address.
5. **"Business Facsimile"** is the fax used at the primary business address.

   "Fictitious Business Name"— check if the business name is fictitious. If this is a fictitious business name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit to the application. If non-applicable, write "N/A".
6. **"Business Address"** is the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office or commercial box is not acceptable.
7. **"Pay-to-Address"** is the address at which the provider wishes to receive payment. The pay-to address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
8. **"Mailing Address"** is the location at which the provider wishes to receive general DHCS correspondence.
9. "**License Number"** enter the license/certificate number, or other approval to provide health care, of the provider. Attach a legible copy of the license, certificate, or approval. Enter the effective date and the expiration date of the license/certificate number, or other approval. If you are a government entity, write "Exempt".
10. "**Taxpayer Identification Number (TIN)**"enter the TIN issued by the IRS under the name of the provider. Attach a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, Form 2363, or Form SS-4 (Confirmation Notification).
11. "**Social Security Number**" if the business is a sole proprietorship not using a TIN, provide the social security number of the sole proprietor. Attach a legible copy to the application.

    "Driver's License" enter the driver's license or the state issued identification number and state of issuance of any individual named in number 1. Attach a legible copy to the application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.

    "Date of Birth" enter the date of birth of the individual named in number 1, if applicable. If not applicable, enter N/A.

    "Additional Service site(s)" are the addresses the provider is requesting to enroll or are enrolled in Family PACT. List the business sites, other than the one listed in number 1, at which Family PACT services will be provided.

"Practitioners" are all practitioners (medical doctors, certified nurse midwifes, nurse practitioners, physician assistants) who will be providing clinical family planning services under the Family PACT program. Enter the practitioner name. Enter the license type (MD, DO, CNM, NP, PA). Enter the practitioners individual NPI.

"Ownership Interest and/or Managing Control Information (Entities)"— list all corporations, unincorporated associations, partnerships, or similar entities having 5% or more (direct or indirect) ownership or control interest, or **any** partnership interest, in the applicant/ provider identified in number 1.

"Printed Name of Applicant or Provider"—print the last, first, and middle name of the person who is signing the application. The application must be signed by a person who is authorized to legally bind the provider.

Enter the driver's license or state-issued identification number and state of issuance of the individual named in number 17. Attach a legible copy to the application.

Enter the date of birth of the individual named in number 17.

Enter the social security number of the individual named in number 17.

An original signature of the individual named in number 17 is required. Also provide the title of the person signing the application. Include the city, state, and the date where and when the application was signed.

To assist in the timely processing of the application package, enter the name, e-mail address, and telephone number of the individual who can be contacted by DHCS to answer questions regarding the application package. Failure to include this information may result in the application package being returned deficient for item(s) that a provider can readily provide by email, fax or telephone.

- Attach CMS/NPPES confirmation for each NPI listed.

Privacy Statement (Civil Code, Section 1798 et seq.)

This information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your application being delayed or not processed.

FAMILY PACT APPLICATION (DHCS 4468) CHECKLIST

Please remember to include a legible copy of the following with your application package;

- ☐ Verification of enrollment into Medi-Cal or Medicare (if applicable)
- ☐ Driver's license or state issued identification card(s)
- ☐ TIN Verification
- ☐ Social Security Card
- ☐ License, Certification, or other approval
- ☐ Fictitious Business Name Statement/Permit
- ☐ National Provider Identifier Verification (CMS/NPPES confirmation) for each NPI listed on the application

If you have any additional questions, please contact the Family PACT program at (916) 650-0414 or by email at ProviderServices@dhcs.ca.gov.

FAMILY PACT PROVIDER APPLICATION

FOR STATE USE ONLY

Important:

- Read all instructions before completing the application
- Type or print clearly, in ink.
- If you must make corrections, please line through, date and initial in ink.
- Return completed forms by email or mail to:

email: ProviderServices@dhcs.ca.gov
Mail: Department of Health Care Services
Office of Family Planning
MS 8400
P.O. Box 997413 Sacramento,
California, 95899-7413

Do not use staples on this form or any attachments.
Do not leave any questions, lines, etc. blank. Enter N/A if not applicable to you.

National Provider Identifier (NPI) _____ Date _____

Enrollment action requested **(check all that apply)**

- ☐ New Provider
- ☐ Change of business address
- ☐ Additional business address
- ☐ Update _____
  Indicate effective date _____
- ☐ Change of Ownership
  New Tax Payer ID number _____
- ☐ Continued Enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Family PACT Program.

Medi-Cal Enrollment Status

- ☐ I am currently enrolled in the Medi-Cal program at this business address and under this legal name. (Attach Verification)
- ☐ I am currently enrolled in the Medi-Cal program under a different business address and/or legal name. (Attach Verification)
- ☐ I have a pending Medi-Cal application. **Application date sent:** _____
- ☐ I am not currently enrolled in the Medi-Cal program.

Type of Entity (check one)

- ☐ Sole Proprietor
- ☐ Group Provider
- ☐ Rural Health Center (RC)
- ☐ Indian Health Center (IC)
- ☐ Licensed Community/Free Clinic
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Government entity
- ☐ Other _____

1. Legal name of provider (as listed with the IRS)	
2. Business name, if different	3. Business telephone number
4. Business email address	5. Business facsimile number

Is this a fictitious business name? ☐ Yes ☐ No	If yes, list the fictitious business name statement/permit number	Effective Date

6. Business address (number, street)	City	County	State	Nine-digit ZIP code
7. Pay-to-address (number, street, P.O. Box number)	City	County	State	Nine-digit ZIP code
8. Mailing address (number, street, P.O. Box number)	City	County	State	Nine-digit ZIP code

9. License number (attach a legible copy)	License effective date	License expiration date

10. Taxpayer Identification Number (TIN issued by the IRS (attach a legible copy of the IRS form)	11. Social Security Number. If sole proprietor not using TIN, you must disclose this number.
12. Driver's license or state-issued identification number and state of issuance (attach a legible copy)	13. Date of birth

14. Additional Service Site(s) Please attach a separate sheet of paper for any additional sites not listed below.

Business name		NPI		Business telephone number
Business address (number, street)	City	County	State	Nine-digit ZIP code
Business name		NPI		Business telephone number
Business address (number, street)	City	County	State	Nine-digit ZIP code

15. Practitioners Please attach a separate sheet of paper for any additional practitioners not listed below.

Practitioner Name	License Type	Professional License Number	Individual NPI
Practitioner Name	License Type	Professional License Number	Individual NPI

16. Ownership Interest and/or Managing Control Information (Entity)

In the table below, list all corporations, unincorporated associations, partnerships, or similar entities having 5% or more (direct or indirect) ownership or control interest, or **any** partnership interest, in the applicant/provider identified in number 1.

☐ **Check here if this section does not apply**

Entity Legal Business Name	Percentage of Ownership or Control	NPI Number (If Applicable)
	0%	
Entity Legal Business Name	Percentage of Ownership or Control	NPI Number (If Applicable)
	0%	

Information about the Individual Signing this Application

17. Print name of provider or person signing the application on behalf of the provider.

18. Driver's license or state-issued identification number and state of issuance.	19. Date of Birth	20. Social Security Number

21. I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider pursuant to CCR, Title 22, Section 51000.30(a)(2)(B).

Signature of provider or person on behalf of the applicant or provider	Title

Executed at: _____ (City) _____ (State) on _____ (Date)

22. Contact Person's Information

☐ Check here if you are the same person identified in item 18. If you checked the box, provide only the email address and telephone number below.

Contact Person's Name:

_____ (last) _____ (first) _____ (middle)

Preferred Method of Contact ☐ Mail ☐ Email ☐ Telephone

Title/Position	E-mail address	Telephone number