COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
CHILD HEALTH AND DISABLILITY PREVENTION (CHDP) PROGRAM
CHDP SUPPLEMENTAL APPLICATION

INSTRUCTIONS FOR COMPLETION OF THE CHDP SUPPLEMENTAL APPLICATION

This form is a supplemental application for changes requested by the provider only at this site address. Providers may also need to provide additional information and documentation when applicable. Omission of any required information or documentation on this form or the failure to sign any of these documents may result in the denial or delay of the action(s) requested. **Incomplete applications will be returned.** A separate CHDP Supplemental Application must be completed if you are making changes at another location.

SECTION I: GENERAL INFORMATION
All information in this section must be completed.

1. Enter your current legal name as listed with Medi-Cal.

2. Enter your current NPI Provider Number: NPI provider number should be for the site listed on SECTION I # 3.

3. Enter your business address:
   - Business address (office/site of practice) means the office or location where the provider applicant is providing services, including the street name and number, room or suite or letter, city, and 9-digit ZIP code. A post office box or commercial box is **not** acceptable.

4. Enter your business telephone number:
   - The primary business telephone number used at the Provider Applicant's business address. A beeper number, answering service, answering machine, pager, facsimile machine, or cellular phone is not acceptable as the business telephone number.
   - Fax number means the facsimile number used at this business address.
   - Email is the electronic mail address used at this business address.

5. Enter the name of a contact person for the site listed on SECTION I # 3. CHDP staff may contact this person for any questions/corrections necessary pertaining to the supplemental application.

6. Enter the phone number of the contact person listed on SECTION I # 5.

7. Check the Provider Type that applies to your business structure.
   - The list of types of practice associations shown on the application must meet certain license, registration, etc. Check the appropriate box that describes your profession or business. Check the "clinic" box if your type is a Hospital Outpatient Clinic, Rural Health Clinic, Community Health Clinic, Indian Health Clinic, etc., and specify what type of clinic. Identify the type of practice if the selection is "Other", such as schools. Call the regional office if assistance is needed in determining your provider type or refer to the CHDP Provider Manual.

SECTION II. CHANGED ACTION REQUESTED
All changes must be made through ACS (Affiliated Computer Services) prior to requesting any change with CHDP. Check the applicable action you would like made to the provider master file.

SECTION III. NEW INFORMATION
Please complete only those boxes necessary to provide the information you are adding, changing, or deleting or to complete the action requested.

1. Enter your new NPI provider number that was assigned by ACS.

2. Enter your new Tax ID/SSN. Attach a legible copy of IRS Form 941, Form 8109-C, Form 147-C, Form SS-4 (Confirmation Notification), or Form 2363. If the business is a Sole Proprietorship not using a FEIN, provide the social security number or Individual Taxpayer Identification Number (ITIN) of the Sole Proprietor. Attach a legible copy of the ITIN or social security card, if applicable.

3. Enter your new CLIA number. Attach a legible copy of the CLIA waiver or certificate to match with the site address of the practice.

4. If you are changing your provider category to become a health assessment only provider, please attach a detailed description of your procedures for referral to diagnosis and treatment signed by provider applicant. If you are changing to a comprehensive provider, describe how you will provide 24-hour on-call services. (Refer to the CHDP Provider Manual)

5. Enter new address to which the provider wishes to receive payment. Include the street number, name, city, and 9-digit ZIP code.

6. Enter the new business telephone number.

7. Enter new business fax number.

8. Enter new email used at this business address.

9. Enter the new name of Provider Applicant and provide necessary documentation. If the Provider will perform CHDP Health Assessments, submit a copy of current Medical Board License; Certification in Pediatrics, or Family Practice; and current Curriculum Vitae (CV). (See 7/03 CHDP Provider Manual).

10. Provide current name as listed with Medi-Cal; attach copy of change from EDS. If this is a fictitious business, attach copy of fictitious name permit.

11. List name(s) of clinicians to be approved to provide CHDP health assessments in the office location pertaining to this supplemental application. Attach a copy of current license, and CV for each clinician. List the specialty for each clinician(s), include relevant certification and/or pediatric experience in the past three years. Specify clinician's CHDP experience. *Please note, if requesting the addition of a Nurse Practitioner or Physician Assistant, additional information is required. Documentation of a minimum of 600 hours of pediatric experience and a written agreement with a physician supervisor must also be submitted (See Provider Enrollment Section pg. 3-4 in the 7/03 CHDP Provider Manual).*

12. List the name of the clinician(s) that you want to delete from this provider site. Provide name, professional license number, and effective date of this request.

13. This action is initiated by the Provider Applicant to disenroll the provider site from the CHDP program. Enter the effective date and reason. Attach written notification on the provider's letterhead stationary including name, Medi-Cal number, Federal Employer Identification Number or Social Security Number, Requested effective date, Reason for termination, and original signature of the provider in any color **other than** black ink.

SECTION IV. COMMENTS

List additional information you wish to clarify. Attach a separate sheet if additional space is needed.

Please print and sign the Provider Applicant's name as indicated and date the form prior to sending.

Did you remember to enclose (as applicable):

- ☐ The original, signed CHDP Health Assessment Program Provider Agreement (DHCS 4491)
- ☐ Copy of FEIN or ITIN verification, or social security card, if applicable
- ☐ Copy of Fictitious Business Name Statement/Permit, if applicable
- ☐ Copy of professional licenses, relevant certifications, and curriculum vitae for all clinicians providing CHDP services
- ☐ Description of 24-hour coverage arrangements
- ☐ Description of arrangements for hospitalizations, if applicable
- ☐ Description of referral procedures for diagnosis and treatment, if applicable
- ☐ Other, if applicable

Send complete form to CHDP Headquarters, Attn: Provider Desk at 9320 Telstar Ave. Ste. 226, El Monte, CA 91731.