

**KERN FAMILY HEALTH CARE
ANCILLARY/FACILITY APPLICATION**

Type of Organization: _____ Tax ID #: _____

Organization Name: _____

Address: _____

City: _____ St: _____ Zip: _____

Mailing Address: _____
(If different from above address)

Phone () _____ Fax () _____

E-mail Address: _____

Note: *If there are additional sites please attach a list with the address and contact information for each facility.*

Services Offered: _____

Ownership: Private Corporate Not for Profit Government

Corporation Name: _____
(If applicable)

Owner Name: _____

Owner Address: _____

Phone () _____ Fax () _____

Number of Years in Operation: _____

Contact Person: _____ Title: _____

Phone () _____ Fax () _____

Date of most recent inspection: _____ (include a copy)

Name of agency/organization issuing certification: _____

Name of Accrediting Organization: _____

Note: Attach copies of all certifications/accreditations/licensures

Do you employ Allied Healthcare Providers? Yes No If Yes include:

<u>Full Name</u>	<u>License #</u>	<u>Exp. Date</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Bilingual Staff Yes No

Liability Carrier: _____
(Minimum Professional limits \$1M / \$3M and General limits \$1M)

Medi-Cal Provider: Yes No If Yes, Medi-Cal Provider #: _____

Medi-Care Provider: Yes No If Yes, Medi-Care Provider #: _____

California Children’s Services (CCS): Yes No

Facility Hours:

Monday _____ to _____

Tuesday _____ to _____

Wednesday _____ to _____

Thursday _____ to _____

Friday _____ to _____

Saturday _____ to _____

Sunday _____ to _____

1. Does this facility comply with all state and federal handicap access requirements?
 YES NO If no, attach an explanation
2. Does this organization have a written and implemented quality management plan?
 YES NO
3. Has the license held by this organization ever been sanctioned, censored, suspended, revoked, limited, not renewed, voluntarily relinquished, or surrendered while under investigation?
 YES NO If yes, attach a detailed explanation.
4. Has this organization been named in a professional malpractice action during the past two (2) years?
 YES NO If yes, number of pending claims ____;
number of claims ____ ; number of judgements/settlements _____. Provide details about claims, judgments or settlements that the organization would like to have considered in review of this application.
5. Has this organization ever been sanctioned, excluded, suspended or disqualified by Medicare, Medicaid, or other federal funded program?
 YES NO If yes, attach a detailed explanation.
6. Has this organization ever been disciplined by a state licensing or other authorizing agency, or by any professional conduct board?
 YES NO If yes, attach a detailed explanation.
7. Is this organization currently under a corrective action plan by any certifying, licensing, or accrediting agency or organization?
 YES NO If yes, attach a detailed explanation.

I confirm that all allied health providers that we employ will maintain a current license for the duration of the contract with KHS. If at anytime action is taken against one of our Allied health provider's license KHS will be notified immediately. By my signature, I attest that to the best of my knowledge all information in this application is true and correct and that I have the authority to sign this attestation on behalf of the applicant organization.

Signature: _____ Date: _____

Print Name: _____ Title: _____