CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Michelle Baass | Director

CYBHI FEE SCHEDULE PARTICIPATION PROVIDER AGREEMENT – LOCAL EDUCATIONAL AGENCIES

Application for Enrollment or Continued Enrollment in the Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule Program

Do not leave any questions, lines, etc. blank. Enter N/A if not applicable to your organization.

		Date	
Legal name of applicant or provider (hereinafter jointly referred to as "Provider")	Business name (if different than legal name)		
Provider number (NPI)		Business Telephone Number ( )	
Business address (number, street)	City	State	Zip code
Mailing address (number, street)	City	State	Zip code
Pay-to address (number, street)	City	State	Zip code
Taxpayer Identification Number[1]			

EXECUTION OF THIS CYBHI PROVIDER PARTICIPATION AGREEMENT BETWEEN AN APPLICANT OR PROVIDER (HEREINAFTER JOINTLY REFERRED TO AS "PROVIDER") AND THE DEPARTMENT OF HEALTH CARE SERVICES (HERINAFTER "DHCS") IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE CYBHI FEE SCHEDULE PROGRAM, PURSUANT TO THE WELFARE AND INSTITUTIONS CODE, SECTION 5961.4, AND THE MEDI-CAL PROGRAM, PURSUANT

[1] The taxpayer identification number may be a Taxpayer Identification Number (TIN) or a social security number for sole proprietors.

TO 42 UNITED STATES CODE, SECTION 1396a(a)(27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431.107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22 OF THE CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).

EXECUTION OF THIS CYBHI FEE SCHEDULE PROVIDER AGREEMENT HAS THE EFFECT OF ENROLLING THE PROVIDER IN THE MEDI-CAL PROGRAM. AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE CYBHI FEE SCHEDULE PROGRAM AND THE MEDI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL APPLICABLE FEDERAL AND STATE LAWS AND REGULATIONS AND ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S)HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE.

A. CYBHI FEE SCHEDULE PROGRAM LEGAL CONTEXT

1. Pursuant to Welfare and Institutions (W&I) Code section 5961.4, DHCS developed the statewide school-linked fee schedule (hereinafter CYBHI Fee Schedule) program and provider network to reimburse providers for the provision of outpatient mental health and substance use disorder services furnished to a student, 25 years of age or younger, at a schoolsite.[2]
2. Each Medi-Cal Managed Care Plan (hereinafter MCP) and the Medi-Cal Fee-for-Service Delivery System, pursuant to the W&I Code section 5961.4, health care service plan, pursuant to Health and Safety (H&S) Code section 1374.722, and disability insurer, pursuant to Insurance Code section 10144.53, shall reimburse providers of medically necessary outpatient mental health or substance use disorder treatment provided at a schoolsite to a student 25 years of age or younger who is an enrollee of the plan or delivery system.
3. Provider will be reimbursed at the published fee schedule rates[3] for the provision of medically necessary outpatient mental health and substance use disorder services furnished to a student under the age of 25 at a schoolsite.

[2] Schoolsite means a facility or location used for public kindergarten, elementary, secondary, or postsecondary purposes. "School site" also includes a location not owned or operated by a public school, or public school district, if the school or school district provides or arranges for the provision of medically necessary treatment of a mental health or substance use disorder to its students at that location, including off-campus clinics, mobile counseling services, and similar locations. See H&S Code § 1374.722(b)(6).

[3] CYBHI Fee Schedule, including applicable rates, is published on the DHCS website: https://www.dhcs.ca.gov/CYBHI/Pages/Fee-Schedule.aspx

4. Pursuant to W&I Code section 5961.4(e), this Agreement does not relieve a local educational agency or institution of higher education from requirements to accommodate or provide services to students with disabilities pursuant to any applicable state or federal law, including, but not limited to, the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.), Part 30 (commencing with Section 56000) of Division 4 of Title 2 of the Education Code, Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, and Chapter 3 (commencing with Section 3000) of Division 1 of Title 5 of the California Code of Regulations.

B. MEDI-CAL AND GENERAL TERMS AND CONDITIONS

1. **Term and Termination.** This Agreement will be effective from the date applicant is enrolled as a provider by DHCS, or, from the date Provider is approved for continued enrollment. Provider may terminate this Agreement by providing DHCS with written notice of intent to terminate, which termination shall result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program unless and until such time as Provider is re-enrolled by DHCS in the Medi-Cal program. DHCS may immediately terminate this Agreement for cause if Provider is suspended/excluded for any of the reasons set forth in Paragraph 26(a) below, which termination will result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program and the CYBHI Fee Schedule program. During any period in which Provider is on provisional provider status or preferred provisional provider status, DHCS may terminate this agreement for any of the grounds stated in W&I Code section 14043.27(c).
2. **Compliance with Laws and Regulations.** Provider agrees to comply with all applicable federal and state laws and regulations, including applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200), any applicable rules or regulations promulgated by DHCS pursuant to these Chapters or pursuant to the W&I Code (commencing with Section 5961), the Medi-Cal Provider Manual;[4] the CYBHI Fee Schedule Manual; and Education Code, Division 1, Part 6, Chapter 5, Articles 1, 2, 3 and 4 and Section 49400. Provider further agrees that if it violates any of the provisions of Chapters 7 and 8 of the Welfare and Institutions Code, or any other regulations

[4] https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual

promulgated by DHCS pursuant to these Chapters, it may be subject to any and all sanctions or other remedies available to DHCS. Provider further agrees to comply with all federal laws and regulations governing and regulating Medicaid providers.

3. **National Provider Identifier (NPI).** Provider agrees not to submit any claims to DHCS using an NPI unless that NPI is appropriately registered with the National Provider and Practitioner Enumeration System (NPPES) and is in compliance with all NPI requirements established by the Centers for Medicare and Medicaid Services (CMS) as of the date the claim is submitted. Provider agrees that submission of an NPI to DHCS as part of an application to use that NPI to obtain payment constitutes an implied representation that the NPI submitted is appropriately registered and in compliance with all CMS requirements at the time of submission. Provider also agrees that any subsequent defect in registration or compliance of the NPI constitutes an "addition or change in the information previously submitted" which must be reported to DHCS under the requirements of California Code of Regulations, title 22, section 51000.40.
4. **Forbidden Conduct.** Provider agrees that it shall not engage in conduct inimical to the public health, morals, welfare and safety of any eligible student member, or the fiscal integrity of the Medi-Cal program or the CYBHI Fee Schedule program.
5. **Nondiscrimination.** Provider agrees that it shall not exclude or deny aid, care, service or other benefits available under Medi-Cal or the CYBHI Fee Schedule program or in any other way discriminate against a person because of that person's race, color, ancestry, marital status, national origin, gender, age, economic status, physical or mental disability, political or religious affiliation or beliefs in accordance with California and federal laws. Provider further agrees that it shall provide aid, care, service, or other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public.
6. **Licensing.** To the extent applicable, Provider agrees to possess at the time this Agreement becomes effective, and to maintain in good standing throughout the term of this Agreement, valid and unexpired license(s), certificate(s), or other approval(s) to provide health care services, which is appropriate to the services, goods, supplies, and merchandise being provided, if required by the state or locality in which Provider is located, or by the Federal Government. Provider further agrees that DHCS shall automatically suspend Provider as a provider in the Medi-Cal program pursuant to W&I section 14043.6, if Provider has license(s),

certificate(s), or other approval(s) to provide health care services, which are revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s), or approval(s) while a disciplinary hearing on that/those license(s), certificate(s), or approval(s) was pending. Such suspension shall be effective on the date that Provider's license, certificate, or approval was revoked, suspended, lost, or surrendered. Provider further agrees to notify DHCS within ten business days of learning that any restriction has been placed on, or of a suspension of Provider's license, certificate, or other approval to provide health care. Provider further agrees to provide DHCS complete information related to any restriction to, or revocation or loss of, Provider's license, certificate, or other approval to provide health care services.

7. **Insurance.** Provider agrees to possess at the time this Agreement becomes effective, and to maintain in good standing throughout the term of this Agreement, liability insurance for the business address and, if a licensed practitioner, professional liability (malpractice) insurance coverage from an authorized insurer pursuant to Insurance Code section 700.
8. **Record Keeping and Retention.** Provider agrees to make, keep and maintain in a systematic and orderly manner, and have readily retrievable, such records as are necessary to fully disclose the type and extent of all services, goods, supplies, and merchandise provided to CYBHI Fee Schedule program beneficiaries, including Medi-Cal members, including, but not limited to, the records described in section 51476 of Title 22, California Code of Regulations, and the records described in section 431.107 of Title 42 of the Code of Federal Regulations. Provider further agrees that such records shall be made at or near the time at which the services, goods, supplies, and merchandise are delivered or rendered, and that such records shall be retained by Provider in the form in which they are regularly kept for a period of ten years from the date the goods, supplies, or merchandise were furnished or the services rendered.
9. **DHCS, AG and Secretary Access to Records; Copies of Records.** Provider agrees to make available, during regular business hours, all pertinent financial records, all records of the requisite insurance coverage, and all records concerning the provision of health care services to CYBHI Fee Schedule program beneficiaries, including Medi-Cal members, to any duly authorized representative of DHCS, the California Attorney General's Medi-Cal Fraud Unit ("AG"), and the Secretary of the United States CMS (Secretary). Provider further agrees to

provide, if requested by any of the above, copies of the records and documentation, and that failure to comply with any request to examine or receive copies of such records shall be grounds for immediate suspension of Provider from participation in the Medi-Cal program. Provider will be reimbursed for reasonable copy costs as determined by DHCS, AG or Secretary.

10. **Confidentiality of Member Information.** Provider agrees that all medical records of CYBHI Fee Schedule program beneficiaries, including Medi-Cal members, made or acquired by Provider shall be confidential and shall not be released without the written consent of the member or his/her personal representative, or as otherwise authorized by law.
11. **Disclosure of Information to DHCS.** Provider agrees to disclose all information as required in Federal Medicaid laws and regulations and any other information required by DHCS, and to respond to all requests from DHCS for information. Provider further agrees that the failure of Provider to disclose the required information, or the disclosure of false information shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status or suspension from the Medi-Cal program, which shall include deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program or the CYBHI Fee Schedule program. Provider further agrees that all bills or claims for payment to DHCS, or its designee, by Provider shall not be due and owing to Provider for any period(s) for which information was not reported or was reported falsely to DHCS, or its designee. Provider further agrees to reimburse those CYBHI Fee Schedule program reimbursements received during any period for which information was not reported, or reported falsely, to DHCS.
12. **Information Regarding Subcontractors and Suppliers.** As applicable, Provider agrees to submit, within 35 days of the date on a request by the Secretary or DHCS, the Medicaid agency, full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.
13. **Background Check.** Provider agrees that DHCS may conduct a background check on Provider for the purpose of verifying the accuracy of the information provided in the application and in order to prevent fraud or abuse. The background check may include, but not be limited to, the following: (1) on-site

inspection prior to enrollment; (2) review of medical and business records; and, (3) data searches.

14. **Unannounced Visits by DHCS, AG and Secretary.** Provider agrees that DHCS, AG and/or Secretary may make unannounced visits to Provider, at any of Provider's business locations, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program or the CYBHI Fee Schedule program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program or the CYBHI Fee Schedule program, and/or as necessary for the administration of the Medi-Cal program and/or the fulfillment of the AG's powers and duties under Government Code section 12528. Premises subject to inspection include billing agents, as defined in W&I Code section 14040.1. Failure to permit inspection by DHCS, AG or Secretary or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of provider from participation in the Medi-Cal program and the CYBHI Fee Schedule program.
15. **Provider Fraud and Abuse.** Provider agrees that it shall not engage in or commit fraud or abuse. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. "Abuse" means either: (1) practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the Medicare program, the Medi-Cal program, another state's Medicaid program, or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state; (2) practices that are inconsistent with sound medical practices and result in reimbursement by the Medi-Cal program, the CYBHI Fee Schedule program or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.
16. **Investigations of Provider for Fraud or Abuse.** Provider certifies that, at the time this Agreement was signed, it was not under investigation for fraud or abuse pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations or under investigation for fraud or abuse by any other government entity. Provider further agrees to notify DHCS within ten

business days of learning that it is under investigation for fraud or abuse. Provider further agrees that it shall be subject to temporary suspension pursuant to W&I section 14043.36(a), which shall include temporary deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program or the CYBHI Fee Schedule program, if it is discovered by DHCS that Provider is under investigation for fraud or abuse. Provider further agrees to cooperate with and assist DHCS and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse.

17. **Provider Fraud or Abuse Convictions and/or Civil Fraud or Abuse Liability.** Provider certifies that it and its owners, officers, directors, employees, and agents, has not: (1) been convicted of any felony or misdemeanor involving fraud or abuse in any government program, within the last ten years; or (2) been convicted of any felony or misdemeanor involving the abuse of any patient; or (3) been convicted of any felony or misdemeanor substantially related to the qualifications, functions, or duties of a provider; or (4) entered into a settlement in lieu of conviction for fraud or abuse, within the last ten years; or, (5) been found liable for fraud or abuse in any civil proceeding, within the last ten years. Provider further agrees that DHCS shall not enroll Provider if within the last ten years, Provider has been convicted of any felony or any misdemeanor involving fraud or abuse in any government program, has entered into a settlement in lieu of conviction for fraud or abuse, or has been found liable for fraud or abuse in any civil proceeding.
18. **Changes to Provider Information.** Provider agrees to keep its application for enrollment in the Medi-Cal program or the CYBHI Fee Schedule program current by informing DHCS, Provider Enrollment Division, in writing on a form or forms to be specified by DHCS, within 35 days of any changes to the information contained in its application for enrollment, its disclosure statement, this Agreement, and/or any attachments to these documents.
19. **Prohibition of Rebate, Refund, or Discount.** Provider agrees that it shall not offer, give, furnish, or deliver any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal member or CYBHI Fee Schedule program beneficiary. Provider further agrees that it shall not solicit, request, accept, or receive, any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal member.

Provider further agrees that it will not take any other action or receive any other benefit prohibited by state or federal law.

20. **Member Billing.** Provider agrees that it shall not submit claims to or demand or otherwise collect reimbursement from a CYBHI Fee Schedule program beneficiaries, including Medi-Cal members, or from other persons on behalf of the program beneficiary, for any service included in the CYBHI Fee Schedule program's scope of benefits.
21. **Compliance with Billing and Claims Requirements.** Provider agrees that it shall comply with all of the billing and claims requirements set forth in the Welfare and Institutions Code and its implementing regulations, and the Medi-Cal provider manual.
22. **Payment from CYBHI Fee Schedule Program Shall Constitute Full Payment.** Provider agrees that payment received from a payer of responsibility in accordance with CYBHI Fee Schedule program shall constitute payment in full.
23. **Deficit Reduction Act of 2005, Section 6032 Implementation.** As a condition of payment for services, goods, supplies and merchandise provided to beneficiaries in the Medical Assistance Program ("Medi-Cal"), providers must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act (42 USC 1396a(a)(68)), set forth in that subsection and as the federal Secretary of Health and Human Services (HHS) may specify.
24. **Termination of Provisional Provider or Preferred Provisional Provider Status.** Provider agrees that, while it is on provisional provider status or preferred provisional provider status, the provider will be subject to immediate termination of its provisional provider status or preferred provisional provider status and disenrollment from the Medi-Cal program or the CYBHI Fee Schedule program in the following circumstances:
    a. The provider, persons with an ownership or control interest in the provider, or persons who are directors, officers, or managing employees of the provider have been convicted of any felony, or convicted of any misdemeanor involving fraud or abuse in any government program, related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse, or have been found liable for fraud or abuse in any civil proceeding, or have entered into a settlement in lieu of conviction for fraud or abuse in any

government program within 10 years of the date of the application package.

b. There is a material discrepancy in the information provided to DHCS, or with the requirements to be enrolled in the Medi-Cal program, that is discovered after provisional provider status or preferred provisional provider status has been granted and that cannot be corrected because the discrepancy occurred in the past.
c. The provider has provided material information that was false or misleading at the time it was provided.
d. The provider failed to have an established place of business at the business address for which the application package was submitted at the time of any onsite inspection, announced or unannounced visit, or any additional inspection or review conducted pursuant to this article or a statute or regulation governing the Medi-Cal program, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods supplies, or merchandise are rendered or delivered at locations other than the business address and this practice of delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status of preferred provisional provider status was granted.
e. The provider fails to possess either of the following:
    i. The appropriate licenses, permits, certificates, or other approvals needed to practice the profession or occupation, or provide the services, goods, supplies, or merchandise the provider identified in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted and for the location for which the application was submitted.
    ii. The business or zoning permits or other approval necessary to operate a business at the location identified in its application package approved by the department when the provisional provider status or preferred provisional provider status was granted.
f. The provider commits any violation of a federal or state statute or regulation governing the Medi-Cal program, the CYBHI Fee Schedule program, or of a statute or regulation governing the provider's profession or occupation and the violation represents a threat of immediate jeopardy

or significant harm to any CYBHI Fee Schedule program beneficiaries, including Medi-Cal members, or to the public welfare.

g. The provider submits claims for payment that subject a provider to suspension under W&I Code section 14043.61.
h. The provider submits claims for payment for services, goods, supplies, or merchandise rendered at a location other than the location for which the provider number was issued, unless services are rendered at a location that meets the definition of a schoolsite in the H&S Code section 1374.722(b)(6).
i. The provider has not paid its fine, or has a debt due and owing, including overpayments and penalty assessments, to any federal, state, or local government entity that relates to Medicare, Medicaid, Medi-Cal, or any other federal or state health care program, including the CYBHI Fee Schedule program, and has not made satisfactory arrangements to fulfill the obligation or otherwise been excused by legal process from fulfilling the obligation.

25. **Provider Suspension; Appeal Rights; Reinstatement.** Provider agrees that it is to be subject to the following suspension actions. Provider further agrees that the suspension by DHCS of Provider shall include deactivation of all of Provider's provider numbers and shall preclude Provider from submitting claims for payment, either personally or through claims submitted by any individual, clinic, group, corporation, or other association to the Medi-Cal program and the CYBHI Fee Schedule program for any services, supplies, goods, or merchandise that provider has provided directly or indirectly to a Medi-Cal member, except for services, supplies, goods, or merchandise provided prior to the suspension.
    a. Automatic Suspensions/Mandatory Exclusions. DHCS shall automatically suspend Provider under the following circumstances:
        i. Upon notice from the Secretary of the United States Department of Health and Human Services that Provider has been excluded from participation in the Medicare or Medicaid programs. No administrative appeal of a suspension on this ground shall be available to Provider. (W&I Code section 14123(b), (c).)
        ii. If Provider has license(s), certificate(s), or other approval(s) to provide health care services, revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s),

or approval(s) while a disciplinary hearing on that license, certificate, or approval was pending. (W&I Code section 14043.6.)

iii. If Provider is convicted of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service. Suspension following conviction is not subject to the proceedings under W&I Code section 14123(c). However, the director may grant an informal hearing at the request of the provider to determine in the director's sole discretion if the circumstances surrounding the conviction justify rescinding or otherwise modifying the suspension.

b. Permissive Suspensions/Permissive Exclusions. DHCS may suspend Provider under the following circumstances:

i. Provider violates any of the provisions of Chapter 7 of the W&I Code (commencing with Section 14000 except for Sections 14043–14044), or Chapter 8 (commencing with Section 14200) or any rule or regulations promulgated by DHCS pursuant to those provisions. Administrative appeal pursuant to H&S Code, Section 100171. (W&I Code section 14123(a), (c).)

ii. Provider fails to comply with DHCS' request to examine or receive copies of the books and records pertaining to services rendered to CYBHI Fee Schedule program beneficiaries, including Medi-Cal members. Administrative appeal pursuant to H&S Code section 100171. (W&I Code section 14124.2.)

26. **Legislative and Congressional Changes.** Provider agrees that this Agreement is subject to any future additional requirements, restrictions, limitations, or conditions enacted by the California Legislature or the United States Congress which may affect the provisions, terms, conditions, or funding of this Agreement in any manner.

27. **Provider Capacity.** Provider agrees that Provider, and the officers, directors, employees, and agents of Provider, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State of California.

28. **Indemnification.** Provider agrees to indemnify, defend, and save harmless the State of California, its officers, agents, and employees, from any and all claims and losses accruing or resulting to any and all persons, firms, or corporations furnishing or supplying services, materials, or supplies in connection with

Provider's performance of this Agreement, and from any and all claims and losses accruing or resulting to any CYBHI Fee Schedule program beneficiaries, including Medi-Cal members, or to any other person, firm, or corporation who may be injured or damaged by Provider in the performance of this Agreement.

29. **Governing Law.** This Agreement shall be governed by and interpreted in accordance with the laws of the State of California.
30. **Venue.** Venue for all actions, including federal actions, concerning this Agreement, lies in Sacramento County, California, or in any other county in which the California Department of Justice maintains an office.
31. **Titles.** The titles of the provisions of this Agreement are for convenience and reference only and are not to be considered in interpreting this Agreement.
32. **Severability.** If one or more of the provisions of this Agreement shall be invalid, illegal, void, or unenforceable, the validity, legality, and enforceability of the remaining provisions shall not in any way be affected or impaired. Either party having knowledge of such a provision shall promptly inform the other of the presumed non-applicability of such provision. Should the nonapplicable provision go to the heart of this Agreement, the Agreement shall be terminated in a manner commensurate with the interests of both parties.
33. **Assignability.** Provider agrees that it has no property right in or to its status as a Provider in the Medi-Cal program or in or to the provider number(s) assigned to it, and that Provider may not assign its provider number for use as a Medi-Cal provider, or in the CYBHI Fee Schedule program, or any rights and obligations it has under this Agreement except to the extent purchasing owner is joining this provider agreement with successor liability with joint and several liability.
34. **Waiver.** Any action or inaction by DHCS or any failure of DHCS on any occasion, to enforce any right or provision of this Agreement, shall not be interpreted to be a waiver by DHCS of its rights hereunder and shall not prevent DHCS from enforcing such provision or right on any future occasion. The rights and remedies of DHCS herein are cumulative and are in addition to any other rights or remedies that DHCS may have at law or in equity.
35. **Complete Integration.** This Agreement, including any attachments or documents incorporated herein by express reference, is intended to be a complete integration and there are no prior or contemporaneous different or additional agreements pertaining to the subject matter of this Agreement.
36. **Amendment.** No alteration or variation of the terms or provisions of this Agreement shall be valid unless made in writing and signed by the parties to this

Agreement, and no oral understanding or agreement not set forth in this Agreement, shall be binding on the parties to this Agreement.

37. **Provider Attestation.** Provider agrees that all information it submits on the application form for enrollment, this Agreement, and all attachments or changes to either, is true, accurate, and complete to the best of Provider's knowledge and belief. Provider further agrees to sign the application form for enrollment, this Agreement, and all attachments or changes to either, under penalty of perjury under the laws of the State of California.

C. CYBHI FEE SCHEDULE TERMS AND CONDITIONS

1. **Compliance with the CYBHI Fee Schedule Program Manual.** As a condition of participation in the CYBHI Fee Schedule program, Provider will comply with provisions of the CYBHI Fee Schedule Program Manual promulgated by DHCS pursuant to W&I Code section 5961(g).
2. **Third-Party Administrator (TPA).** DHCS contracted with a TPA entity to administer and oversee the CYBHI Fee Schedule Program.
    a. Provider will timely execute necessary Memoranda of Understanding (MOUs) and Data-Use Agreements, as applicable, with the TPA entity to establish a contractual relationship with the TPA entity, as DHCS' delegate.
    b. Provider will timely submit data, information, and documentation, as specified by the TPA entity, necessary to enable the TPA entity to administer the CYBHI Fee Schedule program.
    c. Provider will timely respond to requests for additional information from the TPA entity and/or DHCS.
    d. Provider will transmit service claims for reimbursement, student health insurance information, and designated provider and practitioner data to the TPA entity.
    e. By submitting such data and information, including claims, Provider attests, to the best of their knowledge, to the accuracy, completeness, and truthfulness of data and information transmitted to the TPA entity.
    f. To the extent that Provider has a contract for services with a MCP, health care service plan, or insurer, Provider will submit claims for services rendered pursuant to such a contract to the MCP, health care service plan or insurer directly.
        i. If such a contract exists with one or more MCPs, health care service plans, or insurers, Provider will notify, in writing, the TPA

entity via contact information provided by the TPA entity and DHCS via email to DHCS.SBS@dhcs.ca.gov.

3. Designated Providers and Practitioners.

a. Provider will ensure that all CYBHI Fee Schedule covered services are furnished by qualified practitioners acting within their scope of practice, in accordance with 22 CCR section 50000. et. seq.; Business and Professions (B&P) Code sections 500 through 4999.129 and Education (Ed.) Code section 44000.

b. Provider will, on a monthly basis or another frequency specified by the TPA entity, in a format specified by the TPA entity, submit a designated provider and practitioner roster to the TPA entity. Designated providers and practitioners may include any or all of the following:

   i. Provider's employees that are Pupil Personnel Services Credentialed practitioners, licensed mental health professionals, Community Health Workers, Wellness Coaches, or other qualified professionals eligible to furnish services under the CYBHI Fee Schedule program.

   ii. Entities, including organizational providers or sole practitioners, contracted by Provider to furnish behavioral health services to students on Provider's behalf.

   iii. Entities, including organizational providers or sole practitioners, that are not under contract but are affiliated with Provider, whereby Provider makes referrals, directly or indirectly, to the entity for medically necessary services covered under the CYBHI Fee Schedule program.

c. Provider will submit a complete roster to the TPA entity no later than the 15th day of each month for the following month.

d. Designated providers and practitioners must be identified by Provider on the monthly provider roster in order to be eligible for reimbursement under the CYBHI Fee Schedule program for claims with dates of service during that month.

e. If Provider requests a modification to its monthly roster, Provider may make such request, in writing, to the TPA entity.

f. Affiliated providers and practitioners, not employed or contracted by Provider to act on Provider's behalf, must be enrolled in the Medi-Cal program to be eligible for reimbursement under the CYBHI Fee Schedule program.

g. All designated providers or practitioners must maintain good standing to participate in the Medi-Cal program.
h. All designated provider organizations, either contracted or affiliated with Provider, must have a Type II NPI number, which must be included on any claims for reimbursement.
i. All designated rendering practitioners must, if applicable, have a Type I NPI number, which shall be included on any claims for reimbursement.
j. Provider will ensure that all Ordering, Referring and Prescribing (hereinafter "ORP") practitioners, to the extent there exists an enrollment pathway, are enrolled in the Medi-Cal program through DHCS' Provider Application and Validation for Enrollment (PAVE) provider enrollment system.

4. **Eligible Members.** The CYBHI Fee Schedule program covers medically necessary behavioral health services provided to students, under the age of 26, enrolled in a Medi-Cal MCP, Medi-Cal FFS, a health care service plan, or a disability insurer.
    a. Behavioral health services furnished to students not enrolled in one of the mandated plan or insurers, on the date that the service was furnished, are not eligible for reimbursement under the CYBHI Fee Schedule program.
    b. H&S Code section 1374.722 provides that services provided pursuant to its provisions shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing.
        i. High deductible health plans (HDHPs) that qualify for Health Savings Accounts (HSAs) under section 223 of the Internal Revenue Code (IRC) may not provide benefits for non-preventive-care services until the applicable deductible(s) are met.
        ii. Application of H&S Code section 1374.722 shall not disqualify or otherwise disrupt an HDHP from meeting the requirements of the IRC or its implementing rules as they relate to HSA eligibility.
        iii. For enrollees of HDHPs otherwise qualifying under section 223 of the IRC, health care service plans shall not reimburse for services covered under H&S Code section 1374.722 unless (a) the applicable IRC deductible has been met, or (b) the service is for preventive care, as that term is used by the federal government for purposes of implementing IRC section 223 of

the . If the TPA determines that claims for a member enrolled in a HDHP are not eligible for reimbursement, Provider will be notified by the TPA entity and the claim will be rejected.

c. Students enrolled in the Medi-Cal program, if required, must meet any applicable Share of Cost (SOC) requirements before Provider is eligible to receive reimbursement for services furnished to that student.[5] If the TPA determines that a Medi-Cal member has not met SOC requirements, Provider will be notified by the TPA entity and the claim will be rejected.

5. **Student Health Insurance Information.** Provider will collect and transmit student health insurance information for eligible members to the TPA entity.
   a. Provider must establish policies and procedures for collecting, storing and transmitting student health insurance information to the TPA entity. Provider's policies and procedures may include, but are not limited to, strategies for establishing systems and strategies to systematically collect student health insurance information from an eligible member and/or their authorized representative, as applicable; and/or, establishing systems and strategies to collect student health insurance information at the point of service. Provider must submit its policies and procedures to the TPA entity for review. Modifications to the Provider's policy may be subsequently submitted to the TPA entity, as applicable.
   b. If Provider determines that a student has other health care coverage in addition to coverage provided by a CYBHI Fee Schedule mandated Medi-Cal MCP, health care service plan, or insurer, Provider must notify the TPA entity and comply with all state and federal requirements pertaining to third-party liability, this includes but is not limited to any policy directives issued by HHS and CMS and the standards found in 42 USC section 1396a (a) (25); 42 CFR section 433.139; W&I Code sections 14005, 14023.7, 14124.90; and 22 CCR sections 51005 and 50761, et. seq.

[5] https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/32F2D4C6-B1D5-4A83-B325-92E2C579C243/share.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

6. Scope of Services and Reimbursement Rates.

a. Provider is eligible for reimbursement for medically necessary outpatient mental health and substance use disorder services furnished to a student 25 years of age or younger at a schoolsite.

i. Medically necessary treatment of a mental health or substance use disorder means a service addressing the specific needs of an individual, for the purpose of preventing, diagnosing, or treating an illness, injury, condition or symptoms.[6]

ii. For Medi-Cal students under the age of 21, the definition of medically necessary is to correct or ameliorate health defects, physical and mental illnesses, and conditions discovered by screening services.[7]

1) Services are covered when they prevent a condition from worsening and/or prevent the development of additional health problems.

2) Services that maintain or improve a child's current health condition are covered because they "ameliorate" a condition.

iii. For Medi-Cal members 21 years of age or older, a Medi-Cal service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.[8]

iv. The determination of whether a service is medically necessary 1) must take into account the particular needs of the child; and, 2) is made on a case-by-case basis.

b. Specific services and procedure codes eligible for reimbursement under the CYBHI Fee Schedule Program are detailed in the CYBHI Fee Schedule Scope of Services, Codes and Reimbursement Rates, as well as the CYBHI Fee Schedule Program Manual, published on the DHCS website.[9]

c. Claims for services will be reimbursed at the fee-for-service rates determined by DHCS pursuant to W&I Code section 5961.4(a) and

[6] California H&S Code section 1374.72(a)(3)(A); California Insurance Code section 10144.5(a)(3)(A).

[7] https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Provider-Information.aspx

[8] Refer to California W&I Code section 14184.402

[9] https://www.dhcs.ca.gov/CYBHI/Pages/Fee-Schedule.aspx

published in the CYBHI Fee Schedule Scope of Services, Codes and Reimbursement Rates document posted on DHCS' website.

d. Provider will not seek reimbursement through the CYBHI Fee Schedule program for services furnished to a student, if the service is specified on an Individualized Educational Plan (IEP) or an Individualized Family Services Plan (IFSP), pursuant to any applicable state and federal law mandating Provider to accommodate or provide services to students with disabilities, including, but not limited to, the federal Individuals with Disabilities Education Act (20 U.S.C. section 1400 et seq.), Part 30 (commencing with Section 56000) of Division 4 of Title 2 of the Education Code, Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, and Chapter 3 (commencing with Section 3000) of Division 1 of Title 5 of the California Code of Regulations.
e. CYBHI Fee Schedule Program services are not subject to prior authorization requirements.[10]

7. **Participation in the Local Educational Agency Billing Option Program (LEA BOP).** If Provider opts to participate in both the CYBHI Fee Schedule program and the Local Educational Agency Billing Option Program (LEA BOP), Provider will ensure non-duplication of claims submitted for reimbursement.
    a. As a condition of participation in both programs, Provider will submit claims for reimbursement to DHCS under the LEA BOP for behavioral health services specified on an Individualized Educational Plan (IEP) or an Individualized Family Services Plan (IFSP), pursuant to any applicable state and federal law mandating Provider to accommodate or provide services to students with disabilities, including, but not limited to, the federal Individuals with Disabilities Education Act (20 U.S.C. section 1400 et seq.), Part 30 (commencing with Section 56000) of Division 4 of Title 2 of the Education Code, Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, and Chapter 3 (commencing with Section 3000) of Division 1 of Title 5 of the California Code of Regulations..
    b. In accordance with any instructions provided by DHCS, Provider will furnish information to DHCS via the LEA BOP Cost and Reimbursement Comparison Schedule (CRCS) about CYBHI Fee Schedule reimbursements made to Provider for services rendered by

[10] Health and Safety Code § 1374.722(c)(1)

practitioners in both the LEA BOP Participant Pool 1 and the CYBHI Fee Schedule program.

c. Provider agrees to maintain good standing and comply with all LEA BOP and CYBHI Fee Schedule program requirements.

8. Compliance with Billing and Claims Requirements.

a. Provider agrees that it shall comply with all billing and claims requirements set forth in the W&I Code and its implementing regulations, the Medi-Cal Provider Manual, and the CYBHI Fee Schedule Program Manual.

b. Provider further agrees to comply with billing and claiming guidance issued by DHCS and/or the TPA entity, including, but not limited to instructions for claims formatting, required data elements, claims submission timelines, and transmission requirements.

9. Denials, Audits, Overpayments and Provider Disputes.

a. DHCS, the TPA entity and/or a payer of responsibility under the CYBHI Fee Schedule program[11] may deny payment of a claim if the claim is deemed ineligible for reimbursement due to any of the following:

i. The claim is incomplete, inaccurate, or invalid.

ii. A duplicate claim was submitted for payment to the TPA entity, a payer of responsibility pursuant to state law, and/or DHCS.

iii. The furnishing provider and/or rendering practitioner is not eligible for reimbursement under the CYBHI Fee Schedule program. See section 3 above.

iv. The service was not provided by a health care provider appropriately licensed or authorized to provide the service.

v. If DHCS, the TPA entity, or a payer of responsibility reasonably determines that services were provided to a student not enrolled in the health plan on the date of service.

vi. The service was never performed.

vii. The service was not appropriately documented in Provider's record-keeping system (e.g., electronic health record, student education records).

viii. Fraud, waste, or abuse.

b. DHCS, the TPA entity and/or a payer of responsibility may conduct a post-payment claim review and issue a notice of overpayment if it is

[11] Payers of responsibility include the Medi-Cal managed care plans, health care service plans, and disability insurers.

determined, within a reasonable timeframe, that the claim was not eligible for payment due to one or more of the reasons specified in paragraph (a) above.

c. Provider must return funds subject to recoupment pursuant to a notice of overpayment.
    i. If the denial or recoupment is issued because it is determined that the student was not enrolled in the health plan on the date services were rendered and the student is subsequently covered by another payer of responsibility, the TPA entity will submit the claim for reimbursement to the new payer of responsibility if the determination is made within 180 days from the date of service.
d. If Provider disputes the denial or notice of overpayment, it must timely notify the TPA entity in accordance with requirements set forth in the CYBHI Fee Schedule Program Manual.

10. **Member Grievances and Appeals.** Provider must comply with state and federal requirements regarding member grievances and appeals, as specified in the CYBHI Fee Schedule Program Manual.
    a. Provider agrees to provider member grievance and appeal data to the TPA entity and/or to the payer of responsibility.
11. **Care Coordination.** Provider must agree to coordinate care delivery with the student's health plan or insurer and/or the county behavioral health agency when any of the following conditions are met:
    a. The student is experiencing a mental health crisis or is a danger to themselves or others.
    b. Provider is made aware by the student or the student's legal representative that the student is actively engaged in behavioral health services with a network provider of the plan or insurer.
    c. Provider determines that the student requires a referral to a level of care that is not available or appropriate in the school-linked setting (e.g., inpatient or residential treatment).
    d. Provider determines that the student would benefit from evidence-based therapies that Provider does not have the capacity, training, or licensure necessary to furnish.
    e. The student requires continuation of services during a period when Provider is out-of-session (e.g., summer or winter holidays) or otherwise unable to provide timely access to medically necessary treatment.

f. The student and/or the student's legal representative requests a referral.

12. **Data-Sharing.** Provider agrees to share relevant and applicable treatment records and, when necessary, provide professional to professional consultation to ensure a student's community-based provider has the necessary documentation, information, and data necessary to provide clinically appropriate treatment to a student who is also receiving psychoeducation, screening, treatment and/or care coordination services from Provider.
    a. Provider must obtain applicable consents from the student and/or the student's parent or guardian to share treatment records.
13. **Privacy, Confidentiality and Consent.**
    a. As a condition of participation, Provider must execute a Health Insurance Portability and Accountability Act (HIPAA) Business Associates Addendum (hereinafter BAA) as an attachment to this Agreement.
    b. Provider must adhere to all applicable federal and state laws and regulations pertaining to member confidentiality, integrity, and the availability of information that is received, created, processed, stored and transmitted by Provider pursuant to this Agreement. This includes, as applicable, but is not limited to the following:
        i. The Health Insurance Portability and Accountability Act of 1996 (HIPAA);
        ii. W&I Code sections 10850, 10850.1, 10850.2 and 14100.2;
        iii. Information Practices Act of 1977 (Civil Code section 1798 et seq.);
        iv. Confidentiality of Medical Information Act (California Civil Code section 56 et seq.);
        v. California Consumer Privacy Act (CCPA);
        vi. Family Educational Rights and Privacy Act (FERPA), as specified in 42 United States Code (USC) section 1320c-9; 20 USC section 1232g; 42 CFR section 431.300, et. seq.; 34 CFR sections 99.30, 99.31 and 300.154; W&I Code section 14100.2; 22 CCR section 51009; and Ed. Code sections 49060, and 49073 through 49079;
        vii. Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance

Portability and Accountability Act of 1996 (HIPAA) to Student Health Records;[12]

viii. Confidentiality of Medical Information Act (CMIA);

ix. California Civil (Civ.) Code section 56.10;

x. DHCS Data De-identification Guidelines (DDG) v2.2 (https://www.dhcs.ca.gov/dataandstats/Pages/PublicReportingGuidelines.aspx); and,

xi. Other requirements of state and federal law, including related regulations and published guidelines, to the extent that these authorities contain requirements applicable to the Provider pursuant to this Agreement.

c. Minor Consent.

i. Notwithstanding any provision of law to the contrary, pursuant to H&S Code section 124260(b)(1) and the California Family (Fam.) Code 6924(b), a minor may consent to outpatient mental health treatment or counseling services if they are deemed by the attending professional person to be mature enough to participate intelligently in the treatment or counseling services and would present a danger of serious physical or mental harm to themselves or others without the treatment or counseling services.

ii. Notwithstanding any provision of law to the contrary, the mental health treatment or counseling of a minor shall include involvement of the minor's parent or guardian, unless the professional person who is treating or counseling the minor, after consulting with the minor, determines that the involvement would be inappropriate. The professional person who is treating or counseling the minor shall state in the client record whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.[13]

[12] https://studentprivacy.ed.gov/sites/default/files/resource_document/file/2019%20HIPAA%20FERPA%20Joint%20Guidance%20508.pdf

[13] H&S Code § 124260(c).

14. **Documentation Standards and Reporting Requirements.** Provider agrees to comply with all documentation standards and reporting requirements specified in the CYBHI Fee Schedule Program Manual.
15. **Language Access Requirements.** Provider agrees to comply with language access requirements pursuant to state and federal law.
    a. When a bilingual practitioner is unavailable to provide services in a CYBHI Fee Schedule program beneficiary's preferred language, when the preferred language is a language other than English, Provider will provide access to language interpretation and translation services in all Medi-Cal threshold languages for CYBHI Fee Schedule program beneficiaries, including Medi-Cal members, and/or their parent or caregiver.
    b. Provider represents and assures the State that all actions it takes pursuant to and in furtherance of the Agreement complies with the Americans with Disabilities Act (ADA) and all applicable regulations and guidelines issued pursuant to the ADA, which prohibits discrimination on the basis of disability.
    c. Provider will ensure that deliverables developed and produced pursuant to the Agreement comply with federal and state laws, regulations, or requirements regarding accessibility and effective communication, including the ADA (42 USC section 12101, et. seq.), which prohibits discrimination on the basis of disability, and section 508 of the Rehabilitation Act of 1973 as amended (29 USC section 794(d)). Specifically, electronic and printed documents intended as public communications must be produced to ensure the visual-impaired, hearing-impaired, and other special needs audiences are provided material information in the formats needed to provide the most assistance in making informed choices. These formats include but are not limited to braille, large font, and audio.

D. CONSORTIA BILLING

1. **Lead LEA.** If Provider is participating in a consortium for billing, as the lead LEA:
    a. Prior to acting as the lead LEA on behalf of participating LEAs, Provider must submit an attestation letter to DHCS from each participating member LEA stating that:
        i. Provider, as the lead LEA, is acting as the participating member LEA's agent;

ii. Provider is authorized, on behalf of the participating member LEA, to handle all matters concerning the CYBHI Fee Schedule Program with DHCS and/or the TPA entity;
iii. The participating member LEA has an executed CYBHI Fee Schedule Program PPA on file with DHCS;
iv. If the participating member LEA is a HIPAA covered entity, a HIPAA business associate agreement is in place between Provider, as the lead LEA, and the participating member LEA;
v. All personally identifiable data will be protected by FERPA and/or, if applicable, HIPAA; and,
vi. Provider's authority is valid until the letter is replaced or revoked in writing by the participating member LEA (or if the letter expires, it is timely replaced).

b. Prior to acting as the lead LEA on behalf of participating member LEAs, Provider must complete and submit to DHCS and/or the TPA entity, as specified, an executed CYBHI Fee Schedule Program Provider Participation Agreement Addendum A: Consortia Billing Agreement.

2. **Participating member LEA.** If Provider is participating in a consortium for billing, as a participating member LEA:
   a. Provider must execute this PPA.
   b. Prior to requesting reimbursement from the Lead LEA, Provider must submit an attestation letter to the Lead LEA stating that:
      i. Provider, as a participating member LEA, authorizes the Lead LEA to act as the participating member LEA's agent;
      ii. Provider authorizes the Lead LEA to handle all matters concerning the CYBHI Fee Schedule program with DHCS and/or the TPA entity;
      iii. If Provider is a HIPAA covered entity, Provider a HIPAA business associate agreement is in place between Provider and the Lead LEA;
      iv. All personally identifiable data will be protected by FERPA and/or, if applicable, HIPAA; and,
      v. The Lead LEA's authority is valid until the letter is replaced or revoked in writing by the participating member LEA (or if the letter expires, it is timely replaced).
3. **Liability of Consortium or Other Designated Providers.** Provider agrees that, if it is a provider group or consortium for billing, the group or

consortium for billing, and each member of the group or consortium for billing, are jointly and severally liable for any breach of this Agreement, and that action by DHCS against any of the providers in the provider group or consortium for billing may result in action against all of the members of the provider group or consortium for billing.

E. COMPLIANCE AND PROGRAM INTEGRITY MONITORING

1. In addition to the specific auditing and oversight activities specified in Section B of this Agreement, Provider will be subject to regular CYBHI Fee Schedule program monitoring and clinical quality oversight requirements specified in the CYBHI Fee Schedule Program Manual.
2. Provider agrees to participate in monitoring activities and timely compliance with requests for data and information necessary to carry out monitoring activities.

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F. DECLARATION

1. **Provider agrees that compliance with the provisions of this agreement is a condition precedent to payment to Provider.**
2. **The parties agree that this agreement is a legal and binding contract and is fully enforceable in a court of competent jurisdiction.**
3. **The individual signing this agreement is duly authorized and warrants that they have read this agreement and understands it.**
4. **I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief.**
5. **I declare I am the Provider or I have the authority to legally bind the Provider, which is an entity and not an individual person and that I am eligible to sign this agreement under Title 22, CCR section 51000.30(a)(2)(B).**

1. Printed legal name of Provider

2. Printed name of person signing this declaration on behalf of Provider

3. Signature of the person signing this declaration (DocuSign or another electronic signature format)

4. Title of the person signing this declaration

5. Executed at (City, State):

6. Executed on (Date – month, day, year):

STATE OF CALIFORNIA – DEPARTMENT OF HEALTH CARE SERVICES

Signature of DHCS Authorized Representative:
Printed Name of DHCS Authorized Representative:
Printed Title of DHCS Authorized Representative:
Date:

Privacy Statement

(Civil Code Section 1798 et seq.)

All information requested on the Application, the disclosure statement, and the provider agreement is mandatory. This information is required by the California Department of Health Care Services and any other California State Departments that are delegated responsibility to administer the Medi-Cal program, by the authority of Welfare and Institutions Code sections 14043 – 14043.75, the California Code of Regulations, Title 22, sections 51000 – 51451 and the Code of Federal Regulations, Title 42, Part 455. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. Some or all of this information may also be provided to the California State Controller's Office, the California Department of Justice, the California Department of Consumer Affairs, the California Department of Corporations, the California Franchise Tax Board or other California state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, or as required or permitted by law. For more information or access to records containing your personal information maintained by this agency, contact the Office of Strategic Partnerships via email at DHCS.SBS@dhcs.ca.gov.