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COUNTY OF SANTA CLARA
Behavioral Health Services
Supporting Wellness and Recovery

MEMORANDUM

TO: BHSD County Contracted Providers

FROM: Courtney Gray, Quality Director

DocuSigned by: Courtney Gray
FB624C31EF6F4C8...

RE: Facility Credentialing

DATE: March 7, 2025

BHSD in collaboration with VHP will be conducting facility credentialing for the BHSD provider network in FY 26/27. This is in addition to the mental health site certification, Drug Medi-cal certification, and AOD certification. The facility credentialing will be required for the entire BHSD provider network serving Medi-Cal members and will be conducted in accordance with NCQA standards.

What is Facility Credentialing?

Facility credentialing is the process by which a health plan (insurance company) evaluates and then approves a facility to be "in network" with the health plan, and a participating provider of specific healthcare services. Your facility must complete and submit a variety of forms including a facility credentialing application, as well as other documentation like the applicant's licensure, certifications, accreditation, and more.

Process and Documentation

Providers will be given the Facility Credentialing Application form to complete within thirty (30) days. Attestation dates over (30) days, will not be accepted. The application collects information related to the specific facility location and includes an attestation and information release section to be acknowledged and signed. In addition, the application will include a checklist that also identifies required documentation that would need to be submitted with the application. Please see sample attached application.

Timelines

Date	Action
March 7, 2025	Send memo to BHSD providers
March 13, 2025	Presentation to BHCA
March 14, 2025	Provider submits points of contact
April 2025	Pilot facility credentialing process
June 9 – 20, 2025	Office Hours

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July 2025 -December 2025	Begin facility credentialing process phased in 4 groups

Points of Contact
VHP will need a contact person for each CCP to coordinate the facility credentialing application process. **Please submit up to two (2) points of contact information to** BHSDCredentialing@vhp.sccgov.org and BHSDBusinessOffice@hhs.sccgov.org **by Friday, March 14, 2025 with information below.** One of the contacts should be a manager.

- First and Last Name
- Position Title
- Email Address
- Phone Number
- Agency Name

Group Phases
The facility credentialing process will begin in July 2025 in a phased approach to be completed by end of December 2025. Providers will be notified 2-months in advance by VHP when their facility credentialing will begin. It is expected that providers respond in a timely manner to ensure compliance with the requirement. Non-compliance may result in corrective action.

If you have any questions, please contact VHP BHSDCredentialing@vhp.sccgov.org or the BHSD Provider Relations Operations team BHSDBusinessOffice@hhs.sccgov.org

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FACILITY CREDENTIALING APPLICATION

FACILITY TYPE

Please check one:

☐ Ambulatory Surgical Center (Free-standing only) ☐ Skilled Nursing Facility ☐ Hospital

☐ Home Health Agency ☐ Behavioral Health ☐ Other______________________

OWNERSHIP INFORMATION

Please check all that apply:

☐ Non-profit Corporation ☐ Government entity ☐ Subsidiary

☐ Professional Corporation ☐ Limited Liability Corporation (LLC) ☐ Other________________________

Owned by:	Percent Owned:	Year Opened:
Address:	City/State/Zip:	

FACILITY GENERAL INFORMATION

Facility Legal Name:		
Doing Business As (DBA) if different:		Phone:
Business Address (No PO Box):		Fax:
City:	State:	Zip:
Website:	Languages Spoken in office:	
National Provider Identification (NPI):	Medi-Cal Number:	
Taxpayer Identification Number (TIN):		
Wheelchair Accessible: ☐ Yes ☐ No	Other Special Arrangements?	

Office Hours: Mon:	Tues:	Wed:	Thurs:	Fri:	Sat:	Sun:

FACILITY MAILING/PAY-TO ADDRESS

Mailing/Pay-to Address:		
City:	State:	Zip:
Phone:	Fax:	

FACILITY CREDENTIALING ADDRESS

Credentialing Address:		
City:	State:	Zip:
Credentialing Contact:	Phone:	Fax:
Email:		

SAMPLE

FACILITY CREDENTIALING APPLICATION

GENERAL INFORMATION- ADDITIONAL LOCATION

Facility Additional Address:		
City:	State:	Zip:
Phone:	Fax:	
Taxpayer Identification Number (TIN):		
CA Licensure Number:	Type:	Issue Date: Exp Date:
Business License Number:	Issue Date:	Exp Date:

ACCREDITATION INFORMATION

Please check one:

☐ AAAASF	☐ AAAHC	☐ ACHC	☐ CMS/Onsite Review
☐ CHAP	☐ CCAC	☐ CARF	☐ Other: ________________
☐ COLA	☐ JCAHO	☐ NCQA	
☐ AASM (required for Sleep Centers)	☐ AOA	☐ URAC	

SITE VISIT REQUIREMENT

Attach a copy of the most recent on-site survey with the Correction Action Plan, if citation was issued; Or attach a cover letter from state agency stating facility is in substantial compliance.

1. Has the hospital/facility had a post-licensing onsite visit by a government agency (e.g., CMS or DHCS) within the past 36 months?
   ☐ Yes, Date of most recent on-site survey: __/____/____
   ☐ No

2. Were any deficiencies identified in the last full survey? ☐ Yes ☐ No
   - If YES, have all deficiencies been corrected?
     ☐ Yes; provide evidence of State acceptance with the hospital/facility's Corrective Action Plan.
     ☐ No; provider explanation and the hospital/facility's plan to correct all deficiencies.

PROVIDER CREDENTIALING

Does the hospital/facility verify, for each Provider employed under your practice, the credentials necessary to perform health care services?

☐ Yes ☐ No ☐ N/A

If YES, please indicate how the hospital/facility conducts the credentialing process for each Provider:

☐ We perform credentialing procedures internally.

☐ We outsource/delegate the credentialing procedures to ______________________
(Name of Company)

☐ Other, please specify:______________________________

If NO, please explain:______________________________

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FACILITY CREDENTIALING APPLICATION

PROOF OF INSURANCE		
Name of General Liability Insurance Company:		
Insurance Policy Number:	Date policy issued:	Exp date of policy:
Address:	City:	State/Zip
Insurance Policy Amounts: Occurrence: $	Aggregate: $	
Name of Professional Liability (Malpractice) Insurance Policy:		
Insurance Policy Number:	Date policy issued:	Exp date of policy:
Insurance Policy Amounts: Occurrence: $	Aggregate: $	

SIGNATURES	
I hereby affirm that the information submitted to Valley Health Plan and any addenda thereto is true, current, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of the Services Agreement.	
Print Name of Authorized Representative:	Date:
Signature of Authorized Representative:	Title:

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ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to questions A through K is "yes," or if your answer is "no" for questions L through N please provide full detailed explanation on separate sheet.
A. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service? **Yes □ No □**
B. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service? **Yes □ No □**
C. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to the interference with or obstruction of any investigation into any criminal offense described in Title 42 - Code of Federal Regulations Section 1001.100if a1 or 1001.201? **Yes □ No □**
D. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? **Yes □ No □**
E. Has the facility ever had the State license involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or has the facility voluntarily relinquished the State license in anticipation of any of these actions; or are any of these actions pending with respect to the State license? **Yes □ No □**
F. Has the facility ever been charged, suspended, fined, disciplined, or otherwise sanctioned, submitted to probationary conditions, restricted or excluded, or has the facility voluntarily relinquished eligibility to provide services or accepted conditions on its eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending? **Yes □ No □**
G. Has the facility had its membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? **Yes □ No □**
H. Has the facility ever had any other regulatory agency (OSHA, etc.) deny, revoke, suspend, not renew, place under probation, subject to disciplinary action or otherwise limited or curtail operations; or are any actions pending from any other regulatory agency? **Yes □ No □**
I. Has the facility ever had accreditation by an organization (CLIA, JCAHO, etc.) involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or has the facility voluntarily relinquished the accreditation in anticipation of any of these actions; or are any of these actions pending with respect to any such accreditation? **Yes □ No □**
J. Has the facility ever been placed under temporary government ordered management? **Yes □ No □**
K. Has the facility ever permitted the appointment of a receiver for its business or its assets? **Yes □ No □**
L. Do you understand that subject to proper confidentiality restrictions and authorizations, medical records might be subject to on site review by alliance representatives for peer review, utilization review, and quality assurance purposes? **Yes □ No □**
M. Does the facility currently participate or have you ever participated as a provider in the Medi-Cal program or in another state's Medicaid? **Yes □ No □**
N. Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? **Yes □ No □**

SAMPLE

I hereby affirm that the information submitted to Valley Health Plan and any addenda thereto is true, current, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of the Services Agreement.

Print Name of Authorized Representative: ____**Title:** ____________________________

Signature of Authorized Representative:

____**Date:**________________________________

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INFORMATION RELEASE ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to the credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any re-credentialing application regarding applicant organization. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of applicant organization qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to applicant organization participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq, if applicable.

I understand and agree that as an applicant, the applicant organization has the burden of producing adequate information for proper evaluation of professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications. During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or non-renewal of license to practice medicine in California; (ii) any cancellation or non-renewal of professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against applicant organization by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting license to practice medicine; or (ii) any adverse action against applicant organization by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) any material reduction in professional liability insurance coverage; or (iv); receipt of written notice of any adverse action against applicant organization under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of the application or termination of the Services Agreement. A photocopy of this document shall be as effective as the original; however, original signatures and current dates are required on all pages.

Organization Name: ____

Print Name of Authorized Representative:

____**Title:**____________________________

Signature: ____**Date:** _________________________

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SANTA CLARA COUNTY
Behavioral Health Services

VHP Valley Health Plan

FACILITY CREDENTIALING APPLICATION CHECKLIST

Please make sure you have all the following documentation attached that pertains to the facility with your completed application before sending back so that there are no delays. Thank you!

☐ Copy of State License/or local licenses required to operate as a health care facility

☐ Copy of Business License if applicable

☐ Fictitious Business Name Statement if applicable

☐ Copy of Accreditation letter /Certification (if not accredited please provide onsite review within last 36 months)

☐ Copy of CLIA/ CMS letter

☐ Copy of General & Professional Liability Insurance face sheets covering **all** facility employees

☐ W-9 form

☐ Medi-Cal Number (LTCs and SNF's Only)

SAMPLE