Print Form

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State of California - Health and Human Services Agency Primary and Rural Health Care Systems Branch
Department of Health Services Indian Health Program

Indian Health Program (IHP)
Application Cover Sheet
Fiscal Year 2006-2009

LEGAL CORPORATE NAME (APPLICANT):	
MAILING ADDRESS:	ZIP CODE:
LOCATION (If different from mailmailing address):	ZIP CODE:
TELEPHONE NUMBER:	FAX NUMBER:
CORPORATE FISCAL YEAR DATES:	ANTICIPATED DATE OF NEXT FISCAL AUDIT:
MEDICAID / MEDICARE PROVIDER TYPE (select one): ☐ FQHC ☐ IHS / HCFA MOA ☐ FEE FOR SERVICE	**Indicate governance structure from choices below:** ☐ Community Nonprofit Board as filed with Secretary of State / Office of Attorney General ☐ Tribally Authorized Charter for Health Program ☐ Tribal Council Self Governance

The undersigned hereby affirms he/she is a duly authorized officer of the Corporation and that the statements contained in this document are true and complete to the best of his/her knowledge.

CHAIRPERSON *(Please Type)*

SIGNATURE **DATE**

EXECUTIVE DIRECTOR *(Please Type)*	**FISCAL OFFICER** *(Please Type)*
SIGNATURE	**SIGNATURE**
DATE	**DATE**
Email Address	**Email Address**

Clinic Site Information Form

List the names of reservations or rancherias in the service area and indicate contracting status (attach additional page if necessary):

Reservation / Rancheria (List)	Included in Clinic Service Population (Yes or No)	Administers Own Contract Service Funds (Yes or No)

MAIN CLINIC SITE AND ADDRESS		Located on Reservation / Rancheria ☐ Yes ☐ No	Days and hours of operation:
Telephone:	County (s) served:	State licensed: ☐ Yes ☐ No	Medi-Cal certified: ☐ Yes ☐ No
Services Provided:			

Include additional pages if needed to complete the information below on all satellite clinics.

Additional clinic site and address:		Located on Reservation / Rancheria ☐ Yes ☐ No	Days and hours of operation:
Telephone:	County (s) served:	State licensed: ☐ Yes ☐ No	Medi-Cal certified: ☐ Yes ☐ No
Services Provided:			

Clinic Site Information Form Continued

Additional clinic site and address:		Located on Reservation / Rancheria ☐Yes ☐No	Days and hours of operation:
Telephone:	County (s) served:	State licensed: ☐Yes ☐No	Medi-Cal certified: ☐Yes ☐No
Services Provided:			

Additional clinic site and address:		Located on Reservation / Rancheria ☐Yes ☐No	Days and hours of operation:
Telephone:	County (s) served:	State licensed: ☐Yes ☐No	Medi-Cal certified: ☐Yes ☐No
Services Provided:			

Additional clinic site and address:		Located on Reservation / Rancheria ☐Yes ☐No	Days and hours of operation:
Telephone:	County (s) served:	State licensed: ☐Yes ☐No	Medi-Cal certified: ☐Yes ☐No

Additional clinic site and address:		Located on Reservation / Rancheria ☐Yes ☐No	Days and hours of operation:
Telephone:	County (s) served:	State licensed: ☐Yes ☐No	Medi-Cal certified: ☐Yes ☐No

Medi-Cal Provider Status Form

Agency Name:	
Billing Authorization (Attach additional pages if needed) Indicate the clinic provider number for EACH service site certified for Medi-Cal and/or Denti-Cal billing.	
Medi-Cal Clinic Provider Number(s):	
Number	Service Site
Number	Service Site
Number	Service Site
Denti-Cal Clinic Provider Number(s):	
Number	Service Site
Number	Service Site
Number	Service Site
If the program is billing the physician's and/or dentist's provider number, complete the information below. For each provider listed below: submit a copy of the written agreement which states that any income derived from billing under the physician / dentist number is clinic income.	
Provider Number	Provider Name and Title
Provider Number	Provider Name and Title
Provider Number	Provider Name and Title

Licensed Personnel Information Form

List of Licensed Health Personnel
(License must be current by date of submission. Attach additional pages if needed)

Name and Title	Type of License	License Number	Expiration Date

Program Narrative Form

Include a project narrative that describes the following:

1. Major accomplishments July 1, 2005 through May 31, 2006.

2. List the five leading reasons for clinic visits (i.e. Diabetes, Dental, etc.)

Certification of Terms and Conditions of Advance Payment

In submitting this application I certify that I am aware of the Terms and Conditions for approval of advance payments for Fiscal Year (FY) 2006-2007. I understand that advance payments will be deducted from the first semiannual prospective payment which will be available upon execution of FY 2006-07 grants. The grantee shall repay the full amount of any outstanding advance if the grant is not fully approved.

I understand that advance payments are contingent upon the following conditions:

1. The FY 2006-07 State Budget Act must be passed.
2. The grantee must have submitted all of the following fiscal items in the correct format:
   a. Payment Request Letter (PRL) for up to 50% of the FY 2005-2006 grant award due July 2005
   b. Payment Request Letter (PRL) for up to 40% of the FY 2005-06 grant award due January 2006,
   c. Budget Expenditure Report (BER) covering expenditures from January 2006-April 2006,
   d. PRL for 10% of the FY 2005-06 grant award or remaining funds due June 2006,
   e. Annual Budget Reconciliation form due June 2006.
3. The grantee must have submitted all monthly reports in the approved format through May 2006.
4. The grantee must have submitted the required independent audit report referenced in Exhibit "A" of the FY 2005-06 grant.
5. The corporation must be in good standing with the Secretary of State.

_____

CHAIRPERSON *(Please Type)*

_____ **SIGNATURE**

_____ **DATE**

_____	_____
EXECUTIVE DIRECTOR *(Please Type)*	**FISCAL OFFICER** *(Please Type)*
_____ **SIGNATURE**	_____ **SIGNATURE**
_____ **DATE**	_____ **DATE**