

**KERN HEALTH SYSTEMS
PARTICIPATING HOSPITAL/FACILITY APPLICATION**

Facility Name: _____

Address: _____

Telephone No.: _____ Fax No.: _____

Chief Administrative Officer: _____

Chief Financial Officer: _____

Chief Medical Officer: _____

Corporate Tax Status: _____

If Facility Medi-cal Certified? YES NO Medi-cal Provider No.: _____

Is Facility accredited? YES NO

Indicate:

JCAHO AAAHC AOA OTHER _____ Expires: _____

In order to ensure that our files contain accurate information for reporting on IRS 1099 payments made to your organization, please provide your Tax Identification Number and your reporting Name and Address as they appear on your IRS Form W-9.

Tax Identification Number: _____

State or Local Facility Operating License No.: _____

Reporting Name: _____

Reporting Address: _____

In order to properly identify all related services, departments and facilities that should be included in the definition of the Hospital for purposes of this agreement, please list below any affiliated entities such as outpatient centers and diagnostic facilities that are part of the Hospital's Corporate Structure, have the same tax identification number as the Hospital, and would be reimbursed by us, under the same payment rate as we reimburse the Hospital. You understand that any such entity listed herein shall be considered as part of the "Provider" that is a party to this Agreement.

1. Ancillary Provider Name: _____

Address: _____

If different from the Hospital

Telephone No.: _____ Fax No.: _____

Corporate Relationship to the Hospital: _____

2. Ancillary Provider Name: _____

Address: _____

If different from the Hospital

Telephone No.: _____ Fax No.: _____

Corporate Relationship to the Hospital: _____

***Note: Please attach another sheet if additional space is necessary**

1. Please complete and submit the following range of hospital services:

- #1 Service is Hospital based
- #2 Not Available
- #3 Not maintained in hospital, but available through charged service/referral arrangement.

- | | |
|-----------------------------|--|
| _____ Med/Surg Unit | _____ Sub Acute Care |
| _____ Pediatric Unit | _____ Med/Surg or other ICU |
| _____ Post ICU, CPU | _____ Cardiac Intensive Care Unit |
| _____ Obstetrics Unit | _____ Psychiatric Inpatient Care Unit |
| _____ Neonatal ICU | _____ Psychiatric Outpatient Care Unit |
| _____ Level I | _____ Chemical Dependency Inpatient Care Unit |
| _____ Level II | _____ Chemical Dependency Outpatient Care Unit |
| _____ Level III | _____ Outpatient Surgery Center |
| _____ Level IV | _____ Emergency Department |
| _____ Open Heart Surgery | _____ Urgent Care Unit |
| _____ Cardiac Catherization | _____ Outpatient Hemodialysis |

- | | |
|-------------------------------|---|
| _____ Angioplasty | _____ Inpatient Hemodialysis |
| _____ Burn Care Unit | _____ Skilled Nursing, Long Term |
| _____ Certified Trauma Unit | _____ Home Health Services |
| _____ Physical Rehabilitation | _____ Home Care Program |
| _____ MRI Scan | _____ Other Special Care – Specify: _____ |
| _____ Radiation Therapy | _____ Outpatient Therapy |
| | _____ Physical Therapy |
| | _____ Respiration Therapy |
| | _____ Occupational Therapy |
| | _____ Speech Therapy |
| | _____ Infusion Therapy |

2. Please indicate the number of licensed beds, staffed beds and occupancy rate during the most recent fiscal year for the following services:

Specify Time: From _____ To: _____
mm/yy mm/yy

<u>Service</u>	<u>Licensed Bed Total</u>	<u>Staffed Bed Total</u>	<u>Licensed Bed Occupancy Rate</u>
Adult Medical/Surgical	_____	_____	_____
Obstetrics	_____	_____	_____
Pediatrics	_____	_____	_____
Gynecology	_____	_____	_____
Newborn	_____	_____	_____
Psychiatry	_____	_____	_____
ICU (mixed/other)	_____	_____	_____
ICU (Cardiac Care only)	_____	_____	_____
Alcohol/Chemical Dependency	_____	_____	_____
Other Intensive Care/Trauma	_____	_____	_____
Other (Describe)	_____	_____	_____
TOTAL	_____	_____	_____

3. Indicate the overall hospital occupancy for the fiscal year preceding the period in Question Five (5):

Occupancy Rate _____%

Do you have a Quality Assurance Program? YES NO

4. Has the institution been sanctioned, placed on probation or lost accreditation, licensure or certification status during the last five (5) years by any of the following? If you answer yes, please describe the sanction and the date of sanction on an attached sheet of paper.

- | | | | |
|----------------------------------|------------------------------|-----------------------------|------------------------------|
| JCAHO/AAAH/CARF/AOA | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> N/A |
| Medi-Cal | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> N/A |
| State Licensure | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> N/A |
| Professional Review Organization | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> N/A |
| CLIA | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> N/A |
| Other, please state | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> N/A |

5. Please provide evidence of professional and comprehensive general liability insurance or funded self-insurance information.

Kern Health Systems requires all contracted facilities to carry adequate professional liability coverage. The following minimums must be adhered to by all hospitals:

Professional (Malpractice)
 \$3,000,000.00 per occurrence
 \$5,000,000.00 annual aggregate

General Liability
 \$3,000,000.00 per occurrence
 \$5,000,000.00 annual aggregate

6. For each of the last five (5) years, please provide a confidential listing of each general liability and each malpractice claim filed against the hospital, which resulted in either a settlement or court disposition adverse to the hospital and which settlement or disposition resulted in a payment of \$50,000.00 or greater.

PLEASE REFER TO THE FOLLOWING EXAMPLE:

Claim Type	Description	State	Incident	Settlement Date	Settlement Amount
Malpractice	Patient fell/unattended	Lost case	3/24/94	5/12/97	\$20,000.00
General Liab.	Employee fell/broke leg	Settlement	2/19/95	7/22/98	\$60,000.00

If more space is needed, attach a listing and please do not include patient identifiers.

7. Summary of Attachments:

<u>Nature</u>	<u>Included</u>	<u>N/A</u>
Copy of current State Facility License	<input type="checkbox"/>	<input type="checkbox"/>
Copy of JCAHO, AOA	<input type="checkbox"/>	<input type="checkbox"/>
OR		
Copy of latest DHS Site Survey with Corrective Action Plan and Acceptance Letter	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Medi-cal Certification Letter	<input type="checkbox"/>	<input type="checkbox"/>
Liability Insurance	<input type="checkbox"/>	<input type="checkbox"/>
Liability History	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Sanctions Information	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Hospital Pharmacy Permit	<input type="checkbox"/>	<input type="checkbox"/>
Copy of DEA	<input type="checkbox"/>	<input type="checkbox"/>
Copy CLIA Certificate	<input type="checkbox"/>	<input type="checkbox"/>

I attest to the fact that all of the information submitted by me in this document is true, correct and complete, to the best of my knowledge and belief. I fully understand that any significant misstatement in omission from, this application may constitute cause for denial of participation with Kern Health Systems. I warrant that I have authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

Signature of Authorized Representative

Type or print name

Title

Date

Telephone

Fax

Credentialing Contact Person

Telephone

Fax