Riverside University HEALTH SYSTEM Public Health

NEW FACILITY

CHDP PROVIDER APPLICATION CHECKLIST

Below is a checklist of items needed for your new application along with necessary forms. Please return completed checklist with forms and supporting documents. Feel free to call our office at 951.358.5481 if you have any questions.

Applicant: _____

Facility Name: _____

Address: _____

Contact: _____ Email: _____

Phone: _____ Fax: _____

- ☐ **Original, signed** CHDP Health Assessment Provider Application (DHCS 4490), signed in Blue Ink
- ☐ **Original, signed** CHDP Health Assessment Provider Program Agreement (DHCS 4491), signed in Blue Ink
- ☐ Copy of Fictitious Business Name Statement/Permit – *if applicable*
- ☐ Verification from IRS – showing Tax ID number & Facility Name *or* Social Security Number
- ☐ Vaccines for Children ID #:
- ☐ Verification of Medi-Cal Provider Number – showing clinic address NPI #:
- ☐ Copy of CLIA Waiver or Certificate
- ☐ Description of 24-hour coverage arrangements (#18 on DHCS 4490)
- ☐ Description of referral procedures for diagnosis and treatment, if applicable (#20 on DHCS 4490)

Submit application checklist and required documents to the following email addresses:

CHDPRiverside@ruhealth.org

Or you may mail to:

County of Riverside Department of Public Health
CHDP
P.O. Box 7600
Riverside, CA 92513-7600