WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH
OFFICE OF MATERNAL, CHILD AND FAMILY HEALTH
FAMILY PLANNING PROGRAM

PROVIDER APPLICATION

ORGANIZATION INFORMATION

Organization Name:

Organization type:

- ☐ College/University (non-profit)
- ☐ County Health Department
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Free Standing Family Planning Clinic
- ☐ Hospital (non-profit)
- ☐ Planned Parenthood
- ☐ School-based Health Center
- ☐ Other _____

All Family Planning Program clinics must be non-profit. Verification of clinic type and non-profit status must be submitted with this application. Applications received without appropriate verification will NOT be processed.

FEIN:	**OASIS/FIMS ID:**	**NPI Number:**	**Medicaid ID:**
_____	_____	_____	_____

If you do not know this OASIS/FIMS ID or your Medicaid ID or your organization does not have one, please leave blank.

Organization website:

Organization mailing address:

City:	**State:**	**ZIP Code:**

Organization physical address:

City:	**State:**	**Zip Code:**

Organization Phone Number:	**Fax:**

Clinical Service Site Name (if different from above):

Clinical Service Site mailing address (if different from above):

City:	**State:**	**Zip Code:**

Clinical Service Site physical address (if different from above):

City:	**State:**	**Zip Code:**

Clinic Service Site Phone Number:	**Fax:**

PROVIDER STAFF INFORMATION

Organization CEO/Administrator:		**Email:**
Medical Director:		**Email:**
Contact for Family Planning services:		**Email:**
Contact for Family Planning billing:		**Email:**
340B Authorizing Official:	**Title:**	**Email:**

Organizations are required to provide valid email addresses for the staff above. Staff must check and respond to email at least once per week.

Medical Directors of Family Planning Program provider sites must be licensed as an MD or DO in the state of West Virginia and must have special training or experience in family planning. Please include verification of licensure and curriculum vitae or resume.

Organizations are required to list a 340B Authorizing Official who must be C-Suite level staff (i.e., CEO, CFO, COO). 340B Policies and Procedures are available at www.wvdhhr.org/fp.

SERVICE SITE INFORMATION

Days/hours of operation:

Days/hours that Family Planning Program services will be available (if different from above):

Family Planning service sites are required to complete a community assessment. Based on your assessment, provide an estimate of the number of Family Planning clients you anticipate serving per year: _____

Contraceptive methods provided on-site (check all the apply):

- ☐ Intrauterine Device (IUD)
- ☐ Nexplanon
- ☐ Shot/Injectible (Depo)
- ☐ Oral Contraceptives
- ☐ Combined Pill
- ☐ Progestin-only
- ☐ Contraceptive Patch (Xulane)
- ☐ Vaginal Contraceptive Ring (NuvaRing)
- ☐ Male Condom
- ☐ Diaphragm
- ☐ Sponge
- ☐ Cervical Cap
- ☐ Female Condom
- ☐ Spermicide
- ☐ Emergency Contraceptive (PlanB)

PROVIDER APPLICATION

SERVICE SITE INFORMATION (CONTINUED)

Contraceptive methods referred to other provider sites and the reason for referral (check all the apply):

- ☐ Intrauterine Device (IUD) — Reason: _____
- ☐ Nexplanon — Reason: _____
- ☐ Shot/Injectible (Depo) — Reason: _____
- ☐ Combined Oral Contraceptive Pills — Reason: _____
- ☐ Progestin-only Contraceptive Pills — Reason: _____
- ☐ Contraceptive Patch (Xulane) — Reason: _____
- ☐ Vaginal Contraceptive Ring (NuvaRing) — Reason: _____
- ☐ Male Condom — Reason: _____
- ☐ Diaphragm — Reason: _____
- ☐ Sponge — Reason: _____
- ☐ Cervical Cap — Reason: _____
- ☐ Female Condom — Reason: _____
- ☐ Spermicide — Reason: _____
- ☐ Emergency Contraceptive (PlanB) — Reason: _____

Is this clinical site handicap accessible?

- ☐ Yes
- ☐ No

Will Family Planning Program services be provided to:

- ☐ Individuals with disabilities?
- ☐ Adolescents?
- ☐ Males?
- ☐ Individuals with Limited English Proficiency?

Does this clinical service site have a written policy for management of medical and non-medical emergencies?

- ☐ Yes
- ☐ No

If no, is administrative staff willing to develop this?

- ☐ Yes
- ☐ No

Does this clinical service site utilize Electronic Health Records (EHR)?

- ☐ Yes
- ☐ No

If no, does administrative staff plan to implement EHR?

- ☐ Yes
- ☐ No

Does this clinical service site have internet access for billing through the Family Planning Electronic Data System?

- ☐ Yes
- ☐ No

Does this clinical service site bill third party insurances (e.g., BlueCross/BlueShield, PEIA, AETNA, etc.)?

- ☐ Yes
- ☐ No

Does this clinical service site conduct quality assurance activities (i.e., patient satisfaction surveys, peer reviews, performance evaluations, etc.)?

- ☐ Yes
- ☐ No

If yes, please list the activities conducted. If no, please list the reason.

_____

_____

SIGNATURE

By my signature below, I certify that the information provided on and in-connection with this application is true, accurate, and complete to the best of my knowledge. I also understand that any false statements or deliberate omissions on this document, or any other document provide to the Family Planning Program, may be grounds for denial of application or immediate removal from the program without notice.

Signature: Title: Date:

FOR OFFICE USE ONLY

Approved:

- ☐ Yes: **FPP ID:** _____
- ☐ No: **Reason for denial:** _____

NON-PROFIT STATUS VERIFIED:

- ☐ Yes
- ☐ No

FPP STAFF APPROVING SIGNATURE: _____ Date: _____