COMMUNICATION DISORDER CENTER APPLICATION

NOTE: Please review the CCS Standards for Communication Disorder Centers, (CCS Manual of Procedures, Chapter 3.40) for the specific requirements of the program. Attach any additional information about your program which you believe will be of interest and assistance to CCS in evaluating your facility. A facility will be evaluated by a review of this application, a site visit or both.

Name of Facility

Name of hospital/medical center (if different from above)

Medi-Cal provider number	NPI number	Telephone number	FAX	TDD

Address	City	ZIP code

Service Address	City	ZIP code	County

Director	E-mail address

Chief audiologist	E-mail address

Contact person for this application	Telephone number	FAX	E-mail address

CCS APPROVAL REQUESTED—Communication Disorder Center

☐ Type A ☐ Type B ☐ Type C

PERSONNEL*

1. Audiology Staff (Attach Curriculum Vitae for each professional staff member.)

Name	Degree	CA Audiology License/ HA Disp. License Number	On-site Hours at this Facility	Years of Experience Including CFY	CCS Paneled Provider?*
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

* Audiologists and Speech Pathologists are required to complete the CCS panel application (DHCS 4515) if they are not already on the CCS panel.

2. Speech Language Pathology Staff* (Attach Curriculum Vitae for each professional staff member.)

Name	Degree	CA SLP License Number	On-site Hours at this Facility	Years of Experience Including CFY	CCS Paneled Provider?*
					☐ Yes ☐ No
					☐ Yes ☐ No

* Audiologists and Speech Pathologists are required to complete the CCS panel application (DHCS 4515) if they are not already on the CCS panel.

3. Other Staff* (Including Teacher of the Deaf, Test Assistant, Social Worker)

Name	Position	Qualifications	On-site Hours at this Facility

***If professional staff members do not provide services at this facility, please identify their location and the process for referral:**

OPEN FOR SERVICE

Days	Hours	Specific periods not open for service

SERVICES OFFERED AT YOUR FACILITY *(Please check those that apply.)*

	Hearing	Speech
1. Diagnostic Evaluation	☐	☐
2. Hearing Aid Evaluation	☐	☐
3. Hearing Aid Dispensing	☐	☐
4. Audiometric Screening	☐	☐
5. Outpatient Infant Hearing Screening Services (Chapter 3.42)	☐	☐
6. Cochlear Implants	☐	☐
7. Speech Therapy	☐	☐
8. Infant/Preschool Habilitation Program	☐	☐
9. Parent Education Program	☐	☐
10. Aural Rehabilitation	☐	☐
11. Counseling	☐	☐

EQUIPMENT

Type of Equipment Used	Yes	No	Manufacturer	Model/Serial Number
1. Clinical Audiometer	☐	☐		
2. Infant Hearing Screening Equipment	☐	☐		
3. ABR ☐ Screening				
☐ Diagnostic				
☐ Click				
☐ Toneburst				
☐ Bone Condition				
4. OAE ☐ Screening				
☐ TEOAE				
☐ DPOAE				
☐ Diagnostic				
☐ TEOAE				
☐ DPOAE				
Other technology:				

CALIBRATION OF AUDIOLOGICAL EQUIPMENT

1. Who is responsible for maintaining calibration of audiological equipment? ____________________

2. How are calibration records kept? ____________________

AUDIOMETRIC TEST ROOM(S)

Size (Width X Length)	Manufacturer	Model
X		
X		

CLINICAL PRACTICES

1. Who is responsible for maintaining clinical records on each patient? ____________________

2. Who is responsible for developing and maintaining Policy and Procedures Manual? ____________________

CASE CONFERENCES

Describe provisions for case conferences, care coordination, and consultation among the center personnel identified in Section C of this application (Type B and Type C Centers only) of the Communication Disorder Center Standards.

☐ WILL BE INITIATED UPON CCS APPROVAL

Describe your program for habilitating deaf/hard of hearing children under 5 years of age *(Types B and C only)*.

☐ WILL BE INITIATED UPON CCS APPROVAL

WHERE ARE SEDATION SERVICES PERFORMED

Name of facility

Who is responsible for oversight of administration of sedation	Medi-Cal provider number (if known)

I AGREE THAT THIS FACILITY WILL:

1. Refer all children with a CCS-eligible condition to the CCS program.
2. Comply with the CCS requirements including staffing, facility, equipment, and calibration standards.
3. Comply with CCS requirements for care coordination/referral.
4. Accept patients authorized by CCS including those who have Medi-Cal coverage.
5. Submit timely reports to the CCS program on children for whom care is authorized.
6. Bill insurance first (within 2 months of the month of service) before billing CCS or Medi-Cal.
7. Bill CCS within 2 months of service, insurance payment or insurance rejection. (Bill CCS within 12 months of the date of service if insurance fails to respond.)
8. Bill CCS on the Medi-Cal claim form.
9. Accept payment in accordance with state regulations as payment in full.
10. Not bill families in whole or part for any CCS covered benefit.
11. Not question families regarding their ability to pay for CCS covered services.
12. Keep CCS informed of any changes affecting participation in the CCS program.
13. Request prior authorization for services to be covered by CCS.

Application completed by	Position

Signature of director or chief audiologist	Date

RETURN TO:

Attention: Unit Manager
Hearing and Audiology Services Unit
Children's Medical Services Branch , MS 8103
Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413