Provider Recruitment Program (PRP)
Provider Candidate Grant Request Form

Program Overview:
Health Plan San Joaquin/Mountain Valley Health Plan ("Health Plan") is offering Provider Recruitment Program grant funding to Health Plan's contracted Hospitals, FQHCs-RHCs, and Medical Groups to recruit and retain individual providers who agree to join the Plan's network and treat our members to increase access to Health Plan members.

Program Terms:

- The term of this program is 24-months (2 years)
- To be an eligible organization, 25% or more of your practice should consist of Health Plan members
- Organization must already be contracted with Health Plan
- Please refer to the executed MOU for further program details, requirements, and specialties.

To be considered and formally approved for this PRP grant funding, the organization (or facility) must complete this Provider Candidate Grant Request Form for each recruit. All providers must be fully enrolled with Medi-Cal Fee for Service or Ordering, Referring and Prescribing (ORP). Proof of enrollment is required before initial credentialing can be initiated.

Please return this completed form and any supplemental documentation to HPSJ/MVHP via email to ProviderRecruitmentGrant@hpsj.com.

Candidate Information:

Provider/Recruit Name:			
NPI:			
Organization/Hospital or Medical Group Affiliate Name (*if applicable*):			
Practitioner Type (*refer to MOU*): ☐ Licensed Primary Care Physician (PCP) ☐ High-Need Specialists ☐ Licensed Specialty Physician ☐ Non-Physician Provider Types			
Type of Practice/Provider Type/Specialty: Please select one			
Other Specialty Not Included in Drop-down (*pre-approval is required from Health Plan Leadership)*:			
Practice Location			
Address:	**City:**	**State:**	**Zip Code:**
Complete Address Where Funding Should Be Mailed To			
Address:	**City:**	**State:**	**Zip Code:**

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Provider Enrolled with Medi-Cal FFS or ORP (*please provide proof when submitting form*): ☐ Yes ☐ No ☐ Attached	
Credentialing Completed by Organization and Health Plan? ☐ Yes ☐ No Date: _____	
Supervising Provider/Facility/Organization Contact Name:	
Facility/Organization Contact Phone Number:	**Provider Start Date with Organization (*MM/DD/YYYY*):**
Contact E-mail:	
☐ **Full Time** ☐ **Part-Time** ☐ **Half-Time**	☐ **0.75-1.00 FTE** ☐ **0.5 - 0.75 FTE** ☐ **0.25 - 0.5 FTE**
***Please provide this form along with a copy of recruit's C.V, proof of employment/employment verification, copy of medical license and organization's valid W-9 form.**	

Attestation:

_____ I attest that the information provided on this Provider Candidate Grant Request Form is *(Recruit/Supervisor Initials)*

true, accurate and complete to the best of my knowledge. *Please sign and date below.*

.....	.....	.....
Name	**Title**	**Signature**

.....
Date