



**Required Information for Designation as a Team Member or Affiliated Provider of a CSHCN Services Program Comprehensive Cleft/Craniofacial Team**

**Team Member**

**Affiliated Member**

Provider Name:			
Provider's Address:			
Telephone Number:			Fax Number:
E-mail:	Provider's CSHCN TPI:		
NPI:			
<b>Cleft/Craniofacial (CC) Team Information</b>			
C/C Team Name:			
Location of C/C team			
City/State/ZIP			
Hospital(s) where C/C team performs services:			
<b>Team Administrator Information</b>			
Administrator Name:			
Physical Address:			
E-mail:			
Telephone Number:			Fax Number:

**Attestation for comprehensive team member**

Cleft/Craniofacial services are provided by a comprehensive cleft/craniofacial team composed of the following participants: a plastic surgeon and/or an oral surgeon; an otolaryngologist, a primary care physician; an orthodontist and/or a pediatric dentist; a licensed speech language pathologist (master's level); a cleft/craniofacial team care coordinator; and a client educator.

The C/C team assigns to each client a C/C team care coordinator who assures that services are client and family centered, and that the client/family and the C/C team jointly develop a comprehensive treatment plan for the client that is recorded in the client's medical record and provided to the client/family.

The C/C team has an identified administrator who is responsible for coordinating and maintaining all records associated with C/C team activities and assuring that the C/C team abides by the CSHCN Services Program Rules and Regulations.

**Attestation for affiliated members**

Affiliated members are providers who might not be based in the same community with the comprehensive team. Affiliated providers facilitate statewide coverage and must be linked with approved comprehensive teams. Affiliated providers must meet the CSHCN Services Program provider enrollment requirements.

The affiliated member consults and coordinates the development of a treatment plan with the comprehensive C/C team according to each individual client's needs.

***A letter of agreement between the affiliated provider and the C/C team, which verifies the linkage and specifies the method of communication and consultation, must accompany this application.***

\_\_\_\_\_  
**Cleft/Craniofacial Provider Signature**

\_\_\_\_\_  
**Date**

Return this form to:

Texas Medicaid & Healthcare Partnership  
 Attention: Provider Enrollment  
 PO Box 200795  
 Austin, TX 78720-0795