State of California
Department of Health Care Services

Provider Portal: Medi-Cal Hospice Attestation User Guide

California Medicaid Management Information System

V 1.0

September 2026

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Qualifications for Creating a Medi-Cal Hospice Attestation

To create a new Medi-Cal Hospice Attestation, providers must meet all of the following qualifications:

- Be enrolled as provider type 39.
- Have an active California Department of Public Health (CDPH) license listed in the California Health and Human Services (CHHS) [JA1.1]–CDPH public database.
- Have your provider number and National Provider Identifier (NPI) available.
- Complete the *Medi-Cal Hospice Program Election Notice (NOE)* DHCS 8052 before starting the attestation.

Providers must submit the attestation within five (5) calendar days of a hospice election.

Access the application

Follow the steps below to access the Medi-Cal Hospice Attestation Application:

1. Sign in to the Medi-Cal Provider Portal.
2. Select **Medi-Cal Hospice Attestation**.
3. Review the requirements, then select **New Provider Attestation** to begin.

Tips and Troubleshooting

Review the following tips before beginning attestation:

- The session will have a 20-minute time-out if no activity is taken and your data will not be saved.
- Once submitted, the attestation cannot be edited or changed.
- Email the DHCS Hospice Clerk at MCHospiceClerk@dhcs.ca.gov or contact the Telephone Service Center (TSC) at 1-800-541-5555 (Monday through Friday: 8 a.m. through 5 p.m.) for assistance.

Verify Member

Purpose: Verify the member's eligibility details before continuing the attestation.

The information entered in this section is used to confirm the member. Enter the member's Client Identification Number (CIN), date of birth, and date of hospice election. All fields are required. Complete this section before leaving the page.

Member Information

Purpose: Capture the member's contact information for the attestation record.

Review the pre-populated member name, CIN, and date of birth. An email address and phone number are required and complete any additional fields, when available, to help maintain an accurate record.

Navigation

1. Select **Next** to save this information and continue.
2. Select **Previous** to return to the prior section.
3. Select **Cancel Provider Attestation** to exit without saving any information.

Admitting Terminal Diagnosis

Purpose: Complete the member's terminal diagnosis and related admission details to support hospice eligibility, care coordination and compliance.

Admitting Terminal Diagnosis and Related Conditions ICD-10 Code(s)

1. Enter the member's ICD-10 codes(s).
2. Enter primary and secondary terminal diagnoses, and the justification for admission.
3. Select **+ Add Another Code** if more than one diagnosis code applies.

Member's Current Residence

Enter the name and NPI number of the attending physician chosen by the member.

Navigation

1. Select **Next** to save this information and continue.
2. Select **Previous** to return to the prior section.
3. Select **Cancel Provider Attestation** to exit without saving any information.

Services Currently Provided to Member by Other Agencies

Purpose: Help the Department of Health Care Services (DHCS) understand a member's current care and ensure services are coordinated appropriately.

Record Current Services Received

Select **Yes** if the member is actively receiving one of the following services:

- Home Health Services (e.g., nursing care, therapy provided at home)
- Private Duty Nursing (ongoing, individualized nursing care)
- Personal Care Services (assistance with daily living activities like bathing or dressing

Select **No** if:

- The member is **not receiving** any of these services currently, or
- Services were received in the past but are no longer active.

Note: If you are unsure, confirm the member's current service status before selecting a response. Only report services that are active as of today.

Navigation

1. Select **Next** to save this information and continue.
2. Select **Previous** to return to the prior section.
3. Select **Cancel Provider Attestation** to exit without saving any information.

Hospice Provider Statement

Purpose: Confirm that a qualified hospice representative has verified the accuracy of the attestation.

Qualified Hospice Personnel

Hospice Representative Information: Provide details of the individual authorized to complete and certify this section on behalf of the hospice agency.

Table of Hospice Representative Information Field Requirements

Field	Instruction	Guidance
First Name/ Last Name	Enter the legal name of the hospice representative completing the attestation.	This field is optional. Enter the recipient's first name.
Email	Enter a direct, active email address for the representative.	This may be used for follow-up, confirmation, or audit communication.
Title	Enter the representative's official role (for example, Administrator, Clinical Director).	Ensure the title reflects authority to certify hospice program requirements.

Qualified Hospice Agency

Enter the full, licensed name of your hospice agency. Match the name used in Medi-Cal enrollment records to avoid delays.

Certification Checkbox

Select the certification checkbox to confirm that:

- ☐ All information provided is complete and accurate
- ☐ The hospice provider meets Medi-Cal requirements
- ☐ The representative is authorized to submit this attestation

Important: You must select this certification checkbox to proceed.

Agency Location(s)

Identify the hospice location(s) associated with this attestation.

- Select or confirm the applicable location.
- You should typically have one primary location.
- If applicable, you may add up to three locations in total.

Only include locations relevant to the services being attested.

Navigation

1. Select **Next** to save this information and continue.
2. Select **Previous** to return to the prior section.
3. Select **Cancel Provider Attestation** to exit without saving any information.

Summary and Signature

Purpose: The Summary and Sign section allows you to review all entered member information, confirm your authorization as a hospice representative, and complete the attestation with a digital signature.

Review and Sign

Review all member information carefully to ensure it is accurate. By proceeding, you certify that you are an authorized representative of the hospice provider and that the information entered is correct to the best of your knowledge.

To continue, **scroll** to the bottom of the page to enable the signature field. **Enter** your digital signature to attest.

Important: Once submitted, the attestation cannot be edited or changed. After submission, select Print to print or download a PDF copy of the completed attestation for your records. After you submit the completed attestation, you may exit. Your completed attestation will be saved and submitted to DHCS.

Email the DHCS Hospice Clerk at MCHospiceClerk@dhcs.ca.gov or contact the Telephone Service Center (TSC) at 1-800-541-5555 (Monday through Friday: 8 a.m. through 5 p.m.) for assistance.

Navigation

1. Select **Next** to save this information and continue.
2. Select **Previous** to return to the prior section.
3. Select **Cancel Provider Attestation** to exit without saving any information.

Change Summary

Version Number	Date	Description	Notes/Comments
1.0	September 2026	New Medi-Cal Hospice Attestation User Guide	New user guide with steps about how to complete the Medi-Cal Hospice Attestation in the Provider Portal.