

# Hospital/Facility Provider Application

**INSTRUCTIONS:** In order for the application to be considered complete:

1. All information must be legible. Please print or type all information.
2. A separate application must be completed for each Legal Entity/TIN.
3. The Application must be signed and dated.
4. If necessary, use a separate sheet of paper to provide additional information.
5. The original application with attachments should be attached to the Provider Agreement.
6. Fill-in the Tax ID# at the bottom of every page for reference purposes.

**PROVIDER CHECKLIST:**

- HOSPITAL/FACILITY PROVIDER APPLICATION**
- STATE OPERATING LICENSE:** including license number and expiration date, if applicable
- GENERAL LIABILITY INSURANCE:** Certificate detailing address of location being credentialed, amounts & dates of coverage. Minimum Requirement: \$1M per occurrence and \$3M per aggregate
- ACCREDITATION CERTIFICATE:** Accreditation letter or certificate by a nationally recognized accrediting body, e.g., TJC, JCAHO, CARF, COA, AOA, if applicable
- SITE EVALUATION RESULTS:** If not accredited by a nationally recognized accrediting body, attach the Site Evaluation Results from a governmental agency, if applicable
- OTHER APPLICABLE STATE/FEDERAL LICENSURES:** e.g., CLIA, DEA, Pharmacy Permit
- OWNERSHIP AND DISCLOSURE FORM, if applicable**
- W-9**
- HCBS (Home and Community Based Services) Settings Attestation (application pages 15-17) \*REQUIRED FOR ALL HCBS PROVIDERS**

**Initial Credentialing/ Assessment**

**Re-Credentialing/ Re-Assessment**

**Addition of new site to current contract**

Legal Entity/TIN: \_\_\_\_\_

This application applies to the following **Provider Specialties**: (Choose all that apply)

<input type="checkbox"/> Hospital (Critical Access) NPI:	<input type="checkbox"/> Hospital (Swing Bed) NPI:	<input type="checkbox"/> Hospital (General Acute Care) NPI:
<input type="checkbox"/> Hospital (Rehabilitation) NPI:	<input type="checkbox"/> Hospital (Psychiatric) NPI:	<input type="checkbox"/> Hospital NPI:
<input type="checkbox"/> Adult Day Care Center NPI:	<input type="checkbox"/> Clinic –Federally Qualified Health Center (FQHC); NPI:	<input type="checkbox"/> Laboratory NPI:
<input type="checkbox"/> Adult Living Facility/Assisted Living Facility NPI:	<input type="checkbox"/> Clinic – Rural Health Center (RHC) NPI:	<input type="checkbox"/> Outpatient Clinic NPI:
<input type="checkbox"/> Agency (Dept. of Health, State Health) NPI:	<input type="checkbox"/> Community Mental Health Center (CMHC) NPI:	<input type="checkbox"/> Pediatric Day Health Care Facilities (PDHC) NPI:
<input type="checkbox"/> Ambulance NPI:	<input type="checkbox"/> Diagnostic Imaging Center NPI:	<input type="checkbox"/> Personal Care Assistant Facilities (PCAs) NPI:
<input type="checkbox"/> Assisted Long-Term Care Facility NPI:	<input type="checkbox"/> Dialysis (ESRD) NPI:	<input type="checkbox"/> Psychiatric Unit NPI:
<input type="checkbox"/> Ambulatory Surgical Center NPI:	<input type="checkbox"/> Durable Medical Equipment NPI:	<input type="checkbox"/> Rehabilitation Facility (Outside of Hospital) NPI:
<input type="checkbox"/> Autism Facility NPI:	<input type="checkbox"/> Family Planning Clinics NPI:	<input type="checkbox"/> Rehabilitation Unit NPI:
<input type="checkbox"/> Behavioral Health Agency/Child Placing Agency NPI:	<input type="checkbox"/> Home Health Agency NPI:	<input type="checkbox"/> Residential Treatment Center NPI:
<input type="checkbox"/> Board of Health NPI:	<input type="checkbox"/> Hospice NPI:	<input type="checkbox"/> Skilled Nursing Facility NPI:
<input type="checkbox"/> Chemical Dependency/ Substance Abuse NPI:	<input type="checkbox"/> Home and Community Based Services (HCBS) NPI:	<input type="checkbox"/> Urgent Care NPI:
<input type="checkbox"/> Methadone Clinic NPI:	<input type="checkbox"/> Intensive Family Intervention NPI:	<input type="checkbox"/> Other: NPI:

**Contact Information:**

If questions about this application, contact:	Phone Number:
Email:	Fax Number:

**Credentialing Contact Information:** Same as Contact Information

If questions about this application, contact:	Phone Number:
Email:	Fax Number:

**Legal Entity Information** (Name on Income Tax Return)

Tax ID Holder Name:	Federal Tax ID Number:
Legal/Tax Address (where you want the 1099 sent):	

**Insurance Information**

Carrier:	Amount of Coverage Per Occurrence: Per Aggregate:
Policy Number:	Coverage Dates:

**Billing Information**

Pay To Name (Issue check to): Note: May be different than name on the 1099.		
Pay To Address (Send remittance to:	City, State, Zip:	Phone Number:
Billing Contact Name:	Billing Contact Email:	Fax Number:

**Note: Each Provider Specialty/NPI listed on the table on Page 2 must have one service location. Complete for each Service Location that is part of this application.**

<b>Service Location 1 of ____</b>		
<b>Group or Facility Name (to be displayed in the Directory)</b>		
<b>Tax ID Number:</b> <input type="checkbox"/> Same as Legal Entity	<b>Provider Type:</b>	<b>National Provider ID #:</b>
<b>State License Number:</b>	<b>State Registration Number:</b>	<b>State Certification Number:</b>
<b>DEA (If applicable):</b>	<b>CLIA (If applicable):</b>	<b>Other License:</b>
<b>Medicaid Number:</b>	<b>Medicare Number:</b>	
<b>Service Location Address:</b>  <input type="checkbox"/> Same as Legal Entity		
<b>Physical Street Address:</b>	<b>City, State, Zip:</b>	<b>County:</b>
<b>Service Location Phone Number:</b>	<b>Service Location Fax Number</b>	<b>Email:</b>

<b>Service Location Hours:</b>							
<b>Office Hours</b>	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>	<b>Saturday</b>	<b>Sunday</b>
<input type="checkbox"/> 24 Hours <input type="checkbox"/> 8 – 5							
<b>Handicap Accessible? (Check all that apply).</b> <input type="checkbox"/> Building <input type="checkbox"/> Bathroom(s) <input type="checkbox"/> Parking <input type="checkbox"/> Therapy Room(s)			<b>Service Location Accepting New Patients?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>ADA Compliant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Crisis Intervention/ Emergency Services Offered?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>If Yes, explain:</b>		<b>Do you provide services to both Males &amp; Females?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>In No, explain:</b>	
<b>Please list any Foreign Languages spoken at this location:</b>							
<b>Do you provide services to any of the following special needs population? (Check all that apply):</b> <input type="checkbox"/> Deaf/Hearing Impaired <input type="checkbox"/> Physical Disability <input type="checkbox"/> Blind/Vision Impaired <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other (Please specify: _____)							
<b>Is your practice limited to certain ages?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes, specify age restrictions:</b>							

None  
 0-2 years  
 0-6 years  
 0-12 years  
 0-17 years  
 0-20 years  
 6-12 years  
 13+ years  
 13-17 years  
 13-20 years  
 3+ years  
 17+ years  
 21+ years  
 65+ years  
 Other \_\_\_\_\_

**Behavioral Health Services Provided for Service Location 1 of \_\_\_\_\_: (check all that apply)**

<input type="checkbox"/> Inpatient Mental Health <input type="checkbox"/> Inpatient Substance Abuse <input type="checkbox"/> Day Treatment – Mental Health <input type="checkbox"/> Day Treatment – Substance Abuse <input type="checkbox"/> Intensive Outpatient Program (IOP) – Mental Health <input type="checkbox"/> Intensive Outpatient Program – Substance Abuse <input type="checkbox"/> Observation <input type="checkbox"/> Residential Treatment – Mental Health (PRTF) <input type="checkbox"/> OP Treatment Services – Mental Health <input type="checkbox"/> OP Treatment Services – Substance Abuse	<input type="checkbox"/> Inpatient – Eating Disorder <input type="checkbox"/> Electroconvulsive Therapy (ECT) – Inpatient <input type="checkbox"/> Electroconvulsive Therapy (ECT) - Outpatient <input type="checkbox"/> Partial Hospitalization Program (PHP) – Mental Health <input type="checkbox"/> Partial Hospitalization Program (PHP) – Substance Abuse <input type="checkbox"/> Residential Treatment – Chemical Dependency <input type="checkbox"/> Community Based Services <input type="checkbox"/> Targeted Case Management <input type="checkbox"/> Crisis Stabilization <input type="checkbox"/> Detox; Ages Served: _____ <input type="checkbox"/> Other (please specify): _____
---	--

**Billing Information for Service Location 1 of \_\_\_\_\_ :**  
 Same as indicated on Page 2 (If different, complete below)

Pay To Name (Issue check to): Note: May be different than name on the 1099.

Pay To Address (Send remittance to):	City, State, Zip:	Phone Number:
Billing Contact Name:	Billing Contact Email:	Fax Number:

**Insurance Information for Service Location 1 of \_\_\_\_\_ :**  
 Same as indicated on Page 3 (If different, complete below )

Professional Carrier:	Amount of Coverage: Per Occurrence: Per Aggregate	Coverage Dates:
Policy Number:	Coverage Dates:	

**Service Location 1 of \_\_\_\_\_ - Accreditation/Certification Type**

Same as Legal Entity

Check here if the facility is NOT accredited

**\*If not accredited please complete the Site Survey section**

*Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.*

Agency Name	v	Effective Date	Expiration Date
Accreditation Commission for Health Care (ACHC)			
American Association of Ambulatory Health Centers (AAAHC)			
American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)			
American College of Radiology (ACR)			
American Osteopathic Hospital Association (AOHA)			
Board of Orthotist / Prosthetist Certification (BOCUSA)			
Clinical Laboratory Improvement Act (CLIA)			
Commission on Accreditation for Rehab Facilities (CARF)			
Community Health Accreditation Program (CHAP)			
Council on Accreditation (COA)			
DEA Certificate			
Healthcare Quality Association on Accreditation (HQAA)			
The Joint Commission (TJC (aka JCAHO))			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)			
National Association of Boards of Pharmacy (NABP)			
National Committee for Quality Assurance (NCQA)			
Pharmacy			
State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)			
Others (please list):			

### Site Survey (Non-Accredited Facilities)

Attach a copy of your most recent on-site survey along with your Corrective Action Plan(s) , if deficiencies were cited, OR a letter from government agency stating the facility is in substantial compliance with most recent survey standards.

1. Has the facility had a post-licensing on-site survey by a government agency such as the Department of Health or CMS within the past 36 months?  
 Yes – Date of most recent standard survey: \_\_\_\_\_  
 No – Successful completion of a health plan on-site survey may be required to complete credentialing.
2. Were any deficiencies cited during the last full survey?  
 Yes (If yes, attach documents defining deficiencies.)  
 No  
 N/A – no recent survey

**If no survey has been completed, successful completion of a Health Plan onsite survey will be required to complete credentialing. You will be contacted by the Health Plan to schedule the visit.**

### Organizational Service Provider Screening

1. Please select the method used to verify the license/certification of individuals rendering services for your organization:  
 Online directly with the appropriate state and/or federal licensure or certification board  
 Background check agency, contracted organization or vendor  
 Other process (please describe): \_\_\_\_\_  
 No process (please explain): \_\_\_\_\_
2. Please indicate the method used to ensure that each license/certification (and all other credentials) of individuals rendering services for your organization is renewed before expiration:  
 Online directly with the appropriate state and/or federal licensure or certification board  
 Obtaining a current copy of the license/certification  
 Background check agency, contracted organization or vendor  
 Other process (please describe): \_\_\_\_\_  
 No process (please explain): \_\_\_\_\_
3. Please indicate the method used to verify the identity of individuals rendering services for your organization:  
 Verification of a state driver's license or other government identification  
 Background check agency, contacted organization or vendor  
 Other process (please describe): \_\_\_\_\_  
 No process (please explain): \_\_\_\_\_
4. Please indicate the method used to ensure that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service, and that no individuals convicted of a felony for a healthcare-related crime (including but not limited to healthcare fraud; patient abuse; and the unlawful manufacture, distribution, prescription or dispensing of controlled substance) are rendering services:  
 Federal and/or state criminal background check(s)  
 Background check agency, contracted organization or vendor  
 Search a state "misconduct registry" or equivalent  
 Other process (please describe): \_\_\_\_\_  
 No process (please explain): \_\_\_\_\_

**Service Location 1 of \_\_\_\_\_ – Sanctions** **Same as Legal Entity***If yes, to any question below, please explain on a separate sheet of paper.*

Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Has the any license or certification held by the Organization (if applicable) ever been denied, suspended or revoked for any reason or voluntarily surrendered any license or certification while under investigation, or any actions or investigations underway that may lead to one of these outcomes?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Has an officer of your Organization ever been convicted of, pled guilty to, or pled “no lo contendere” to any felony including an act of violence, child abuse, or a sexual offense?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Has the corporation, an officer or board member ever been convicted of a felony?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>

Complete for each Service Location that is part of this application.

Service Location 2 of _____		
Group or Facility Name (to be displayed in the Directory)		
Tax ID Number: <input type="checkbox"/> Same as Legal Entity	Provider Type:	National Provider ID #:
State License:	State Registration:	State Certification:
DEA (If applicable):	CLIA (If applicable):	Other License:
Medicaid Number:	Medicare Number:	
Service Location Address:  <input type="checkbox"/> Same as Legal Entity		
Physical Street Address:	City, State, Zip:	County:
Main Switchboard Phone Number:	Service Location Fax Number	Email:

Service Location Hours:							
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<input type="checkbox"/> 24 Hours <input type="checkbox"/> 8 – 5							
Handicap Accessible? (Check all that apply). <input type="checkbox"/> Building <input type="checkbox"/> Bathroom(s) <input type="checkbox"/> Parking <input type="checkbox"/> Therapy Room(s)			Service Location Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		ADA Compliant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Crisis Intervention/ Emergency Services Offered? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, explain:		Do you provide services to both Males & Females? <input type="checkbox"/> Yes <input type="checkbox"/> No		In No, explain:	
Please list any Foreign Languages spoken at this location:							
Do you provide services to any of the following special needs population? (Check all that apply): <input type="checkbox"/> Deaf/Hearing Impaired <input type="checkbox"/> Physical Disability <input type="checkbox"/> Blind/Vision Impaired <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other (Please specify: _____)							

Is your practice limited to certain ages?  Yes  No

If Yes, specify age restrictions:

- None  0-2 years  0-6 years  0-12 years  0-17 years  0-20 years  6-12 years  13+ years  
 13-17 years  13-20 years  3+ years  17+ years  21+ years  65+ years  Other \_\_\_\_\_

**Behavioral Health Services Provided for Service Location 2 of \_\_\_\_\_: (check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Inpatient Mental Health<br><input type="checkbox"/> Inpatient Substance Abuse<br><input type="checkbox"/> Day Treatment – Mental Health<br><input type="checkbox"/> Day Treatment – Substance Abuse<br><input type="checkbox"/> Intensive Outpatient Program (IOP) – Mental Health<br><input type="checkbox"/> Intensive Outpatient Program – Substance Abuse<br><input type="checkbox"/> Observation<br><input type="checkbox"/> Residential Treatment – Mental Health (PRTF)<br><input type="checkbox"/> OP Treatment Services – Mental Health<br><input type="checkbox"/> OP Treatment Services – Substance Abuse | <input type="checkbox"/> Inpatient – Eating Disorder<br><input type="checkbox"/> Electroconvulsive Therapy (ECT) – Inpatient<br><input type="checkbox"/> Electroconvulsive Therapy (ECT) - Outpatient<br><input type="checkbox"/> Partial Hospitalization Program (PHP) – Mental Health<br><input type="checkbox"/> Partial Hospitalization Program (PHP) – Substance Abuse<br><input type="checkbox"/> Residential Treatment – Chemical Dependency<br><input type="checkbox"/> Community Based Services<br><input type="checkbox"/> Targeted Case Management<br><input type="checkbox"/> Crisis Stabilization<br><input type="checkbox"/> Detox; Ages Served: _____<br><input type="checkbox"/> Other (please specify): _____ |
|---|--|

**Billing Information for Service Location 2 of \_\_\_\_\_:**

Same as indicated on Page 2 (If different, complete below)

Pay To Name (Issue check to): Note: May be different than name on the 1099.

Pay To Address (Send remittance to):	City, State, Zip:	Phone Number:
Billing Contact Name:	Billing Contact Email:	Fax Number:

**Insurance Information for Service Location 2 of \_\_\_\_\_:**

Same as indicated on Page 3 (If different, complete below)

Professional Carrier:	Amount of Coverage: Per Occurrence: Per Aggregate	Coverage Dates:
Policy Number:	Coverage Dates:	

**Service Location 2 of \_\_\_\_\_ - Accreditation/Certification Type**

Same as Legal Entity

Check here if the facility is NOT accredited

**\*If not accredited please complete the Site Survey section**

*Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.*

Agency Name	v	Effective Date	Expiration Date
Accreditation Commission for Health Care (ACHC)			
American Association of Ambulatory Health Centers (AAAHC)			
American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)			
American College of Radiology (ACR)			
American Osteopathic Hospital Association (AOHA)			
Board of Orthotist / Prosthetist Certification (BOCUSA)			
Clinical Laboratory Improvement Act (CLIA)			
Commission on Accreditation for Rehab Facilities (CARF)			
Community Health Accreditation Program (CHAP)			
Council on Accreditation (COA)			
DEA Certificate			
Healthcare Quality Association on Accreditation (HQAA)			
The Joint Commission (TJC (aka JCAHO))			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)			
National Association of Boards of Pharmacy (NABP)			
National Committee for Quality Assurance (NCQA)			
Pharmacy			
State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)			
Others (please list):			

### Site Survey (Non-Accredited Facilities)

Attach a copy of your most recent on-site survey along with your Corrective Action Plan(s) , if deficiencies were sited, OR a letter from government agency stating the facility is in substantial compliance with most recent survey standards.

1. Has the facility had a post-licensing on-site survey by a government agency such as the Department of Health or CMS within the past 36 months?  
 Yes – Date of most recent standard survey: \_\_\_\_\_  
 No – Successful completion of a health plan on-site survey may be required to complete credentialing.
2. Were any deficiencies cited during the last full survey?  
 Yes (If yes, attach documents defining deficiencies.)  
 No  
 N/A – no recent survey

**If no survey has been completed, successful completion of a Health Plan onsite survey will be required to complete credentialing. You will be contacted by the Health Plan to schedule the visit.**

### Organizational Service Provider Screening

1. Please select the method used to verify the license/certification of individuals rendering services for your organization:  
 Online directly with the appropriate state and/or federal licensure or certification board  
 Background check agency, contracted organization or vendor  
 Other process (please describe): \_\_\_\_\_  
 No process (please explain): \_\_\_\_\_
2. Please indicate the method used to ensure that each license/certification (and all other credentials) of individuals rendering services for your organization is renewed before expiration:  
 Online directly with the appropriate state and/or federal licensure or certification board  
 Obtaining a current copy of the license/certification  
 Background check agency, contracted organization or vendor  
 Other process (please describe): \_\_\_\_\_  
 No process (please explain): \_\_\_\_\_
3. Please indicate the method used to verify the identity of individuals rendering services for your organization:  
 Verification of a state driver's license or other government identification  
 Background check agency, contacted organization or vendor  
 Other process (please describe): \_\_\_\_\_  
 No process (please explain): \_\_\_\_\_
4. Please indicate the method used to ensure that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service, and that no individuals convicted of a felony for a healthcare-related crime (including but not limited to healthcare fraud; patient abuse; and the unlawful manufacture, distribution, prescription or dispensing of controlled substance) are rendering services:  
 Federal and/or state criminal background check(s)  
 Background check agency, contracted organization or vendor  
 Search a state "misconduct registry" or equivalent  
 Other process (please describe): \_\_\_\_\_  
 No process (please explain): \_\_\_\_\_

**Service Location 2 of \_\_\_\_\_ – Sanctions** **Same as Legal Entity***If yes, to any question below, please explain on a separate sheet of paper.*

Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Has the any license or certification held by the facility (if applicable) ever been denied, suspended or revoked for any reason or voluntarily surrendered any license or certification while under investigation, or any actions or investigations underway that may lead to one of these outcomes?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Has an officer of your Organization ever been convicted of, pled guilty to, or pled “no lo contendere” to any felony including an act of violence, child abuse, or a sexual offense?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Has the corporation, an officer or board member ever been convicted of a felony?	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>

## PROVIDER RESPONSIBILITY STATEMENT

I hereby understand that as a prospective/current Centene Corporation Health Plan provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice, if applicable. In all such cases, I will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to Centene Corporation Health Plan credentials/re-credentials requirements for my organization.

By applying for participation in the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Centene Corporation Health Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

## STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

Name of Facility: \_\_\_\_\_ Date: \_\_\_\_\_  
*Print or type name*

\_\_\_\_\_  
Signature of Provider or Authorizing Representative  
*A stamp signature is not acceptable*

\_\_\_\_\_  
Title



**HCBS Final Rule Compliance: Residential Provider Attestation and Evidence Tool (continued)**

<b>Requirement 1:</b> The setting is integrated in the community and supports the same access for Medicaid and non-Medicaid enrollees receiving HCBS services. [42 CFR 441.301(c)(4)(i)]		<b>Mark the answer that applies</b>		
		<b>NA</b>	<b>Yes</b>	<b>No</b>
1.	Are Members able to control their own daily schedules and activities?			
2.	Are Members able to come and go (with or without support) from the setting at any time without restrictions?			
3.	Are Members supported to explore and pursue competitive integrated employment in the community if Members choose to do so?			
4.	Are Members supported to engage in off-site community activities based on their individual preferences, such as shopping, dining, religious activities, voting, volunteering, personal appointments?			
5.	Are Members provided (or supported to access) transportation to/from the setting for community and social activities of their choosing?			
6.	Are Members supported to access and keep/carry their own money?			
7.	Are Members supported to control their own personal belongings and resources?			
<b>Requirement 2:</b> Person-centered plan is based on the individual's needs and preferences [42 CFR 441.301(c)(4)(ii)]			<b>Yes</b>	<b>No</b>
8.	Are Members supported to lead and actively participate in their person-centered planning process, including pre-planning and planning meetings?			
9.	Do Members have regular opportunities to update their plan, including their activities and preferences, or when there is a change in their needs?			
10.	Are Members able to receive services and support in location(s) of their choosing?			
<b>Requirement 3:</b> Right to privacy, dignity, and respect and freedom from coercion and restraint [42 CFR 441.301(c)(4)(iii)]		<b>NA</b>	<b>Yes</b>	<b>No</b>
11.	Are Members supported to know and understand their program rights, including access to a copy of the rights in a manner and format that is accessible and understandable for them?			
12.	Do Members know what to do if Members have a problem with support staff or their services (i.e., do Members know how to reach out to their case manager, or how to file an anonymous complaint)?			
13.	Are Members supported to access information on resources like the Hawaii Disability Rights Center (HDRC) and Adult Protective Services (APS)?			
14.	Do Members feel that support staff interact and communicate with Members respectfully and in a manner that Members would like to be addressed?			
15.	Do Members know that support staff are trained in appropriate use of restrictive interventions if written in individualized plan?			
16.	Do Members know if their personal information is kept private and maintained in a secure location?			
17.	Do Members have privacy when personal care is provided?			
18.	Do Members have support staff to promote informed decision-making?			
19.	Do Members have privacy when using the phone or internet?			
<b>HCBS Requirement 4:</b> Individual initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact. [42 CFR 441.301(c)(4)(iv)]			<b>Yes</b>	<b>No</b>
20.	Do Members have individual and variable schedules that change (daily or weekly) consistent with their individual preferences and needs?			
21.	Are Members supported to make informed choices, and to exercise those choices, about opportunities to participate in activities of interest, both within the setting and in the broader community?			
22.	Are Members supported if Members want to use, or learn how to use, public transportation options (e.g., bus schedules, training to use the bus, etc.)?			
23.	Do Members have opportunities to develop and maintain relationships with people from the broader community, including people without disabilities?			

**HCBS Final Rule Compliance: Residential Provider Attestation and Evidence Tool (continued)**

<b>HCBS Requirement 5:</b> Choice regarding services, supports, and who provides them [42 CFR 441.301 (c)(4)(v)]		<b>Yes</b>	<b>No</b>
24.	Are Members asked about their needs and preferences, and are Members provided support to understand their choices and make informed decisions?		
25.	Are Members supported to know how to request a change in service provider, setting, or support staff?		
26.	Do Members know how to relocate or request new day program if Members choose to move?		

**HEALTH AND SAFETY RISKS**

<b>HCBS Requirement 6:</b> Lease or other legally enforceable agreement providing the same responsibilities and protections from eviction that tenants have under state landlord or local landlord tenant laws [42 CFR 441.301 (c)(4)(vi)(A)]		<b>Yes</b>	<b>No</b>
27.	Do Members have a legally enforceable residential agreement with the same responsibilities and protections from evictions that tenants have under state or local landlord-tenant laws?		
<b>HCBS Requirement 7:</b> Right to privacy in their living unit [42 CFR 441.301 (c)(4)(vi)(B)(1)], [42 CFR 441.301 (c)(4)(vi)(B)(2), [42 CFR 441.301 (c)(4)(vi)(B)(3)]		<b>Yes</b>	<b>No</b>
28.	Are Members able to close and lock doors to their personal or private spaces in the setting, including their bedroom and bathroom, with only appropriate staff able to access keys?		
29.	Do Members have the opportunity to choose to have a private room if one is available?		
30.	Do Members have the opportunity to choose and change their roommate situation?		
31.	Are Members able to furnish and decorate their personal or private spaces as Members choose, as described within the lease or residential agreement?		
<b>HCBS Requirement 8:</b> Freedom and support [42 CFR 441.301 (c)(4)(vi)(C)]		<b>Yes</b>	<b>No</b>
32.	Are Members able to control their own daily schedules and activities?		
33.	Do Members have access to food of their choosing at any time, without restrictions (e.g., without limitations on where food can be consumed, or offering substitute meal options in residential settings)?		
<b>HCBS Requirement 9:</b> Right to visitors and access to family and friends [42 CFR 441.301 (c)(4)(vi)(D)]		<b>Yes</b>	<b>No</b>
34.	Are Members allowed to have visitors at any time, without restrictions?		
35.	Do Members have a comfortable private place for Members to meet with visitors?		
<b>HCBS Requirement 10:</b> Physically accessible to the member [42 CFR 441.301 (c)(4)(vi)(E)]		<b>Yes</b>	<b>No</b>
36.	Do Members have physical access to areas around the setting (i.e., are Members able to maneuver through the hallways, doorways, bathrooms, and common areas with or without assistive devices such as walkers and wheelchairs)?		