IOWA STATEWIDE
UNIVERSAL FACILITY APPLICATION
ATTACHMENT WORKSHEET

This worksheet is intended to provide you with additional information that may be required to be submitted with or attached to your Iowa Statewide Facility Application. Credentialing entities to which you are applying will require some or all of the following documents to be submitted with this application. Some entities require originals, copies or notarized copies. This list may not be all-inclusive. A specific list of required documents is available from the entity to which you are applying or providing credentialing information.

Documents that may be required:

Copy of Malpractice Insurance Face Page

Original Federal W-9 Tax Identification Form

Copy of Quality Assurance Plan

You should contact the entity to which you are providing the Iowa Statewide Facility Application for additional information on any documents that will be required.

IOWA STATEWIDE
UNIVERSAL FACILITY APPLICATION

Name: _____
(Please print full name of facility)

FOR: ☐ **INITIAL CREDENTIALING**

☐ **RECREDENTIALING**

☐ **OTHER**

- **Type or print responses in ink.**
- **Complete this form in its entirety and attach all requested documentation and explanations.**
- **If a question does not apply to your facility, answer with "Non-Applicable" or "NA".**
- **If additional space is necessary to provide answers, attach additional sheet(s) of paper.**
- **All dates must be formatted as: Month/Date/Year (MM/DD/YYYY).**

THIS APPLICATION MUST BE SIGNED AND DATED WHERE INDICATED

SECTION A: **PROVIDER INFORMATION:**

Type of Provider: (*Choose all that apply*)

☐ Ambulance

☐ Ambulatory Surgery Center

☐ Birthing Center

☐ Community Mental Health Center

☐ Dialysis Center

☐ Durable/Home Medical Equipment Supplier

☐ Free Standing Substance Abuse Facility

☐ Home Health Agency

☐ Home Infusion Therapy

☐ Hospice

☐ Hospital
- ☐ Acute Care
- ☐ Critical Access

☐ Independent Laboratory

☐ Magnetic Resonance Imaging Center

☐ Orthotics & Prosthetics Supplier

☐ Radiology Center (X-Ray)

☐ Skilled Nursing Facility

☐ Other: _____

Is your facility ADA accessible? ……☐ Yes ☐ No

SECTION B: **DEMOGRAPHIC INFORMATION:**

(Please provide appropriate information for all your services/locations.)

Facility Name: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Contact Person (*the person you wish us to contact regarding information on this application*):

Contact Name: _____ Title: _____

Phone Number: (_____)_____ Fax Number: (_____)_____ Email Address: _____

SECTION C: **PAYMENT/BILLING INFORMATION:**

Facility Name: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

NPI #: _____ Tax Identification Number: _____ (Please provide an Original Federal W-9 tax identification form)

Billing Contact Name: _____ Phone #: (_____)_____

Quality Assurance Contact: _____ Phone #: (_____)_____

SECTION D: **OWNERSHIP/MANAGEMENT:**

President /CEO
Name: _____ Title: _____ Phone #: (_____)_____

CFO
Name: _____ Title: _____ Phone #: (_____)_____

Medical Director
Name: _____ Title: _____ Phone #: (_____)_____

SECTION E: **ACCREDITATION/CERTIFICATION/LICENSURE {See (A.) or (B.) below}:**

Agency	License or Certification or Accreditation Number *(if applicable)*	Last Review /Renewal	Expiration Date
Accrediting Association for Ambulatory Healthcare			
American Board of Certification			
American College of Radiology			
American Institute of Ultrasound in Medical OB & Abdominal Ultrasound			
American Osteopathic Association			
Chemical Dependency Certificate			
Clinical Laboratory Improvement Act			
College of American Pathologists			
DEA Registration			
Department of Health and Human Services			
FDA Mammography Facility Certification			
Joint Commission			
Medicaid			
Medicare			
State Controlled Substance Certificate			
State License			
State Nuclear/Radioactive Materials License			
State Radiological Registration			
The Rehabilitation Accreditation Commission			
Others (*please list*)			

A. Please provide a copy of these documents as applicable, including the results of the survey and a report that shows the effective dates of accreditation or certification, deficiencies, and approved plan for corrective action.

B. If not accredited or certified, please note where you are in the process of obtaining accreditation or certification and by what date you expect to complete the process. _____
_____

C. Hospice providers – If not licensed, please provide copy of most recent CMS survey.

SECTION F: **LIABILITY COVERAGE:**

A. In the space provided, list your liability carrier and the dates of general liability coverage to include month, day and year of beginning coverage and expiration date.

Current Carrier: _____

Agency Name: _____

City: _____ State: _____ Phone #: (_____)_____

$ Amount Per Occurrence: _____ $ Amount Aggregate: _____

Dates of Coverage: From:_____ /_____/_____ To:_____/_____/_____

List any privileges/procedures which are excluded or restricted under your current policy. Be specific. If none, click this box. ☐

_____

_____

B. Please check the appropriate answer for the following questions:	Yes	No
1. Have you ever had a liability case brought against you?	☐	☐
2. Have any judgments ever been brought against you in a liability case?	☐	☐
3. Have any settlements ever been made on your behalf?	☐	☐
4. Are there any open claims or cases presently filed against you?	☐	☐

If you answered "Yes" to a question, explain on a separate sheet. Explanations should include a concise summary of all pertinent facts, dates, and current status or disposition.

SECTION G: **ADDITIONAL INFORMATION:**

Please answer all of the questions, explaining any "Yes" answers on the space provided below.

A. In the past five years:	Yes	No	NA
1. Has the corporation, an officer or a board member ever been convicted of a felony?	☐	☐	
2. Has your State License *(if applicable)* ever been denied, suspended or revoked for any reason?	☐	☐	☐
3. Has your DEA Registration or State Controlled Substance Certificate *(if applicable)* ever been denied, suspended, or revoked for any reason?	☐	☐	☐
4. Have you ever been subjected to sanctions by a Professional Review Organization *(PSRO or PRO)*, the Medicare/Medicaid Program, a Third Party Payor, or a Regulatory agency *(CLIA, OSHA, etc.)*?	☐	☐	

Explanation:

_____

_____

_____

SECTION H: **MALPRACTICE HISTORY:**

A. In the past five years: Yes No

1. Has this facility's professional liability insurance coverage ever been denied or cancelled? ☐ ☐

2. Has this facility's current or previous professional liability carrier ever made an out of court settlement or paid a judgment of a professional liability claim on the facility/service behalf? ☐ ☐

3. Is or has the facility ever been involved in a malpractice suit(s), grievance(s) filed with a county or state medical society or licensing agency, or arbitration(s) proceeding(s)? ☐ ☐

If you answered "Yes" to any of the above three questions, please supply a claims summary from your malpractice carrier.

SECTION I: **CERTIFICATION AND RELEASE:**

I understand that any information entered on this application and any addenda appropriate to my specialty, which subsequently is found to be false, could result in immediate dismissal from the health insurance program or health plan.

I hereby certify that the information contained in my completed application is accurate, true and complete. I authorize release of information as it may be required to process this application. My signature on this complete application does not constitute a contract with the health insurance program or health plan.

Officer/CEO/Owner Signature: _____ Date:_____/_____/_____

Name: _____
(Please type or print)

SECTION J: **CERTIFICATION AND RELEASE OF THE INDIVIDUAL PREPARING THE APPLICATION:**

This section is to be completed if someone other than this applicant has prepared this application:
I, _____, hereby attest that the information included on this application is true and can be
(Preparer's Name)
retrieved from the files located at:

Facility Name, Address/City: _____

Preparer's Signature:_____ Date: _____/_____/_____

SECTION K: **HOSPITAL ADDENDUM** *(Complete only if you are a hospital provider)***:**

A. Beds

Total Licensed Bed Capacity: _____ Total Number of Medicare Certified Beds: _____

B. Services Available

- ☐ Air Ambulance
- ☐ Alcohol/Chemical Dependency
  - ☐ Inpatient
  - ☐ Outpatient
  - ☐ Adolescent
- ☐ Alzheimer's Diagnosis and Assessment
- ☐ Birthing Rooms
- ☐ Blood Bank
- ☐ Burn Unit
- ☐ Cardiac Care Unit
- ☐ Cardiac Rehab Program
- ☐ CT Scanner
- ☐ Diabetic Education Program
- ☐ Dialysis
- ☐ Geriatric Services
- ☐ Home Health Services
- ☐ Home Infusion
- ☐ Hospice
- ☐ Hospital Based Ambulance
- ☐ Intensive Care Unit
- ☐ Lithotripsy
- ☐ MRI Scanner
- ☐ Neonatal ICU
- ☐ Nuclear Medicine
- ☐ Nursery
- ☐ Nursing Facility
- ☐ Obstetrics
- ☐ Occupational Therapy
  - ☐ Inpatient
  - ☐ Outpatient
- ☐ Open Heart Surgery
- ☐ Organ Transplant
  - ☐ Specify _____
- ☐ Outpatient Surgery
- ☐ Pain Management
- ☐ Pediatrics
- ☐ PET Scanner
- ☐ Physical Therapy
  - ☐ Inpatient
  - ☐ Outpatient
- ☐ Psychiatric Services
  - ☐ Inpatient
  - ☐ Outpatient
  - ☐ Pediatric
  - ☐ Adolescent
- ☐ Radiation Therapy
- ☐ Speech Pathology
  - ☐ Inpatient
  - ☐ Outpatient
- ☐ Tissues Transplant
- ☐ Trauma Facility/ER Dept.
  - ☐ Resource
  - ☐ Regional
  - ☐ Area
  - ☐ Community
- ☐ Ultrasound
- ☐ Urgent Care Center
- ☐ Ventilator Care –Long Term
- ☐ Residential Day Care
- ☐ Skilled Nursing Facility
- ☐ Sports Medicine
- ☐ Swing Bed Program

Other Services: _____

Are there services provided off-campus that would fall under the hospital outpatient billing and Tax ID? ☐Yes ☐No
If yes, please list these services, names, and locations: *(use additional sheet if necessary)* _____
_____
_____
_____

Are there any other certified facilities based at your hospital and if so, what are they (i.e., home health, hospice, skilled nursing, dialysis)? _____
_____
_____
_____

Do you contract with any facility or provider group to provide services at the hospital? If so, what are the services, i.e., radiology, MRI, lab, ER, anesthesiology, DME, reference lab) _____
_____
_____
_____

SECTION L: **DURABLE/HOME MEDICAL EQUIPMENT & ORTHOTIC AND PROSTHETIC SUPPLIERS ADDENDUM** *(Complete only if you are a DME or O&P provider)*:

A. Categories of Services

Which of the following services do you provide?

1. DME
   - ☐ Respiratory
   - ☐ Orthotics
   - ☐ Medical Equipment and Supplies
   - ☐ Urological Supplies
   - ☐ Prosthetics
2. Critical Care
   - ☐ Mechanical Ventilators
   - ☐ Parenteral
   - ☐ Bi-Pap
   - ☐ Enteral
3. Rehabilitation (Customer fabricator of products):
   - ☐ Wheelchairs
   - ☐ Power wheel chairs
   - ☐ Prosthetics
   - ☐ Orthotics
   - ☐ Other (please specify):
4. Medical Equipment Repair/Service
   - ☐ Repair/Service of Medical Equipment by Certified, Licensed or Technically Trained Personnel

Please provide a description of services you provide that are not listed above: _____
_____

Do you provide emergency maintenance or back-up equipment? ☐Yes ☐No
If yes, please explain your process: _____
_____
_____

B. Permit/License Information

Please provide the following permit/license numbers and a copy of the license as applicable.

Agency	**License or Certification or Accreditation Number *(if applicable)***	**Last Review /Renewal**	**Expiration Date**
Retail Sales Tax Permit Number			
Wholesale Drug License Number			
Household Hazardous Materials Retailers Permit Number			

C. Service Area

Please describe your service area: _____
_____
_____

Please provide information regarding any limitation of services due to geographic reasons: _____
_____
_____