Home and Community Based Services (HCBS) Provider Credentialing/Re-Credentialing Application

GENERAL INFORMATION	
Corporate Name (as assigned on W-9)	
Doing Business As (if applicable)	
Individual Provider Name (if applicable)	Individual Provider DOB (if applicable)
Federal Tax Identification (TIN) Number	
NPI Number or Social Security Number	

ORGANIZATIONAL/INDIVIDUAL PROVIDER TYPE:

- ☐ Adult Day Care
- ☐ Assistive Devices
- ☐ Assisted Living
- ☐ Case Management
- ☐ Chore Services
- ☐ Consumer Directed Attendant Care (CDAC)
- ☐ Counseling Services
- ☐ Emergency Response System
- ☐ Home and Vehicle Modification
- ☐ Home Delivered Meals
- ☐ Home Health Aide
- ☐ Home Maker Services
- ☐ Nursing Services
- ☐ Nutritional Counseling
- ☐ Personal Emergency Response System (PERS)
- ☐ Pest Control
- ☐ Respite
- ☐ Respite Care: ☐ Institutional ☐ In-Home
- ☐ Senior Companions
- ☐ Specialized Medical Equipment
- ☐ Respite Care: ☐ Institutional ☐ In-Home
- ☐ Supported Community Living: ☐ Residential ☐ In-Home
- ☐ Transportation
- ☐ Other ____________________________

Copy this page, prior to completing, for additional offices.

DEMOGRAPHIC/LOCATION INFORMATION		
Please indicate the facility's main office, mailing, payment and contact information by completing the appropriate information and checking one or more address type.		
ADDRESS #1 (choose both, if applicable): ☐ Primary Office ☐ Mailing		
Facility/Organization Name (DBA)		
NPI Number	Effective Date	
Street Address		
City	State	ZIP Code
Phone Number	Fax Number	
Contact(s) at this address:		
Credentialing Contact Name	E-mail Address	
Phone Number	Fax Number	

ADDRESS #2 (choose both, if applicable): ☐ Additional Location ☐ Mailing		
Facility/Organization Name (DBA)		
NPI Number	Effective Date	
Street Address		
City	State	ZIP Code
Phone Number	Fax Number	
Contact(s) at this address:		
Credentialing Contact Name	E-mail Address	
Phone Number	Fax Number	

ADDRESS #3 (choose both, if applicable): ☐ Additional Location ☐ Mailing		
Facility/Organization Name (DBA)		
NPI Number	Effective Date	
Street Address		
City	State	ZIP Code
Phone Number	Fax Number	
Contact(s) at this address:		
Credentialing Contact Name	E-mail Address	
Phone Number	Fax Number	

PAYMENT/BILLING INFORMATION		
Reporting Name		
Corporate Name		
Tax ID Number		
Street Address		
City	State	ZIP Code
Billing Contact Name	Phone Number	
E-mail Address	Fax Number	
Please provide a copy of the W-9 IRS form		

LICENSURE/CERTIFICATION/ACCREDITATION:	
State License Number	Expiration Date
Is the facility/provider a participating Medicare provider? ☐ Yes ☐ No	Medicare Number
Is the facility/provider a participating Medicaid provider? ☐ Yes ☐ No	Medicaid Number
Business/Retail License Number	
Effective Date	Expiration Date
Is the agency bonded? ☐ Yes ☐ No	Are the caregivers bonded? ☐ Yes ☐ No If no, please provide proof of insurance for all caregivers
Please provide a copy of all licenses and certificates including State or City	

LIABILITY INSURANCE:	
Insurance Carrier	Phone Number
Policy Number	Dates of Coverage
Dollar Amount per Occurrence	Dollar Amount Aggregate
Please provide a copy of your current professional and general liability insurance.	

OWNERSHIP/MANAGEMENT INFORMATION	
President/CEO:	
Name	
Title	Phone Number
Chief Financial Officer (CFO):	
Name	
Title	Phone Number
Medical Director:	
Name	
Title	Phone Number

OWNERSHIP/MANAGEMENT INFORMATION (continued):	
Other Managing Employees 1 or Persons with Ownership or Control Interest 2:	
Name	
Title	Phone Number
Name	
Title	Phone Number
Name	
Title	Phone Number

ATTESTATION QUESTIONNAIRE:

If any of the following questions are answered "Yes", please provide details on a separate sheet.

1. ☐Yes ☐No Has the practitioner/facility ever had or currently have pending, any legal actions excluding medical malpractice?
2. ☐Yes ☐No Has the practitioner/facility ever been convicted of a crime, excluding misdemeanors?
3. ☐Yes ☐No Has any government agency ever investigated, suspended, revoked, or taken other action against your license to practice or conduct business?
4. ☐Yes ☐No At any time has any license or certification ever been revoked, denied, or suspended by others or voluntarily given up by the practitioner/facility, or are any actions which may lead to such conclusions now under way?
5. ☐Yes ☐No At any time, has the practitioner/facility been assessed a penalty, conviction or suspension or is the practitioner/facility currently under investigation by the Medicaid or Medicare programs?
6. ☐Yes ☐No At any time, has any third party payors ever revoked, reduced, denied, or suspended your or the facility's participation due to inappropriate utilization management or any quality of care issues?
7. ☐Yes ☐No Has any managing employee or person with an ownership or control interest been excluded from participation in a government program (e.g., Medicare, Medicaid)?

1· "Managing employee" means "a general manager, business manager, administrator, director, or other
Individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to- day operation of an institution, organization, or agency.

2· "A Person with an ownership or control interest" means "a person or corporation that: (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity; (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by a disclosing entity if that interest equals at least 5 percent of the value of the property or assets of a disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership?"

STAFFING:
Does the facility validate the credentials for licensed practitioners employed or contracted at the facility? ☐ Yes ☐ No If Yes, indicate how the facility validate the credentials for each practitioner employed or contracted at the facility: ☐ Validations are performed internally ☐ Validations are outsourced to ☐ Other, specify________________________________ If No, Please explain: ________________________________ ________________________________ ________________________________

EXCLUSION CERTIFICATION:	
I hereby certify that the on-line exclusion lists for the Health and Human Services, Office of Inspector General (OIG) and General Services Administration (GSA) are checked for all new hires and monthly for existing employees to ensure that no excluded employees work on any jobs related to any Federal health care programs. I also hereby certify that I will remove any employee found on one of the above-referenced lists from any work related to a Federal health care program. The OIG exclusion list can be found at **http://exclusions.oig.hhs.gov/**. The GSA exclusion list can be found at **https: //www.sam.gov/.**	
Authorized Signature for Facility ►	Date
Print Name	Title

RELEASE OF INFORMATION, INCLUDING BACKGROUND CHECKS AND AUTHORIZATION:	
I hereby certify that, to the best of my knowledge, the responses and information contained in this application are complete, accurate and current. I acknowledge that any misstatements or omissions constitute cause for denial of admission to, or summary dismissal from, membership in the AmeriHealth Caritas Iowa provider network. I hereby authorize AmeriHealth Caritas Iowa and its designated agents and representatives to conduct a comprehensive review of the background and credentials of those named on this application. I acknowledge that such review may cause a consumer report and/or an investigative consumer report to be generated. I understand that the scope of the consumer report/ investigative consumer report may include, but is not necessarily limited to the following areas: verification of social security number/tax identification number; credit reports; current and previous residences; employment history; education background; character references; drug testing; civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records; birth records; and any other public records. I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me and any others I have presented on this application, to AmeriHealth Caritas Iowa and its agents. I further authorize the complete release of any records or data pertaining to me or others I have presented on this application which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. AmeriHealth Caritas Iowa and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicant's personal information, including, but not limited to, addresses, social security numbers, and dates of birth. I warrant that I have the authority to sign this authorization, and to thereby authorize the release of information and the performance of a background check, on behalf of all parties named on this application.	
Signature ►	Date
Print Name	Title