Facility Credentialing 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:

- ☐ **FACILITY CREDENTIALING 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 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.**
- ☐ **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**

***Recredentialing Application Return to email: facilitycredentialing@centene.com Due to no in-office presence any documents mailed will not be accepted.**
***Initial Credentialing Applications should be returned to the Health Plan Representative**

Legal Entity/TIN: _____

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

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

Service Location 1 of _____		
Group or Facility Name (to be displayed in the Directory)		
Tax ID Number: ☐ **Same as Legal Entity**	**Provider Type:**	**National Provider ID #:**
State License Number:	**State Registration Number:**	**State Certification Number:**
DEA (If applicable):	**CLIA (If applicable):**	**Other License:**
Medicaid Number:	**Medicare Number:**	
Service Location Address: ☐**Same as Legal Entity**		
Physical Street Address:	**City, State, Zip:**	**County:**
Service Location Phone Number:	**Service Location Fax Number**	**Email:**

Service Location Hours:

Office Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
☐ **24 Hours** ☐ **8 – 5**							

Handicap Accessible? (Check all that apply). ☐ **Building** ☐ **Bathroom(s)** ☐ **Parking** ☐ **Therapy Room(s)**	**Service Location Accepting New Patients?** ☐ **Yes** ☐ **No**	**ADA Compliant?** ☐ **Yes** ☐ **No**

Crisis Intervention/ Emergency Services Offered? ☐ **Yes** ☐ **No**	**If Yes, explain:**	**Do you provide services to both Males & Females?** ☐ **Yes** ☐ **No**	**If 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): ☐ **Deaf/Hearing Impaired** ☐ **Physical Disability** ☐ **Blind/Vision Impaired** ☐ **Developmental** ☐ **Disability 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 1 of _: (check all that apply)

☐ Inpatient Mental Health ☐ Inpatient Substance Abuse ☐Day Treatment – Mental Health Day ☐Treatment – Substance Abuse ☐Intensive Outpatient Program (IOP) – Mental Health ☐Intensive Outpatient Program – Substance Abuse ☐Observation ☐Residential Treatment – Mental Health (PRTF) ☐OP Treatment Services – Mental Health ☐OP Treatment Services – Substance Abuse	☐Inpatient – Eating Disorder ☐Electroconvulsive Therapy (ECT) – Inpatient ☐Electroconvulsive Therapy (ECT) - Outpatient ☐Partial Hospitalization Program (PHP) – Mental Health ☐Partial Hospitalization Program (PHP) – Substance Abuse ☐Residential Treatment – Chemical Dependency ☐Community Based Services ☐Targeted Case Management ☐Crisis Stabilization ☐Detox; Ages Served: _____ ☐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:**	

Laboratory Services (Please attach current copy of CLIA Certificate)

Does the Laboratory meet the requirements of Federal Public Law, Clinical Laboratory Improvement Amendments of 1988 (CLIA)? ☐ Yes ☐ No ☐ N/A

If the answer to the above question is No, provide an explanation:

Pharmacy

If the answer is YES to the following questions, please provide a copy of any DEA Registration Certificates, State DEA/CSR Certificates, and Pharmacy Licenses for each location where applicable.

Does this Facility dispense medication?	☐ **Yes** ☐ **No** ☐ **N/A**
Can a patient fill a prescription at this Facility?	☐ **Yes** ☐ **No** ☐ **N/A**
If the answer to either question is NO, provide an explanation:	

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	√	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)	☐		
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)	☐		
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 <u>identity</u> 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 rending 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?	☐ **Yes** ☐ **No**
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?	☐ **Yes** ☐ **No**
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.)?	☐ **Yes** ☐ **No**
Has 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?	☐ **Yes** ☐ **No**
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?	☐ **Yes** ☐ **No**
Has the corporation, an officer or board member ever been convicted of a felony?	☐ **Yes** ☐ **No**
Do you agree to continuously monitor staff against exclusion lists prior to employment and monthly thereafter? *In the event a staff member is listed, immediately remove staff member from providing services under the agreement with the MCO and notify MCO within 3 business days. If NO, please provide an explanation.	☐ **Yes** ☐ **No**

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: ☐ **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: ☐**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**
☐ **24 Hours** ☐ **8 – 5**							

Handicap Accessible? (Check all that apply). ☐ **Building** ☐ **Bathroom(s)** ☐ **Parking** ☐ **Therapy Room(s)**	**Service Location Accepting New Patients?** ☐ **Yes** ☐ **No**	**ADA Compliant?** ☐ **Yes** ☐ **No**

Crisis Intervention/ Emergency Services Offered? ☐**Yes** ☐ **No**	**If Yes, explain:**	**Do you provide services to both Males & Females?** ☐ **Yes** ☐ **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):
☐ **Deaf/Hearing Impaired** ☐ **Physical Disability** ☐ **Blind/Vision Impaired** ☐ **Developmental Disability**
☐ **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)

☐ **Inpatient Mental Health**	☐ **Inpatient – Eating Disorder**
☐ **Inpatient Substance Abuse**	☐ **Electroconvulsive Therapy (ECT) – Inpatient**
☐ **Day Treatment – Mental Health Day**	☐ **Electroconvulsive Therapy (ECT) - Outpatient**
☐ **Treatment – Substance Abuse**	☐ **Partial Hospitalization Program (PHP) – Mental Health**
☐ **Intensive Outpatient Program (IOP) – Mental Health**	☐ **Partial Hospitalization Program (PHP) – Substance Abuse**
☐ **Intensive Outpatient Program – Substance Abuse**	☐ **Residential Treatment – Chemical Dependency**
☐ **Observation**	☐ **Community Based Services**
☐ **Residential Treatment – Mental Health (PRTF)**	☐ **Targeted Case Management**
☐ **OP Treatment Services – Mental Health**	☐ **Crisis Stabilization**
☐ **OP Treatment Services – Substance Abuse**	☐ **Detox; Ages Served:** _____
	☐ **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:**	

Laboratory Services (Please attach current copy of CLIA Certificate)

Does the Laboratory meet the requirements of Federal Public Law, Clinical Laboratory Improvement Amendments of 1988 (CLIA)? ☐ **Yes** ☐ **No** ☐ **N/A**

If the answer to the above question is No, provide an explanation:

Pharmacy

If the answer is YES to the following questions, please provide a copy of any DEA Registration Certificates, State DEA/CSR Certificates, and Pharmacy Licenses for each location where applicable.

Does this Facility dispense medication?	☐ Yes ☐ No ☐ N/A
Can a patient fill a prescription at this Facility?	☐ Yes ☐ No ☐ N/A
If the answer to either question is NO, provide an explanation:	

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.

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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)	☐		
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)	☐		
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.)
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   - ☐ Background check agency, contracted organization or vendor
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   - ☐ No process (please explain): _____

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   - ☐ 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 rending 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?	☐ **Yes** ☐ **No**
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?	☐ **Yes** ☐ **No**
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.)?	☐ **Yes** ☐ **No**
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?	☐ **Yes** ☐ **No**
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?	☐ **Yes** ☐ **No**
Has the corporation, an officer or board member ever been convicted of a felony?	☐ **Yes** ☐ **No**
Do you agree to continuously monitor staff against exclusion lists prior to employment and monthly thereafter? *In the event a staff member is listed, immediately remove staff member from providing services under the agreement with the MCO and notify MCO within 3 business days. If NO, please provide an explanation.	☐ **Yes** ☐ **No**

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 **Title**
A stamp signature is not acceptable

HCBS Final Rule Compliance: Residential Provider Attestation and Evidence Tool

Date:	
Health Plan Name:	
Medicaid Provider Name:	
Medicaid Provider ID#:	
NPI# (if applicable):	
Phone:	
Email:	
Servicing Address:	

I, _____, attest to have reviewed the HCBS Settings Final Rule requirements and understand the expectations as a Medicaid provider. The evidence presented to the health plans as part of credentialing is true, accurate and complete and understand that any falsification or omission of information may warrant further evaluation by the health plan.

_____ _____ _____

Signature of Authorized Person Attesting Title Date

HCBS Requirement – Physical Location: Home and community-based settings do not include nursing facilities, institutions for mental diseases, intermediate care facilities for individuals with intellectual disabilities, hospitals, settings that isolate members from the broader community, or any other locations that have qualities of an institutional setting.

**Responses to this section are based on the provider evaluation of the servicing address*.

HCBS Requirement – Physical Location: Home and community-based settings do not include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, hospitals, settings that isolate members from the broader community, or any other locations that have qualities of an institutional setting. **Responses to this section are based on the provider evaluation of the servicing address*.		**Mark the answer that applies**	
		Yes	**No**
A	The setting is NOT located in a building, attached to a building, on the grounds of, or immediately adjacent to a publicly or privately operated facility that provides inpatient institutional treatment (e.g., nursing home, hospital).	☐	☐
B	The setting is NOT located where there are multiple settings serving people with disabilities, co-located and operated or controlled by the same provider agency (e.g., a street with multiple care homes, in a row, owned by same provider).	☐	☐
C	The setting is NOT surrounded by high walls, high fences, security locks or gates.	☐	☐
D	The setting IS located in a community with other private homes, retail businesses, food establishments, and other community resources.	☐	☐

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

	Requirement 1: 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)]	**Mark the answer that applies**		
		NA	**Yes**	**No**
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?		☐	☐
	Requirement 2: Person-centered plan is based on the individual's needs and preferences [42 CFR 441.301(c)(4)(ii)]		**Yes**	**No**
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?		☐	☐
	Requirement 3: Right to privacy, dignity, and respect and freedom from coercion and restraint [42 CFR 441.301(c)(4)(iii)]	**NA**	**Yes**	**No**
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?		☐	☐
	HCBS Requirement 4: 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)]		**Yes**	**No**
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)

	HCBS Requirement 5: Choice regarding services, supports, and who provides them [42 CFR 441.301 (c)(4)(v)]	**Yes**	**No**
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

	HCBS Requirement 6: 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)]	**Yes**	**No**
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?	☐	☐
	HCBS Requirement 7: 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)]	**Yes**	**No**
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?	☐	☐
	HCBS Requirement 8: Freedom and support [42 CFR 441.301 (c)(4)(vi)(C)]	**Yes**	**No**
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)?	☐	☐
	HCBS Requirement 9: Right to visitors and access to family and friends [42 CFR 441.301 (c)(4)(vi)(D)]	**Yes**	**No**
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?	☐	☐
	HCBS Requirement 10: Physically accessible to the member [42 CFR 441.301 (c)(4)(vi)(E)]	**Yes**	**No**
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)?	☐	☐