

HEALTH DELIVERY ORGANIZATION APPLICATION

The Health Delivery Organization (HDO) is an organization, or a group of related organizations, involved with delivering healthcare services. HDOs that provide health care and/or services to Community Care Network (CCN) members are reviewed for conformance to CCN's standards of participation (e.g., hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers, behavioral health facilities, and other organizations). HDOs must submit an application prior to contracting as a network provider for members. Thereafter, HDOs are reviewed at least every thirty-six (36) months.

HDO Applicant Instructions

Application must be filled out completely, and all questions answered. For any question or section that is not applicable to your organization, mark as "N/A".

The information listed below **must** accompany the completed application. ***These attachments make it possible for our Credentials Committee to assess the quality, type of care, and services your organization will provide to CCN members.***

- A current copy of the facility's state business license, or license issued by the State Department of Health or Department of Social and Health Services.
- Current copy of accreditation letter or certificate from a recognized agency (e.g., AAAHC, CLIA, JCAHO, CARF, etc.).
 - If not accredited, include a copy of the most recent survey results from CMS or State Department of Health. If deficiencies were cited, include your corrective action plan or cover letter from CMS or the State Department of Health stating the facility is in substantial compliance.
- Current professional liability insurance face sheet showing dates and amounts
- Copy of DEA Certificate, if applicable
- CLIA Certificate, if applicable
- Evidence of Medicaid Certification
- W-9 Form signed and dated in current year
- Medical Staff Roster (include name, NPI and specialty)
- A list of any employed and contracted physicians or physicians' extenders (e.g., emergency medicine physicians, pathologists, radiologists, physician's assistants, CRNAs and/or NPs).

***Please note: a separate HDO application must be completed for each location with a unique/different Tax ID.**

IDENTIFYING INFORMATION: (Please use a separate sheet of paper for multiple locations)

Name of Facility (Legal name listed with the IRS) _____
DBA (if applicable) _____

Physical Practice Location

Mailing Address (Billing)

Street Address: _____
 City: _____
 Zip/State: _____
 Phone #: _____
 Fax #: _____
 County: _____

Street Address: _____
 City: _____
 Zip/State: _____
 Phone #: _____
 Fax #: _____
 County: _____

If multiple sites are under the same Tax ID, complete section 12 of this application

CREDENTIALING CONTACT

Contact Name: _____

Email: _____

Phone: _____

Fax: _____

Federal Tax ID#: (This must be the number issued to the entity to which remittances are made): _____

NPI Number: (If multiple sites, attach list of NPI numbers for each site) _____

AHCA ID #: _____

Medicare Provider #: _____

Are you Medicare Certified?
 Yes No

Is this location handicap accessible?
 Yes No

Please list any languages spoken by office personnel:

Billing Contact Person: _____

Phone #: _____

Checks made payable to: _____

Fax #: _____

Describe your service area (States, Counties, Cities):

Email: _____

FACILITY TYPE: (Check all boxes that apply to you participating in CCN's Network)

- | | | |
|---|---|---|
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Ambulatory Surgery Ctr. | <input type="checkbox"/> Skilled Nursing Facility | <input type="checkbox"/> Birthing Center |
| <input type="checkbox"/> Behavioral Health Facility | <input type="checkbox"/> Durable Medical Equipment Provider | <input type="checkbox"/> Free-Standing Acute Rehab Facilities |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Diagnostic Imaging Center | <input type="checkbox"/> Other |

Is there any age restriction on the services you provide?

- No Yes: _____

Do you currently participate with other Managed Care Organizations? If so, please list them.

- No Yes: _____

Are providers listed in the roster rendering services outside of the facility?

If "Yes", indicate on the roster which providers will be working outside of the facility under the agreement.

- No Yes: _____

ACCREDITATIONS/CERTIFICATIONS: Specify the name of the organization that accredited/certified your facility/ organization and attach a copy of your certificate.

Accredited by: _____	Certified by: _____
Date of original accreditation: _____	Date of original certification: _____
Date of re-accreditation(s): _____	Date of re-certification(s): _____
Date of last survey: _____	Date of last survey: _____
Level of Accreditation: _____	Level of Certification: _____

LICENSING INFORMATION: (attach current copies of all licenses)

Type of License	License Number and State	Date of Most Recent Survey
State License	_____	_____
State Registration	_____	_____
State Certification	_____	_____
DEA	_____	_____
CLIA	_____	_____
Other	_____	_____

CURRENT INSURANCE COVERAGE: (attach a copy of your current insurance face sheet)

Current Carrier Name: _____	Dates Current Coverage: _____
Policy Number: _____	Policy Type(s): _____
Coverage type:	If claims based, does this facility have tail coverage?
<input type="checkbox"/> Occurrence based <input type="checkbox"/> Claims based	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coverage amounts per occurrence: _____	Retro date: _____
Aggregate: _____	

PREVIOUS INSURANCE COVERAGE: Please provide the name and address of any carrier, other than the facility's current one, which has provided professional liability coverage at any time.

Carrier	Dates	Address, City, State, Zip

QUALITY IMPROVEMENT (QI): Please answer all the following questions. Attach an additional sheet if necessary.

QI Contact Person: _____

Phone No: _____ Fax No: _____

If you are not accredited by a recognized accreditation organization (JCAHO, CARF, AAAHC, etc.), please attach copies of the current Quality Improvement Program Description and Signature Page.

- Current Quality Improvement Work Plan and Signature Page
- Most recent Quality Improvement Evaluation and Signature Page
- Policies for verifying and monitoring professional licenses (e.g., RN, LVN, PT, OT, Pharm. D., etc.)
- Copy of the most recent survey results from CMS (formerly HCFA) or State Department of Health, including your corrective action plan if deficiencies were cited, or a cover letter from CMS or the State Department of Health stating the facility is in substantial compliance.

CREDENTIALING PROCESS

Please indicate how credentialing is ensured for all healthcare professionals employed or contracted at the facility:

- Credentialing procedures are performed internally
- Credentialing procedures are outsourced/delegated to: _____

ORGANIZATIONAL SERVICE PROVIDER SCREENING

Please select the method used to verify the license/certification of individuals rendering services for your organization:

- Online directory 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): _____

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/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): _____

Please indicate the method used to verify the identity of individuals rendering services for your organization:

- Verification of state driver's license or other government identification
- Background check agency, contracted organization, or vendor
- Other process (please describe): _____
- No process (please describe): _____

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 a 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): _____

Hospital-Based Provider Groups: Please attach provider roster

Emergency Medicine

Group Name _____
 Group Address _____
 Group NPI _____
 Group Tax ID _____
 Group Taxonomy _____
 Group Medicaid Number _____
 Group Phone & Fax No. _____
 Office Manager/Administrator _____
 Office Manager Contact Info. _____

Radiology

Group Name _____
 Group Address _____
 Group NPI _____
 Group Tax ID _____
 Group Taxonomy _____
 Group Medicaid Number _____
 Group Phone & Fax No. _____
 Office Manager/Administrator _____
 Office Manager Contact Info. _____

Pathology

Group Name _____
 Group Address _____
 Group NPI _____
 Group Tax ID _____
 Group Taxonomy _____
 Group Medicaid Number _____
 Group Phone & Fax No. _____
 Office Manager/Administrator _____
 Office Manager Contact Info. _____

Anesthesiology

Group Name _____
 Group Address _____
 Group NPI _____
 Group Tax ID _____
 Group Taxonomy _____
 Group Medicaid Number _____
 Group Phone & Fax No. _____
 Office Manager/Administrator _____
 Office Manager Contact Info. _____

Other

Group Name	_____
Group Address	_____
Group NPI	_____
Group Tax ID	_____
Group Taxonomy	_____
Group Medicaid Number	_____
Group Phone & Fax No.	_____
Office Manager/Administrator	_____
Office Manager Contact Info.	_____

Other

Group Name	_____
Group Address	_____
Group NPI	_____
Group Tax ID	_____
Group Taxonomy	_____
Group Medicaid Number	_____
Group Phone & Fax No.	_____
Office Manager/Administrator	_____
Office Manager Contact Info.	_____

Facility Practice Locations Under the Same Tax ID

Please include a roster of locations if there are more than six

Location #1 Name: _____
 Address _____
 Phone: _____ Fax: _____
 NPI: _____ Taxonomy: _____

Accredited by: _____
 If not accredited, the most recent
 CMS survey results and date: _____

Location #2 Name: _____
 Address _____
 Phone: _____ Fax: _____
 NPI: _____ Taxonomy: _____

Accredited by: _____
 If not accredited, the most recent
 CMS survey results and date: _____

Location #3 Name: _____
 Address _____
 Phone: _____ Fax: _____
 NPI: _____ Taxonomy: _____

Accredited by: _____
 If not accredited, the most recent
 CMS survey results and date: _____

Location #4 Name: _____
 Address _____
 Phone: _____ Fax: _____
 NPI: _____ Taxonomy: _____

Accredited by: _____
 If not accredited, the most recent
 CMS survey results and date: _____

Location #5 Name: _____
 Address _____
 Phone: _____ Fax: _____
 NPI: _____ Taxonomy: _____

Accredited by: _____
 If not accredited, the most recent
 CMS survey results and date: _____

Location #6 Name: _____
 Address _____
 Phone: _____ Fax: _____
 NPI: _____ Taxonomy: _____

Accredited by: _____
 If not accredited, the most recent
 CMS survey results and date: _____

OWNERSHIP AND CONTROL DISCLOSURE FORM

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are executing a provider agreement or submitting a provider application to disclose to managed care organizations that contract with the state Medicaid agency: 1) the identity of all persons with an ownership or control interest (e.g., has an ownership interest of 5% or more in a disclosing entity, is an officer or director of a disclosing entity organized as a corporation or a partner of a disclosing entity organized as a partnership, owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity under certain circumstances, etc.), 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this Statement, an updated Statement should be completed and submitted to CCN within 30 days of the change. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network.

INSTRUCTIONS FOR COMPLETING THE DISCLOSURE OF OWNERSHIP FORM (“Form”)

1. Read all definitions and instructions outlined throughout the Form and then reference the definitions and instructions while completing the Form.
2. Answer all questions as of the current date.
3. If there is no information to include, indicate “None” or “Not applicable” (N/A) in the space provided. Do not leave blank spaces unless advised to do otherwise in the instructions. Incomplete Forms will be reported back to the applicable state agency or Health Plan.
4. Re-submit a new Form when any information in your disclosure changes.
5. If more space is needed, please attach additional sheets.
6. Complete this Form whether or not you have any information to report.
7. In any space requesting “Name”, if it is the name of an individual, include First, Middle, and Last.
8. Business and Service Address: The address for corporate/legal entities must include, as applicable, the primary business address, every business location, and the P.O. Box address. Individuals must provide their home address.
9. Provide the Employer Identification Number (EIN) or Tax Identification Number (TIN) for legal entities. Provide the Social Security Number (SSN) for individuals.

Section 1. Identifying Information

Specify in what capacity the disclosing entity is doing business as (DBA). (e.g., name of trade or corporation.).

Section 2. Criminal Offenses

42 C.F.R. §455.106 requires that before the health plan enters into or renews a provider agreement, or at any time by written request by the Medicaid agency, the provider must disclose the identity of any person who: (1) has ownership or control interest in the provider, or is an agent or managing employee of the provider, and (2) has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, or title XX services program since the inception of those programs.

Answer the following questions by checking “Yes” or “No.” If any of the questions are answered “Yes,” list the names and addresses of individuals or corporations.

Section 3. Former Employees

Answer the following question by checking “Yes” or “No.” If the question is answered “Yes,” list the names and addresses of individuals or corporations.

Section 4. Ownership, Financial, or Control Interest

- (a) In Table 1 list the names, titles, addresses, date of birth, and Social Security Number (SSN) for all individuals having ownership (including indirect ownership interest) or controlling interest in the disclosing entity, fiscal agent, or managed care entity. For owners, indicate the percentage of ownership if applicable. "Persons with an ownership or control interest" is broadly defined at 42 C.F.R. 455.101.
- (b) Answer the following question by checking the appropriate box.
- (c) In Table 2 list the name, address, tax identification number (TIN), and percentage of ownership of any corporation with an ownership or control interest in the Disclosing Entity. The address for corporate entities must include all applicable primary business addresses, every business location, and P.O. Box addresses.
- (d) In Table 3 list the name, address, TIN, and percentage of ownership of any subcontractor in which the Disclosing Entity has direct or indirect ownership interest totaling 5 percent or more.
- (e) Answer the following question by checking the appropriate box. If yes, in Table 4 list their names and the relationships.
- (f) In Table 4 list the names and relationships of each related party.
- (g) Answer the following question by checking the appropriate box. N/A is only an acceptable response for those providers with no owners. If a provider lists owners on the list of persons with ownership or control interest, then the response should be "Yes" or "No."
- (h) If the response is "Yes," in Table 5 list the name of each owner and the name of the other disclosing entity(ies) in which they have an ownership or control interest. "Other disclosing entity" is defined at 42 C.F.R. 455.101.

Section 5. Change in Ownership or Control

Answer the following questions by checking the appropriate box. If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Section 6. Facility Management

- (a) Answer the question by checking the appropriate box.
- (b) If yes, list the name of the management firm and TIN, or the name of the leasing organization.

Section 7. Management Employees

- (a) Answer the question by checking the appropriate box. If yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include the name of the newly appointed person.
- (b) In Table 7 list the name, address, date of birth and SSN of any managing employee of the disclosing entity. "Managing employee" is defined at 42 C.F.R. 455.101

Section 8. Chain Affiliates

Answer the question by checking the appropriate box. If yes, list name, address of Corporation, and TIN

Section 9. Facility Beds

Answer the question by checking the appropriate box. If yes, list the actual number of beds in the facility now and the previous number. By signing the Ownership Disclosure Form, I certify that the information provided on this Form is complete and accurate. I will notify CCN within 30 days if any information changes. I will comply with all aspects of this Form. By completing and signing this Disclosure Form, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation or termination of an existing contract.

Name (Print or Type:
First/Middle/Last) _____

Title
(Print or Type) _____

Signature
(Provider/Disclosing Entity
or Authorized Agent of the
Provider/Disclosing Entity) _____

Date
(MM/DD/YYYY) _____

d) Table 4. Related Parties

Name	Relationship

(e) Do any of the owners listed in Table 1 or Table 2 have an ownership or control interest in another organization(s) that would qualify as a disclosing entity?

- No
 Yes
 N/A

SECTION 7. Employees

Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? **No**
 Yes

Table 7. Managing Employees

Name	Title	Address	DOB

SECTION 8. Chain Affiliates

(a) Is this facility chain affiliated? **No**
 Yes

If the answer to Question 8(a) is "Yes:"

Name	TIN #	Address

If the answer to Question 8(a) is "No," was the facility ever affiliated with a chain?

Name	TIN #	Address

SECTION 9. Facility Beds

Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years?

No Yes Year of change: _____
 Current beds: _____
 Prior beds: _____

DISCLOSURE QUESTIONS

Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned, or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military, or state Department of Health program?

No **Yes** (provide an explanation): _____

At any time, has any third-party payer ever revoked, reduced, denied or suspended your organization’s participation due to inappropriate utilization management or quality-of-care issue.

No **Yes** (provide an explanation): _____

Has your organization’s liability insurance coverage ever been restricted, limited, denied, not renewed or special-rated for any reasons other than the carrier’s termination of operations in your state?

No **Yes** (provide an explanation): _____

At any time, has any third-party payer ever revoked, reduced, denied, or suspended your organization’s participation due to inappropriate utilization management or quality-of-care issues?

No **Yes** (provide an explanation): _____

Does your organization currently employ any person who has been or is currently excluded from participation in a government program (e.g., Medicare, Medicaid)?

No **Yes** (provide an explanation): _____

Has the facility been denied accreditation by its selected body (e.g., TJC), or has its accreditation status been reduced, suspended, revoked, or in any way revised by the accrediting body?

No **Yes** (provide an explanation): _____

Does each service location associated with the facility follow the policies and procedures as defined by the facilities service location?

No **Yes** (provide an explanation): _____

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative _____ **Title** _____

Signature _____ **Date** _____



ATTESTATION AND RELEASE OF INFORMATION FORM

RELEASE OF INFORMATION

As part of the application process and for the purpose of verifying any information provided on this application, I, the undersigned authorized agent of the applicant facility/organization, grant CCN permission to contact any individual, institution, facility or agency identified on, or relative to, this application. Further, I hereby consent and authorize CCN to request, receive, and inspect any and all records pertinent to consideration of this application.

As a CCN facility/organization applicant, I, the undersigned authorized agent, am required to supply the Plan with verification of current malpractice coverage and claims history.

SITE REVIEW AUTHORIZATION

I hereby grant permission for CCN to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support CCN Quality Improvement and Utilization Review Programs.

ATTESTATION

I, the undersigned authorized agent, hereby attest and certify that all statements on this application are true, accurate, and correct to the best of my knowledge. I fully understand that any falsification of information or omissions from this application may be grounds for denial of this application as a CCN Participating Provider, cause for summary dismissal from CCN, or be subject to applicable state or federal penalties for perjury. Further, I understand that acceptance of this application does not constitute approval or acceptance or participating status with CCN this facility/organization no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this facility/organization by CCN.

I acknowledge that action on this application will be delayed until all required information is received and/or verified.

This facility/organization complies with all federal, state, and local handicapped access requirements as well as the standards required by the 1992 Federal American Disability Act.

I certify that the appropriate state license or certification source is checked for all new employees or contracted service providers prior to the first provision of service. I certify that the appropriate state license or certification source is checked at least annually for existing and contracted service providers to ensure that every licensed individual providing services as a representative of the applicant holds a current license or certification to provide services. I certify that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service. I certify that the applicant does not employ or contract with any individual 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 a controlled substance.

I certify that the online exclusion lists for the Department of Health and Human Services Office of Inspector General (http://oig.hhs.gov/exclusions/exclusions_list.asp) and System for Award Management (<https://sam.gov/content/exclusions>) are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthly basis to ensure that no state or federally excluded individuals perform any function related to any state or federal healthcare program.

I certify that I will remove any employee or contracted service provider found on one of the above-referenced federal exclusion lists from any functions related to a state or federal healthcare program. The individual executing this Attestation is duly authorized and has the proper authority and proper authorization to execute this Attestation and does so with the intent to fully bind the Facility to the truthfulness of its answers.

Name of Authorized Representative _____ **Signature** _____
Title of Authorized Representative _____ **Date** _____