INDEPENDENT CARE HEALTH PLAN

Long-Term Care Provider Application 3.24

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED
UNTIL ALL INFORMATION REQUIRED HAS BEEN RECEIVED

1. **ALL applications** - complete and submit the following documents

   - ☐ Long-Term Care Provider Application
   - ☐ Certificate of Liability Insurance, see requirements
   - ☐ W-9 Form
   - ☐ Employee Roster reflecting Employee Name, Hire Date, Title
   - ☐ Civil Rights Compliance Forms

2. **Licensed or Certified Residential & Adult Day Care Facilities** - in addition to documents in section 1, complete and submit the following

   - ☐ Copy of License or Certification for each location
   - ☐ Copy of your Program Statement for each location
   - ☐ Last Division of Quality Assurance (DQA) or Certifying Agency survey (with plan of correction if applicable)

3. **Providers seeking *i*Care 1-2 Bed AFH Certification** - in addition to documents in section 1, complete and submit the following

   - ☐ **Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Home** - ensure ability to comply
   - ☐ **Submit experience/resume** for client Target Groups for which you are applying
   - ☐ **1-2 Bed AFH requirements**
   - ☐ **1-2 Bed AFH Certification form**
   - ☐ **Submit financial documentation**, such as, bank statement, savings, investments, etc., that reflects funds or income that may be used to continue the operation of the facility for 30 days based on the total operating costs for a 1-2 Bed AFH.
   - ☐ **If you are renting the 1-2 Bed AFH location**, submit a copy of the rental agreement reflecting the landlord's approval to operate a business from the address you are seeking Certification.

Submit application form and other documents by one of the following methods:

Email: providerupdates@icarehealthplan.org

Fax: 1-414-272-5618

Instructions: All fields **must** be completed, unless identified as "if applicable"

Person Completing This Form		
First Name Last Name:	**Phone:**	**Email:**

SECTION I – COMPANY / AGENCY INFORMATION

Legal Business Name (as it appears on your W-9 Form):	
Doing Business as Name (DBA) if applicable:	
Address (as it appears on W-9 Form):	
City, State, Zip:	**Website** if applicable:
General Phone Number:	**General Fax Number:**
Tax Identification Number (TIN), EIN/SSN:	**National Provider Identifier (NPI)** if applicable:

SECTION II – CONTACT INFORMATION

Contract Contact Information		
Name:	**Title:**	
Address:	**City, State, Zip:**	
Phone:	**Email:**	**Fax:**
Billing Contact Information		
Name:	**Title:**	
Address:	**City, State, Zip:**	
Phone:	**Email:**	**Fax:**
Credentialing Contact Information		
Name:	**Title:**	
Address:	**City, State, Zip:**	
Phone:	**Email:**	**Fax:**
Checks Payable to Information		
Billing Name:	**Title:**	
Billing Address:		
Billing City, State, Zip:		

SECTION III: MUST be completed for each location. Additional pages found on the website.

Please select your provider type(s) from the drop-down lists below

*Provider Type

*Provider Type

Location Name:	Address, City, State, Zip:	
Location Contact/Title:	Location Email Address:	Location Phone Number:
Location Fax Number:	Language(s) spoken other than English:	NPI (if applicable):

Accepting New Patient: ☐Yes ☐No	**Same Day Appointments:☐Yes ☐No**
Electronic Health Records (EHR):☐Yes ☐No	**Pets Accepted: ☐Yes ☐No**

Specialty Programs Served:

- ☐ Advanced Aged
- ☐ AODA
- ☐ Correctional Clients
- ☐ Developmentally Disabled
- ☐ Emotionally Disturbed/Mental Illness
- ☐ Irreversible Dementia/Alzheimer's
- ☐ Physically Disabled
- ☐ Pregnant Women/Counseling
- ☐ Public Finding
- ☐ Terminally Ill
- ☐ Traumatic Brain Injury
- ☐ Female only
- ☐ Male only

Provider Service Location:

- ☐ Dane
- ☐ Kenosha
- ☐ Milwaukee
- ☐ Racine
- ☐ Sauk
- ☐ other

Location Hours:
24/7 ☐Yes ☐No If location is not 24/7, please list hours below

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Licensure, Certifications or Accreditation (if applicable):	Number	Effective Date	Expiration Date	Date of Last Full Survey	Any Deficiencies
Medicaid Provider					
Wisconsin DQA Certified/Licensed					☐Yes ☐No
Accrediting Organization					☐Yes ☐No
Other Memberships/Certifications					☐Yes ☐No
WI Coalition for Collaborative Excellence in Assisted Living (WCCEAL)					☐Yes ☐No
WI Supplier Diversity Program					☐Yes ☐No
Has this location or facility ever been revoked or denied any of the above?					☐Yes ☐No

Please describe in detail if this location or facility has ever been revoked or denied any of the above.

For Residential Facilities, check applicable facility type ☐ **Owner Occupied** ☐ **Corporate**

SECTION IV: SERVICES, CREDENTIALS & RATES

Complete below for each Service Category. Additional pages for additional services found on the website.

*Provider Type	
Service Description 1. ______________________ 2. ______________________ 3. ______________________ 4. ______________________ 5. ______________________	Rate/Unit of Service: 1. ______________________ 2. ______________________ 3. ______________________ 4. ______________________ 5. ______________________
*Provider Type	
Service Description 1. ______________________ 2. ______________________ 3. ______________________ 4. ______________________ 5. ______________________	Rate/Unit of Service: 1. ______________________ 2. ______________________ 3. ______________________ 4. ______________________ 5. ______________________
*Provider Type	
Service Description 1. ______________________ 2. ______________________ 3. ______________________ 4. ______________________ 5. ______________________	Rate/Unit of Service: 1. ______________________ 2. ______________________ 3. ______________________ 4. ______________________ 5. ______________________
*Provider Type	
Service Description 1. ______________________ 2. ______________________ 3. ______________________ 4. ______________________ 5. ______________________	Rate/Unit of Service: 1. ______________________ 2. ______________________ 3. ______________________ 4. ______________________ 5. ______________________

SECTION V: EXCLUSION CERTIFICATION

I hereby certify the online exclusion list for Health and Human Services, Office of Inspector General (OIG) is checked for all new hires and at least quarterly for existing employees to ensure that no excluded employees work in any capacity related to any state or federal health care program. I understand that Managed Care Organizations are precluded from contracting with providers who have been excluded from participation in any state or federal health care program. I also hereby certify that I will remove any employee found on one of the above referenced list from any work related to any state or federal health care program.

_____ _____

Signature of Authorized Representative | Printed Name of Authorized Representative

_____ _____

Authorized Representative's Title | Date Signed

SECTION VI: ATTESTATION QUESTIONS

Please answer the following questions "Yes" or "No." If your answer to any of the following questions is "Yes," please provide details and reasons, as specific to each question, on a separate sheet or letterhead. Please sign and date each additional sheet submitted. Provider attests that as it relates to the facilities and services selected:

Has this provider, under any current or former business identity, **ever** had any felony or misdemeanor convictions, under Federal or State law, related to (a) the delivery of an item or service under Medicare or State health care program, or (b) the abuse or neglect of a patient in connection with delivery of a health care item or service?	☐Yes ☐No
Has this provider, under any current or former name or business identity, **ever** had any felony or misdemeanor convictions, under Federal or State law, related to fraud, theft, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?	☐Yes ☐No
Has this provider, under any current or former name or business identity, **ever** had any felony or misdemeanor convictions, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	☐Yes ☐No
Has this provider, under any current or former name or business identity, **ever** had licensure to provide health care by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.	☐Yes ☐No
Has this provider, under any current or former name or business identity, **ever** had accreditation revoked or suspended?	☐Yes ☐No

cont'd SECTION VII: ATTESTATION QUESTIONS

Has this provider, under any current or former name or business identity, **ever** been suspended or excluded from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive procurement or non-procurement program?	☐Yes ☐No
Is this provider, under any current or former name or business identity, currently suspended from Medicare payment under any Medicare billing number?	☐Yes ☐No

Agency attests that as it relates to the facilities and services selected:

Has verified qualifications of each staff member, including academic preparation and relevant experience.	☐Yes ☐No
Maintains a training plan for each staff member and has a mechanism for ensuring that all necessary training has been completed *prior* to performing work.	☐Yes ☐No
Completes Caregiver Background Checks on all employees *prior* to the employee providing direct services to Member, and every four (4) years thereafter or any time that entity has a reason to believe that a new check should be obtained.	☐Yes ☐No
Has a mechanism to track the completion of Caregiver Background Checks to ensure compliance with the requirements in the *i*Care contract.	☐Yes ☐No
Maintains the Caregiver Background Check results on its premises for at least the duration of the Long-Term Care contract with *i*Care.	☐Yes ☐No
Change in Program: Prior approval by the certifying and licensing agencies is required for all program changes.	☐Yes ☐No
Prior approval by the licensing agency is required for all program changes. In addition, iCare requires proposed changes for approval 30 days prior to implementing the proposed program change.	☐Yes ☐No
Organization has trained or will train its employees and downstream related entities on cultural competency each calendar year. The content used is *i*Care's Cultural Competency Training or is materially similar.	☐Yes ☐No

The individual identified below acknowledges that they have reviewed the statements above and attests that the information herein be true and accurate:

_____ _____

Signature of Authorized Representative Printed Name of Authorized Representative

_____ _____

Authorized Representative's Title Date Signed

AUTHORIZATION FOR RELEASE OF INFORMATION AND ATTESTATION

The organization identified below (hereinafter "the Organization") has applied to be a participating provider with Independent Care Health Plan (*i*Care). In order for *i*Care to evaluate the Organization's qualifications, Organization authorizes *i*Care and its authorized representatives and agents to consult with any third party who may have information (including information that otherwise may be privileged or confidential) relating to the qualifications, competence and conduct of said Organization. Organization also authorizes any such third party (including the credentials verification organization) to release such information, related reports and documents to *i*Care and its authorized representatives and agents upon request and receipt of a copy of this Authorization for Release of Information.

The undersigned certifies that all information in the Organization's application is warranted to be true, accurate and complete. Organization also agrees to immediately update *i*Care on any changes in the information submitted in the application and agrees to provide such additional information and execute such additional forms as may be requested by *i*Care in order to evaluate the Organization's qualifications, competence and conduct.

As an applicant for credentialing or recredentialing with *i*Care, Organization has the right to review the information submitted in support of the credentialing application. Organization acknowledges that *i*Care will notify the Organization of any information obtained during the credentialing process that varies substantially from the information provided by Organization to *i*Care and that it will have the right to correct any and all erroneous information in the application.

By submitting an application for credentialing or recredentialing with *i*Care, Organization agrees to be bound by the terms of the credentialing program, as it may be amended by *i*Care from time to time. Organization understands that *i*Care will use this information solely in conjunction with the application for and status as a participating provider and that the information is not subject to re-disclosure except as permitted by Federal and State Law.

Organization hereby releases from liability *i*Care and its directors, officers, employees and authorized representatives, including the credentialing agent, its directors, employees, representatives, agents and third parties for any acts performed in good faith in providing or receiving information, reports or other documents relating to or in evaluating Organization's professional qualifications, competence or conduct. This release from liability shall include but not be limited to, actions related to the following:

- Organization's application to be a participating provider with *i*Care.
- Periodic appraisals undertaken for recredentialing, utilization review or otherwise for quality management; and
- Proceedings for termination, suspension or restriction of the Organization's status as a participating provider with iCare or any other disciplinary action.

This authorization is valid for 365 days and if the Organization becomes an *i*Care participating provider, for the time period that the Organization remains an *i*Care provider.

_____ _____

Signature of Authorized Representative Printed Name of Authorized Representative

_____ _____

Authorized Representative's Title Date Signed

_____

Print Name of Organization

WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION

FOR WAIVER SERVICE PROVIDER AGENCIES OR INDIVIDUALS

Completion of this form is required under Federal Law by the Centers for Medicare & Medicaid Services, Department of Health and Human Services, under the Code of Federal Regulations 42 CFR 431.107.

Name of Provider (Typed or Printed—Must exactly match name used on all other documents)		Phone Number	
Address – Street	City	State	Zip Code

The above-referenced provider of home and community-based waiver services under Wisconsin's Medicaid program, hereinafter referred to as the provider, hereby agrees and acknowledges as follows:

1. To provide only the items or services authorized by the managed care organization or IRIS program.
2. To accept the payment issued by the managed care organization or IRIS program as payment in full for provided items or services.
3. To make no additional claims or charges for provided items or services.
4. To refund any overpayment to the managed care organization or IRIS program.
5. To keep any records necessary to disclose the extent of services provided consistent with the provider's business type.
6. To provide, upon request by the managed care organization, the IRIS program, or the Department of Health Services (DHS) or its designee, information regarding the items or services provided.
7. To comply with all other applicable federal and state laws, regulations, and policies relating to providing home and community-based waiver services under Wisconsin's Medicaid program including the caregiver background check law.
8. Medicaid Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant's status as a waiver participant and items or services the participant receives from the Provider.
9. To respect and comply with the waiver participant's right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. Medicaid Fraud Prevention Policies and Procedures (including records retention): To keep records necessary to disclose the extent of services provided to waiver participants **for a period of ten (10) years** and to furnish upon request to the DHS, the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program. This requirement includes retaining all records and documents according to the terms provided by Wis. Admin. Code § DHS 106.02(a)-(d); (f)-(g).
11. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements and address real or potential conflict of interest that may influence service provision, among other things the provider shall furnish to the managed care organization and upon request, to the Department in writing:

    a) The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

    b) The names and addresses of all persons who have a controlling interest in the provider;

c) Whether any of the persons named in compliance with (a) and (b) above are related to any owner or to a person with a controlling interest as spouse, parent, child or sibling;

d) The names and addresses of any subcontractors who have had business transactions with the provider;

e) The identity of any person named in compliance with (a) and (b) above, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services programs since the inception of those programs.

12. To provide to the DHS identifying information, including name, specialty, date of birth, Social Security number, national provider identifier, (NPI) (if eligible for an NPI), Federal taxpayer identification number, and State license or certification for purposes of enrollment with the State Medicaid program.
13. To include its NPI (if eligible for an NPI) on all claims submitted under the Medicaid program.
14. To comply with the advance directives requirements specified in 42 CFR Part 489, Subpart I.

Modifications to this agreement cannot and will not be agreed to. Altering this agreement in any way voids the Department of Health Services' signature. This agreement is not transferable or assignable.

Name – Provider (Typed or Printed)

SIGNATURE – Provider	Date Signed

FOR DMS USE ONLY (DO NOT WRITE BELOW THIS LINE)	
SIGNATURE – Department of Health Services	Date Signed
	8/14/17