Community Care Plan
The Health Plan with a Heart

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 Plan (CCP) members are reviewed for conformance to CCP'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". **All required Attestation and Disclosure Forms must be signed by an authorized representative.**

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 CCP 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).

☐ The authorized representative must possess the legal authority to bind the organization and attest to application veracity.

***A separate HDO application must be completed for each location with a unique Tax ID.**

Community Care Plan
The Health Plan with a Heart

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

Fax #: _____

Email: _____

Checks made payable to: _____

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

Community Care Plan
The Health Plan with a Heart

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

☐ Hospital	☐ Home Health Care	☐ Nursing Home
☐ Ambulatory Surgery Ctr.	☐ Skilled Nursing Facility	☐ Birthing Center
☐ Behavioral Health Facility	☐ Durable Medical Equipment Provider	☐ Free-Standing Acute Rehab Facilities
☐ Laboratory	☐ Diagnostic Imaging Center	☐ 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:
☐ Occurrence based ☐ Claims based
If claims based, does this facility have tail coverage?
☐ Yes ☐ 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
- ☐ Other process (please describe): _____
- ☐ Background check agency, contracted organization, or vendor: _____
- ☐ 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 CCP 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 CCP 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 of Authorized Representative _____ **Date** (MM/DD/YYYY) _____

SECTION 1. Identifying Information

Name of Entity (D/B/A)	**Provider #**	**Vendor #**	**Telephone #**	
Street Address	**City**	**State**	**Zip Code**	**County**

SECTION 2. Criminal Offenses

Are there any individuals or organizations having an ownership or control interest in the Disclosing Entity that have been convicted of a criminal subject to a civil monetary penalty or excluded from the programs from any activities related to their involvement in such programs established by titles XVII, XIX, XX or V?

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

Are there any directors, officers, agents, or managing employees of the Disclosing Entity who have ever been convicted of a criminal offense subject to civil monetary penalty or excluded from the programs for any activities related to their involvement in such programs established by titles XVII, XIX, XX or V?

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

Does the Disclosing Entity or any of its authorized representatives currently have any pending legal actions (excluding medical malpractice and misdemeanors)?

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

SECTION 3. Former Employee

Are there any individuals currently employed by the Disclosing Entity in a managerial, accounting, auditing, or similar capacity who were employed by the Disclosing Entity's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

☐ No ☐ Yes

SECTION 4. Ownership, Financial, or Control Interest

(a) Table 1. Individuals with an Ownership or Control Interest in Disclosing Entity

Name	Title	Address	DOB	SSN	% Ownership

(b) Type of Entity:

☐ Sole Proprietorship ☐ Unincorporated Associations
☐ Partnership ☐ Other (Specify)
☐ Corporation _____

(c) Table 2. Corporations/Subcontractors with an Ownership or Control Interest in Disclosing Entity

Name	Primary Business Address(es)	Other Business Address	PO Box Address	TIN	% Ownership

(d) Table 3. Subcontractors in which Disclosing Entity has an Ownership or Control Interest

Name	Primary Business Address(es)	Other Business Address	PO Box Address	TIN	% Ownership

Name	Name of Other Disclosing Entity

SECTION 5. Change in Ownership or Control

Has there been a change in ownership or control within the last year?
☐ **No**
☐ **Yes** (give date): _____

Do you anticipate any change of ownership or control within the year?
☐ **No**
☐ **Yes** (give date): _____

Do you anticipate filing for bankruptcy within the year?
☐ **No**
☐ **Yes** (give date): _____

SECTION 6. Facility Management

Is this facility operated by a management company, or leased in whole or part by another organization?
☐ No ☐ Yes _____

(a) Table 6. Facility Operators

Name	TIN

c) Are any of the parties named in Section 4 related to each other as a spouse, parent, child, or sibling? This includes any individuals listed in Table 1 who are related to individuals with an ownership or control interest in any of the subcontractors listed in Table 3.
☐ No ☐ Yes ☐ N/A

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:

Community Care Plan
The Health Plan with a Heart

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** _____

Community Care Plan
The Health Plan with a Heart

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 CCP permission to contact any individual, institution, facility or agency identified on, or relative to, this application. Further, I hereby consent and authorize CCP to request, receive, and inspect any and all records pertinent to consideration of this application.
As a CCP 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 CCP to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support CCP Quality Improvement and Utilization Review Programs.

ATTESTATION

I, **the undersigned authorized representative**, 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 CCP Participating Provider, cause for summary dismissal from CCP, 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 CCP 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 CCP.

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 signing this Attestation has the legal authority to bind the Facility and certify to the truthfulness of these answers.**

Name of Authorized Representative _____ **Signature** _____

Title of Authorized Representative _____ **Date** _____