Application Packet

Checklist

Please ensure you have completed all items on this checklist prior to submission.

All required items, on the application checklist below, must be submitted with this application to be considered. If all required items are not submitted at time of application, this application will be denied.

- ☐ **Healthcare Provider Application**
- ☐ **Attestation Form**
- ☐ **W-9 Form**
- ☐ **Certificate of Liability Insurance**
  - **General Liability**
  - **Professional Liability**
  - **Worker's Compensation & Employer's Liability**

  Please contact your insurance agent to obtain a Certificate of Insurance with Community Care, Inc. (1801 Dolphin Drive, Waukesha, WI 53186) as the certificate holder.
- ☐ **Electronic Funds Transfer Form**
- ☐ **Medicare certification/enrollment letter**
- ☐ **Wisconsin Medicaid certification/enrollment letter**

Application to continue on the following pages

HEALTHCARE PROVIDER APPLICATION

General Information

Business / Legal Name _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Contact Name: _____ Title: _____

E-mail Address: _____

Website: _____

NPI: _____ Tax ID: _____

Handicap Accessible: Yes ☐ No ☐ _____ Fluent Languages (other than English): _____

Group Medicare Enrolled: ☐ No ☐ Yes* Number _____ *send letter verification

Group WI Medicaid Certified: ☐ No ☐ Yes* Number _____ *send letter verification

Ownership (for profit or not for profit): _____

Mailing Address (if different): _____

City: _____ State: _____ Zip: _____

Billing Address(if different):: _____

City: _____ State: _____ Zip: _____

Billing Telephone Number: _____ Billing Fax Number: _____

Do you wish to be published in Community Care's public provider directory? ☐ Yes ☐ No

Type of Provider

For contract consideration, service providers must meet service definitions and standards as listed in ADDENDUM IX. Benefit Package Service Definitions of the MCO Family Care Contract located at https://www.dhs.wisconsin.gov/familycare/mcos/contract.htm

☐ Physician Group/Individual	☐ Radiology Facility	☐ Laboratory
☐ Free Standing Surgical Center	☐ Hospice	☐ Rehabilitation Agency
☐ Dialysis	☐ OT, PT, ST Group	☐ Dental Group
☐ Mental Health	☐ AODA	☐ Home Health Agency
☐ Skilled Nursing Facility	☐ DME ☐ DMS	☐ Respiratory Services/Vent Care

☐ Mobile Service Provider **(type)**: _____

☐ Other *(please specify)*: _____

Target Group Selection - Please select the population you serve.

Physically Disabled (**PD**)	☐	Frail Elderly (**FE**)	☐
Developmentally Disabled (**DD**)	☐	All (**PD, DD, FE**)	☐

Specialized Expertise Offered by your Agency

Please check below any specialized expertise or unique services offered by your agency.

	Advanced Aged		Bariatric – 500 lbs. or more
	Developmentally Disabled		Bariatric – under 500 lbs.
	Physically Disabled		RN on staff
	Alcohol/Drug Dependent		Vent Care
	Emotionally Disturbed/Mental Illness		Wound Care
	Terminally Ill		Memory Care
	Correctional Clients		Bathing Services
	Irreversible Dementia/Alzheimer's		Diabetic Expertise
	Traumatic Brain Injury		

Service Locations (List all facilities/locations other than the billing location listed above)

Office/Name for this Location: _____

Main Telephone _____ Office Fax _____

TDD/TTY Number: Yes ☐ No ☐ If yes, specify: _____

Street: _____

City: _____ State: _____ Zip: _____

Handicap Accessible: Yes ☐ No ☐ Fluent Languages (other than English) _____

Contact Person: _____ Telephone: _____

Medicare Number _____ Medicaid Number _____ NPI _____

Hours of Operation

24 Hour Facility Yes ☐ No ☐

Weekdays (Mon – Fri) Hours: _____

Weekends (Sat – Sun) Hours: _____

Please check the holidays your organization will be open:

New Years Day		Labor Day	
Easter		Thanksgiving	
Memorial Day		Christmas	
Fourth of July			

Office/Name for this Location: _____

Main Telephone _____ Office Fax _____

TDD/TTY Number: Yes ☐ No ☐ If yes, specify: _____

Street: _____

City: _____ State: _____ Zip: _____

Handicap Accessible: Yes ☐ No ☐ Fluent Languages (other than English) _____

Contact Person: _____ Telephone: _____

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Easter		Thanksgiving	
Memorial Day		Christmas	
Fourth of July			

PLEASE ATTACH A SEPARATE LIST IF NECESSARY.

Key Organization Contacts

Position	Name and Title	Telephone	Email
Chief Executive Officer/President/ Administrator			
Medical Director/ Vice President, Medical Affairs			
Managed Care Contracting			
Quality Assurance & Utilization Review			
Patient Accounts /Billing Manager			
Medical Records (if applicable)			

Signer (name and title) of the contract:

Does your business/facility have a formal Quality Assessment and Performance Improvement Program? ☐ Yes ☐ No

Does your agency perform Cultural Competency Training? ☐ Yes ☐ No

Licensure – Please submit a copy of each certificate and/or license for every location.

Has any license or certification held by your organization ever been surrendered while under investigation, denied, suspended, revoked, limited not renewed, or voluntarily relinquished?
☐ Yes ☐ No

If yes, give details:

Has your business ever had any sanctions taken or imposed by either Medicare or Medicaid?
☐ Yes ☐ No
If yes, give details:

Accreditation – Please attach a copy of the certificate of accreditation.

Accrediting Organization: _____

Accreditation status and term of accreditation:

Insurance

Facility – Please attach a copy of the Certificate of Insurance for all insurance policies indicating policy numbers, expiration date and coverage amounts.

Name of Professional Liability Carrier: _____

Name of General Liability Carrier: _____

Name of Worker's Comp Carrier: _____

Number of pending malpractice Claims (if none, please write none): _____

Number of Claims in the past 5 years _____ Judgments/Settlements in the past 5 years _____

(if none, please write none)

If yes, attach details about each claim, judgment, or settlement.

Are there any specific exclusions to your professional liability coverage? ☐ Yes ☐ No

If yes, please provide details below:

Has the professional liability coverage for the organization ever been denied, limited, reduced, terminated, or not renewed? ☐ Yes ☐ No

If yes, give details:

LICENSED HOME HEALTH AGENCIES:

Attach copy of License and list all Counties your organization is licensed to provide home health services.

SKILLED NURSING FACILITIES (SNF)

Please list the Pharmacy your organization is partnered with to provide eMar and medications:

Does SNF accept ventilator dependent residents? ☐ **Yes** ☐ **No**
List applicable facility name(s) if applying for more than one facility:

Does SNF accept bariatric residents? ☐ **Yes** ☐ **No**
Please specify and list applicable facility name(s) if applying form more than one facility:

_____

_____

_____

Does SNF require PCP/NP to complete an application for credentialing?
☐ **Yes** - please send the process and copy of application. ☐ **No**

Name of Rehabilitation Agency providing services within your SNF: _____

Does your agency offer outpatient therapy services? ☐ **Yes** ☐ **No**

Name and NPI # of the Medical Director at facility: __ _____

Name and NPI# of the PCP at facility: _____

General Provisions

In order to evaluate this application for participation or continued participation in the Community Care Network, I authorize Community Care and its authorized representatives to consult with any third party, which may have information bearing on the subject matter addressed by this Application. This includes the inspection or acquisition of any reports, records, recommendations, or other documents or disclosures of third parties, such as NPDB, FSMB, Hospital Peer activity, or insurance companies, that may be material to the questions in this Application. I also authorize any third parties to release information to Community Care and/or its authorized representative to, from, or by any third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this application.

I certify that the information provided or attached to this Application is accurate and complete. Any information entered into this application which subsequently is found to be false, could result in Community Care's refusal to enter into a contract with Provider or termination of a current Agreement.

I warrant that I have the authority to sign this Application, on my own behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of this Application does not constitute approval or acceptance by Community Care.

Business Name: _____

Signature: _____ **Date:** _____

Print Name: _____ **Title:** _____

- **Electronic signature is considered valid only when document is submitted by e-mail from the signer's email address.**
- **If mailing or faxing application, signature must be a handwritten.**

RETURN YOUR APPLICATION WITH ALL REQUIRED DOCUMENTATION TO:

Email:

ContractInquiries@communitycareinc.org

Mail to:

Community Care, Inc.
Provider Management Department
1801 Dolphin Drive
Waukesha, WI 53186

Fax to:

(262) 446-6707

For questions please contact our Provider Hotline at 866-937-2783, option 2