***General Application***

***Checklist***

**Please ensure you have completed all applicable 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.

**General** **Provider Application**

**Attestation Form**

**W-9 Form**

**Copy of Certification and/or License**

**Certificate of Liability Insurance**

* **General and Professional Liability (500,000/1,000,000 limits)**
* **Worker’s Compensation & Employer’s Liability**
* **Auto**

Please contact your insurance agent to obtain a Certificate of Insurance with Community Care, Inc. (1801 Dolphin Drive, Waukesha, WI 53186) listed as the certificate holder.

**Residential Summary Form (required for all residential facilities)**

**HCBS Compliance Letter (required for all licensed residential facilities)**

**Program Statement (required for all licensed/certified providers)**

**Data Collection Form – Fiscal (required for corporate residential**

**providers)**

**Electronic Funds Transfer Form with a Voided Check**



**COMMUNITY CARE, INC.**

### PROVIDER APPLICATION

1. PROVIDER CONTACT INFORMATION

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Business Name:** | | | | |  | | | | | | | | | |
| **Mailing Address** | | | | | | | | | | | | | | |
| **Street:** | |  | | | | | | | | | | | |
| **City:** |  | | | | | | **State:** | |  | | | **Zip:** |  |
| **Phone:** | | |  | | | | **Fax:** | |  | | | | |
| **Business Address** | | | | | | | **Same as Mailing Address Above** | | | | | | | |
| **Street:** | |  | | | | | | | | | | | |
| **City:** |  | | | | | | **State:** | |  | | | **Zip:** |  |
| **Phone:** | | |  | | | | **Fax:** | |  | | | | |
|  | | | | |  | |  | | | |  | | |
| **Tax Id #:** | | | | |  | | **NPI #** | | | |  | | |
| **Medicaid #** | | | | |  | | **Medicare #** | | | |  | | |
| **Contact Name:** | | | | |  | | | | **Title:** | |  | | | |
| **Contact E-Mail:** | | | | |  | | | | **Phone** | |  | | | |
| **Contract Signer and Title:** | | | | |  | | | | | | | | | |
| **Website:** | | | | |  | | | | | | | | | |
| **Days of Operation:** | | | | |  | | | |  | |  | | | |
| **Hours of Operation:** | | | | |  | | | | | | | | | |

1. SERVICES OFFERED

Please indicate the services you provide by placing a check mark next to the corresponding service(s). 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>

| SERVICES OFFERED | | **Check Service(s)**  **you provide** |
| --- | --- | --- |
| Adaptive Aids (general and vehicle) | |  |
| Adult Day Care | |  |
| Communication Aids/Interpreter Services | |  |
| Community Support Program | |  |
| Consumer Education and Training | |  |
| Daily Living Skills Training | |  |
| Day Services/Treatment | |  |
| Financial Management Services | |  |
| Home Modifications | |  |
| Home Delivered Meals | |  |
| Interpretation Services: | |  |
| Personal Care Agency ***(Certified)* – NPI Required** | |  |
| Personal Emergency Response Services | |  |
| Prevocational Services | |  |
| Relocation Services | |  |
| Rep Payee | |  |
| **Residential Services**: Adult Family Home ***(Certified)*** | |  |
| **Residential Services**: Adult Family Home ***(Licensed)*** | |  |
| **Residential Services**: Community-Based Residential Facility (CBRF) | |  |
| **Residential Services**: Certified Residential Care Apartment Complex (RCAC) | |  |
| Respite Care (for caregivers and members in non-institutional and institutional settings) | |  |
| Self Directed Supports | |  |
| Supported Employment | |  |
| Supportive Home Care (Routine Homemaking, Assist with ADLs) / Supported Living | |  |
| Vocational Futures Planning | |  |
| Other: |  |  |

1. GENERAL INFORMATION

* Target Group Selection: Please select the population you serve.

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

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

1. LICENSE AND CERTIFICATION REQUIREMENTS

**Please attach a copy of all licenses or certifications** that relate to services you wish to provide: Some examples are listed below.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Adult Day Care Certification** |  | **Personal Care Agency Certification** |
|  | **Adult Family Home License** |  | **Sign Language License** |
|  | **Adult Family Home Certification** |  | **National Accreditation** |
|  | **CBRF License** |  | **Other:** *(Please Specify)* |
|  | **RCAC Certification** |  |  |

1. PROVIDER ACCESSIBILITY AND AVAILABILITY

TDD/TTY Number  Yes  No If yes, specify:

Handicapped accessible  Yes  No

Sign Language  Yes  No

List fluent languages spoken (other than English):

|  |
| --- |
|  |

1. 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 |  |  |

1. CULTURAL COMPETENCIES

Please indicate the cultural composition of your organization by checking all that apply:

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

Minority/Disadvantaged Provider:

At least 51% of the Board of Directors is minorities/women.

The organization is owned and operated by at least 51% minorities/women.

1. INELIGIBLE ORGANIZATIONS

The MCO shall exclude from participation all organizations which could be included in any of the following categories (references to the Act in this section refer to the Social Security Act):

1. **Ineligibility**

Entities which could be excluded under Section 1128(b)(8) of the Social Security Act are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has a direct or indirect ownership or control interest of 5% or more in the entity, or a person with beneficial ownership or control interest of 5% or more in the entity has:

* + 1. Been convicted of the following crimes:
       1. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid (see Section 1128(a)(1) of the Act);
       2. Patient abuse, i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care (see Section 1128(a)(2) of the Act);
       3. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government (see Section 1128(b)(1) of the Act);
       4. Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described directly above (see Section 1128(b)(2) of the Act); or,
       5. Offenses relating to controlled substances, i.e., conviction of a State of Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (see Section 1128(b)(3) of the Act).
    2. Been Excluded from Participation in Medicare or a State Health Care Program. A State health care program means a Medicaid program or any State program receiving funds under title V or title XX of the Act. (See Section 1128(b)(8)(iii) of the Act).
    3. Been Assessed a Civil Monetary Penalty under Section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHS Office of Inspector General. Section 11238A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards.

(See Section 1128(b)(8)(B)(ii) of the Act).

1. LENGTH OF TIME IN BUSINESS

Please indicate the length of time the agency has been in business ***providing the services for which you are applying.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Years** |  |  | **Months** |

1. ORGANIZATIONAL STRUCTURE

Please indicate your **organizational structure** as reported on your federal income tax returns:

**Corporation**   **Limited Liability Corporation**

**Partnership**  **Sole Proprietor**

1. AGENCY OFFICERS/RESPONSIBLE PARTY

Please list the responsible person’s name and telephone number for each agency position listed. If your agency has no such position, please indicate “N/A” for “not applicable”.

|  |  |  |  |
| --- | --- | --- | --- |
| **Position** | **Name & Title** |  | **Telephone & Email** |
| Chief Operations Officer: |  |  |  |
| Executive Director/President: |  |  |  |
| Chief Financial Officer: |  |  |  |
| Chief Information Technology Officer: |  |  |  |
| Human Resources  /Personnel Director: |  |  |  |

1. GOVERNANCE

|  |  |
| --- | --- |
| Does your agency have a Board of Directors? | Yes  No |
| If yes, how many members are on the Board? |  |
| How often does your Board of Directors meet? |  |
| Are Board members paid or do they serve voluntarily? |  |
| Name and Telephone Number of Board Chair: |  |
| Name and Telephone Number of Vice Chair: |  |

1. CLIENT DATA AND RECORDKEEPING

**Is each business location HIPAA compliant?**   Yes  No

**If no, please explain:**

|  |
| --- |
|  |
|  |
|  |
|  |

1. FISCAL MANAGEMENT

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Agency Accountant/Bookkeeper Name:** | | | | | | | |  | | | | | | |
| **Phone Number:** | | |  | | | | | | | | | | | |
| **Address:** | |  | | | | | | | | | | | | |
| **Telephone Number:** | | | | |  | | | | | | | | | |
| BILLING/PAYEE INFORMATION | | | | | | | | | | | | | | |
| **Billing/Payee Name:** | | | | | |  | | | | | | | | |
| **Billing Address:** | | | |  | | | | | | | | | | |
| **City:** |  | | | | | | **State:** | | |  | **Zip:** | | |  |
| **Billing Contact Name:** | | | | | |  | | | | | | | | |
| **Billing Contact Phone and Fax Numbers:** | | | | | | | | |  | | |  |  | |

## Service Location Information Page

**\*Complete this page only if you are a non-residential provider and have multiple locations.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Business Name:** | |  | | | | | | | | | | | | | | | | |
| **Location Name** (if applicable): | | | | | | | |  | | | | | | | | | | |
| **Location Address:** | | | | | |  | | | | | | | | | | | | |
| **City:** |  | | | | | | | | | | **State:** | |  | | | **Zip:** | |  |
| **Telephone Number:** | | | |  | | | | | | | | | |  | **Fax #** | |  | |
| **Contact Person:** | | |  | | | | | | | | | | | | | | | |
| **Location NPI # (if applicable):** | | | | | | | | |  | | | | | | | | | |
| **Services offered at this Location:** | | | | | | | | | |  | | | | | | | | |
| **Handicapped Accessible:** | | | | | Yes  No | | | | | | | | | | | | | |
| **Sign Language:** | | | | | Yes  No | | | | | | | | | | | | | |
| **List Languges spoken other than English:** | | | | | | | | | | | |  | | | | | | |
| **Populations Served:** | | | | | | | Physically Disabled (**PD**) | | | | | | | | | | | |
|  | | | | | | | Developmentally Disabled (**DD**) | | | | | | | | | | | |
|  | | | | | | | Frail Elderly (**FE**) | | | | | | | | | | | |
|  | | | | | | | All (**PD, DD, FE**) | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Business Name:** | |  | | | | | | | | | | | | | | | | |
| **Location Name** (if applicable): | | | | | | | |  | | | | | | | | | | |
| **Location Address:** | | | | | |  | | | | | | | | | | | | |
| **City:** |  | | | | | | | | | | **State:** | |  | | | **Zip:** | |  |
| **Telephone Number:** | | | |  | | | | | | | | | |  | **Fax #** | |  | |
| **Contact Person:** | | |  | | | | | | | | | | | | | | | |
| **Location NPI # (if applicable):** | | | | | | | | |  | | | | | | | | | |
| **Services offered at this Location:** | | | | | | | | | |  | | | | | | | | |
| **Handicapped Accessible:** | | | | | Yes  No | | | | | | | | | | | | | |
| **Sign Language:** | | | | | Yes  No | | | | | | | | | | | | | |
| **List Languges spoken other than English:** | | | | | | | | | | | |  | | | | | | |
| **Populations Served:** | | | | | | | Physically Disabled (**PD**) | | | | | | | | | | | |
|  | | | | | | | Developmentally Disabled (**DD**) | | | | | | | | | | | |
|  | | | | | | | Frail Elderly (**FE**) | | | | | | | | | | | |
|  | | | | | | | All (**PD, DD, FE**) | | | | | | | | | | | |

**Make copies of this page for additional locations if necessary.**

# COMMUNITY CARE, INC.

# PROVIDER ASSURANCES AND CERTIFICATIONS

|  |  |  |
| --- | --- | --- |
| *I* |  | *agree that all information included in this* |

*application is true and correct and that the provider understands and agrees to the application information and requirements. Provider further acknowledges that the information in this application is subject to periodic verification without notice and that any misrepresentation on this form may result in disqualification from receiving public (MCO) funds and legal action or fiscal sanctions may be taken as determined appropriate by Community Caren Inc. or its designated representative(s). Provider understands that completion of provider application does not guarantee network admission and/or subsequent contract with the MCO.*

|  |  |  |
| --- | --- | --- |
| *I* |  | *constitute as the Provider to allow authorized* |

*representatives of Community Care, Inc. funding sources to have access to all records necessary to confirm the provision of services by the Provider. Failure on the part of the Provider to comply with program requirements or not have sufficient documentation to verify provision of the services billed may result in withholding or forfeiture of any payments. At a minimum, the Providers must have client records that include: names and address, the type and dates of service provided, the number of units of service provided, and documentation that service was provided.*

*The applicant certifies to the best of its knowledge and belief, that it is not an* ***“Ineligible Organization”*** *as defined in section VIII of this application. The applicant further certifies to the best of its knowledge and belief, that it and its principals: (1) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency; (2) have not within a three-year period preceding this application been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (3) are not presently indicted for or otherwise criminally charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in (2) of this certification; and , (4) have not within a three-year period preceding this application had one or more public transactions (Federal, State or local) terminated for cause or default.*

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Authorized Signature and Title | | Date |
|  | | |
| Business Name | | |

* **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 handwritten.**

**RETURN YOUR APPLICATION WITH ALL REQUIRED DOCUMENTATION TO:**

**Email:**

[**ContractInquiries@communitycareinc.org**](mailto: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