Application Packet Checklist

Checklist

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

- ☐ **Provider Application**
- ☐ **W-9 Form**
- ☐ **Data Collection Form – Fiscal (required by all corporate residential providers)**
- ☐ **Data Collection Form – Indirect Overhead (required by all corporate residential providers)**
- ☐ **Data Collection Form – Scheduling (required by all corporate residential providers – 8 beds or fewer)**
- ☐ **Copy of Certification and/or License**
- ☐ **Certificate of Liability Insurance – insurances applicable to your organization**
  - **General, Professional, and Worker's Compensation**
  - **Auto**
- ☐ **Attestation Sheet**
- ☐ **Direct Deposit Form (*optional*)**

Application to continue on the following pages

COMMUNITY CARE, INC.
PROVIDER APPLICATION

I. PROVIDER CONTACT INFORMATION

Provider Name: ______________________________

Mailing Address

Street: ______________________________

City: ____________________ **State:** ________ **Zip:** ________

Phone: ____________________ **Fax:** ____________________

Business Address **Same as Mailing Address Above** ☐

Street: ______________________________

City: ____________________ **State:** ________ **Zip:** ________

Phone: ____________________ **Fax:** ____________________

Provider Contact Name: ______________________________

Provider Contact E-Mail: ______________________________

Revised: 11/2011

NON-RESIDENTIAL PROVIDERS:

Please complete the Facility Information Page for each of your organization's locations. This page is located at the end of the application.

RESIDENTIAL PROVIDERS:

Please complete the Long Term Care Program Summary for each of your organization's residential facilities. This statement is located at the end of this application. All corporate residential provider must complete the Data Collection Form-Fiscal and all corporate facilities with 8 beds or fewer must also complete the Data Collection Form-Scheduling.

LICENSED HOME HEALTH AGENCIES:

Please list all Counties your organization is licensed in to provide home health services.

____

____

____

____

II. GENERAL INFORMATION

- Target Group Selection:

  Please select the population you serve.

  Physically Disabled (**PD**) ☐

  Developmentally Disabled (**DD**) ☐

  Frail Elderly (**FE**) ☐

  All (**PD, DD, FE**) ☐

III. SERVICES AND PROCEDURES OFFERED TO FAMILY CARE MEMBERS

Please indicate the services you provide by placing a check mark next to the corresponding service(s). For more information (definitions, etc.) related to services in the Family Care Benefit Package, please visit www.dhs.wisconsin.gov/LTCare/Generalinfo/Benpackage.htm.

SERVICES IN FAMILY CARE BENEFIT PACKAGE	CHECK SERVICE(S) YOU PROVIDE
➢ Adaptive Aids (general and vehicle)	☐
➢ Adult Day Care	☐
➢ Alcohol and Other Drug Abuse Day Treatment Services (AODA) (in all settings)	☐
➢ Alcohol and Other Drug Abuse Services (AODA) (except those provided by a physician or on an inpatient basis)	☐
➢ Care/Case Management (including Assessment and Case Management)	☐
➢ Communication Aids/Interpreter Services	☐
➢ Community Support Program	☐
➢ Consumer Education and Training	☐
➢ Counseling and Therapeutic Resources	☐
➢ Daily Living Skills Training	☐
➢ Day Services/Treatment	☐
➢ Durable Medical Equipment (except for hearing aids and prosthetics, in all settings)	☐
➢ Financial Management Services	☐
➢ Home Health Agency	☐
➢ Home Modifications	☐
➢ Housing Counseling	☐
➢ Meals: home delivered	☐
➢ Medical Supplies	☐
➢ Mental Health Day Treatment Services (in all settings)	☐
➢ Mental Health Services, except those provided by a physician or on	☐

SERVICES IN FAMILY CARE BENEFIT PACKAGE	CHECK SERVICE(S) YOU PROVIDE
an inpatient basis, and except for Coordinated Community Services	
➢ Nursing Facility (all stays including Intermediate Care Facility for People with Mental Retardation (ICF/MR) and Institution for Mental Disease (IMD)	☐
➢ Nursing Services (including respirator care, intermittent and private duty nursing)	☐
➢ Occupational Therapy (in all settings except for hospital)	☐
➢ Orthotics	☐
➢ Personal Care	☐
➢ Personal Emergency Response Services (Life Line)	☐
➢ Physical Therapy (in all settings except for inpatient hospital)	☐
➢ Prevocational Services	☐
➢ Protective Payment/Guardianship Services	☐
➢ Relocation Services	☐
➢ **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 (Support Broker)	☐
➢ Specialized Medical Supplies	☐
➢ Speech & Language Pathology Services (in all settings except for inpatient hospital)	☐
➢ Supported Employment	☐
➢ Supportive Home Care	☐

SERVICES IN FAMILY CARE BENEFIT PACKAGE	CHECK SERVICE(S) YOU PROVIDE
➢ **Transportation**: Select Medicaid covered (i.e. Medicaid covered transportation except ambulance & transportation by common carrier)	☐
➢ **Transportation**: Non-Medicaid covered	☐
➢ Vocational Futures Planning	☐
➢ Other:	☐

IV. PROVIDER ACCESSIBILITY AND AVAILABILITY

1. Program/facility accessibility:

Handicapped parking	Yes	No
TDD/TTY Number	Yes (Specify) ____________	☐ No
Wheelchair accessible	☐ Yes	☐ No
Sign Language	☐ Yes	☐ No

2. List Languages spoken other than English:

____

____

____

____

V. SPECIALIZED EXPERTISE OFFERED BY YOUR AGENCY

Please briefly describe any specialized expertise or unique services offered by your agency (i.e., specialization in Alzheimer's care). Please attach a separate sheet if your explanation requires additional space.

____

____

____

____

VI. 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**

VII. CULTURAL COMPETENCIES

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

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.

VIII. 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:

   a. Been convicted of the following crimes:

      i. 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);

      ii. 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);

      iii. 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);

iv. 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,

v. 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).

b. 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).

c. 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).

IX. ORGANIZATIONAL STRUCTURE

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

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

☐ **Partnership** ☐ **Sole Proprietor**

X. 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**	**Telephone Number**
Executive Director/President:	______________________	______________
Chief Financial Officer:	______________________	______________
Chief Information Technology Officer:	______________________	______________
Human Resources/Personnel Director:	______________________	______________

XI. 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: ______________________________

XII. 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**
- ☐ **Adult Family Home License**
- ☐ **Adult Family Home Certification**
- ☐ **CBRF License**
- ☐ **Home Health Agency License**
- ☐ **RCAC Certification**
- ☐ **Skilled Nursing Facility License**
- ☐ **Tax ID #** ____________________
- ☐ **NPI #** ____________________
- ☐ **Agency Medicaid #** ____________________
- ☐ **Agency Medicare #** ____________________
- ☐ **Other:** ____________________

XIII. CLIENT DATA AND RECORDKEEPING

Is each business location HIPAA compliant? Yes ☐ No
If no, please explain:

____

____

____

____

XIV. FISCAL MANAGEMENT

Agency Accountant/Bookkeeper Name: ______________________________
Phone Number: ______________________________
Address: ______________________________
Telephone Number: ______________________________

BILLING/PAYEE INFORMATION

Provider Billing Name: ____

Billing Address: ____

City: _________________________ **State:** _______ **Zip:** _______________

Billing Contact Name: ____

Billing Contact Phone and Fax Numbers: ________________ ________________

INSURANCE COVERAGE:

Please attach a copy of the Certificate of Liability Insurance of each insurance policy indicating expiration date and coverage amounts.

* Professional Liability
* General Liability
* Worker's Compensation
* Auto
* Homeowners

RETURN YOUR APPLICATION WITH ALL REQUIRED DOCUMENTATION TO:

Email: ContractInquiries@communitycareinc.org

Community Care, Inc.
Provider Management Department
1801 Dolphin Drive
Waukesha, WI 53186
866-937-2783 (Provider Hotline)
262-446-6707 (Fax)

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 Care Health Plan, 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 Health Plan, 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 VII 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

____

Name of Agency (Service Provider)

*** An email receipt of this application will be considered an acceptable signature***

ATTESTATION SHEET

Agency Name:________________________________

Owner/Operator has a file that contains the current information for all staff with direct member contact.

1) Job Description for each staff. ☐ Yes or ☐ No

2) Training plan for staff including documentation of completed trainings.
☐ Yes or ☐ No

3) Staff are able to demonstrate the necessary skills to perform their specific duties prior to initial performance. ☐ Yes or ☐ No

4) The provider will include as part of initial staff orientation, Community Care's mission, philosophy, policies on participants rights, emergency plan, ethics, the PACE benefit (if applicable) and any policies related to job duties of specific staff. This information can be found in Community Care's Employee Reference Guide (Guide will be distributed to provider upon completion of a contract). ☐ Yes or ☐ No

5) Qualifications of each staff member including academic preparation and relevant experience, verification of current license, certifications or registrations to practice in the State as applicable. ☐ Yes or ☐ No

6) Documented one year of experience with frail or elderly or disabled population. May include personal or professional experience. ☐ Yes or ☐ No

7) Employees are free of communicable diseases and are up to date with immunizations before performing direct patient care. ☐ Yes or ☐ No

i. Staff are adequately trained in member outcome based care and personal preferences.
☐ Yes or ☐ No

Additional Information Maintained on all agency employees

1) Pre-employment and every two years thereafter, documentation that any staff who has experience as a nursing assistant, home health aide or hospice aide, as defined under HFS 129, has not had a substantial finding listed on the Nurse Aid Registry that they have abused or neglected a client or misappropriated the funds or property of a client.
☐ Yes or ☐ No

2) A current copy of the driver's record check at pre-employment and every two years thereafter documenting a valid driver's license for any staff that may transport members. ☐ Yes or ☐ No

3) Proof of criminal background check for each staff member prior to employment and updated every four years thereafter. ☐ Yes or ☐ No

4) Current certification of insurance for any vehicles owned by staff that are used to transport Members. ☐ Yes or ☐ No

5) Provider has a mechanism in place to validate that employees have not been listed on Office of Inspector Generals exclusion list. (Monthly validation is recommended)
☐ Yes or ☐ No
Website: **http://oig.hhs.gov/fraud/exclusions.asp**

** Provider shall immediately notify Community Care, Inc. should they as a provider or any of their employees appear on the provider exclusion list of the Office of Inspector General.

Additional Agency Information:

1) Agency has a back-up plan in place when there are staff shortages? Briefly define or attach additional forms/ policy as necessary. ☐ Yes or ☐ No

____
____
____
____
____

2) Agency has a plan in place for regular and emergency medical needs? Briefly define or attach additional forms/policy as necessary. ☐ Yes or ☐ No

____
____
____

3) Agency has a policy to prevent any member from being left in a vehicle? Briefly define or attach transportation policy or practices. Include any forms that staff must document on who is in the vehicle at start and end of trips. ☐ Yes or ☐ No

____
____
____

4)) Agency has an emergency preparedness plan. ☐ Yes or ☐ No

Note: Answering no to one or more of these questions does not automatically disqualify a provider from receiving a contract. Community Care will review the provider's responses and follow-up where appropriate.

Falsification and/or omission of information on this application may lead to contract denial and/or contract termination. Community Care reserves the right to deny or end a contract at any time based on information they may receive that is inconsistent with provider submission. Please ensure accuracy on all application material to avoid further action.

Person completing this form (please print): ______________________________

Signature: ____________________________________ Date: ____________

By signing I attest the information in this document is true and accurate.

QI, pf 3/11

FACILITY INFORMATION PAGE

Complete this page only if you are a non-residential provider and have multiple locations. Make copies of this page if necessary.

Legal Name of Provider: ______________________________

Facility Address: ______________________________

City: ____________ **State:** ______ **Zip:** __________

Telephone Number: ______________ **Fax #** ______________

Email Address: ______________________________

Contact Person: ______________________________

Facility Medicare # (if applicable): ______________________________

Facility Medicaid # (if applicable): ______________________________

Facility NPI # (if applicable): ______________________________

Services offered at this facility: ______________________________

Legal Name of Provider: ______________________________

Facility Address: ______________________________

City: ____________ **State:** ______ **Zip:** __________

Telephone Number: ______________ **Fax #** ______________

Email Address: ______________________________

Contact Person: ______________________________

Facility Medicare # (if applicable): ______________________________

Facility Medicaid # (if applicable): ______________________________

Facility NPI # (if applicable): ______________________________

Services offered at this facility: ______________________________

RESIDENTIAL SUMMARY

Provider: ______________________________

Please complete one form per residential facility

Facility Name: ______________________________
Facility Address: ______________________________
Facility Contact Person (s): ______________________________
Title: ______________________________
Contact Phone Number: ______________________________
E-mail: ______________________________
Site Phone Number: ______________________________
Site Fax Number: ______________________________
Facility Licensed or Certified (list CBRF, AFH, etc.): ______________

Live-in staff: ☐ Yes ☐ No
Owner-occupied: ☐ Yes ☐ No
Corporate: ☐ Yes ☐ No

List Class if CBRF: __________

Number of licensed or certified beds: ______

Number of years in operation: __________

Facility Licensed/Certified to Serve

Check as Appropriate:

Gender	☐ **M**	☐ **F**	Physically Disabled	☐ **Y**	☐ **N**
Advanced Age	☐ **Y**	☐ **N**	Alzheimer's/Dementia	☐ **Y**	☐ **N**
Traumatic Brain Injury	☐ **Y**	☐ **N**	Serious & Persistent Mental Illness	☐ **Y**	☐ **N**
Developmental Disabilities	☐ **Y**	☐ **N**			

Facility Capabilities

Behavioral Needs: (check one box in each category to indicate your facility's capability to serve members displaying the described behavior)

Verbal Aggression

- ☐ **None**
- ☐ **Mild**: Occasional use of profanity or inappropriate comments. Behavior is easily redirected with verbal cues.
- ☐ **Moderate**: A moderate use of profanity, inappropriate comments and/or screaming and/or yelling. Behaviors can be redirected with verbal cues.
- ☐ **Severe**: Frequent screaming and/or yelling that is not easily redirected and/or verbal threats to harm others that are not acted upon.

Physical Aggression

- ☐ **None**
- ☐ **Mild**: Self injurious and/or self stimulating behavior that is mild and easily redirected verbally.
- ☐ **Moderate**: Self injurious and/or self stimulating behaviors that may cause injury to self or others such as hair pulling, kicking, slapping, and punching that is able to be verbally redirected with one or multiple cues.
- ☐ **Severe**: Self injurious and/or self stimulating behaviors that may cause serious injury to self or others such as hair pulling, kicking, slapping and punching that is not easily/not redirected verbally.

Property Destruction

- ☐ **None**
- ☐ **Mild**: Easily verbally-redirected behavior such as fist pounding, tearing clothes, and door slamming.
- ☐ **Moderate**: Verbally redirected behavior that destroys property such as punching walls, throwing and/or breaking objects without causing harm to others.
- ☐ **Severe**: Property destruction that requires modification to the environment to avoid injury to self or others such as recessed lighting, unbreakable windows, and/or special furniture not easily destroyed.

Sexual Behaviors

- ☐ **None**
- ☐ **Mild**: Inappropriate sexual comments that are easily redirected verbally and/or masturbation that requires verbal redirection to be done in privacy (this does not include public masturbation).

☐ **Moderate**: Flashing, stripping, and/or frequent inappropriate sexual comments that can be verbally redirected and occurs within the home and not in public.

☐ **Severe**: Flashing, stripping and/or masturbation that may occur within the home and may not be easily redirected verbally. Acts of flashing, stripping and/or masturbation that occur in public that may or may not be easily verbally redirected. The individual may exhibit predatory type sexual behaviors towards peers and/or others. The individual may have a need for an environment that is all male/all female peers and/or all male/all female staff due to sexually inappropriate behaviors. The individual may be a registered sex offender.

Medical Needs: (please check all boxes that apply to indicate your facility's capability to serve members with the listed medical need)

☐ Diabetic Blood Sugar Monitoring
☐ Insulin-Dependent Diabetic
☐ Sliding-scale Insulin-Dependent Diabetic
☐ Tracheotomy Care
☐ Tube-Feeding
☐ Incontinence

Wheelchair accessible entrances? (two entrances to grade) ☐ Yes ☐ No

Hoyer lift? ☐ Yes ☐ No

Transfer Status (check one) ☐ Independent ☐ Assist of One ☐ Assist of Two

Number of bedrooms: ________ Number of wheelchair accessible bedrooms? ________

Number of shared bedrooms: ________ Number of wheelchair accessible shared bedrooms? ________

Number of bathrooms: ________ Number of wheelchair accessible bathrooms? ________

Is the facility alarmed? ☐ Yes ☐ No

Does the facility have pets? ☐ Yes ☐ No

List types of pet(s):

Are members allowed to smoke? ☐ Yes ☐ No

Consumer transportation options:

Agency vehicle(s): ☐ Agency Van ☐ Agency Car ☐ Staff Vehicle ☐ Public Transit ☐ Lift Equipped

or other options: ________________________________

Consumer Resources:

Please provide the available community resources to members residing in the home: ___________

Staff Information: ___________

Owner/Operator Name: ___________

Academic preparation: ___________

Relevant experience or training: ___________

Has the owner/operator ever been convicted of a crime? ☐ Yes ☐ No

If Yes, please explain: ___________

On-Site Manager Name: ___________

Academic preparation: ___________

Relevant experience or training: ___________

Has the on-site manager ever been convicted of a crime? ☐ Yes ☐ No

If Yes, please explain: ___________

Please list required staff trainings: ___________

Additional facility expertise/experience not identified above:

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Attestation Statement:

I certify that the information completed on this long-term care program summary is true and accurate as of its completion.

If the long-term care program summary information changes at any time, I will submit a new long-term care program summary.

Name of Person Completing Form:

Date Completed:

Signature: ____

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