



# *General Application*

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## *Checklist*

The items below must be completed *prior to submission* and included with this application to be considered. If all items are not received at time of application, this application will not be accepted.

- General Provider Application
- Attestation Form ([Word](#) or [PDF](#) format)
- [W-9 Form](#)
- Copy of any applicable Certifications and/or Licenses
- 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’ form naming Community Care, Inc. as a certificate holder (1801 Dolphin Drive, Waukesha, WI 53186)
- Electronic Funds Transfer Form ([Word](#) or [PDF](#) format)
- Voided Check *OR* Bank Letter to accompany the Electronics Funds Transfer form
- DHS Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation <https://www.dhs.wisconsin.gov/library/collection/f-00180c>
- Residential Summary Form - required for all residential facilities ([Word](#) or [PDF](#) format)
- Program Statement - required for all licensed/certified providers
- [Residential Data Collection](#) - required for residential providers



**COMMUNITY CARE, INC.  
PROVIDER APPLICATION**

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**I. PROVIDER CONTACT INFORMATION – *Please Type or Print***

**Legal Entity Name:** \_\_\_\_\_

**Business Address (cannot be a P.O. Box):**

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **Same as Business Address Above**

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Tax Id: \_\_\_\_\_ NPI #: \_\_\_\_\_

Medicaid #: \_\_\_\_\_ Medicare #: \_\_\_\_\_

EVV #: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Contact E-Mail: \_\_\_\_\_ Phone: \_\_\_\_\_

Contract Signer: \_\_\_\_\_

Signer's Title: \_\_\_\_\_

Website: \_\_\_\_\_

Days of Operation: \_\_\_\_\_

Hours of Operation: \_\_\_\_\_

## II. 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>

<input type="checkbox"/> Adaptive Aids (general, vehicle, service dog)	<input type="checkbox"/> Residential Services: Adult Family Home (1-2 Bed)
<input type="checkbox"/> Adult Day Care (licensed)	<input type="checkbox"/> Residential Services: Adult Family Home (3-4 Bed)
<input type="checkbox"/> Assistive Technology/Communication Aids (includes interpreter services)	<input type="checkbox"/> Residential Services: Community Based Residential Facility (CBRF)
<input type="checkbox"/> Consultative Clinical & Therapeutic Services for Caregivers (CCTS)	<input type="checkbox"/> Residential Services: Residential Care Apartment Complex (RCAC)
<input type="checkbox"/> Consumer Directed Supports (self-directed supports) broker	<input type="checkbox"/> Respite Care (in non-institutional & institutional settings)
<input type="checkbox"/> Consumer Education and Training	<input type="checkbox"/> Respite Care (in substitute living facility)
<input type="checkbox"/> Counseling & Therapeutic Resources (licensed, non-Medicaid certified therapies)	<input type="checkbox"/> Skilled Nursing Services (RN/LPN)
<input type="checkbox"/> Environmental Accessibility Adaptations (home modifications)	<input type="checkbox"/> Specialized Medical Equipment & Supplies
<input type="checkbox"/> Financial Management Services	<input type="checkbox"/> Supported Employment – Small Group
<input type="checkbox"/> Habilitation Services: Daily Living Skills Training	<input type="checkbox"/> Supported Employment - Individual
<input type="checkbox"/> Habilitation Services: Day Habilitation Services	<input type="checkbox"/> Supportive Home Care (chore services)
<input type="checkbox"/> Home Delivered Meals	<input type="checkbox"/> Supportive Home Care (general; including non-medical personal care)
<input type="checkbox"/> Housing Counseling	<input type="checkbox"/> Training for unpaid caregivers
<input type="checkbox"/> Personal Care Agency (Wisconsin Medicaid certified)	<input type="checkbox"/> Vocational Futures Planning & Support
<input type="checkbox"/> Personal Emergency Response Service (PERS)	<input type="checkbox"/> Other ( <i>please specify</i> ): _____
<input type="checkbox"/> Prevocational Services	
<input type="checkbox"/> Relocation Services	

**III. GENERAL INFORMATION**

**OWNERSHIP INFORMATION**

- The organization is minority-owned.
  The organization is disabled veteran-owned.  
 The organization is woman-owned.
  The organization is a small business.

Do you currently have or have you previously had a contract with CCI?

Yes    No   Please explain: \_\_\_\_\_

Do you have an affiliation with another Legal Entity currently contracted with CCI?

Yes    No   What is the affiliation: \_\_\_\_\_

Is each business location HIPAA compliant?    Yes    No

If no, please explain: \_\_\_\_\_

**SUPPORTIVE HOME CARE ONLY**

Do you offer apartments or have locations identified for members to reside:    Yes    No

If yes, please attach a copy of a program summary of services offered as a Supportive Home Care Agency.

If no, do your services only occur in members' own existing residence:    Yes    No

**RESIDENTIAL PROVIDERS ONLY**

Vacancy Contact Name/Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone #: \_\_\_\_\_

**ALL PROVIDERS:**

Service Area(s): *Please select the county(ies) you serve*

All 72 Wisconsin Counties	<input type="checkbox"/>										
Adams	<input type="checkbox"/>	Dane	<input type="checkbox"/>	Iowa	<input type="checkbox"/>	Marathon	<input type="checkbox"/>	Polk	<input type="checkbox"/>	Taylor	<input type="checkbox"/>
Ashland	<input type="checkbox"/>	Dodge	<input type="checkbox"/>	Iron	<input type="checkbox"/>	Marinette	<input type="checkbox"/>	Portage	<input type="checkbox"/>	Trempealeau	<input type="checkbox"/>
Barron	<input type="checkbox"/>	Door	<input type="checkbox"/>	Jackson	<input type="checkbox"/>	Marquette	<input type="checkbox"/>	Price	<input type="checkbox"/>	Vernon	<input type="checkbox"/>
Bayfield	<input type="checkbox"/>	Douglas	<input type="checkbox"/>	Jefferson	<input type="checkbox"/>	Menominee	<input type="checkbox"/>	Racine	<input type="checkbox"/>	Vilas	<input type="checkbox"/>
Brown	<input type="checkbox"/>	Dunn	<input type="checkbox"/>	Juneau	<input type="checkbox"/>	Milwaukee	<input type="checkbox"/>	Richland	<input type="checkbox"/>	Walworth	<input type="checkbox"/>
Buffalo	<input type="checkbox"/>	Eau Claire	<input type="checkbox"/>	Kenosha	<input type="checkbox"/>	Monroe	<input type="checkbox"/>	Rock	<input type="checkbox"/>	Washburn	<input type="checkbox"/>
Burnett	<input type="checkbox"/>	Florence	<input type="checkbox"/>	Kewaunee	<input type="checkbox"/>	Oconto	<input type="checkbox"/>	Rusk	<input type="checkbox"/>	Washington	<input type="checkbox"/>
Calumet	<input type="checkbox"/>	Fond du Lac	<input type="checkbox"/>	LaCrosse	<input type="checkbox"/>	Oneida	<input type="checkbox"/>	Sauk	<input type="checkbox"/>	Waukesha	<input type="checkbox"/>
Chippewa	<input type="checkbox"/>	Forest	<input type="checkbox"/>	Lafayette	<input type="checkbox"/>	Outagamie	<input type="checkbox"/>	Sawyer	<input type="checkbox"/>	Waupaca	<input type="checkbox"/>
Clark	<input type="checkbox"/>	Grant	<input type="checkbox"/>	Langlade	<input type="checkbox"/>	Ozaukee	<input type="checkbox"/>	Shawano	<input type="checkbox"/>	Waushara	<input type="checkbox"/>
Columbia	<input type="checkbox"/>	Green	<input type="checkbox"/>	Lincoln	<input type="checkbox"/>	Pepin	<input type="checkbox"/>	Sheboygan	<input type="checkbox"/>	Winnebago	<input type="checkbox"/>
Crawford	<input type="checkbox"/>	Green Lake	<input type="checkbox"/>	Manitowoc	<input type="checkbox"/>	Pierce	<input type="checkbox"/>	St. Croix	<input type="checkbox"/>	Wood	<input type="checkbox"/>

Target Group(s): *Please select the population(s) you serve*

- |  |                          |                             |                          |
|--|--------------------------|-----------------------------|--------------------------|
| Physically Disabled ( <b>PD</b> )                      | <input type="checkbox"/> | Frail Elderly ( <b>FE</b> ) | <input type="checkbox"/> |
| Intellectually/Developmentally Disabled ( <b>IDD</b> ) | <input type="checkbox"/> | All ( <b>PD, IDD, FE</b> )  | <input type="checkbox"/> |

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

**IV. LICENSE AND CERTIFICATION REQUIREMENTS**

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

- |  |   |
|--|---|
| <input type="checkbox"/> Adult Day Care Certification    | <input type="checkbox"/> Sign Language License              |
| <input type="checkbox"/> Adult Family Home License       | <input type="checkbox"/> National Accreditation             |
| <input type="checkbox"/> Adult Family Home Certification | <input type="checkbox"/> Personal Care Agency Certification |
| <input type="checkbox"/> CBRF License                    | <input type="checkbox"/> Other: <i>(please specify)</i>     |
| <input type="checkbox"/> RCAC Certification              |   |
- 

**V. PROVIDER ACCESSIBILITY AND AVAILABILITY**

- |                        |                              |                             |                        |
|------------------------|------------------------------|-----------------------------|------------------------|
| TDD/TTY Number         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, specify: _____ |
| Handicapped accessible | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                        |
| Sign Language          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                        |

**List fluent languages spoken by staff (other than English):**

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**VI. 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
Intellectually/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	

## VII. CULTURAL COMPETENCIES

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

Does your agency perform Cultural Competency Training?  Yes  No

Has your agency implemented National Standards for Culturally and Linguistically Appropriate Services (CLAS)? <https://thinkculturalhealth.hhs.gov/clas>  Yes  No

## 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 or 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. LENGTH OF TIME IN BUSINESS**

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

\_\_\_\_\_ Years \_\_\_\_\_ Months

**X. AGENCY OFFICERS/RESPONSIBLE PARTY**

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

Those listed in this section have authority to speak with and receive information from Community Care, Inc.

Position	Name	Telephone & Email
Chief Operations Officer:	_____	_____
Executive Director/President:	_____	_____
Chief Financial Officer:	_____	_____
Chief Information Technology Officer:	_____	_____
Human Resources Director:	_____	_____
Other:	_____	_____

**XI. GOVERNANCE**

Does your agency have a Board of Directors?  Yes  No

If yes, please answer the below:

How many members are on the Board? \_\_\_\_\_

Does at least 51% of the Board of Directors include minorities, women, disabled Veterans and/or small business owners?  Yes  No

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. BILLING/PAYEE INFORMATION**

Billing/Payee Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing Contact Name: \_\_\_\_\_

Billing Contact Phone and Fax Numbers: \_\_\_\_\_



# Service Location Information Page

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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): \_\_\_\_\_  
Medicaid #: \_\_\_\_\_ Medicare #: \_\_\_\_\_  
Services offered at this Location: \_\_\_\_\_  
Handicapped Accessible:  Yes  No  
Sign Language:  Yes  No  
List Languages spoken other than English: \_\_\_\_\_  
Populations Served:  Physically Disabled (PD)  
 Intellectually/Developmentally Disabled (IDD)  
 Frail Elderly (FE)  
 All (PD, IDD, FE)

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Business Name: \_\_\_\_\_  
Location Name (if applicable): \_\_\_\_\_  
Location Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Fax # \_\_\_\_\_  
Contact Person: \_\_\_\_\_  
Location NPI # (if applicable): \_\_\_\_\_  
Medicaid #: \_\_\_\_\_ Medicare #: \_\_\_\_\_  
Services offered at this Location: \_\_\_\_\_  
Handicapped Accessible:  Yes  No  
Sign Language:  Yes  No  
List Languages spoken other than English: \_\_\_\_\_  
Populations Served:  Physically Disabled (PD)  
 Intellectually/Developmentally Disabled (IDD)  
 Frail Elderly (FE)  
 All (PD, IDD, 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 Care 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 (preferred method):**

[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