General Application

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)
- ☐ Wisconsin Medicaid Approval Letter(s) for each service/location
- ☐ **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)
- ☐ Program Statement - required for all licensed/certified providers
- ☐ Residential Summary Form - required for all residential facilities (**Word** or **PDF** format)

Return your application with ALL REQUIRED documentation to:

Email (preferred method):
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

COMMUNITY CARE, INC.
PROVIDER APPLICATION

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 #: _____

EVV #: _____ Medicare #: _____

Medicaid Number: *Please include all applicable Medicaid Enrollment Letters with this applicatior*

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

- ☐ Adult Day Care services
- ☐ Assistive Technology
- ☐ CIE (Competitive Integrated Employment) Exploration
- ☐ Communication Assistance
- ☐ Consultative Clinical & Therapeutic Services for Caregivers (CCTS)
- ☐ Consumer Directed Supports (self-directed supports) broker
- ☐ Consumer Education and Training
- ☐ Counseling & Therapeutic Resources
- ☐ Daily Living Skills Training
- ☐ Day Habilitation
- ☐ Environmental Accessibility Adaptations (home modifications)
- ☐ Financial Management Services
- ☐ Health & Wellness Services offered: _____
- ☐ Home Delivered Meals
- ☐ Housing Counseling
- ☐ Personal Care Agency (Wisconsin Medicaid certified)
- ☐ Personal Emergency Response Service (PERS)
- ☐ Prevocational Services
- ☐ Relocation Services
- ☐ Remote Monitoring and Support
- ☐ Residential Services: Adult Family Homes (1-2 Bed)
- ☐ Residential Services: Adult Family Homes (3-4 Bed)
- ☐ Residential Services: Community Based Residential Facilities (CBRF)
- ☐ Residential Services: Residential Care Apartment Complexes (RCAC)
- ☐ Respite Care (in non-institutional & institutional settings)
- ☐ Respite Care (in substitute living facility)
- ☐ Skilled Nursing Services (RN/LPN)
- ☐ Specialized Medical Equipment & Supplies
- ☐ Supported Employment – Small Group
- ☐ Supported Employment - Individual
- ☐ Supportive Home Care (chore services)
- ☐ Supportive Home Care (general; including non-medical personal care)
- ☐ Training for unpaid caregivers
- ☐ Vehicle Modifications
- ☐ Vocational Futures Planning & Support
- ☐ Other (*please specify*): _____

ALL PROVIDERS:

Service Area(s): *Please select the county(ies) you serve. If members must come to your location for services, select the county(ies) where your locations are located.*

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

III. GENERAL INFORMATION

OWNERSHIP INFORMATION

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

OWNERSHIP RACE/ETHNICITY (*Optional-If information is provided, it will be included in our Provider Directory*)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Prefer not to answer

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 #: _____

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

Physically Disabled (**PD**)	☐	Frail Elderly (**FE**)	☐
Intellectually/Developmentally Disabled (**IDD**)	☐	All (**PD, IDD, FE**)	☐

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.

- ☐ Adult Day Care Certification
- ☐ Adult Family Home License
- ☐ Adult Family Home Certification
- ☐ CBRF License
- ☐ RCAC Certification
- ☐ Sign Language License
- ☐ National Accreditation
- ☐ Personal Care Agency Certification
- ☐ Other: *(please specify)* _____

V. PROVIDER ACCESSIBILITY AND AVAILABILITY

TDD/TTY Number	☐ Yes	☐ No	If yes, specify: _____
Handicap accessible	☐ Yes	☐ No	
Sign Language	☐ Yes	☐ No	

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

_____

VI. 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 (per page 3)*.

_____ Years _____ Months

VII. 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			

VIII. 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

IX. 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).

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

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): _____

Medicare #: _____ Medicaid: *Please include Medicaid Enrollment Letter*

Services offered at this Location: _____

Handicapped Accessible: ☐ Yes ☐ No

Sign Language: ☐ Yes ☐ No

List Languges spoken other than English: _____

Populations Served:
- ☐ Physically Disabled (PD)
- ☐ Intellectually/Developmentally Disabled (IDD)
- ☐ Frail Elderly (FE)
- ☐ All (PD, IDD, FE)

Business Name: _____

Location Name (if applicable): _____

Location Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax # _____

Contact Person: _____

Location NPI # (if applicable): _____

Medicare #: _____ Medicaid: *Please include Medicaid Enrollment Letter*

Services offered at this Location: _____

Handicapped Accessible: ☐ Yes ☐ No

Sign Language: ☐ Yes ☐ No

List Languges 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 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 addresses, 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 IX 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 in eligible, 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

_____
Legal Entity 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.