

ORGANIZATIONAL PROVIDER ASSESSMENT APPLICATION

INSTRUCTIONS

1. *This form should be completed only for the provider types listed below:*

Medical

- Ambulatory Surgical Center (Free-standing only)
- Home Health Agency (Not PCA agency)
- Hospital (All types)
- Nursing Home
- Skilled Nursing Facility Nursing Home

2. *This form must be typed or printed legibly in black or dark blue ink. If more space is needed, attach additional sheets and reference the question being answered.*

3. *Modification to the wording or format of the Application will invalidate the Application.*

4. *A separate Application is required for each practice location and for each provider type.*

5. *Complete Pages 2 – 6. ALL fields must be completed. Sign and date Page 6.*

6. *If provider is Home Health Agency not CMS (Medicare) certified - complete Attachment A.*

7. *See shaded areas of this form for further instructions.*

Please fax the completed application along with all necessary attachment to 612-884-2184 or email to credentialinginfo@ucare.org. Or, mail to the following address:

UCare Credentialing Department
P.O. Box 52
Minneapolis, Minnesota 55440-0052

IMPORTANT

Failure to legibly complete all sections of this Application *and* submit current copies of all required documentation will constitute an incomplete Application that will be returned to the provider without processing.

ORGANIZATIONAL PROVIDER ASSESSMENT APPLICATION

I. PROVIDER IDENTIFICATION			
A. Corporate Identification Information			
1. Legal Business Name as Reported to the IRS:			
2. Doing Business As (DBA) Name (if applicable):		3. County where DBA Name Registered:	
4. Address:		5. Tax Identification Number:	
6. Medicaid Number: <i>(Required if Certified)</i>		National Provider Identifier (NPI): <i>(Required)</i>	
B. Current Practice Location - <i>Must be a street address, not a Post Office Box.</i>			
Practice Location Name:			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	County:
Phone:	Fax:	Website:	
Primary Contact Name:		Contact Title:	
Phone:	Fax:	E-Mail:	
Administrator (Full Name):			
C. Mailing / Correspondence Address - <i>Must be an address where provider can be contacted directly.</i>			
<input type="checkbox"/> Check here if all correspondence can be directed to the practice location in Section B above. If not, complete the section below.			
Provider Name:			
Mailing Address Line 1:			
Mailing Address Line 2:			
City:	State:	Zip:	County:

D. Provider Type - Indicate provider type.

- A separate Application is required for each provider type
- A separate Application is required for each practice location.

Medical

- Ambulatory Surgical Center (Free-standing only)
- Home Health Agency – Providing Skilled Services only - No PCA Services
- Must complete Attachment A if not CMS certified.
- Hospital (All types)
- Skilled Nursing Facility (Nursing home)

II. HEALTH CARE LICENSURE / REGISTRATION

- A copy of each FACILITY license must accompany this Application.
- Do not submit Practitioner licenses.

	Facility License Number	INITIAL Issue Date	Renew Date	Expiration Date	Licensing Agency
State of _____					
State of _____					
Other:					
Other:					

III. CERTIFIED LABORATORY IMPROVEMENT AMENDMENTS (CLIA) CERTIFICATION

- A copy of the CLIA certification must accompany this Application.

CLIA Certification Number:	Effective Date:	Expiration Date:
----------------------------	-----------------	------------------

IV. ACCREDITATION / CERTIFICATION

A. Accreditation - *At least one box must be checked.*

- If accredited, attach copy of current Accreditation certificate.

1. Specify:	<input type="checkbox"/> AAAAPSF/AAAASF	<input type="checkbox"/> ACHC	<input type="checkbox"/> COA
	<input type="checkbox"/> AAAHC	<input type="checkbox"/> AOA	JOINT COMMISSION
	<input type="checkbox"/> AASM*	<input type="checkbox"/> CARF	URAC
	*Required for Sleep Centers	CHAP	<input type="checkbox"/> NOT ACCREDITED

2. Date of initial accreditation: _____ / _____ / _____
Month Day Year

3. Date of last survey: _____ / _____ / _____
Month Day Year

4. Has the accreditation organization been granted deeming authority* by CMS for this provider type? Yes No

* If the provider is accredited by a national accreditation organization that has been granted deeming authority by CMS, the site survey performed by the accrediting organization meets the site visit requirement.

5. Has this provider ever been denied accreditation by any accrediting body? Yes No

6. If Yes, provide details: _____

B. Certification - *Attach copy of most recent survey with Corrective Action Plan (if applicable).*

1. Is this provider participating in the Medicare program? Yes No Pending

If Yes, provide the following: Date of initial CMS certification: _____ / _____ / _____
Month Day Year

Date of last full CMS survey: _____ / _____ / _____
Month Day Year

2. Has provider had an on-site survey by a State (such as DHS) agency? Yes No Pending

If Yes, provide the following: Date of last full State survey: _____ / _____ / _____
Month Day Year

3. Were any deficiencies identified during the last full CMS or State survey? Yes No

If Yes, have all deficiencies been corrected?

Yes - *Provide evidence of acceptance of your Corrective Action Plan by CMS or State agency.*

No - *Provide explanation and your plan to correct all deficiencies:*

► PROVIDERS THAT DO NOT HOLD APPROVED ACCREDITATION OR CMS CERTIFICATION OR THAT HAVE NOT PASSED A STATE AGENCY ON-SITE REVIEW WILL BE REQUIRED TO PASS AN ON-SITE SURVEY CONDUCTED BY THE HEALTH PLAN.

V. INSURANCE –

- Both General and Professional Liability are required. Minimum coverage requirements are \$1,000,000 per occurrence and \$3,000,000 per aggregate. **Except for government providers subject to statutory limits.** (showing coverage amounts and dates).

A. General Liability Coverage - Attach certificate showing current coverage amounts and effective dates.

Current Carrier (Not Agency) Name:		Policy Number:	
Street/PO Box:		Coverage Type: <input type="checkbox"/> Occurrence Based <input type="checkbox"/> Claims Based	
City:	State:	Zip:	
Effective Date: ____/____/____ Month Day Year		Expiration Date: ____/____/____ Month Day Year	
Per Incident: \$		Aggregate: \$	

B. Professional Liability (Malpractice) Coverage - Attach certificate showing current coverage amounts and effective dates.

Current Carrier (Not Agency) Name:		Policy Number:	
Street/PO Box:		Coverage Type: <input type="checkbox"/> Occurrence Based <input type="checkbox"/> Claims Based	
City:	State:	Zip:	
Effective Date: ____/____/____ Month Day Year		Expiration Date: ____/____/____ Month Day Year	
Per Incident: \$		Aggregate: \$	

VI. ATTACHMENTS

The following is a list of documents that must be submitted with this completed Application. - Indicate which documents, as applicable or required, from the list below that are being included with this completed Application.

- Copies of all Federal, State, and/or local business licenses, certifications and/or registrations specifically required to operate as a health care facility.
- Copy of General Liability and Malpractice insurance covering organization.
- Copies of all Accreditation Certificates (must include practice site listed on this application).
- Copy of Federal Register Final Notice documenting deeming authority to any applicable accrediting organization which exempts provider from the CMS survey process.
- Copy of most recent CMS survey, including corrective action plan if deficiencies were cited and evidence from CMS that all deficiencies are remedied, if no CMS exemption provision applies.
- Copy of most recent state Department of Human Services (DHS) or Department of Health on-site survey, including corrective action plan if deficiencies were cited and evidence that all deficiencies have been remedied.
- Certified Laboratory Improvement Amendments (CLIA) Certification

VII. ATTESTATION QUESTIONS

Answer each of the following questions "Yes" or "No". If you answer "Yes" to any of the following questions, provide details and reasons as specified in each question, on a separate sheet. Sign and date this and each additional sheet. Modification to the wording or format will invalidate this attestation.

1. Has this provider, under any current or former name or business identity, <u>ever</u> had any felony or misdemeanor convictions, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has this provider, under any current or former name or business identity, <u>ever</u> had any felony or misdemeanor convictions, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has this provider, under any current or former name or business identity, <u>ever</u> had any felony or misdemeanor convictions, under Federal or State law, related to the interference with or obstruction of any investigation into any criminal offense described in Title 42 - Code of Federal Regulations Section 1001.1001 or 1001.201?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has this provider, under any current or former name or business identity, <u>ever</u> had any felony or misdemeanor convictions, under federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has this provider, under any current or former name or business identity, <u>ever</u> had licensure to provide health care by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has this provider, under any current or former name or business identity, <u>ever</u> had accreditation revoked or suspended?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has this provider, under any current or former name or business identity, <u>ever</u> been suspended or excluded from participation in, or any sanction imposed by, a Federal or State health care program, or any disbarment from participation in any Federal Executive Branch procurement or non-procurement program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is this provider, under any current or former name or business identity, currently suspended from Medicare or Medicaid payment under any Medicare or Medicaid billing number?	<input type="checkbox"/> Yes <input type="checkbox"/> No

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire Application are true, accurate, and complete to the best of my knowledge. I fully understand that any falsification of information or omissions from this Application may be grounds for denial of this Application as a Health Plan participating provider or cause for summary dismissal from the Health Plan, Further, I understand that acceptance of this Application does not constitute approval or acceptance of participating status with the Health Plan and grants this provider no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued by the Health Plan.

Printed Name of Authorized Representative

Signature of Authorized Representative

Authorized Representative's Title

Date Signed

ORGANIZATIONAL PROVIDER ASSESSMENT APPLICATION – Attachment A

**Home Health Agency
Medicare Certification Exception Form**

- Complete this form only if provider is a Home Health Agency that is not CMS (Medicare) certified.
- Type or print legibly using black or dark blue ink.
- ALL fields are required.

Agency Name: _____

Address: _____

City and State: _____

1. State the number of hours and days per week that you are available to serve clients:

_____/_____
Hours Days

2. List all states and years that you have been in business:

State: _____ Year(s): _____

State: _____ Year(s): _____

State: _____ Year(s): _____

3. List number of clients you have served in the past three years:

Number of Clients: _____ Year: _____

Number of Clients: _____ Year: _____

Number of Clients: _____ Year: _____

4. Indicate percentage of your clients, in the past year through present, who primarily received **personal care attendant (PCA)** or home health **aide** services:

_____ %