



COMMUNITY BASED SERVICES CREDENTIALING APPLICATION FORM

Community Based Services:

Adult Day Care; Social Day Care; Home Delivered Meals; Housekeeping/Chore Services; Companion/Personal Care Services; Adaptation Services; Licensed Home Care Services Agency; Health Safety Monitoring (PERS).

NAME OF COMPANY: _____ **TYPE OF SERVICE:** _____

In order to expedite processing, please complete every item on this application. Please enclose copies of the documentation listed below, as applicable, and the application should be signed and dated by an authorized representative of the organization. Thank you for your assistance!

“X” if enclosed

- Evidence of Accreditation (if applicable)
- Listing of all locations included under the contract;
- Current Liability Insurance Certificate per location;
- Copy of Current State Survey; (as applicable)
- W9 Form.

FOR PLAN USE ONLY – To be completed by Provider Representative:

- Site Inspection Evaluation (SIE) (non-accredited facilities) attached /not applicable; (please circle)
- Application information and supporting documentation has been reviewed;
- All information meets Plan criteria and documentation is current and complete.

Signature of Plan Provider Representative

Date

Signature of Plan In-house Representative

Date



Name of Service Organization &

Address and if applicable Bus Route Handicapped Access Handicapped Assistance

City, State, Zip County Office Phone # Office Fax #

Age Range of Members Served Languages Spoken

Name to whom Reimbursement is made payable

Billing Address (Location where payments will be sent) City, State, Zip

Billing Office Telephone Number Billing Office Fax Number

Correspondence Address (for credentialing purposes only) City State Zip

Office Telephone Number Office Fax Number Contact name

SPECIALTY OF SERVICES/TAXONOMY

<i>Name of Specialty</i>	<i>Taxonomy Code</i>

NAME OF STATE AND/OR LOCAL AGENCY THAT REGULATES SERVICES

<i>Name of State/Local Agency:</i>	<i>Address of Agency:</i>
<i>Name of State/Local Agency:</i>	<i>Address of Agency:</i>

REGULATORY (PLEASE COMPLETE ALL APPLICABLE BOXES)

<i>Tax ID#</i>	<i>Medicaid Provider #</i>	<i>Medicare Provider #</i>	<i>License #</i>
<i>National Provider Identification #</i>	<i>Status:</i>	<i>Status:</i>	<i>Status:</i>

CERTIFICATION OR ACCREDITATION STATUS (AS APPLICABLE)

<i>Certification Agency Name</i>	<i>Certification Status</i>	<i>Certification Date</i>	<i>Expiration Date</i>

HOURS OF SERVICE

<i>Day of Week</i>	<i>Hours</i>	<i>Comments</i>
<i>Monday</i>		
<i>Tuesday</i>		
<i>Wednesday</i>		
<i>Thursday</i>		
<i>Friday</i>		
<i>Saturday</i>		
<i>Sunday</i>		



Provider Name: _____

Information Sheet Required for Additional Locations

(PLEASE PRINT)

Name of Service Organization: _____

List any additional Locations: Please include all necessary information listed below.

Second Physical Address: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Tax Identification Number: _____

Contact Name: _____

Handicapped Access Yes ___ No ___ Handicapped Assistance Yes ___ No ___ Bus Rte. Yes ___ No ___

Office Hours _____

Second Billing Address: _____

Checks payable to: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Tax Identification Number: _____

Contact Name: _____

Third Physical Address: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Tax Identification Number: _____

Contact Name: _____

Handicapped Access Yes ___ No ___ Handicapped Assistance Yes ___ No ___ Bus Rte. Yes ___ No ___

Office Hours _____

Third Billing Address: _____

Checks payable to: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Tax Identification Number: _____

Contact Name: _____

Please attach additional location information as necessary.



Provider Name: _____

PROFESSIONAL/GENERAL LIABILITY DATA - Please provide full address

<i>Name and address of Carrier</i>	<i>Policy # Effective and end dates</i>	<i>Policy Limits of Coverage</i>	<i>Retroactive date of coverage</i>

QUESTIONNAIRE - If the answer to any of the questions is yes, please provide details on a separate sheet.

<i>Please answer the following questions by checking the appropriate box:</i>	YES	NO
Have criminal proceedings ever been initiated against your Company or its authorized representative(s)		
Has your Company ever been the subject of an investigation or ever been suspended, sanctioned or otherwise restricted from participating in any private, state or federal health insurance program (for example Medicare or Medicaid)?		

AFFIRMATION OF ACCURACY AND COMPLETENESS

I affirm that information provided in or attached to this application is current, correct and complete. I understand that a condition of this application is that any misrepresentation or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and it shall not be processed any further.

RELEASE AND HOLD HARMLESS

By applying for provider participation, the following conditions are accepted as legally binding. These conditions shall remain in effect for the duration of any term of participation granted:

To the extent permitted by law, applicant shall release and hold harmless from liability, the Company, its authorized representatives and any third parties, as defined below, for any actions, recommendations, reports, statements, communications, or disclosures, that are made, taken or received in good faith by the Company or its authorized representatives relating to the following:

- a. applications for provider participation;
- b. periodic reappraisals undertaken for renewal thereof.

Authorization is given to the Company and its authorized representatives to consult with any third party who may have information bearing on services as a provider.

SIGNATURE OF APPLICANT/AUTHORIZED REPRESENTATIVE

DATE

PRINTED NAME