INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISe™ PROVIDER ENROLLMENT BASE APPLICATION

EXTENDED CARE NURSING FACILITY OR INTERMEDIATE CARE FACILITY/INTELLECTUAL DISABILITIES

Applications must be typed or completed in black ink, or they will not be accepted. Applications will be scanned - please do NOT staple.

1. Enter the complete name of the facility.

2a-b Check the appropriate boxes for the action(s) you request and complete the entire application.

2c. If you are reactivating a provider number, indicate the PROMISe™ **9 digit** provider number you wish to have reactivated and complete the application as an initial enrollment.

3. Enter your National Provider Identifier (NPI) Number and taxonomy(s). Include a legible copy of the NPPES Confirmation letter that shows the NPI Number and Taxonomy(s) assigned to the healthcare provider applying for enrollment. Refer to: http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/nationalprovideridentifiernpiinformation

4. Enter the requested effective date for your action request.

5. Enter your Tax Identification Number (FEIN/TIN).
A copy of the TIN label or document generated by the Federal IRS containing the name and IRS number of the entity applying for enrollment must accompany this application. A W-9 form will not be accepted.

6. Enter your legal name as it is filed with the IRS and as it appears on IRS-generated documents.

7. Enter your provider type number and description (e.g., provider type 03, Extended Care Facility)

8. Enter your specialty code number and name. **Refer to Pg. 5 for the Specialty Codes.**

9a. Indicate whether or not you participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs).

9b. Enter the names of any Pennsylvania Medicaid Managed Care Organizations with which you participate.

10a. Indicate whether the provider operates under a fictitious business/doing-business as (d/b/a) name.

10b. If applicable, enter the statement/permit number and the name. **Attach a legible copy of the recorded/ stamped fictitious business name statement/permit.**

11a. Enter your IRS (Legal Entity) address. **This address is where your 1099 tax documents will be sent.**

11b-f. Enter the contact information for the IRS address.

12. Check the appropriate box for the business type of the facility applying for enrollment. Check only one box.
***Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.**

13a. Enter a valid service location address.
***The address must be a physical location, not a post office box.**
Please indicate if the physical address is handicap accessible.
Please indicate if the physical address has been screened by one of the listed entities.
***The zip code must contain 9 digits and the phone number must be for the service location.**
***Refer to blocks #19 and #20 of the application to list an additional address(es) for Mail-To and Pay-To if different from the Service Location address entered in Block 13a.**

NOTE: You can sign up for the **Electronic Funds Transfer Direct Deposit Option** by following the link below:
http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/electronicfundstransferdirectdepositinformation

13b. Answer question. If yes, enter your E-mail Address. If no, follow directions to access the bulletin information yourself. If you require paper bulletins or RA's please call 1-800-537-8862 option 1 to see if you meet the requirements.

13c-f. Enter Administrator's information.

13g. Indicate whether you or your staff is able to communicate with patients in any language other than English.

13h. If applicable, list the additional languages in which you or your staff can communicate.

13i. Enter the appropriate Provider Eligibility Program (PEP). **Refer to Pgs. 4 and 5 for PEP Descriptions.**

14a-e. Enter facility's license number, issue date, expiration date, number of licensed beds and issuing state.
***A copy of your current license must be included with the application.**

15. Enter your CMS (Medicare) Certification number.

16. Check date the facility will submit their annual MA cost report and enter projected resident days.

17a-e. The representative of the facility applying for enrollment must complete ALL confidential information questions, A through E.
***If you answer "Yes" to any of the questions, you must provide a detailed explanation (on a separate piece of paper) and attach it to your application. (Refer to the Confidential Information sheet).**

17f. If you answered YES to any of the questions in 17a-e., include responses to 17f, 1 to 14.

18. Sign the application and print your name, title, and date. **(The signature should be that of someone able to represent the facility applying for enrollment). Use BLACK ink.**

19. This page, beginning with block #19, may be used to add a Mail-To and/or Pay-To address to the **previously defined** service location address listed in 13a.

19a. Enter the corresponding Mail-To address for the service location.

19b-e. Enter the contact information for the Mail-To address.

20a. Enter the corresponding Pay-To address for the service location.

20b-e. Enter the contact information for the Pay-To address.

- Facilities must complete a new base application to add additional service locations or provider types to their profile.
- A representative of the facility applying for enrollment must complete the Extended Care Nursing Facility and Intermediate Care Facility/Intellectual Disabilities Provider Agreement included with the application.

When completed, review the "Did You Remember…" Checklist included with the application.

<u>Mail application and other documentation to the following address</u>:

OLTL / BQPM
Attention: Provider Enrollment
PO Box 8025
Harrisburg, PA 17105-8025

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

Provider Eligibility Program (PEP) Descriptions

A Provider Eligibility Program (PEP) code identifies a program for which a provider may apply. A provider must be approved in that program to be reimbursed for services to beneficiaries of that program. Providers should use the following PEP codes when enrolling in Medical Assistance (MA). Providers should use the descriptions in this document to determine which PEP code to use when enrolling in MA.

Contact Number: (717) 772-2570 or (800) 932-0939
Email: ra-hcbsenprov@pa.gov

AGING WAIVER (Formerly PDA Waiver/Bridge Program)

Website: http://www.dhs.state.pa.us/fordisabilityservices/alternativestonursinghomes/agingwaiver

This program provides services to eligible persons over the age of 60 in order to prevent institutionalization and allows them to remain as independent as possible.

Eligibility:
Recipients must be 60 years of age or older, meet the level of care needs for a Skilled Nursing Facility, and meet the financial requirements as determined by the County Assistance Office (CAO).

Services:

- Accessibility Adaptation
- Adult Daily Living
- Community Transition Services
- Home Delivered Meals
- Home Health
- Non-Medical Transportation
- Personal Assistance Services
- Personal Emergency Response System
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies
- Telecare Services
- Therapeutic and Counseling Services
- Transition Service Coordination

NOTE: If the facility wishes to provide any of the home and community-based services under this PEP, you must complete the entire application and enroll as a Provider Type 59, OLTL Programs provider. All providers in this PEP must be approved by the Office of Long-Term Living (OLTL).

Provider Eligibility Program (PEP) Descriptions (continued)

FEE-FOR-SERVICE (FFS)

The traditional delivery system of the Medical Assistance (MA) program which provides payment on a per-service basis for health care providers who render services to eligible MA recipients.

Eligibility:
All MA Recipients.

Services:

- Behavioral health services
- Inpatient services
- Outpatient services
- Physical health services

Specialty Codes for Provider Type 03

Please choose one (1) from the following list:		Required License:
030	Nursing Facility	Dept. of Health
031	County Nursing Facility	Dept. of Health
032	ICF/ID 8 Beds or Less	Dept. of Human Services
033	ICF/ID 9 Beds or More	Dept. of Human Services
037	State LTC Unit	Dept. of Health
038	State Mental Retardation Center	Dept. of Human Services
039	ICF/ORC	Dept. of Human Services
040	Special Rehabilitation Nursing Facility	Dept. of Health
042	DMVA Nursing Facilities	Dept. of Health
382	Hospital Based Nursing Facility	Dept. of Health

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PROMISe™ PROVIDER ENROLLMENT BASE APPLICATION

1. Enter Name of Facility:

_____

2. Action Request: Check Boxes that Apply:

a. ☐ Initial Enrollment

b. ☐ Revalidation

c. ☐ Check here if previously enrolled in Medical Assistance (MA).

Enter Provider Number (if known): _____**(9 digits)**
(Complete the application as an initial enrollment.)

3. National Provider Identifier Number: _ _ _ _ _ _ _ _ _ _ (10 digits)

Taxonomy(s): _ _ _ _ _ _ _ _ _ _ (10 digits) _ _ _ _ _ _ _ _ _ _ (10 digits)

Taxonomy(s): _ _ _ _ _ _ _ _ _ _ (10 digits) _ _ _ _ _ _ _ _ _ _ (10 digits)

4. Requested Effective Date:
(yyyy/mm/dd)

___ ___ _____/_____/_____

5. Federal Tax ID Number:

___ ___ _____ _____**(9 Digits)**

***A copy of a document generated by the Federal IRS with your name and IRS number must accompany this application**

6. Legal Name Shown on Attached Document: _____

_____

7. Provider Type Number and Description:

Number:_____**(2 digits)**

Description: _____

8. Specialty(s) and Code(s), if applicable:

Code Number:_____**(3 digits)**

Specialty: _____

9a. Do you intend to participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs)?

☐ Yes ☐ No

9b. If yes, list the MCO(s):

_____

_____

FOR INTERNAL USE ONLY:

MPI Legal Entity Number:_____

Reviewed by:_____***Date Completed:***_____

10a. Does the provider operate under a fictitious business/doing business as (d/b/a) name?

☐ Yes ☐ No

10b. If yes, list the Statement/Permit number and the name:

Number: _____

Name: _____

*A legible copy of the recorded/stamped fictitious business name statement/permit is required for your application to be processed.

11a. IRS Address: **Note: This is the address where your 1099 tax document will be sent.**

Street: _____ Room/Suite: _____

City: _____ State: _____ Zip: _____ - _____ **(9 digits)**

11b. Contact Name/Title:

Name: _____

Title: _____

11c. Contact E-Mail Address:

_____

11d. Phone Number:

(_____)_____

11e. Contact Toll-Free Phone:

(_____) _____

11f. Fax Number:

(_____)_____

12. Business Type: (Check 1 Box Only)

☐ Business Corporation, For Profit ☐ Not for Profit ☐ Partnership

☐ Government Owned ☐ Estate/Trust ☐ Sole Proprietorship

13a. Service Location Address: **(A POST OFFICE BOX IS NOT A VALID SERVICE LOCATION. THE ADDRESS MUST BE A PHYSICAL LOCATION.)**

Street: _____ Room/Suite: _____

City: _____ State: _____ Zip: _____ -- _____

County: _____

Business Phone: (_____)_____ Fax Number: (_____) _____

(1) Does the facility have exterior or interior steps leading to the main entrance doorway?
☐ Yes ☐ No ☐ Exterior ☐ Interior

(2) If the answer to (1) is **YES**, does the facility have a permanent or portable wheelchair ramp?
☐ Yes ☐ No ☐ Permanent ☐ Portable

(3) If the answer to (1) is **YES**, is there an alternate entrance that has no exterior or interior steps or has a wheelchair ramp?
☐ Yes ☐ No ☐ No exterior steps ☐ No interior steps
☐ Permanent ramp ☐ Portable ramp

Has the provider named in Block 1 been screened for this location within the last 12 months by:

CMS/Medicare? ☐ Yes ☐ No

Another state's Medicaid program? ☐ Yes (Complete below) ☐ No

_____ _____ _____

Screening State | Screening Contact Phone Number | Screening contact email address

Check all applicable boxes. This service location is also a: ☐ **Mail-to** ☐ **Pay-to**

If Pay-to and/or Mail-to are different from above address, refer to Blocks #19 and #20.

If you wish to utilize the Electronic Funds Transfer Direct Deposit Option please follow link for further information:
http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/electronicfundstransferdirectdepositinformation

13b. Would you like to receive E-Mail notification of new bulletins (MAB)? Yes ☐ No ☐
E-Mail address is **required if answered YES** to receive notification of MABs:

_____

By answering **NO** you are agreeing to be responsible to check for new MABs on your own by visiting the following website: http://www.dhs.state.pa.us/publications/bulletinsearch **OR** by signing up to receive notifications of new MABs through the MA Electronic Bulletins Listserv
If you wish to continue receiving paper bulletins call 1.800.537.8862 Option 1 to see if you meet the requirements.
Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 Option 1 to see if you meet the requirements.

13c. Administrator's Name: _____

d. Email Address: _____

13e. Phone Number: (_____)_____

13f. Fax Number: (_____) _____

13g. In addition to English, do you or your staff communicate with patients in another language?
Yes ☐ No ☐

13h. If "Yes", list language(s):
_____
_____

13i. Provider Eligibility Program (PEP). Refer to PEP descriptions included in the instructions. **You must choose at least one (1) PEP:**

(1)_____(2)_____ (3) _____

14. a. License Number:_____ b. Issue Date:_____ c. Expiration Date:_____

d. Issuing State:_____ e. Number of Licensed Beds: _____

***A copy of your current license is required for your application to be processed.**

15. CMS (Medicare) Certification number: _____

16. For Cost Reporting Purposes:

Fiscal Year Ending Date: ☐ June 30 ☐ December 31

Projected Resident Days for the next 12 months:_____

17. **CONFIDENTIAL INFORMATION**

Have you, any agent, or managing employee ever:

A. Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?

☐ Yes ☐ No

B. Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?

☐ Yes ☐ No

C. Had a controlled drug license withdrawn?

☐ Yes ☐ No

D. Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation?

☐ Yes ☐ No

E. In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?

☐ Yes ☐ No

F. **If you answered "Yes" to any of the questions listed above, you <u>MUST</u> provide a detailed explanation (on a separate piece of paper) and submit three (3) statements from professional associates or peer review bodies giving factual evidence of why they believe the violation(s) will not be repeated and attach it to your application. Include the following information as applicable to the situation:**

1. Name and title of individual
2. Name of federal or state health care program
3. Name of licensing/certifying agency taking the action
4. Date of action
5. Type of action taken
6. Length of action
7. Basis for action
8. Disposition/State
9. Date license was surrendered
10. Name of court
11. Date of conviction
12. Offense(s) convicted of
13. Sentence(s)
14. Categorization of offense (e.g. felony, misdemeanor)

18. This form requires the original signature of the individual representing the facility applying for enrollment.

_____ _____

Printed Name Title

_____ _____

Original Signature Date

Mail-To and/or Pay-To Information for the Service Location Entered in Block 13a

NOTE: Do not use this sheet to add service locations.

19a. **"MAIL TO" Address:**

Street:_____ Room/Suite:_____

City:_____ State:_____ Zip:_____ _-- _____

b. Contact Name/Title:

Name:_____ Title: _____

E-Mail address: _____

c. Business Phone: (_____) _____

d. Fax Number: (_____) _____

20a. **"PAY TO" Address:**

Street:_____ Room/Suite:_____

City:_____ State:_____ Zip:_____ _-- _____

b. Contact Name/Title:

Name:_____ Title: _____

E-Mail address: _____

c. Business Phone: (_____) _____

d. Fax Number: (_____) _____

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COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
OFFICE OF LONG TERM LIVING

Extended Care Nursing Facility and
Intermediate Care Facility/Intellectual Disabilities Provider Agreement

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Pennsylvania Medical Assistance Program; and

Whereas_____,
(NAME OF FACILITY)

(hereafter, the Facility), wishes to participate as a provider in the Pennsylvania Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the Facility agrees to comply with all applicable State and Federal laws, regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance Programs.

2. The submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.

3. The Facility agrees to keep records necessary to fully disclose the extent of services provided to medical assistance residents.

4. The Facility agrees to provide information, as requested, to the Department of Human Services (Department), the U.S. Department of Health and Human Services, the Medicaid Fraud Control Unit, any other authorized governmental agencies, or their agents, any information maintained under the paragraph above and to provide any additional information needed regarding payments the Facility has claimed.

5. The Facility agrees to comply with the disclosure requirements specified in 42 CFR Part 455, Subpart B (relating to Disclosure of Information by Providers and Fiscal Agents), or any amendments hereto.

6. The Facility agrees that it will submit within 35 days of the date of request by the Department or the United States Department of Health and Human Services Secretary full and complete information about the following:

    A. the ownership of any subcontractor with whom the Facility has had business transactions totaling more than $25,000 during the 12–month period ending on the date of the request; and

    B. any significant business transactions between the Facility and any wholly owned supplier, or between the Facility and any subcontractor, during the 5–year period ending on the date of the request.

7. The Facility agrees that it will allow the Centers for Medicare and Medicaid Services, its agents and its contractor and the Department to conduct unannounced on-site inspections of any and all of its locations, including locations where services are provided.

8. The Facility agrees that it will consent to criminal background checks, including fingerprinting, of individuals with an ownership interest in the Facility, and will provide to the Department any information needed for the Department to conduct a background check of the Facility and its owners.

9. The Facility agrees that upon written request from the Department it will disclose the identity of any person who has an ownership or control interest in the Facility or is an agent or managing employee of the Facility that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI (CHIP).

10. The Facility agrees that if there is any change in the ownership or control of the Facility, it will submit updated disclosure information to the Department within 35 days of the change in ownership or control of the Facility.

11. To the extent applicable, the Facility agrees to comply with the advance directive requirements for hospitals, nursing facilities, providers of home health care and personal care services and hospices as specified in 42 C.F.R. § 489, subpart I.

12. That the Facility's enrollment, when approved by the Department, will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by State or Federal officials.

13. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department; and, may be terminated by the Department immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.

14. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

The Facility represents and warrants that the person signing this agreement is a duly authorized representative of the Facility and has the authority to enter into a legal, valid, and binding obligation on behalf of the Facility.

(Provider – Original Signature) **(Chief Executive Officer/Chief Financial Officer/ Administrator)**	**(Date)**
(Name – Please Type or Print)	**(PROMIS*e*™ ID)**

Pennsylvania Provider Reimbursement and Operations Management Information System electronic (PROMISe™) Medicaid Management Information System (MMIS) is a HIPAA compliant database.

Provider Disclosure Statement Definitions

The definitions below are designed to clarify certain questions on the following Ownership and Control Disclosure Forms. The full text of the regulations governing the disclosure of information by providers and fiscal agents can be found in 42 CFR Part 455 Subpart B.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or a group of practitioners), or a fiscal agent.

Other Disclosing entity means any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

b. Any Medicare intermediary or carrier; and

c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not the share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity.

Note: The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example:

If you own 10 percent of the stock in Corporation A, which owns 80 percent of the stock of the disclosing entity, you would have an 8 percent indirect ownership interest in the disclosing entity.

If you own 20 percent of the stock in Corporation A, which owns 50 percent of the stock in Corporation B which owns 80 percent of the stock of the disclosing entity, you would have an 8 percent indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Ownership means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that:

a. Has an ownership interest totaling 5 percent or more in a disclosing entity.

b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity.

c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity.

d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.

Note: The percentage of ownership of a mortgage, deed of trust, note, or other obligation is determined by multiplying the percentage of interest owned in the obligation by the percentage of the disclosing entity's assets used to secure the obligation. For example:

If you own 10 percent of a note secured by 60 percent of the disclosing entity's assets, you would have a 6 percent interest in the disclosing entity's assets.

e. Is an officer or director of a disclosing entity that is organized as a corporation; or,

f. Is a partner in the disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means**:**

a. An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer or hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

OWNERSHIP AND CONTROL INTEREST DISCLOSURE

Note: Ownership and Control Interest information is required in accordance with the Federal Regulations at 42 CFR, Part 455.

Name of disclosing entity: _____

13-digit PROMISe™ Provider Number: _____

Contact Name (for questions on this form): _____

Contact Phone: (_____)_____-_____ Contact Email Address: _____

Section I: Managing Employee or Agent Disclosure

A. Please enter the full name, address, social security number, and date of birth of any person who is a managing employee or agent of the disclosing entity.

The following individual is a: ☐ **Managing Employee** ☐ **Agent**

Name: _____ _____ _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP) or a state health care program?

   ☐ **Yes (Provide details below)** ☐ **No**

2. Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

****COPY SECTION I A TO ADD ADDITIONAL MANAGING EMPLOYEES/AGENTS****

Section II: Ownership and Control

If the provider is organized as a corporation, partnership, estate trust or is a government entity that is organized as a corporation, complete this section.

In completing this section, an individual with at least 5% direct or indirect ownership interest includes individuals that have a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity and individuals who own an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.

INDIVIDUALS WITH AN OWNERSHIP OR CONTROL INTEREST IN THE DISCLOSING ENTITY

A. Please enter the full name, social security number, date of birth, and address of individuals with an ownership or control interest in the disclosing entity and all officers, partners, and directors.

Name: _____ _____ _____
(First Name) (Middle Name) (Last Name)

Social Security Number:_____Date of Birth: _____

Address: _____Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. a. If the individual listed above has an ownership interest in the disclosing entity, please enter the percentage and ownership type that the individual listed above has in the disclosing entity.

☐ **Direct:**_____% ☐ **Indirect:**_____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

b. If the individual listed above is an officer or director, what position does the individual hold?

☐ **President**	☐ **Chairman**	☐ **Member**
☐ **Vice President**	**Vice Chairman**	
☐ **Secretary**	**Director**	
☐ **Treasurer**	☐ **Officer**	

2. a. Is the individual listed above the spouse, parent, child, or sibling of any other individual with at least 5% direct or indirect ownership or a control interest in the disclosing entity?

☐ **Yes (Provide details below)** ☐ **No**

Name:_____ Relationship: _____
Attach separate sheet, if necessary

Section II: (cont.)

b. Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity?

☐ **Yes (Provide details below)** ☐ **No**

Name:_____ Relationship: _____

Attach separate sheet, if necessary

3. Does the individual listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

☐ **Yes (Provide details below)** ☐ **No**

Name: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

Attach separate sheet, if necessary

4. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?

☐ **Yes (Provide details below)** ☐ **No**

5. Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

****COPY SECTION II A TO ADD ADDITIONAL INDIVIDUALS****

Section II: (cont.)

CORPORATE ENTITIES WITH AN OWNERSHIP OR CONTROL INTEREST IN THE DISCLOSING ENTITY

B. Please enter the full name, tax identification number, and primary business address of corporate entities that have at least 5% direct or indirect ownership interest in the disclosing entity.

Name: _____

Federal Tax ID: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. Please enter the percentage and ownership type that the corporate entity listed above has in the disclosing entity.

☐ **Direct:**_____% ☐ **Indirect:**_____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

2. Please enter any additional business locations and PO Boxes for the corporate entity listed above.

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

Attach separate sheet, if necessary

3. Does the corporate entity listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

☐ **Yes (Provide details below)** ☐ **No**

Name: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

Attach separate sheet, if necessary

****COPY SECTION II B TO ADD ADDITIONAL CORPORATE ENTITIES****

Section II: (cont.)

OWNERSHIP OR CONTROL INTEREST IN SUBCONTRACTORS

C. Please enter the full name, date of birth, and address of each person with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

Name: _____ _____ _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. a. Name of Subcontractor: _____

   Federal Tax ID of Subcontractor: _____

   b. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

   ☐ **Direct:**_____% ☐ **Indirect:**_____% _____
   (Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

   c. Please enter the percentage and ownership type that the individual listed above has in the subcontractor.

   ☐ **Direct:**_____% ☐ **Indirect:**_____% _____
   (Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

   d. Is the individual listed above the spouse, parent, child, or sibling of any other individuals with at least 5% direct or indirect ownership or control interest in the disclosing entity?

   ☐ **Yes (Provide details below)** ☐ **No**

   Name: _____ Relationship: _____

   e. Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity?

   ☐ **Yes (Provide details below)** ☐ **No**

   Name: _____ Relationship: _____

   f. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?

   ☐ **Yes (Provide details below)** ☐ **No**

Section II: (cont.)

g. Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

****COPY SECTION II C TO ADD ADDITIONAL INDIVIDUALS****

D. Please enter the full name, tax identification number, and primary business address of any corporate entity with an ownership or control interest in any subcontractor which the disclosing entity has a direct or indirect ownership interest of 5% or more.

Name: _____

Federal Tax ID: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. a. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

☐ **Direct:**_____% ☐ **Indirect:**_____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

b. Please enter the percentage and ownership type that the corporate entity listed above has in the subcontractor.

☐ **Direct:**_____% ☐ **Indirect:**_____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

****COPY SECTION II D TO ADD ADDITIONAL CORPORATE ENTITIES****

Section II: (cont.)

E. Please enter the full name, tax identification number, and primary business address of all subcontractors in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

1. a. Name of Subcontractor: _____

   Federal Tax ID of Subcontractor: _____

   b. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

   ☐ **Direct:**_____% ☐ **Indirect:**_____% _____
   (Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

****COPY SECTION II E TO ADD ADDITIONAL SUBCONTRACTORS OF THE DISCLOSING ENTITY****

OWNERSHIP OR CONTROL INTEREST IN OTHER ENTITIES

F. Does the disclosing entity have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

☐ **Yes (Provide details below)** ☐ **No**

Name: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

****COPY SECTION II F TO ADD ADDITIONAL ENTITIES****

SIGNIFICANT BUSINESS TRANSACTIONS

G. Has the disclosing entity had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period?

☐ **Yes (Provide details below)** ☐ **No**

Name of Supplier/Subcontractor: _____

Social Security Number or Federal Tax ID:_____ Date of Birth: _____
(Individuals only)

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

****COPY SECTION II G TO ADD ADDITIONAL SIGNIFICANT BUSINESS TRANSACTIONS****

Section III: Non-Profit Organization Disclosure (Not Organized as a Corporation)

If the disclosing entity is a non-profit organized as a corporation, please complete Section II

A. Please enter the full name, address, social security number, and date of birth of any person who is a director (board member) or officer of the disclosing entity.

Name: _____ _____ _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

1. What position is held by the individual listed above?

☐ **President**	☐ **Chairman**	☐ **Member**
☐ **Vice President**	**Vice Chairman**	
☐ **Secretary**	**Director**	
☐ **Treasurer**	☐ **Officer**	

2. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XX (CHIP), or a state health care program?

3. ☐ **Yes (Provide details below)** ☐ **No**

Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

****COPY SECTION III TO ADD ADDITIONAL INDIVIDUALS****

The following checklist contains the most common reasons Pennsylvania Medicaid Program enrollment applications are returned. Please complete this checklist and submit it with your application. Incomplete applications will be returned.

Please remember applications will be scanned - do not staple.

Did you remember to….

- ❑ USE BLACK INK or TYPEWRITE. Application must be typed or printed in black ink.
- ❑ **Complete all spaces** as required on the application with either your correct information or N/A.
- ❑ Complete the **Provider Ownership and Control Interest Disclosure form** included with the application
- ❑ Ensure that you have entered the **correct number of digits** where specified.
- ❑ Indicate provider type and provider specialty(s), as applicable.
- ❑ Include **documentation generated by the Federal IRS** showing the name and number associated with the FEIN. Remember, a **W-9 is not permissible**.
- ❑ Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.
- ❑ Include a copy of your Department of Health license or Department of Human Services Certificate of Compliance, whichever is applicable.
- ❑ Include a legible copy of the **NPPES Confirmation letter** that shows the NPI Number and Taxonomy(s) assigned to the entity applying for enrollment.
- ❑ Enter at least one (1) Provider Eligibility Program (PEP).
- ❑ **Only the representative of the facility applying for enrollment can sign and date the Confidential Information Sheet and the OLTL provider agreements. Signature stamp is not accepted.**

Then return your application and other documentation to the following address:

OLTL / BQPM
Attention: Provider Enrollment
PO Box 8025
Harrisburg, PA 17105-8025