INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISe™ PROVIDER ENROLLMENT BASE APPLICATION

Applications must be typed or completed in black ink, or they will not be accepted.

Note: Out-of-State providers must submit proof of participation in your State's Medicaid Program.

1. Enter the complete name of the individual or facility.

2a. Check the appropriate boxes for the action(s) you request.

2b. If you are reactivating a provider number, indicate the PROMISe™ **13 digit** provider number you wish to have reactivated and complete the application as an initial enrollment.

2c. If this is a name change, indicate the old name and the new name. **To verify your updated name, a copy of a document generated by the Federal IRS listing your name and SSN or FEIN must accompany your application. (i.e. SSN, W-2 or tax label).**

2d. If this is a change of ownership with no change in the IRS number, complete the "Ownership or Control Interest" sheet.

2e. If you are adding a provider to an existing group, enter the PROMISe™ 13 digit group provider number. The 4-digit service location code must correspond with a valid active street address. **We will not assign fees to a service location listed as a P.O. Box.**
•Fee assignments may only be made between "like provider types". Call the Enrollment Hotline for verification at 1-800-537-8862 prompt 1.

3. **Enter your National Provider Identifier (NPI) Number and taxonomy(s). If you have more than 4 taxonomy codes, please attach an additional sheet noting the additional codes. 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.**

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

5. Enter your provider type number and description (e.g., provider type 31, Physician).

6. Enter your specialty name and code number. **See the requirements for your provider type**.

7. Enter your sub-specialty name(s) and code number(s), if applicable. **See the requirements for your provider type**.

8. Enter your Social Security Number**. A copy of your Social Security card, W-2, or document generated by the Federal IRS containing your Social Security Number must accompany your application. If completing #8, do not complete #9. Refer to checklist for additional requirements.**

9. Enter your Tax Identification Number (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. If completing #9, do not complete #8.**

10. Enter your legal name as it is filed with the IRS and as it appears on the IRS documentation.

11a. Indicate whether or not you participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs).

11b. Enter the names of any Pennsylvania Medicaid Managed Care Organizations with which you participate.

12a. Indicate whether the provider operates under a fictitious business/doing-business as (d/b/a) name.

12b. If applicable, enter the statement/permit number and the name. **Attach a legible copy of the recorded/stamped fictitious business name statement/permit.**

13. Enter your date of birth.

14. Enter your gender.

15. Enter the title/degree you currently hold.

16a. Enter your legal entity address. The address must be a physical location where you want to have tax documents sent**. A post office box is not a valid legal entity address. The zip code must contain 9 digits.**

16b-f. Enter the contact information for the legal entity address.

17. Check the appropriate box for the business type of the individual or facility applying for enrollment. Check 1 box only. Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.

18. Enter your license number (if applicable), issuing state, issue date, and expiration date.
*__A copy of your license must be included with the application.__

19. Enter your Drug Enforcement Agency (DEA) Number (if applicable).
__* A copy of your DEA certificate must be included with the application.__

20a. Enter a valid service location address. **The address must be a physical location, not a post office box. The zip code must contain 9 digits. See block # 23 of the application to list an additional address (es) for Pay-to, Mail-to, and/or Home Office locations if different from the Service Location address entered in Block 20a.**

20b-c. Answer questions and enter your E-Mail address, if applicable.

20d. Enter the Medicare number(s) assigned from Medicare specifically to the individual or facility applying for enrollment. Do not use Medicare numbers assigned to other entities. **Please provide a letter from CMS documenting the assignment of the number(s) to the individual or entity applying for enrollment.**

20e-h. Enter contact information.

20i. Indicate whether you or your staff is able to communicate with patients in any language other than English.

20j. If applicable, list the additional languages in which you or your staff can communicate.

20k. Answer questions 1 through 4 pertaining to the Americans with Disabilities Act (ADA).

20l. Enter the appropriate Provider Eligibility Program(s) (PEP(s)). **See the PEP Descriptions and the requirements for your provider type (included in the instructions).**

21a-e. The individual applying for enrollment OR 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, provide a detailed explanation (on a separate piece of paper) and attach it to your application.

21f. Include responses to 21f, 1 to 14, if you answered YES to any of the questions in 20A-E.

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

23. Block #23 of the application may be used to add a mail-to, pay-to, and/or home office address to the **previously defined** service location address listed in 20a. **This sheet cannot be used to add a service location.**

23a. Enter the corresponding mail-to, pay-to, and/or home office address for the service location.

23b. Indicate whether you are adding a mail-to, pay-to, and/or home office address.

23c. Enter the e-mail address of the contact person for this address.

23d-g. Enter the contact information for this address.

- **Entities other than initial individual enrollments must complete a new base application to add additional service locations to their file.**

- **The individual applying for enrollment or a representative of the entity applying for enrollment must complete the Provider Agreement included with the application.**

When completed, review the "Did You Remember…" Checklist included with the application. Then return your application and other documentation to the address listed on the requirements for your specific provider type.

Mail application to your local Area Agency on Aging

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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 consumers of that program. Providers should use the following PEP codes when enrolling in PROMIS*e*™ and should use the descriptions in this document to determine which PEP code to use when enrolling in PROMIS*e*™.

AIDS Waiver

Providers may enroll in the AIDS waiver to provide home- and community-based services to individuals 21 and older with AIDS or Symptomatic HIV Disease. Services provided are Home Health care, Homemaker, Nutritional Consultation and Supplements and Specialized Medical Equipment and Supplies. Providers in non-mandatory Managed Care Counties must be approved by the Waiver Implementation Unit of the Bureau of Long-Term Care Programs in the Office of Medical Assistance. Providers in mandatory Managed Care Counties should apply to be a provider with the Managed Care entity in their area. **Contact Number: (717) 772-2525**

Attendant Care Waiver

Services provided through the Attendant Care Waiver include:

- Attendant Care (Agency and Consumer Model), such as:
  - Assisting a person to get in and out of bed, wheelchair and/or motor vehicles
  - Assisting a person to perform routine bodily functions
  - Homemaker type services, such as shopping, laundry, cleaning, and seasonal chores
  - Companion-type services, including assistance with transportation, letter writing, reading mail, and escort
  - Assistance with cognitive tasks including managing finances, planning activities, and making decisions
- Personal Emergency Response System (Installation and Maintenance)
- Service Coordination

Contact Number: (717) 772-2525 OMR Customer Service: 1-888-565-9435

COMMCARE Waiver

Services provided through the COMMCARE Waiver include:

- Respite (Consumer or Agency Model)
- Prevocational Services
- Educational Services
- Supported Employment
- Community Integration
- Environmental Adaptations
- Part-Time Nursing (RN or LPN)
- Transportation
- Assistive Tech/Specialized Medical Equipment Supplies
- Personal Emergency Response System (Installation and Maintenance)
- Personal Care Services (Consumer or Agency Model)
- Habilitation and Support
- Structured Day Program
- Chore Services
- Coaching/Cueing (Consumer and Agency Model)
- Night Supervision (Consumer and Agency Model)
- Counseling
- Behavioral Specialist Consultant
- Cognitive Therapy
- Extended State plan services: Speech, Occupational, and Physical Therapy
- Supports Coordination

Contact Number: (800) 757-5042

Consolidated Waiver

Home and Community-Based program developed for Pennsylvania residents age 3 and older with a medically determined diagnosis of mental retardation. The Consolidated Waiver is designed to provide services to eligible persons with mental retardation so that they can remain in the community.

Elwyn Waiver

Providers may enroll in the Elwyn Waiver if they would like to provide home- and community-based services to Nursing Facility Clinically Eligible individuals who are 40 and over; reside in Delaware County and who are deaf or deaf and blind. At the present time all consumers in this waiver reside in Valley View Assisted Living on the campus of Elwyn Institute. Assisted Living Services is the only service in this waiver. A provider of this service must be able to successfully demonstrate sign language proficiency or be a native user of American Sign Language as a primary language, or provide interpretive/communication facilitation services when interacting with residents and staff who utilize American Sign Language as a primary language. All providers in this waiver must be approved by the Delaware County Area Agency on Aging. **Contact Number: (717) 772-2525 OMR Customer Service: 1-888-565-9435**

Fee-for-Service (FFS)

A comprehensive set of Medical Assistance services which include reimbursement for direct inpatient and outpatient, physical health, and behavioral health services to consumers through components of the Medical Assistance Program. If you are trying to provide services under the Managed Care and/or FFS programs, you should select the FFS PEP. **Contact Number: (717) 772-6150**

If you are requesting enrollment to be a provider of a HealthChoices Supplemental Service(s) for Behavioral Health, contact the BH-MCO with which you will be doing business as this application is not applicable.

Healthy Beginnings Plus (HBP)

Healthy Beginnings Plus (HBP) is Pennsylvania's effort to assist low-income pregnant women, who are eligible for Medical Assistance, to have a positive prenatal care experience. HBP expands the scope of maternity services that can be reimbursed by the Medical Assistance Program. Care coordination, early intervention, and continuity of care as well as medical/obstetric care are important features of the HBP program. Services covered by HBP include childbirth and parenting classes, nutritional and psychosocial counseling, smoking cessation counseling, home health services and other individualized client services. **Contact Number: (717) 772-6300**

Independence Waiver

Services provided through the Independence Waiver include:

- Daily Living Services
- Respite Care
- Educational Services
- Community Integration
- Environmental Adaptations
- Transportation Services
- Personal Emergency Response System (Installation and Maintenance)
- Service Coordination
- Visiting nurses (RN and LPN)
- Occupational, Speech, Physical, and Behavioral Therapy
- Assistive Technology/Specialized Medical Equipment

Contact Number: (717) 783-3173

Long-Term Care Capitation (LTCCap)

Providers should enroll as a provider under the Long-Term Care Capitated Assistance Program (LTCCAP) if they plan to provide long-term care services to Nursing Facility Clinically Eligible (NFCE) individuals age 55 or over. All providers in this PEP must be approved by the Division of LTC Client Services and have an existing agreement with the Department to provide services under the national Program of All-inclusive Care for the Elderly (PACE) model under either federal PACE provider status or under Prepaid Health Plan Authority. The goal is to maintain individuals in the community, but services are also provided in institutional settings when appropriate. Providers manage and provide an all-inclusive package of services to enrolled recipients and are reimbursed a monthly capitation payment for services provided. **Contact Number: (717) 772-2525**

Medical Assistance Transportation Program (MATP)

The MATP program provides transportation for Medical Assistance (MA) consumers who do not have other transportation available to them. Transportation services are provided through the County and are available for almost any medical service paid for by MA. The Counties may either provide transportation services directly or hire a transportation provider to provide the services.

Mental Retardation Base Program (MR Base Program)

The MR Base Program is an Office of Mental Retardation program that is designed for Pennsylvania residents of any age who have a medically determined diagnosis of mental retardation.

Michael Dallas Waiver (MDW)

Providers may enroll in the Michael Dallas waiver if they would like to provide home- and community-based services to individuals of all ages who are technology-dependent (i.e. require technology to sustain life or replace a vital bodily function). Services provided are Attendant Care, Case Management, Durable Medical Equipment, Private Duty Nursing and Respite Care. All providers of private duty nursing and respite care must be certified by the Department of Health as well as Medicare certified. All providers must be approved by the Waiver Implementation Unit of the Bureau of Long-Term Care Programs in the Office of Medical Assistance. **Contact Number: (717) 772-2525**

OBRA Waiver

Services provided through the OBRA Waiver include:

- Daily Living Services (Consumer or Agency Model or Clustered Shared Living Arrangement)
- Respite Care (Consumer or Agency Model or Clustered Shared Living Arrangement)
- Adult Day Services
- Prevocational Services
- Educational Services
- Supported Employment Services
- Community Integration
- Physical, Occupational, Speech, and Behavioral Therapy
- Personal Emergency Response System (Installation and Maintenance)
- Assistive Technology/Specialized Medical Equipment
- Transportation Services
- Visiting Nurses (RN and LPN)
- Environmental Adaptations
- Service Coordination

Contact Number: (717) 783-3173

PDA Waiver/Bridge Program

Providers should enroll in the PDA Waiver/Bridge Program PEP if they would like to provide home- and community-based services to Nursing Facility Clinically Eligible (NFCE) individuals age 60 or over. All providers in this PEP must be approved by the Area Agency on Aging (AAA) serving the county in which they would like to provide services. Services provided in this PEP are personal care, respite, transportation, adult day care, durable medical equipment (DME) and supplies, environmental modifications, home health care, home delivered meals, personal emergency response services, counseling, and personal assistance services (attendant care). **Contact Number: (717) 772-2525**

Person/family Directed Support Waiver (Per/Family Services)

The Person/Family Directed Support Waiver is a Home and Community-Based waiver program that is designed for Pennsylvania residents age 3 and older with a medically determined diagnosis of Mental Retardation. This waiver is designed to prevent the institutionalization of individuals with mental retardation who do not require Office of Mental Retardation licensed community residential services and allows these individuals to remain in the community. **OMR Customer Service- 1-888-565-9435**

Physical Health HealthChoices (Phys Health HC)

This program was created to allow providers that would normally not be eligible to provide physical health services through the Fee for Service program to participate with the Managed Care Organizations.

- Providers with this PEP can only participate with the Managed Care Organizations and render physical health services to MA recipients enrolled in the Managed Care program.
- This PEP cannot be active during the same period as any PEP other than Behavioral Health HealthChoices.

Physical Health Managed Care (PHMC)

An assignment of PHMC indicates enrollment in the Pennsylvania Medical Assistance Program that identifies a capitated Managed Care Organization, which contract with the Commonwealth to manage Physical Health Services.
Contact Number: (717) 772-6300

ATTENTION OMR PROVIDERS: Fax completed application to ODP @ 717-783-5141 or mail to: Office of Mental Retardation Room 413 Health and Welfare Building Harrisburg, PA 17101 Attn: Provider Enrollment

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PROMISe™ PROVIDER ENROLLMENT BASE APPLICATION

1. Enter Name of Enrollee:
   Facility: _____
or
   Last Name: _____First: _____MI: _____

2. Action Request: Check Boxes that Apply:

a. ☐ Initial Enrollment: ☐ Individual ☐ Facility
b. ☐ Reactivate Provider Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **(13 digits)**
(Complete the application as an initial enrollment.)
c. ☐ Name Change: (Name change only. Must match IRS generated documentation.)
Old Name: _____
New Name: _____
d. ☐ Change of Ownership
☐ No Change in IRS number (Complete the "Ownership or Control Interest" form.)
☐ Change in IRS Number (Complete the application as an initial enrollment.)
e. ☐ Fee Assignment — Add this provider to existing provider group. Specify group provider number:
___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (**Must be a 13 digit number to be processed**).

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

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

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

4. Requested Effective Date:
ccyy / m m / d d – (2004/07/31)

_ _ _ _/_ _/_ _

5. Provider Type Number and Description:

Number: ___ ___ **(2 digits)**

Description: _____

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

Specialty: _____

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

7. Sub-Specialty(s) and Code(s), if applicable:

Sub-Specialty(s): _____

Code Number(s): ___ ___ ___ / ___ ___ ___ **(3 digits)**

8. Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___
*** A copy of a document generated by the Federal IRS with your name and SSN must accompany this application.**

9. Federal Tax ID Number: **(If #8 is completed, DO NOT** complete this item.)
___ ___ ___ ___ ___ ___ ___ ___ ___ **(9 digits)**
***A copy of a document generated by the Federal IRS with your name and IRS number must accompany this application.**

10. Legal Name Shown on Attached Document:

For Internal Use Only: MPI Legal Entity Number: _____ Service Location Code: _____

11a. Do you intend to participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs)?

☐ Yes ☐ No

11b. If so, list the MCO(s):

_____

_____

12a. Does the provider operate under a fictitious business/doing business as (d/b/a) name?

☐ Yes ☐ No

12b. 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.**

13. Date of Birth: c c y y / m m / dd (2004/07/31)

__ __ __ __ /__ __ /__ __

14. Gender: Male ☐ Female ☐

15. Title/Degree as it appears on license:

16a. Legal Entity Address: **(A POST OFFICE BOX IS NOT A VALID LEGAL ENTITY ADDRESS. THE ADDRESS MUST BE A PHYSICAL LOCATION).**

Street: _____ Room/Suite:_____

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

County:_____

16b. Contact Name/Title:

Name: _____

Title: _____

16c. E-Mail Address:

16d. Business Phone: ( )

16e. Toll-Free Phone: ( )

16f. Fax Number: ( )

17. Business Type: (Check **1** Box Only)

☐ Business Corporation, For Profit ☐ Not For Profit ☐ Sole Proprietorship
☐ State/Trust ☐ Partnership ☐ Chain
☐ Government Owned ☐ Public Service Corporation

18.

a. License Number: _____ b. Issuing State:_____

c. Issue Date: _____ d. Expiration Date: _____

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

19. Drug Enforcement Agency (DEA) Number: _____

***If you have a DEA number, a copy of your DEA certificate is required for your application to be processed.**

20a. 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:_ _ _ _ _-_ _ _ _ **(9 digits)** County: _____

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

*** If Pay-to, Mail-to, and/or Home Office are different from above address, see block #23.**

20b. If you are assigning fees to a group on page 1 block 2e, please do not complete this section as the group will receive the bulletin notification.

Do you wish to receive bulletin notification on-line through PROMISe and eliminate receipt of paper bulletins? ☐ Yes ☐ No

E-Mail address to receive notification of MA bulletins: _____

Do you wish to receive paper bulletins via US mail? ☐ Yes ☐ No *If no, please see instructions.

20c**.** Once enrolled, you can retrieve RAs from PROMISe™ online.

Do you wish to: Access RAs on-line through PROMISe and eliminate receipt of paper RAs? ☐ Yes ☐ No

Receive Paper RAs via US Mail? ☐ Yes ☐ No

*Paper RAs will be sent to the pay-to address for this service location.

20d. Medicare Number(s) for this Service Location: Medicare A: _____ Medicare B: _____

Railroad: _____ DMERC: _____

*** See instructions regarding required documentation**.

20e. Contact Name: _____ Business Phone: _____

Title: _____

20f. Toll-Free Phone: ( )	20g. Fax Number: ( )	20h. E-Mail address:

20i. In addition to English do you or your staff communicate with patients in another language?
Yes ☐ No ☐

20j. If "Yes", list language(s):

_____ _____

20k. (1) Does the office 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 office 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 ☐

(4) Does the office have an official exemption from the U.S. Department of Justice excusing compliance with Title III of the Americans with Disabilities ACT (ADA)? If yes, attach a copy of the exemption to your application.
Yes ☐ No ☐

20l. Provider Eligibility Program (PEP). Refer to PEP descriptions and requirements (included with instructions)

You must choose at least 1 PEP:

a. _____ b. _____ c. _____

21. **CONFIDENTIAL INFORMATION**

Have you or any director, officer, manager, consultant, agent, employee, or volunteer of your organization/facility:

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

21F

If you answered "Yes" to any of the questions listed above, 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)

22. This form requires the original signature of the individual applying for enrollment.

_____ _____

Title Printed Name

_____ _____

Original Signature Date

Mail-To/Pay-To/Home Office Information For The Service Location Entered In 20a

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

23 a. **Address:** Street Suite/Box City State Zip **(9-digits)** County

b. This address is a: ☐ Mail-to ☐ Pay-to ☐ Home Office	c. E-Mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone: ( )	f. Toll-Free Phone ( )	g. Fax Number:

a. **Address:** Street Suite/Box City State Zip (**9-digits)** County

b. This address is a: ☐ Mail-to ☐ Pay-to ☐ Home Office	c. E-Mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone: ( )	f. Toll-Free Phone ( )	g. Fax Number:

a. **Address:** Street Suite/Box City State Zip **(9-digits)** County

b. This address is a: ☐ Mail-to ☐ Pay-to ☐ Home Office	c. E-Mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone: ( )	f. Toll-Free Phone ( )	g. Fax Number:

OWNERSHIP OR CONTROL INTEREST

Note: Ownership information is required in accordance with Federal Regulations 42 CFR, Part 455, published July 17, 1979.

Please enter the full name and address of partners, stockholders, corporate owners, or officers that have at least 5% direct or indirect ownership interest.

Name: (First)	**(Middle)**	**(Last)**	**SSN:**
Street Address:			
City:	**State:**		**Zip Code:**
Name: (First)	**(Middle)**	**(Last)**	**SSN:**
Street Address:			
City:	**State:**		**Zip Code:**

****ATTACH ADDITIONAL SHEETS IF NECESSARY****

DO YOU HAVE A CONTROLLING INEREST IN, OR OWN OTHER PROVIDERS OF SERVICES? If "YES", list the name and address of each provider. □ Yes □ No

Name: (First)	**(Middle)**	**(Last)**	**SSN:**
Street Address:			
City:	**State:**		**Zip Code:**
Name: (First)	**(Middle)**	**(Last)**	**SSN:**
Street Address:			
City:	**State:**		**Zip Code:**
Name: (First)	**(Middle)**	**(Last)**	**SSN:**
Street Address:			
City:	**State:**		**Zip Code:**

Provider Enrollment Base Application Checklist

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.

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.

Ensure that you have entered the **correct number of digits** where specified.

If you have more than 4 taxonomy codes, please attach a separate sheet listing the additional codes.

Indicate ***one*** **primary** provider type, provider specialty and sub-specialty(s), as applicable.

Include a copy of your **Social Security card, W-2 or any document generated by the Federal IRS** showing your name and SS number. If the Social Security card states "Valid for work only with INS authorization", please submit the paperwork generated by with the INS or Department of Homeland Security that shows proof of authorization to work in the United States.

Include **documentation generated by the Federal IRS** showing the name of the entity and the FEIN associated with it. 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.

If applicable, **include a copy** of your:

- Professional license
- CLIA certificate
- Mammography certificate, including the list of mammography certified members and their PROMISe™ 13 digit provider numbers
- Permit from the Department of Health
- Any other certification, license, or permit that applies.

Include a legible copy of your **DEA certificate**, if 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.

Include a **letter from Medicare** showing the assignment of the Medicare number(s) to the entity applying for enrollment.

Enter **at least 1** Provider Eligibility Program (PEP).

Only **a representative of the entity applying for enrollment** can sign and date the **Confidential Information Sheet and Provider Agreement. Signature stamp not accepted.**

When completed, return your application and other documentation to your local Area Agency on Aging.

OFFICE OF MEDICAL ASSISTANCE PROGRAMS

BUREAU OF LTC PROVIDER SERVICES

PDA WAIVER PROGRAM ENROLLMENT FORM

The following forms must be completed for enrollment in the Long Term Care PDA Waiver Program:

a. Pennsylvania Medicaid Program Provider Enrollment Base Application (PEBA)
b. PDA Waiver Addendum
c. Provider Agreement for PDA Waiver Services

Addendum Instructions:

1. If applicable, include the specified information for anyone with at least a 5% direct or indirect ownership interest. This is required by Federal Regulation 42 C.F.R. Part 455, published July 17, 1979. Attach a separate sheet if needed.

2. Indicate if you have a controlling interest in or own other providers of Medical Assistance Services and complete the name and address blanks if applicable.

3. Indicate the counties for which you are available to provide services. Attach a separate sheet if needed.

4. A copy of the FEIN letter and/or label from the IRS must be included with the enrollment application. **W-9 Forms are unacceptable.**

5. Sign and return the Provider Agreement. Original signatures are required.

Submittal Address:

When completed, return all forms to your local Area on Aging.

PDA Waiver Addendum

1. Ownership or controlling interest: Enter full name and address of partners, stockholders, corporate owners or officers that have at least a 5% direct or indirect ownership interest.

Name	Address	SSN

2. Do you have controlling interest in or own other providers of Medical Assistance services?

☐ Yes ☐ No

If yes, list name and address of each provider. Attach another sheet if necessary.

Name	Address

3. Indicate the counties in which you will be available to provide services. Please specify any restrictions within each county.

COUNTY	RESTRICTIONS

AAA APPROVAL REQUIRED BELOW:

(Approval Name)	(Approval's Signature)
(Approval Phone Number)	(Date)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

PROVIDER AGREEMENT FOR PDA WAIVER SERVICES

1. This is to certify that _____
(Provider's Name)

agrees to participate as a provider in the Pennsylvania Medical Assistance Program on the following terms:

2. The provider shall comply with all applicable State and Federal laws, regulations, and policies, which pertain to participation in the Pennsylvania Medical Assistance Program.

3. Specifically, and without limitations, the provider shall:

   A. Keep any records necessary to disclose the extent of services the provider furnishes to recipients;

   B. Upon request, furnish to the Department Of Public Welfare, the United State Department of Health and Human Services, the Medicaid Fraud Control Unit any other authorized governmental agencies, and the designee of any of the foregoing, any information maintained under paragraph (A) above and any information regarding payments claimed by the provider for furnishing services under the Pennsylvania Medical Assistance Program; and

   C. Comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B (relating to Disclosure of Information by Provider and Fiscal Agents), or any amendments thereto.

4. This agreement shall continue in effect unless and until it is terminated by either the provider or the Department. Either the provider or the Department may terminate this agreement, without cause, upon thirty (30) days prior written notice to the other. The provider's participation in the Pennsylvania Medical Assistance Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State laws and regulations.

PROVIDER

By: _____ _____
Original Signature Date

_____
(Type or Print Name)

01/07/09