Managed Long-Term Care (MLTC) Medicaid

Please complete the form in its entirety. If a field/section does not apply, write "N/A". Attach additional information on separate sheets as needed.

The completed form can be submitted:

- Online: https://nascentiahealth.org/managed-long-term-care-plan/provider-information/service-provider-application/
- Email: providerrelations@nascentiahealth.org
- Fax: (315) 671-5129
- Mail: Nascentia Health Options
  Attn: Provider Relations Department
  1050 West Genesee Street
  Syracuse, NY 13204-2215

Questions: Call (315) 477-9820

Service Provider Application

General Information

Legal Provider Name:					
Street Address:					
City:		State:		Zip Code:	
Phone:	( )	Fax (for authorizations):		( )	
Billing Address:					
City:		State:		Zip Code:	
Phone:	( )	Fax (for authorizations):		( )	
Tax ID (EIN) #:					
Medicaid Provider Number:					
Medicare Certification:	☐	Yes	☐	No	☐ N/A
Medicare Provider Number:		NPI #:			
Electronic Visit Verification Software (*required for FI and Home Care providers*):					

If your facility has more than one NPI #, please list the NPI # and the facility name below:			
NPI #:		Facility Name:	
NPI #:		Facility Name:	
NPI #:		Facility Name:	
License/Facility Operating Certificate#:			

Parent Company Information (if applicable):					
Parent Company:					
Street Address:					
City:		State:		Zip Code:	
Primary Contact Person:		Contact Person Title:			
Contact Person Phone:	( )	Contact Person Email:			

Location Information

Please indicate counties serviced by main address location:

Address and Phone Number of Branch or Satellite Offices (with counties serviced):	
1.	
2.	

3.	
4.	
5.	

Operating Hours: Please list hours (a.m. and p.m.)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours:							

Contact Information (include name, title, phone and email):

Compliance:	
Contracts:	
Credentialing:	
Scheduling:	
Billing:	

If your facility uses a third-party billing agency, please provide the legal name and address below:

Billing Format and Forms Used: (i.e. UB-92, HCFA-1500)	

Select all items applicable to your location:

☐	Public Transportation Accessibility		
☐	Wheelchair Accessible		
☐	Foreign Languages Spoken	If selected, list languages:	
☐	American Sign Language		
☐	Network Hearing System (TDD)		
☐	Elevator		
☐	Vision Accessible		
☐	Other	If selected, list “Other Services” offered:	

******THE FULLY EXECUTED CONTRACT WILL BE MAILED BACK TO THE PERSON WHO SIGNED IT. IF YOU WISH FOR IT TO BE MAILED TO A DIFFERENT PERSON/ADDRESS PLEASE LIST BELOW******

Name:	
Street Address:	

City:		State:		Zip Code:	

Service Provider Applications:

Please select what type of service provider(s) you are applying for:	
☐	Adult Day Care (page 6)
☐	Certified Home Care Agency (CHHA) / Licensed Home Care Services Agency (LHCSA) (pages 7-10)
☐	Consumer-Directed Personal Aid (FI) (pages 11-12)
☐	Durable Medical Equipment / Personal Emergency Response System (pages 13-14)
☐	Home and Safety Modification (page 15)
☐	Licensed / Certified Professional Services (pages 16-17)
☐	Meals Provider (page 18)
☐	Skilled Nursing Facility (SNF) (pages 19-20)
☐	Transportation Provider (page 21)

Complete the required sections for each service provider you are applying for.

The page number for the required sections for each service provider is listed in the table above.

After completing pages 1-4 and the necessary Service Provider Applications REMEMBER TO COMPLETE the Attestation, Credentialing Attestation and Release Form and Certification / Affirmation of Accuracy and Completeness on pages 22-24.

Adult Day Care:

Please attach the following documents:

- Business Associates Agreement (Social adult day only)
    - Nascentia will send for review and signature along with finalized contract
- EIN, Medicaid Provider Number & NPI number (provide information in this form; Medicaid Provider Number and NPI *not* required for Adult Social Day Care)
- W-9 with legal name and remit address
- Proof of OMIG Certification (Social adult day only)
- Proof of adequate insurance coverage
    - Commercial General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204 listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Note:

- Provider Compliance Certification **is required** for Adult Medical Day Care Providers, but is **not applicable** to Adult Social Day Care providers (Attestation section to be completed on page 22).
- BE ADVISED: Before contract may be executed with an Adult Social Day Care an in-person site inspection visit must be completed. Your regional Provider Relations Representative will request to schedule one upon receipt of all necessary credentialing documentation listed above.

Adult Day Care Services offered (Check all that apply):

☐	Adult Medical Day Care – Full Day
☐	Adult Medical Day Care – Half Day
☐	Adult Social Day Care – Full Day
☐	Adult Social Day Care – Half Day
☐	Meals Included
☐	Day Care Transportation – Taxi
☐	Day Care Transportation – Wheelchair

Certified Home Care Agency (CHHA) /

Licensed Home Care Services Agency (LHCSA):

Please attach the following documents:

- Valid state license(s) or operating certificate(s)
- JCAHO accreditation report (if applicable)
- Most recent NYSDOH State Survey & Plan of Correction
- EIN, Medicaid Provider Number, NPI number and Electronic Visit Verification (EVV) Software (provide information on page 1 of this form)
- W-9 with legal name and remit address
- Copy of patient satisfaction survey
- FLSA Attestation Form (complete form(s) on pages 9 and/or 10 and sign)
- Proof of adequate insurance coverage
    - Commercial General Liability, Professional Liability and Transportation (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Note:

- Provider Compliance Certification **is required** for Certified Home Health Agency (CHHA) / Licensed Home Care Services Agency (LHSCA) providers (Attestation section to be completed on page 22).

JCAHO Accreditation:	☐	Yes	☐	No	☐	N/A
CARF Accreditation:	☐	Yes	☐	No	☐	N/A

Home Health Care Agency Services offered (Check all that apply):				
Certified	Licensed			
☐	☐	Home Health Aide		
☐	☐	Housekeeping (Personal Care Aide, Level I)		
☐	☐	Personal Care Aide, Level II		
☐	☐	Medical Social Work		
☐	☐	Medication Dispensing Services		
☐	☐	Nutritional Counseling		
☐	☐	Nursing, in home (LPN, RN)		
☐	☐	Occupational Therapy		
☐	☐	Physical Therapy		
☐	☐	Speech Therapy		
☐	☐	Personal Emergency Response Systems (PERS) – Landline		
☐	☐	Personal Emergency Response Systems (PERS) – Cellular		
☐	☐	Personal Emergency Response Systems (PERS) – GPS		
☐	☐	Personal Emergency Response Systems (PERS) – Fall Detection		
☐	☐	PRI & Screen Assessment Services		
☐	☐	Private Duty Nursing, LPN		
☐	☐	Private Duty Nursing, RN		
☐	☐	Respiratory Therapy		
☐	☐	Telehealth Services		
☐	☐	UAS Assessment Services		
☐	☐	Wound Care		
☐		Other Certified Home Health Services	If selected, list “Other Certified Home Health Services”:	
	☐	Other Licensed Home Health Services	If selected, list “Other Licensed Home Health Services”:	

NEW YORK STATE DEPARTMENT OF HEALTH OFFICE OF HEALTH INSURANCE PROGRAMS

CERTIFIED HOME HEALTH AGENCY

Attestation of Compliance with Fair Labor Standards Act (FLSA) Funding

I hereby certify that funding for all Medicaid home care services provided by my organization in accordance with the Department's April 2017 Dear Colleague Letter on FLSA Implementation, will be passed through to the home care worker, in its entirety. I further certify that I will maintain all records necessary to verify compliance with this directive (including required licensed home care service agency attestations and information) for a period of no less than ten years from the end of the applicable calendar year; and that such records will be subject to audit by the Department and/or its agents for possible retroactive recoupment of Medicaid payments for services that are determined to be in less than full compliance.

In addition, I will provide the managed care organization, if applicable, and/or the Department (when applicable) with all information to verify my compliance with the terms of this directive (including this attestation) and that such information shall be made available to the Department upon request.

Check the appropriate box:	☐	Fee-For-Service	☐ Managed Care
Name of CHHA:			
Operating Cert. #:		Date	
Signature:			
Name (Please print):			
Title (Please print):			

Please note that in accordance with Parts 86-1.2 of Title 10 of the Commissioner's Administrative Rules and Regulation, only the following individuals may sign this attestation:

Proprietary Sponsorship – Operator/ Owner
Voluntary Sponsorship – Officer (President, Vice President, Secretary or Treasurer),
Chief Executive officer, Chief Financial Officer or Chairperson
Public Sponsorship – Public Official Responsible for the Operation of the Facility

Please note that the Department reserves the right to request additional information in the future to ensure compliance with terms of the April 2017 Dear Colleague Letter on FLSA Implementation.

NEW YORK STATE DEPARTMENT OF HEALTH OFFICE OF HEALTH INSURANCE PROGRAMS

LICENSED HOME CARE AGENCY

Attestation of Compliance with Fair Labor Standards Act (FLSA) Funding

I hereby certify that funding for all Medicaid home care services provided by my organization in accordance with the Department's April 2017 Dear Colleague Letter on FLSA Implementation, will be passed through to the home care worker, in its entirety. I further certify that I will maintain all records necessary to verify compliance with this directive (including this attestation and related information) for a period of no less than ten years from the end of the applicable calendar year; and that such records will be subject to audit by the Department and/or its agents for possible retroactive recoupment of Medicaid payments for services that are determined to be in less than full compliance.

In addition, I will provide the managed care organization, if applicable, and/or the Department (when applicable) with all information to verify my compliance with the terms of this directive (including this attestation) and that such information shall be made available to the Department upon request.

Check the appropriate box:	☐	Fee-For-Service	☐	Managed Care
Name of LHCSA:				
License #:		Date		
Signature:				
Name (Please print):				
Title (Please print):				

Please note that in accordance with Parts 86-1.2 of Title 10 of the Commissioner's Administrative Rules and Regulation, only the following individuals may sign this attestation:

Proprietary Sponsorship – Operator/ Owner

Voluntary Sponsorship – Officer (President, Vice President, Secretary or Treasurer), Chief Executive Officer, Chief Financial Officer or any Member of the Board of Directors

Public Sponsorship – Public Official Responsible for the Operation of the Facility

Please note that the Department reserves the right to request additional information in the future to ensure compliance with terms of the April 2017 Dear Colleague Letter on FLSA Implementation.

Consumer-Directed Personal Aid (FI):

Please attach the following documents:

- EIN, Medicaid Provider Number, NPI number and Electronic Visit Verification (EVV) Software (provide information on page 1 of this form)
- W-9 with legal name and remit address
- FLSA Attestation Form (complete form on page 12 and sign)
- Proof of adequate insurance coverage
    - Commercial General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Note:

- Provider Compliance Certification **is required** for Consumer-Directed Personal Aid (FI) providers (Attestation section to be completed on page 22).

NEW YORK STATE DEPARTMENT OF HEALTH OFFICE OF HEALTH INSURANCE PROGRAMS

CONSUMER DIRECTED FISCAL INTERMEDIARY

Attestation of Compliance with Fair Labor Standards Act (FLSA) Funding

I hereby attest that funding for all Medicaid consumer directed personal assistance services provided by my organization in accordance with the Department's April 2017 Dear Colleague Letter on FLSA Implementation, will be passed through to the consumer directed worker, in its entirety. I further certify that I will maintain all records necessary to verify compliance with this directive (including this attestation and related information) for a period of no less than ten years from the end of the applicable calendar year; and that such records will be subject to audit by the Department and/or its agents for possible retroactive recoupment of Medicaid payments for services that are determined to be in less than full compliance.

In addition, I will provide the managed care organization, if applicable, and/or the Department (when applicable) with all information to verify my compliance with the terms of this directive (including this attestation) and that such information shall be made available to the Department upon request.

Check the appropriate box:	☐	Fee-For-Service	☐	Managed Care
Name of FI:				
MMIS No. (Medicaid ID):		Date		
Signature:				
Name (Please print):				
Title (Please print):				

The following individuals may sign this attestation:
Proprietary Sponsorship – Operator/ Owner
Voluntary Sponsorship – Officer (President, Vice President, Secretary or Treasurer), Chief Executive Officer, Chief Financial Officer, or any Member of the Board of Directors

Please note that the Department reserves the right to request additional information in the future to ensure compliance with terms of the April 2017 Dear Colleague Letter on FLSA Implementation.

Durable Medical Equipment / Personal Emergency Response System:

Please attach the following documents:

- Business Associates Agreement
  - Nascentia will send for review and signature along with finalized contract
- EIN, Medicaid Provider Number & NPI number (provide information in this form)
- W-9 with legal name and remit address
- Incontinence Products Verification (only applicable to DME providers who offer incontinence supplies)
- Proof of adequate insurance coverage
  - Commercial General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Note:

- Provider Compliance Certification **may be required** for Durable Medical Equipment / Personal Emergency Response System providers (Attestation section to be completed on page 22).

Durable Medical Equipment/Personal Emergency Response System Services offered (Check all that apply):

☐	CPAP Supplies
☐	Diabetic Supplies
☐	Durable Medical Equipment and Supplies
☐	Enteral Therapy
☐	Incontinence Supplies
☐	Medicare-Authorized DME Provider (Lift Chairs, Wheelchairs, Walkers, etc.)
☐	Medication Dispensing Systems
☐	Orthotics/Prescription Footwear
☐	Oxygen Related Equipment
☐	Personal Emergency Response Systems (PERS) – Basic / Landline
☐	Personal Emergency Response Systems (PERS) – Cellular
☐	Personal Emergency Response Systems (PERS) – GPS
☐	Personal Emergency Response Systems (PERS) – Fall Detection
☐	Prosthetics
☐	Other — If selected, list “Other Services” offered:

For Durable Medical Equipment (DME) vendors who supply incontinence products:

The Department of Health (DOH) issued an incontinence supply initiative effective September 1st, 2016. DME companies must now ensure that incontinence products that they dispense to Medicaid members meet minimum quality standards put in place by the DOH.

The minimum standards include:

- No plastic (non-breathable) backed products
- Rewet rate of <2.0g
- Rate of Acquisition (ROA) of <60 seconds
- Retention Capacity >250g
- Presence of breathable zones with a minimum value of >100 cubic feet per minute (cfm)
- Presence of closure system which allows for multiple fastening and unfastening occurrences

Verification that your incontinence products meet minimum standards must be on file with Provider Relations at VNA Options. Verification must be in the form of test results obtained from an independent testing laboratory.

IF your company purchases incontinence products from Twin Med, LLC, the State's new preferred supplier, you do not have to verify incontinence product quality standards. Proof that your products are being purchased from Twin Med, LLC will suffice.

Further, most First Quality and Covidien brands meet minimum quality standards, however, verification for these brands must also be on file.

☐	Twin Med verification	☐	or Minimum quality standards verification

Home and Safety Modification:

Please attach the following documents:

- Business Associates Agreement
  - Nascentia will send for review and signature along with finalized contract
- EIN, Medicaid Provider Number & NPI number (provide information in this form; Medicaid Provider Number and NPI *not* required)
- W-9 with legal name and remit address
- Copy of contractor's license
- Proof of adequate insurance coverage
  - Commercial General Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Environmental Modifications and Support Services offered (Check all that apply):

☐	Installation of Ramps (Portable, Threshold, Modular)		
☐	Installation of Wheelchair Lifts (Platform, Incline)		
☐	Installation of Stair Lifts (Straight, Curved)		
☐	Installation of DME Supplies (Grab Bars, Handheld Shower, etc.)		
☐	Other Services	If selected, list "Other Services offered:"	
☐	Other Home and Safety Modifications	If selected, list "Other Home and Safety Modifications" offered:	

Licensed / Certified Professional Services:

Please attach the following documents:

- Valid state licensure information (provide Licensure/Certification information on page 17)
- EIN, Medicaid Provider Number & NPI number (provide information in this form)
- W-9 with legal name and remit address
- Proof of adequate insurance coverage
    - Commercial General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Note:

- Provider Compliance Certification **may be required** for Licensed / Certified Professional Service providers (Attestation section to be completed on page 22).

Services offered (Check all that apply):

☐	Audiology (exam only)
☐	Audiology (hearing aid services available)
☐	Nutritional Counseling
☐	Outpatient Occupational Therapy
☐	Outpatient Physical Therapy
☐	Outpatient Speech Therapy
☐	Orthotics/Prescription Footwear (provide copy of current Certification for each practitioner)
☐	Podiatry, in Home
☐	Podiatry, in Outpatient Setting
☐	Podiatry, in Skilled Nursing Facility
☐	Prosthetics (provide copy of current Certification for each practitioner)
☐	Respiratory Therapy
☐	Other Services — If selected, list “Other Services” offered:

Please list License/Certification information for all professionals employed at your facility. Applicable to all licensed staff, including but not limited to: Audiologists, Dieticians, Nutritionists, Optometrists, Opticians, Outpatient Therapists (PT, OT, ST, Respiratory), and Podiatrists. Copy this page if you need more space.

1. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
2. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
3. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
4. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
5. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			

Meals Provider:

Please attach the following documents:

- Business Associates Agreement
    - Nascentia will send for review and signature along with finalized contract
- EIN, Medicaid Provider Number & NPI number (provide information in this form; Medicaid Provider Number and NPI *not* required)
- W-9 with legal name and remit address
- Proof of adequate insurance coverage
    - Commercial General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 2 million aggregate, or umbrella coverage)

Meal Services offered (Check all that apply):

☐	Congregate Meals
☐	Home Delivered Meals

Skilled Nursing Facility (SNF):

Please attach the following documents:

- Valid state license(s) or operating certificate(s)
- JCAHO accreditation report (if applicable)
- Most recent NYSDOH State Survey & Plan of Correction
- EIN, Medicaid Provider Number & NPI number (provide information in this form)
- W-9 with legal name and remit address
- Copy of patient satisfaction survey
- Proof of adequate insurance coverage
    - Commercial General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Note:

- Provider Compliance Certification **is required** for Skilled Nursing Facility providers (Attestation section to be completed on page 22).

Permanent Facility Identifier:					
JCAHO Accreditation:	☐	Yes	☐	No	☐ N/A
CARF Accreditation:	☐	Yes	☐	No	☐ N/A

Covered Services offered:

☐	Adult Medical Day Care (ADHC)
☐	Adult Social Day Care (SADC)
☐	Audiology (hearing aid dispensing)
☐	Audiology (hearing exam services)
☐	Dentistry (on-site)
☐	Outpatient Occupational Therapy
☐	Outpatient Physical Therapy
☐	Outpatient Speech Therapy
☐	Podiatry (on-site)
☐	Transportation (Day Care)
☐	Transportation (to member appointments)
☐	Vision Care (on-site)

Skilled Nursing Facility Services:			
☐	Daily Room and Board		
☐	Specialty Beds (Behavioral, Neurological, Ventilation)		
☐	Respite Care		
For SNFs providing OUTPATIENT THERAPY: Please list License/Certification information for all OT/PT/ST professionals employed at your outpatient facility. Copy this page if you need more space.			
1. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
2. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
3. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
4. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			

Transportation Provider:

Please attach the following documents:

- Business Associates Agreement
  - Nascentia will send for review and signature along with finalized contract
- EIN, Medicaid Provider Number & NPI number (provide information in this form, NPI *not* required)
- W-9 with legal name and remit address
- Proof of adequate insurance coverage
  - Commercial General Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 2 million aggregate, or umbrella coverage)
  - Automobile coverage (may be listed on the same or different ACORD form detailed above; minimum requirement of 1 million combined single limit)

Note:

- Provider Compliance Certification **may be required** for Transportation providers (Attestation section to be completed on page 22).

DOT Certificate # (Required for wheelchair transportation):	

Transportation Services offered (Check all that apply):

☐	After Hours Transportation
☐	Door to Door Assist
☐	Non-Emergent Ambulance
☐	Stretcher
☐	Wheelchair
☐	Bariatric Wheelchair
☐	Taxi

After filling out the necessary Service Provider Applications REMEMBER TO COMPLETE the Attestation, Credentialing Attestation and Release Form and Certification / Affirmation of Accuracy and Completeness on pages 22-24.

Provider Compliance Certification

As required, I agree to submit a copy of the Certification Statement for Provider Billing Medicaid pursuant to NYS Social Services Law (SOS) § 363-d and Title 18 of the New York Codes, Rules and Regulations (18 NYCRR) Part 521. For more information on the Provider Compliance Program, please go to the program website at https://omig.ny.gov/compliance/compliance.

Please initial the appropriate box (CHOOSE ONE):

	I confirm that I have submitted a certification statement to Medicaid as required
	I confirm that I am not required to submit a certification statement to Medicaid pursuant to NYS Social Services Law (SOS) § 363-d and Title 18 of the New York Codes, Rules and Regulations (18 NYCRR) Part 521

Attestation

I agree to use best efforts to inform Nascentia Health Options in writing within 15 business days if there is any change in the information provided or the answers to questions on the application as a result of developments subsequent to signing this application.

I agree that a photocopy or facsimile of this document with my signature may be accepted with the same authority as the original.

Credentialing Attestation and Release Form

In the past 3 years or presently, has your company or any of its representatives:				
Had disciplinary actions, criminal proceedings, or other adverse actions initiated against them (this includes license or certification limitations, revocations, suspensions, terminations, or voluntary relinquishment)?	☐	Yes	☐	No
Been subject of an investigation, or ever been suspended, sanctioned or otherwise excluded from participating in any private, state, or federal health insurance program (examples – Medicare, Medicaid, other Managed Care Organization)?	☐	Yes	☐	No
Been subject to (in whole or in part) professional liability or malpractice claims, suits, settlements, arbitration proceedings, or complaints?	☐	Yes	☐	No
Been subjected to any investigation, claim, or disciplinary action due to unethical conduct?	☐	Yes	☐	No
Been denied liability insurance (in whole or in part) or had your insurance canceled, involuntarily restricted, denied renewal, or rated up because of the nature volume of claims against your company?	☐	Yes	☐	No

If you answered “yes” to any of the above questions, please explain below.

Please initial:

	I confirm that there is a process in place to monitor and screen employees, volunteers, governing body members, and downstream entities for Healthcare related criminal convictions.
	I confirm that there is a process in place to monitor and screen employees, volunteers, governing body members, and downstream entities against the List of Excluded Individuals (LEIE) – https://exclusions.oig.hhs.gov/, Excluded Parties List System (EPLS) https://sam.gov/SAM/ , and the New York Exclusions Database – https://www.omig.ny.gov/search-exclusions prior to hiring and monthly thereafter.

Certification / Affirmation of Accuracy and Completeness

I hereby affirm that all information provided in or attached to this application for credentialing/re-credentialing is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I understand that any misrepresentation or omission of any fact requested, whether intentional or not, is cause for automatic and immediate rejection and/or termination of the credentialing/re-credentialing process.

I hereby agree to immediately notify Nascentia Health Options if such representation ever ceases to be accurate and true. I understand that this credentialing/re-credentialing review process will occur prior to approval of participation. I hereby authorize Nascentia Health to consult with any third party who may have information bearing on any services that my company provides. I hereby release any person, institution or other party from any liability in connection with the provision of such information or documentation.

Name of Organization:	
Authorized Representative Signature:	
Authorized Representative Printed Name:	
Authorized Representative Title:	
Date:	