

Managed Long Term Care (MLTC) Medicaid Service Provider Application

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.

Online: <https://nascentiahealth.org/managed-long-term-care/provider-information/service-provider-application/>
Email: providerrelations@nascentiahealth.org
Fax: (315) 671-5129
Mail: Nascentia Health Options, 1050 West Genesee Street
Syracuse, NY 13204-2215
Questions: (315) 477-9280

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 7
	Audiologist/Hearing Aids — Page 8
	Consumer Personal Aid (FI) — Page 10
	Home and Safety Modification — Page 11
	Licensed Home Care Services Agency (LHCSA) — Pages 12-13
	Meals Provider — Page 14
	Personal Emergency Response System — Page 15

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 1-5 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 16-18.

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 16).
- 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

Audiologist/Hearing Aids

Please attach the following documents:

- Valid state licensure information (provide Licensure/Certification information on page 9)
- 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 Audiologist/Hearing Aids providers (Attestation section to be completed on page 16).

Services offered (Check all that apply):

	Audiology (exam only)		
	Audiology (hearing aid services available)		
	Other Services	If selected, list "Other Services" offered:	

Please list License/Certification information for all professionals employed at your 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):			
5. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			

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
- 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 16).

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 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
- 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 Licensed Home Care Services Agency (LHSCA) providers (Attestation section to be completed on page 16).

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

Licensed Home Care Services Agency services offered (Check all that apply):			
	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		
	PRI & Screen Assessment Services		
	Private Duty Nursing, LPN		
	Private Duty Nursing, RN		
	Respiratory Therapy		
	Other Licensed Home Health Services	If selected, list "Other Licensed Home Health Services":	

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 (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

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
- 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 Personal Emergency Response System providers (Attestation section to be completed on page 16).

Personal Emergency Response System Services offered (Check all that apply):

	Medication Dispensing Systems	
	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	
	Other	If selected, list “Other Services” offered:

Provider Compliance Certification

As required, I agree to submit a copy of the [Certification Statement for Provider Billing Medicaid](https://omig.ny.gov/compliance/compliance) 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: