General Application

Checklist

Please ensure you have completed all applicable items on this checklist prior to submission.

All required items (on the application checklist below) must be submitted with this application to be considered. If all required items are not submitted at time of application, this application will be denied.

- ☐ **General Provider Application**
- ☐ **Attestation Form**
- ☐ **W-9 Form**
- ☐ **Copy of Certification and/or License**
- ☐ **Certificate of Liability Insurance**
  - **General and Professional Liability (500,000/1,000,000 limits)**
  - **Worker's Compensation & Employer's Liability**
  - **Auto**

  Please contact your insurance agent to obtain a Certificate of Insurance with Community Care, Inc. (1801 Dolphin Drive, Waukesha, WI 53186) listed as the certificate holder.
- ☐ **Residential Summary Form (required for all residential facilities)**
- ☐ **HCBS Compliance Letter (required for all licensed residential facilities)**
- ☐ **Program Statement (required for all licensed/certified providers)**
- ☐ **Data Collection Form – Fiscal (required for corporate residential providers)**
- ☐ **Electronic Funds Transfer Form with a Voided Check**

COMMUNITY CARE, INC.
PROVIDER APPLICATION

I. PROVIDER CONTACT INFORMATION

Business Name: _____

Mailing Address

Street: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Business Address **Same as Mailing Address Above** ☐

Street: _____

City: _____ **State:** **Zip:**

Phone: _____ **Fax:** _____

Tax Id #: _____ **NPI #** _____

Medicaid # _____ **Medicare #** _____

Contact Name: _____ **Title:** _____

Contact E-Mail: _____ **Phone** _____

Contract Signer and Title: _____

Website: _____

Days of Operation: _____

Hours of Operation: _____

II. SERVICES OFFERED

Please indicate the services you provide by placing a check mark next to the corresponding service(s). For contract consideration, service providers must meet service definitions and standards as listed in ADDENDUM IX. Benefit Package Service Definitions of the MCO Family Care Contract located at https://www.dhs.wisconsin.gov/familycare/mcos/contract.htm

SERVICES OFFERED	Check Service(s) you provide
Adaptive Aids (general and vehicle)	☐
Adult Day Care	☐
Communication Aids/Interpreter Services	☐
Community Support Program	☐
Consumer Education and Training	☐
Daily Living Skills Training	☐
Day Services/Treatment	☐
Financial Management Services	☐
Home Modifications	☐
Home Delivered Meals	☐
Interpretation Services:	☐
Personal Care Agency ***(Certified)*** **– NPI Required**	☐
Personal Emergency Response Services	☐
Prevocational Services	☐
Relocation Services	☐
Rep Payee	☐
Residential Services: Adult Family Home ***(Certified)***	☐
Residential Services: Adult Family Home ***(Licensed)***	☐
Residential Services: Community-Based Residential Facility (CBRF)	☐
Residential Services: Certified Residential Care Apartment Complex (RCAC)	☐
Respite Care (for caregivers and members in non-institutional and institutional settings)	☐
Self Directed Supports	☐
Supported Employment	☐
Supportive Home Care (Routine Homemaking, Assist with ADLs) / Supported Living	☐
Vocational Futures Planning	☐
Other:	☐

III. GENERAL INFORMATION

- Target Group Selection: Please select the population you serve.

Physically Disabled (**PD**)	☐
Developmentally Disabled (**DD**)	☐
Frail Elderly (**FE**)	☐
All (**PD, DD, FE**)	☐

Do you wish to be published in Community Care's public provider directory? ☐ Yes ☐ No

IV. LICENSE AND CERTIFICATION REQUIREMENTS

Please attach a copy of all licenses or certifications that relate to services you wish to provide: Some examples are listed below.

- ☐ **Adult Day Care Certification**
- ☐ **Adult Family Home License**
- ☐ **Adult Family Home Certification**
- ☐ **CBRF License**
- ☐ **RCAC Certification**
- ☐ **Personal Care Agency Certification**
- ☐ **Sign Language License**
- ☐ **National Accreditation**
- ☐ **Other:** *(Please Specify)*

_____

V. PROVIDER ACCESSIBILITY AND AVAILABILITY

TDD/TTY Number	☐ Yes	☐ No	If yes, specify: _____
Handicapped accessible	☐ Yes	☐ No	
Sign Language	☐ Yes	☐ No	

List fluent languages spoken (other than English):

_____

VI. SPECIALIZED EXPERTISE OFFERED BY YOUR AGENCY

Please check below any specialized expertise or unique services offered by your agency.

	Advanced Aged		Bariatric – 500 lbs. or more
	Developmentally Disabled		Bariatric – under 500 lbs.
	Physically Disabled		RN on staff
	Alcohol/Drug Dependent		Vent Care
	Emotionally Disturbed/Mental Illness		Wound Care
	Terminally Ill		Memory Care
	Correctional Clients		Bathing Services
	Irreversible Dementia/Alzheimer's		Diabetic Expertise
	Traumatic Brain Injury		

VII. CULTURAL COMPETENCIES

Please indicate the cultural composition of your organization by checking all that apply:

Does your agency perform Cultural Competency Training? ☐ Yes ☐ No

Minority/Disadvantaged Provider:

☐ **At least 51% of the Board of Directors is minorities/women.**

☐ **The organization is owned and operated by at least 51% minorities/women.**

VIII. INELIGIBLE ORGANIZATIONS

The MCO shall exclude from participation all organizations which could be included in any of the following categories (references to the Act in this section refer to the Social Security Act):

1. **Ineligibility**
   Entities which could be excluded under Section 1128(b)(8) of the Social Security Act are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has a direct or indirect ownership or control interest of 5% or more in the entity, or a person with beneficial ownership or control interest of 5% or more in the entity has:

   a. Been convicted of the following crimes:
      i. Program related crimes, i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid (see Section 1128(a)(1) of the Act);
      ii. Patient abuse, i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care (see Section 1128(a)(2) of the Act);
      iii. Fraud, i.e., a State or Federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by Federal, State or local government (see Section 1128(b)(1) of the Act);
      iv. Obstruction of an investigation, i.e., conviction under State or Federal law of interference or obstruction of any investigation into any criminal offense described directly above (see Section 1128(b)(2) of the Act); or,
      v. Offenses relating to controlled substances, i.e., conviction of a State of Federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (see Section 1128(b)(3) of the Act).

   i. Been Excluded from Participation in Medicare or a State Health Care Program. A State health care program means a Medicaid program or any State program receiving funds under title V or title XX of the Act. (See Section 1128(b)(8)(iii) of the Act).

   ii. Been Assessed a Civil Monetary Penalty under Section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHS Office of Inspector General.

Section 11238A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards. (See Section 1128(b)(8)(B)(ii) of the Act).

IX. LENGTH OF TIME IN BUSINESS

Please indicate the length of time the agency has been in business ***providing the services for which you are applying.***

_____ **Years** _____ **Months**

X. ORGANIZATIONAL STRUCTURE

Please indicate your **organizational structure** as reported on your federal income tax returns:

☐ **Corporation** ☐ **Limited Liability Corporation**

☐ **Partnership** ☐ **Sole Proprietor**

XI. AGENCY OFFICERS/RESPONSIBLE PARTY

Please list the responsible person's name and telephone number for each agency position listed. If your agency has no such position, please indicate "N/A" for "not applicable".

Position	Name & Title	Telephone & Email
Chief Operations Officer:		
Executive Director/President:		
Chief Financial Officer:		
Chief Information Technology Officer:		
Human Resources /Personnel Director:		

XII. GOVERNANCE

Does your agency have a Board of Directors? ☐ Yes ☐ No

If yes, how many members are on the Board? _____

How often does your Board of Directors meet? _____

Are Board members paid or do they serve voluntarily? _____

Name and Telephone Number of Board Chair: _____

Name and Telephone Number of Vice Chair: _____

XIII. CLIENT DATA AND RECORDKEEPING

Is each business location HIPAA compliant? ☐ Yes ☐ No
If no, please explain:

_____

_____

_____

_____

XIV. FISCAL MANAGEMENT

Agency Accountant/Bookkeeper Name: _____

Phone Number: _____

Address: _____

Telephone Number: _____

BILLING/PAYEE INFORMATION

Billing/Payee Name: _____

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

Billing Contact Name: _____

Billing Contact Phone and Fax Numbers: _____ _____

Service Location Information Page

***Complete this page only if you are a non-residential provider and have multiple locations.**

Business Name: _____

Location Name (if applicable): _____

Location Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone Number: _____ **Fax #** _____

Contact Person: _____

Location NPI # (if applicable): _____

Services offered at this Location: _____

Handicapped Accessible: ☐ Yes ☐ No

Sign Language: ☐ Yes ☐ No

List Languges spoken other than English: _____

Populations Served:

☐ Physically Disabled (**PD**)

☐ Developmentally Disabled (**DD**)

☐ Frail Elderly (**FE**)

☐ All (**PD, DD, FE**)

Business Name: _____

Location Name (if applicable): _____

Location Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone Number: _____ **Fax #** _____

Contact Person: _____

Location NPI # (if applicable): _____

Services offered at this Location: _____

Handicapped Accessible: ☐ Yes ☐ No

Sign Language: ☐ Yes ☐ No

List Languges spoken other than English: _____

Populations Served:

☐ Physically Disabled (**PD**)

☐ Developmentally Disabled (**DD**)

☐ Frail Elderly (**FE**)

☐ All (**PD, DD, FE**)

Make copies of this page for additional locations if necessary.

COMMUNITY CARE, INC.
PROVIDER ASSURANCES AND CERTIFICATIONS

I _____ agree that all information included in this application is true and correct and that the provider understands and agrees to the application information and requirements. Provider further acknowledges that the information in this application is subject to periodic verification without notice and that any misrepresentation on this form may result in disqualification from receiving public (MCO) funds and legal action or fiscal sanctions may be taken as determined appropriate by Community Caren Inc. or its designated representative(s). Provider understands that completion of provider application does not guarantee network admission and/or subsequent contract with the MCO.

I _____ constitute as the Provider to allow authorized representatives of Community Care, Inc. funding sources to have access to all records necessary to confirm the provision of services by the Provider. Failure on the part of the Provider to comply with program requirements or not have sufficient documentation to verify provision of the services billed may result in withholding or forfeiture of any payments. At a minimum, the Providers must have client records that include: names and address, the type and dates of service provided, the number of units of service provided, and documentation that service was provided.

*The applicant certifies to the best of its knowledge and belief, that it is not an **"Ineligible Organization"** as defined in section VIII of this application. The applicant further certifies to the best of its knowledge and belief, that it and its principals: (1) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency; (2) have not within a three-year period preceding this application been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (3) are not presently indicted for or otherwise criminally charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in (2) of this certification; and , (4) have not within a three-year period preceding this application had one or more public transactions (Federal, State or local) terminated for cause or default.*

_____ _____
Authorized Signature and Title Date

_____
Business Name

- **Electronic signature is considered valid only when document is submitted by e-mail from the signer's email address.**
- **If mailing or faxing application, signature must be handwritten.**

RETURN YOUR APPLICATION WITH ALL REQUIRED DOCUMENTATION TO:

Email:

ContractInquiries@communitycareinc.org

Mail to:

Community Care, Inc.
Provider Management Department
1801 Dolphin Drive
Waukesha, WI 53186

Fax to:

(262) 446-6707

For questions please contact our Provider Hotline at 866-937-2783, option 2