



ATTESTATION FORM

Provider Name: _____

Please provide the legal name of your business.

** Owner/Operator must have a file that contains the current information for all staff including volunteers.*

Initial Training/ Competency:

- 1) Job Description for each staff. Yes or No
- 2) Training plan for staff including documentation of completed trainings. Yes or No
- 3) Staff is able to demonstrate the necessary skills to perform their specific duties prior to initial performance. Yes or No
- 4) Qualifications of each staff member including academic preparation and relevant experience, verification of current license, certifications or registrations to practice in the State as applicable. Yes or No
- 5) Staff working with frail elders or disabled populations have documented experience with population they will work with or provider has plan to ensure they are adequately trained.
(This may include personal or professional experience) Yes or No
- 6) Staff will be trained annually on Fraud, Waste and Abuse Yes or No
Visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>
for training resources
- 7) Staff having contact with members are free of communicable diseases. Yes or No

Initial and On-Going Validation of Credentials

- 8) Pre-employment and every four years thereafter, documentation that any staff who has experience as a nursing assistant, home health aide or hospice aide, as defined under DHS 12 has not had a substantial finding listed on the Nurse Aid Registry that they have abused or neglected a client or misappropriated the funds or property of a client. Yes or No
Website: http://www.asivcs.com/services/registry/search_generic.asp?CPCat=0750NURSE
- 9) A current copy of the driver's record check at pre-employment and every four years thereafter documenting a valid driver's license for any staff who may transport members. Yes or No
Website: <https://trust.dot.state.wi.us/occsin/occsinservlet?whoami=status1>
- 10) Providers who transport members will maintain corporate auto insurance policy. If staff use personally-owned vehicles to transport members, provider will validate and obtain proof staff are properly insured. Yes or No
- 11) Wisconsin Department of Justice (DOJ) Criminal & Caregiver background checks completed for each staff, including transportation staff, prior to employment and updated every four years thereafter. Yes or No
Website: <https://recordcheck.doj.wi.gov/>

- 12) Does owner/operator have any criminal charges pending against them or were they ever convicted of any crime anywhere, including in federal, state, local, military and tribal courts?
 Yes or No If yes, please explain:
-
-
-

Excluded Individuals and Entities

- 13) Provider acknowledges that Community Care, Inc. will not pay for any goods or services provided by an individual (i.e., employee) or entity that has been excluded from participation in government programs, and will recover any payments previously made for goods or services provided by an excluded individual or entity. Community Care, Inc. will not make payment to an individual – directly or indirectly – or entity while that individual or entity is under a government imposed payment suspension. Yes or No
- 14) Provider will immediately notify Community Care, Inc. of any exclusion or suspension – including a payment suspension - involving the provider’s operation. Yes or No
- 15) Provider understands that the US Department of Justice may impose civil monetary penalties (CMP) on anyone who hires an excluded individual or entity. Yes or No

Providers are encouraged to regularly check employees and other associated individuals and entities (e.g., vendors, volunteers, board members, etc.) to verify that exclusions have not been imposed. Government exclusion databases can be found at <https://exclusions.oig.hhs.gov/> and <https://www.sam.gov>. Other resources include: <http://oig.hhs.gov/exclusions/background.asp>.

Transportation

- 16) Providers who transport individuals must have a communication system in place on all transportation vehicles which would allow contact with members’ care teams. Yes or No
- 17) Providers who transport individuals attest they have a mechanism in place to ensure all vehicles are maintained in accordance with manufacturer’s recommendations and undergo regularly documented safety checks to ensure vehicles are safe, accessible and equipped to meet the needs of those being transported (including staff’s own vehicles if they are used for transport of individuals)
 Yes or No

Contract

- 18) Provider has reviewed and attests to meeting all service definitions and standards as listed in ADDENDUM IX. Benefit Package Service Definitions of the MCO Family Care Contract which can be viewed at <https://www.dhs.wisconsin.gov/familycare/mcos/contract.htm> Yes or No
- 19) Provider will make available to staff working with Community Care, Inc. members the contract with Community Care, Inc. and all related documents such as; Model of Care, the Benefit Grid, CCI Summary Sheet for Network Providers, Communication Requirements (at time of contract) and Practice Guidelines. (all documents are available on CCI website at communitycareinc.org).
 Yes or No

Provider Information

20) Provider has a back-up plan in place when there are staff shortages? Briefly define or attach additional forms/ policy as necessary. Yes or No

21) Provider has a plan in place for regular and emergency medical needs? Yes or No
Briefly define or attach additional forms/policy as necessary.

22) Provider has a policy to prevent any member from being left in a vehicle? Briefly describe or attach transportation policy or practices. Include any forms that staff must document on who is in the vehicle at start and end of trips. Yes or No

23) Provider has an emergency preparedness plan. Yes or No

24) Provider and/or Owner has ever been licensed or certified Yes or No
(If yes, please answer the questions below)

- a) What type of license or certification? _____
- b) Who issued the license or certification? _____
- c) What dates were you licensed or certified? _____

25) Provider and/or Owner had a license or certification revoked Yes or No
If yes, please explain including name of licensed or certified entity:

26) Provider has had a contract terminated or requested a termination with any entity previously contracted with
 Yes or No

If yes, please attach letter or supporting information regarding the decision.

Note: Answering no to one or more of these questions does not automatically disqualify a provider from receiving a contract. Community Care, Inc. will review the provider's responses and follow-up where appropriate.

Contracting Requirement

All providers must check the following box stating that they have read & understand the following statement.

Community Care, Inc. will not contract directly with a program member’s relative for the purpose of providing care to the member. (“Relative” means a spouse, parent, step-parent, child, step-child, sibling, grandchild, grandparent, aunt, uncle, niece or nephew, including in-laws)

I have read and understand.

Falsification and/or omission of information on this application may lead to contract denial and/or contract termination. Community Care, Inc. reserves the right to deny or end a contract at any time based on information Community Care, Inc. may receive that is inconsistent with provider submission. Please ensure accuracy on all application materials to avoid further action.

If any requirements are missing during the application process or subsequent Community Care, Inc. provider contract review, it may result in Community Care, Inc. decision to deny an application or, if provider is already contracted, take action up to and including contract termination.

Print Name of Person
Completing Form: _____

Phone Number: _____

**Signature: _____

Date: _____

** By signing, I attest the information in this document is true and accurate.

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