

***General Application***

***Checklist***

The items below must be completed *prior to submission* and included with this application to be considered. If all items are not received at time of application, this application will not be accepted.

[ ]  General Provider Application

[ ]  Attestation Form ([**Word**](https://www.communitycareinc.org/docs/default-source/providers/attestation-form.docx?sfvrsn=cdd59b54_2) or [**PDF**](https://www.communitycareinc.org/docs/default-source/providers/attestation-formfbce1cb4-fbd9-4142-9404-64cbe0ef29b6.pdf?sfvrsn=c03b7d2d_2) format)

[ ]  [**W-9 Form**](http://www.irs.gov/pub/irs-pdf/fw9.pdf)

[ ]  Copy of any applicable Certifications and/or Licenses

[ ]  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’ form naming Community Care, Inc. as a certificate holder (1801 Dolphin Drive, Waukesha, WI 53186)

[ ]  Electronic Funds Transfer Form ([**Word**](https://www.communitycareinc.org/docs/default-source/provider-applications/cci_direct_deposit_form_word.doc?sfvrsn=1eeae4c2_1) or [**PDF**](https://www.communitycareinc.org/docs/default-source/provider-applications/cci_direct_deposit_form_pdf7a9cdc2d53006410815dff01001bd2cb.pdf?sfvrsn=c19a64c7_1) format)

[ ]  Voided Check *OR* Bank Letter to accompany the Electronics Funds Transfer form

[ ]  DHS Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation

<https://www.dhs.wisconsin.gov/library/collection/f-00180c>

[ ]  Residential Summary Form - required for all residential facilities ([**Word**](https://www.communitycareinc.org/docs/default-source/provider-applications/residential-summary.doc?sfvrsn=d8231069_1) or [**PDF**](https://www.communitycareinc.org/docs/default-source/provider-applications/residential-summary570c35b3-e023-4b3e-9a9d-cf606e88d9a6.pdf?sfvrsn=9eb95be5_1) format)

[ ]  Program Statement - required for all licensed/certified providers

[ ]  [**Residential Data Collection**](https://www.communitycareinc.org/docs/default-source/provider-applications/residential-data-collection.xlsx?sfvrsn=e0fd226c_1) - required for residential providers



**COMMUNITY CARE, INC.**

### PROVIDER APPLICATION

1. PROVIDER CONTACT INFORMATION – *Please Type or Print*

|  |  |
| --- | --- |
| **Legal Entity Name:** |       |
| **Business Address (cannot be a P.O. Box):** |
| Street: |       |
| City: |       | State: |       | Zip: |       |
| Phone: |       | Fax: |       |
| **Mailing Address: Same as Business Address Above** [ ]  |
| Street: |       |
| City: |       | State: |       | Zip: |       |
| Phone: |       | Fax: |       |
|  |  |  |  |
| Tax Id: |       | NPI #: |       |
| Medicaid #: |       | Medicare #: |       |
| EVV #: |       |  |  |
|  |  |  |  |
| Contact Name: |       | Title: |       |
| Contact E-Mail: |       | Phone: |  |
| Contract Signer: |       |
| Signer’s Title: |       |
| Website: |       |
| Days of Operation: |       |  |  |
| Hours of Operation: |       |

1. 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>

|  |  |
| --- | --- |
| **[ ]**  Adaptive Aids (general, vehicle, service dog)**[ ]**  Adult Day Care (licensed)**[ ]**  Assistive Technology/Communication Aids (includes interpreter services)**[ ]**  Consultative Clinical & Therapeutic Services for Caregivers (CCTS)**[ ]**  Consumer Directed Supports (self-directed supports) broker**[ ]**  Consumer Education and Training **[ ]**  Counseling & Therapeutic Resources (licensed, non‐Medicaid certified therapies)**[ ]**  Environmental Accessibility Adaptations (home modifications)**[ ]**  Financial Management Services **[ ]**  Habilitation Services: Daily Living Skills Training**[ ]**  Habilitation Services: Day Habilitation Services**[ ]**  Home Delivered Meals**[ ]**  Housing Counseling**[ ]**  Personal Care Agency (Wisconsin Medicaid certified)**[ ]**  Personal Emergency Response Service (PERS)**[ ]**  Prevocational Services**[ ]**  Relocation Services | **[ ]**  Residential Services: Adult Family Home (1‐2 Bed)**[ ]**  Residential Services: Adult Family Home (3‐4 Bed)**[ ]**  Residential Services: Community Based Residential Facility (CBRF)**[ ]**  Residential Services: Residential Care Apartment  Complex (RCAC)**[ ]**  Respite Care (in non-institutional & institutional settings)**[ ]**  Respite Care (in substitute living facility)**[ ]**  Skilled Nursing Services (RN/LPN)**[ ]**  Specialized Medical Equipment & Supplies**[ ]**  Supported Employment – Small Group**[ ]**  Supported Employment - Individual**[ ]**  Supportive Home Care (chore services)**[ ]**  Supportive Home Care (general; including  non‐medical personal care)**[ ]**  Training for unpaid caregivers**[ ]**  Vocational Futures Planning & Support**[ ]**  Other (*please specify*):            |

1. GENERAL INFORMATION

OWNERSHIP INFORMATION

[ ]  The organization is minority-owned. [ ]  The organization is disabled veteran-owned.

[ ] [ ]  The organization is woman-owned. [ ]  The organization is a small business.

Do you currently have or have you previously had a contract with CCI?

[ ] Yes [ ]  No Please explain:

Do you have an affiliation with another Legal Entity currently contracted with CCI?

[ ] Yes [ ]  No What is the affiliation:

Is each business location HIPAA compliant? [ ]  [ ]  Yes [ ]  No

If no, please explain:

SUPPORTIVE HOME CARE *ONLY*

Do you offer apartments or have locations identified for members to reside: [ ]  Yes [ ]  No

If yes, please attach a copy of a program summary of services offered as a Supportive Home Care Agency.

If no, do your services only occur in members’ own existing residence: [ ]  Yes [ ]  No

RESIDENTIAL PROVIDERS *ONLY*

Vacancy Contact Name/Title:

Email:  Phone #:

ALL PROVIDERS:

Service Area(s): *Please select the county(ies) you serve*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| All 72 Wisconsin Counties | [ ]  |  |  |  |  |  |  |  |  |
| Adams | [ ]  | Dane | [ ]  | Iowa | [ ]  | Marathon | [ ]  | Polk | [ ]  | Taylor | [ ]  |
| Ashland | [ ]  | Dodge | [ ]  | Iron | [ ]  | Marinette | [ ]  | Portage | [ ]  | Trempealeau | [ ]  |
| Barron | [ ]  | Door | [ ]  | Jackson | [ ]  | Marquette | [ ]  | Price | [ ]  | Vernon | [ ]  |
| Bayfield | [ ]  | Douglas | [ ]  | Jefferson | [ ]  | Menominee | [ ]  | Racine | [ ]  | Vilas | [ ]  |
| Brown | [ ]  | Dunn | [ ]  | Juneau | [ ]  | Milwaukee | [ ]  | Richland | [ ]  | Walworth | [ ]  |
| Buffalo | [ ]  | Eau Claire | [ ]  | Kenosha | [ ]  | Monroe | [ ]  | Rock | [ ]  | Washburn | [ ]  |
| Burnett | [ ]  | Florence | [ ]  | Kewaunee | [ ]  | Oconto | [ ]  | Rusk | [ ]  | Washington | [ ]  |
| Calumet | [ ]  | Fond du Lac | [ ]  | LaCrosse | [ ]  | Oneida | [ ]  | Sauk | [ ]  | Waukesha | [ ]  |
| Chippewa | [ ]  | Forest | [ ]  | Lafayette | [ ]  | Outagamie | [ ]  | Sawyer | [ ]  | Waupaca | [ ]  |
| Clark | [ ]  | Grant | [ ]  | Langlade | [ ]  | Ozaukee | [ ]  | Shawano | [ ]  | Waushara | [ ]  |
| Columbia | [ ]  | Green | [ ]  | Lincoln | [ ]  | Pepin | [ ]  | Sheboygan | [ ]  | Winnebago | [ ]  |
| Crawford | [ ]  | Green Lake | [ ]  | Manitowoc | [ ]  | Pierce | [ ]  | St. Croix | [ ]  | Wood | [ ]  |

Target Group(s): *Please select the population(s) you serve*

|  |  |  |  |
| --- | --- | --- | --- |
| Physically Disabled (**PD**) | [ ]  | Frail Elderly (**FE**) | [ ]  |
| Intellectually/Developmentally Disabled (**IDD**) | [ ]  | All (**PD, IDD, FE**) | [ ]  |

Do you wish to be published in Community Care’s public provider directory? [ ]  Yes [ ]  No

1. LICENSE AND CERTIFICATION REQUIREMENTS

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

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  | Adult Day Care Certification | [ ]  | Sign Language License |
| [ ]  | Adult Family Home License | [ ]  | National Accreditation |
| [ ]  | Adult Family Home Certification | [ ]  | Personal Care Agency Certification |
| [ ]  | CBRF License | [ ]  | Other: *(please specify)* |
| [ ]  | RCAC Certification |  |       |

1. PROVIDER ACCESSIBILITY AND AVAILABILITY

 TDD/TTY Number [ ]  Yes [ ]  No If yes, specify:

 Handicapped accessible [ ]  Yes [ ]  No

 Sign Language [ ]  Yes [ ]  No

 List fluent languages spoken by staff (other than English):

|  |
| --- |
|  |

1. 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 |
|  | Intellectually/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 |  |  |

1. CULTURAL COMPETENCIES

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

Does your agency perform Cultural Competency Training?[ ] Yes [ ]  No

Has your agency implemented National Standards for Culturally and Linguistically Appropriate Services (CLAS)?<https://thinkculturalhealth.hhs.gov/clas> [ ] Yes [ ]  No

1. 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:

* + 1. Been convicted of the following crimes:
			1. 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);
			2. 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);
			3. 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);
			4. 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,
			5. 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).
		2. 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).
		3. 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).
1. LENGTH OF TIME IN BUSINESS

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Years |  |       | Months |

1. AGENCY OFFICERS/RESPONSIBLE PARTY

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

Those listed in this section have authority to speak with and receive information from Community Care, Inc.

|  |  |  |  |
| --- | --- | --- | --- |
| **Position** | **Name** |  | **Telephone & Email** |
| Chief Operations Officer: |       |  |       |
| Executive Director/President: |       |  |       |
| Chief Financial Officer: |       |  |       |
| Chief Information Technology Officer: |       |  |       |
| Human Resources Director: |       |  |       |
| Other: |       |  |       |

1. GOVERNANCE

|  |  |
| --- | --- |
| Does your agency have a Board of Directors? | [ ]  Yes [ ]  No |
| If yes, please answer the below:How many members are on the Board? |       |
| Does at least 51% of the Board of Directors include minorities, women, disabled Veterans and/or small business owners? | [ ]  Yes [ ]  No |
| 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: |       |

1. 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): |       |
| Medicaid #:  |       | Medicare #:  |       |
| Services offered at this Location: |       |
| Handicapped Accessible: | [ ] [ ]  Yes [ ]  No |
| Sign Language: | [ ] [ ]  Yes [ ]  No  |
| List Languges spoken other than English: |       |
| Populations Served: | [ ] [ ]  Physically Disabled (PD) |
|  | [ ] [ ]  Intellectually/Developmentally Disabled (IDD) |
|  | [ ] [ ]  Frail Elderly (FE) |
|  | [ ] [ ]  All (PD, IDD, FE) |

|  |  |
| --- | --- |
| Business Name: |       |
| Location Name (if applicable): |       |
| Location Address: |       |
| City: |       | **State:** |       | **Zip:** |       |
| Telephone Number: |       | **Fax #** |       |
| Contact Person: |       |
| Location NPI # (if applicable): |       |
| Medicaid #:  |       | **Medicare #:**  |       |
| Services offered at this Location: |       |
| Handicapped Accessible: | [ ] [ ]  Yes [ ]  No |
| Sign Language: | [ ] [ ]  Yes [ ]  No  |
| List Languges spoken other than English: |       |
| Populations Served: | [ ] [ ]  Physically Disabled (**PD**) |
|  | [ ] [ ]  Intellectually/Developmentally Disabled (**IDD**) |
|  | [ ] [ ]  Frail Elderly (**FE**) |
|  | [ ] [ ]  All (**PD, IDD, 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 (preferred method):**

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