Healthcare Provider 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.

- ☐ Healthcare Provider Application
- ☐ Attestation Form (**Word** or **PDF** format)
- ☐ **W-9 Form**
- ☐ Copy of any applicable Certifications, Accreditations and/or Licenses for each location
- ☐ Certificate of Liability Insurance –
  - General Liability
  - Professional Liability
  - Worker's Compensation & Employer's Liability

  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** or **PDF** format)
- ☐ Voided Check *OR* Bank Letter to accompany the Electronics Funds Transfer form
- ☐ Medicare certification/enrollment letter
- ☐ Wisconsin Medicaid certification/enrollment letter

Application to continue on the following pages

HEALTHCARE PROVIDER APPLICATION

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

Legal Entity Name: _____

Business Address: (cannot be a P.O. Box)

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

TDD/TTY #: _____

Handicapped accessible: ☐ Yes ☐ No Sign Language: ☐ Yes ☐ No

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

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

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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

Street: _____

City: _____ State: _____ Zip:

Phone: _____ Fax: _____

Tax Id: _____ Group NPI #: _____

Group Medicaid #: _____ Group Medicare #: _____

POP #: EVV #: _____

Contact Name/Title: _____

Contact Phone/Email: _____

Contract Signer/Title: _____

Website: _____

Days/Hours of Operation: _____

Revised: 08.14.24

II. PROVIDER SERVICE INFORMATION

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

☐ Physician Group/Individual ☐ Radiology Facility ☐ Laboratory
☐ Free Standing Surgical Center ☐ Hospice ☐ Rehabilitation Agency
☐ Dialysis ☐ OT, PT, ST Group ☐ Dental Group
☐ Mental Health ☐ AODA ☐ Home Health Agency
☐ Skilled Nursing Facility* ☐ DME ☐ DMS ☐ Respiratory Services/Vent Care
☐ Mobile Service Provider **(type)**: _____
☐ Other *(please specify):* _____

*for Skilled Nursing Facilities only – *additional information required on page 5, Section IX.*

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	☐	La Crosse	☐	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	☐

Please mark all that apply:

☐ Services offered in office
☐ Services offered via telehealth
☐ Services offered in member's home
☐ Other _____

III. GENERAL 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: _____

Is your agency a FQHC (Federally Qualified Health Center)? ☐ Yes ☐ No

For Profit ☐ Yes ☐ No Not For Profit ☐ Yes ☐ No

Does your business/facility have a formal Quality Assessment and Performance Improvement Program? ☐ Yes ☐ No

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

IV. SPECIALIZED EXPERTISE OFFERED BY YOUR AGENCY

TARGET GROUP SELECTION - ***Please select the population you serve***

Physically Disabled (**PD**)	☐	Frail Elderly (**FE**)	☐
Intellectually/Developmentally Disabled (**IDD**)	☐	All (**PD, IDD, FE**)	☐

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

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

V. 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

VI. LICENSURE

Has any license or certification held by your organization ever been surrendered while under investigation, denied, suspended, revoked, limited not renewed, or voluntarily relinquished?

☐ Yes ☐ No

If yes, give details:

Has your business ever had any sanctions taken or imposed by either Medicare or Medicaid?

☐ Yes ☐ No

If yes, give details:

Accreditation

Accrediting Organization: _____

Accreditation status and term of accreditation:

VII. INSURANCE

Number of pending malpractice Claims (if none, please write none): _____

Number of Claims in the past 5 years (if none, please write none) _____

Judgments/Settlements in the past 5 years _____

If yes, attach details about each claim, judgment, or settlement:

Are there any specific exclusions to your professional liability coverage? ☐ Yes ☐ No

If yes, please provide details below:

Has the professional liability coverage for the organization ever been denied, limited, reduced, terminated, or not renewed? ☐ Yes ☐ No

If yes, give details:

VIII. KEY ORGANIZATIONAL CONTACTS

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 and Title	Telephone	Email
Chief Executive Officer/President/ Administrator			
Medical Director/ Vice President, Medical Affairs			
Managed Care Contracting			
Quality Assurance & Utilization Review			
Patient Accounts /Billing Manager			
Medical Records (if applicable)			

IX. SKILLED NURSING FACILITIES (SNF) ONLY

Please list the Pharmacy your organization is partnered with to provide eMar and medications:

_____

Does SNF accept ventilator dependent residents? ☐ **Yes** ☐ **No**
List applicable facility name(s) if applying for more than one facility:

_____

Does SNF accept bariatric residents? ☐ **Yes** ☐ **No**
Please specify and list applicable facility name(s) if applying form more than one facility:

_____

Does SNF require PCP/NP to complete an application for credentialing? ☐ **Yes*** ☐ **No**
If yes, please send the process and copy of application

Name of Rehabilitation Agency providing services within your SNF: _____

Does your agency offer outpatient therapy services? ☐ Yes ☐ No

Name and NPI # of the Medical Director at facility: _____

Name and NPI# of the PCP at facility: _____

SERVICE LOCATIONS

Please list all facilities/locations other than the business location listed above. Attach additional pages, if necessary

OFFICE/NAME for this Location: _____

Main Telephone _____ Office Fax _____

TDD/TTY Number: _____

Street: _____

City: _____ State: _____ Zip: _____

Handicap Accessible: Yes ☐ No ☐ Fluent Languages (other than English) _____

Contact Person: _____ Telephone: _____

Medicare Number _____ Medicaid Number _____ NPI _____

Hours of Operation

24 Hour Facility Yes ☐ No ☐

Weekdays (Mon – Fri) Hours: _____

Weekends (Sat – Sun) Hours: _____

Please list the holidays your organization will be open:

OFFICE/NAME for this Location: _____

Main Telephone _____ Office Fax _____

TDD/TTY Number: _____

Street: _____

City: _____ State: _____ Zip: _____

Handicap Accessible: Yes ☐ No ☐ Fluent Languages (other than English) _____

Contact Person: _____ Telephone: _____

Medicare Number _____ Medicaid Number _____ NPI _____

Hours of Operation

24 Hour Facility Yes ☐ No ☐

Weekdays (Mon – Fri) Hours: _____

Weekends (Sat – Sun) Hours: _____

Please list the holidays your organization will be open:

General Provisions

In order to evaluate this application for participation or continued participation in the Community Care Network, I authorize Community Care and its authorized representatives to consult with any third party, which may have information bearing on the subject matter addressed by this application. This includes the inspection or acquisition of any reports, records, recommendations, or other documents or disclosures of third parties, such as NPDB, FSMB, Hospital Peer activity, or insurance companies, that may be material to the questions in this application. I also authorize any third parties to release information to Community Care and/or its authorized representative to, from, or by any third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this application.

I certify that the information provided or attached to this application is accurate and complete. Any information entered into this application which subsequently is found to be false, could result in Community Care's refusal to enter into a contract with Provider or termination of a current agreement.

I warrant that I have the authority to sign this application, on my own behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of this application does not constitute approval or acceptance by Community Care.

Business Name: _____

Signature: _____ Date: _____

Print Name: _____ Title: _____

- 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