CHOICE℠ Health Plans

# Facility Provider Credentialing Application

TEL: 212-630-5303 FAX: 212-609-1780

**Instructions: Please complete all questions/sections applicable to your service(s) or specialties.**

Facility Type_____

## ORGANIZATION INFORMATION

NPI # _____ TAX ID #_____

NY Medicaid # _____ Medicare #_____

Legal Name _____

DBA or Other Name_____

## SERVICE INFORMATION

Street Address _____

City, State, Zip Code _____

Directory Telephone _____ Directory Fax _____

Contact Person Name & Title_____

Email Address _____

Service Area (Counties)_____

Capacity (if applicable) _____

Foreign Languages of the Facility Provider _____

**What is the organization's hours of operation? List all hours in corresponding days.**

| | | |
|---|---|---|
| Monday | From: _____ | To: _____ |
| Tuesday | From: _____ | To: _____ |
| Wednesday | From: _____ | To: _____ |
| Thursday | From: _____ | To: _____ |
| Friday | From: _____ | To: _____ |
| Saturday | From: _____ | To: _____ |
| Sunday | From: _____ | To: _____ |

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## CORPORATE/REMITTANCE address, if different from facility

Street Address _____

City, State, Zip Code _____

## ACCREDITATION/CERTIFICATION TYPE

1. **Is the organization licensed by the New York State Dept of Health?** ☐Yes ☐No ☐Not Applicable
   Type of License: _____

   Effective Date: _____ Expiration Date: _____

   Date of most recent survey: _____ Were there any deficiencies? ☐Yes ☐No
   (if Yes, attach copy of corrective action plan with letter of acceptance by NYSDOH)

2. **Is the organization accredited?** ☐Not Accredited

   Effective Date: _____ Expiration Date: _____ Date of most recent survey: _____

   Services accredited for: _____

**Agency Name**

☐ Accreditation Commission for Health Care (ACHC)

☐ American Association of Ambulatory Health Centers (AAAHC)

☐ American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)

☐ American College of Radiology (ACR)

☐ American Osteopathic Hospital Association (AOHA)

☐ Board of Orthotist / Prosthetist Certification (BOCUSA)

☐ Clinical Laboratory Improvement Act (CLIA)

☐ College of American Pathologists (CAP)

☐ Commission on Accreditation for Rehab Facilities (CARF)

☐ Community Health Accreditation Program (CHAP)

☐ Healthcare Quality Association on Accreditation (HQAA)

☐ The Joint Commission (TJC)

☐ Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)

☐ National Association of Boards of Pharmacy (NABP

☐ National Committee for Quality Assurance (NCQA)

☐ State Facility Operating License

☐ The National Board of Accreditation for Orthotic Suppliers (NBAOS)

☐ Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)

☐ Other (please list) _____

## PROVIDER CREDENTIALING ORGANIZATION BACKGROUND

**3.** Does the facility validate for each licensed provider employed or contracted at the facility the credentials necessary to perform health care services? ☐ Yes ☐ No

If yes, indicate how the facility conducts the credentialing process for each provider:
☐ Credentialing procedures are performed internally.

☐ Credentialing procedures are outsourced or delegated to _____

If no, please explain: _____

## ORGANIZATION BACKGROUND

**4.** Does your organization have any financial interest in the Visiting Nurse Service of New York? (if yes, please provide details on a separate sheet) ☐ Yes ☐ No

**5.** Please indicate the facility's organization type by checking all terms applicable: ☐N/A
☐ Non-profit ☐ Minority Business ☐Small Business ☐ Women-Owned Business

## OPERATIONS AND SERVICES

**Complete only the questions applicable to the service(s) you provide.**

**6.** Is the facility a participating provider in the NY State Medicaid program? ☐ Yes ☐ No

**7.** Is the facility a participating provider in the federal Medicare program? ☐ Yes ☐ No

**8.** Does the organization subcontract any of its services to another entity? (if yes, please attach a list of subcontracted services, the name of the organization(s) providing those services, and the copy(ies) of the subcontract(s) ☐ Yes ☐ No

**Americans With Disabilities Act Information (if services provided to members/patients at the facility)**

**9.** Do the staff have the ability to communicate with the visually impaired? ☐ Yes ☐ No

**10.** Do the staff have the ability to communicate with the hearing impaired? ☐ Yes ☐ No

**11.** Is the facility wheelchair accessible? ☐ Yes ☐ No

**12.** Services/Operations conducted: On-Site or Off-Site ☐ On-Site ☐ Off-Site

**13.** If applicable, is there a current Certificate of Occupancy which follows all applicable city, town, and state building and fire codes? (If no, credentialing may not proceed.) ☐ Yes ☐ No ☐ N/A

**14.** Total number of members/patients per day the program can accommodate ____

**15.** Current attendees per shift/day ____

**16.** At least annually, do you assess and document the health status of each staff person who may or will have contact with participants to ensure he or she is free from any health impairment potentially risking others or may interfere with the performance of his or her duties? ☐ Yes ☐ No

Do you require each staff person who may or will make contact with members/patients to have a PPD (Mantoux) skin test for tuberculosis prior to employment and no less than every two (2) years, thereafter? ☐ Yes ☐ No

**17.** Does your facility conduct drug and/or background screenings? (Please indicate specific reasons if not conducted.) ☐ Yes ☐ No

_____

## STAFFING

**18.** Composition of professional and paraprofessional (aides) staff, including paid and non-paid: _____

**19.** How many staff?_____

**20.** List all staff trainings conducted: _____

_____

**21.** How many staff members are involved in the coordination of this program?

____

**22.** What is the minimum number of staff with the participants during the program session?

____

**23.** What is the maximum ratio of staff to participants during the program session?

____

**24.** What type of personal care do you provide? **(list all applicable)**

_____

## TRANSPORTATION (PLEASE COMPLETE ONLY IF FACILITY PROVIDES TRANSPORTATION DIRECTLY OR INDIRECTLY TO MEMBERS)

**25.** *If provided by a subcontractor, specify transportation company name and address:

_____

**26.** Can wheelchairs be accommodated in transportation? ☐ Yes ☐ No

**27.** Is an escort provided to accompany attendees on transport? ☐ Yes ☐ No

**28.** Do participants go on program-sponsored off-site trips? ☐ Yes ☐ No

If so, please describe: _____

**29.** How do you track patients who use transportation to and from your site?

_____

## POLICIES AND PROCEDURES (PLEASE ATTACH FOR SADCS, LHCSAS, & ADHCS (MDY) ONLY)

**30.** Does the facility have a bill of rights or similar document? Please attach a copy. ☐ Yes ☐ No

**31.** Do you conduct a self-evaluation at least annually of your administrative, fiscal, and program operations? ☐ Yes ☐ No

## IF APPLICABLE, FOOD AT THE FACILITY (menu required to be attached for SADCs):

**32.** Does a nutritionist or dietician oversee and approve the menu? ☐ Yes ☐ No

**33.** Do you participate in the USDA Child and Adult Care Food Program? ☐ Yes ☐ No

**34.** NYC providers, do you have a NYCDOH Food Service Est. Permit? ☐ Yes ☐ No

**35.** Are you able to accommodate special dietary needs? ☐ Yes ☐ No

**36.** What types of meals are provided? Please indicate types, e.g. Kosher, vegetarian, Chinese, Spanish, etc.

_____

_____

**37.** If applicable, are meals prepared on site? If not, please provider supporting documentation. ☐ Yes ☐ No ☐ N/A

**38.** For NYC providers, is the program funded by the NYC Department for the Aging (DFTA)? ☐ Yes ☐ No

**39.** If so, how many slots are funded by DFTA? ____ ☐ N/A

**40.** For NYC providers, are you in compliance with DFTA's Quality Assurance Guidelines? ☐ Yes ☐ No ☐ N/A

**41.** Is the program in the facility funded by City Meals on Wheels? ☐ Yes ☐ No

**42.** Does the program have other funding sources? If so, please list below: ☐ Yes ☐ No

_____

**If applicable, Record Keeping (with policies and procedures required to be attached for SADCs, ADHC(MDY), & LHCSAs):**

**43.** Participant personal records, including identifying emergency, and medical information including physician name, diagnosis, and medications, service records for each participant, including the individual assessment, the service plan and documentation of the delivery of services are kept confidential? ☐ Yes ☐ No

**Please attach a copy of a blank assessment and care plan (only SADC and ADHC(MDY) facilities).**

**44.** How do you track participant attendance at your site?_____

_____

## SERVICES (only if applicable)

**45.** Please check all of the chore services below which your facility can provide:

☐Light duty cleaning ☐Heavy duty cleaning ☐Chores/Shopping

☐Carpet cleaning ☐Mattress cleaning ☐Laundry

☐Furniture cleaning ☐Furniture removal ☐Furniture disposal

☐Extermination ☐Bed bug treatment ☐Other (list): _____

**46.** Please check all of the home or health services below which your facility can provide:

☐Nursing Care ☐ Wound Care ☐ Home Infusion

☐ Social Services ☐ Physical Therapy ☐ Occupational Therapy

☐ Speech Therapy ☐ Home Health Aides ☐ Personal Care

☐ Other (list):_____

**47.** Do you have a licensed training program? ☐ Yes ☐ No

**48.** Are the facility's employees bonded? ☐ Yes ☐ No

**49.** Is the facility's staff timekeeping done? ☐ Yes ☐ No
If yes, how is it done?
☐Paper ☐Telephonic ☐Electronic

**50.** Please check all of the radiology services below in which your facility can provide:

| | | | |
|---|---|---|---|
| ☐ MRI | ☐ Fluoroscopy | ☐ CCTA | ☐ Nuclear Medicine Doppler Studies |
| ☐ PET | ☐ Echocardiography | ☐ CT | ☐ Bone Densitometry |
| ☐ EMG | ☐ Mammography | ☐ CTA | ☐ MR Guided Breast Biopsy |
| ☐ EKG | ☐ Ultrasound | ☐ X-Ray | ☐ Nuclear Cardiography |
| ☐ MRA | ☐ Breast MRI | ☐ Holter Monitoring | ☐ Myelography |
| ☐ IVP | ☐ Arthrography | ☐ Other: _____ | |

**51.** Does the facility hold a CLIA Certificate? If so, provide number: _____ ☐ Yes ☐ No

## OTHER SERVICES (mainly Nursing Homes)

**52.** List all of the nursing home treatments, procedures, and programs the facility can accommodate:

_____

_____

_____

**53.** Other Special Programs:

| | | |
|---|---|---|
| ☐Traumatic Brain Injury Program | ☐Bariatric Program | ☐Younger Adults Program |
| ☐Alzheimer's/Dementia Program | ☐Wandering Unit | |

**54.** Special Services or Programs:

_____

***The information below will be helpful in determining placements (answer only applicable questions):***

**55.** Are there transfer agreements with hospitals? If so, which hospitals: ☐ Yes ☐ No

_____

**56.** Are there any specialty/ethnic foods offered? If so, please list: ☐ Yes ☐ No

_____

**57.** Are there any religious affiliations and/or services at the facility? If so, please list: ☐ Yes ☐ No

_____

**58.** Is there resident council? ☐ Yes ☐ No

**59.** Is there family member sleepover allowed? ☐ Yes ☐ No

**60.** Is there family council or caregiver support group? ☐ Yes ☐ No

**61.** Is there any special transportation available to the facility for visitors? ☐ Yes ☐ No

**62.** Is there public transportation available nearby? ☐ Yes ☐ No

**63.** Are there any Ambulette/Ambulance providers utilized? ☐ Yes ☐ No

## DISCLOSURE QUESTIONS & SANCTIONS

If yes, to any question below, please explain on a separate sheet of paper.

1. Have there been any settled malpractice claims, suites, settlements or proceedings involving your organization? ☐ Yes ☐ No

2. Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted regarding participation in the Medicare or Medicaid program, or in regards to other federal or state government health care plans or programs? ☐ Yes ☐ No

3. Has an officer of your Organization ever been convicted of, pled guilty to, or pled “no lo contendere” to any felony including an act of violence, child abuse, or a sexual offense? ☐ Yes ☐ No

4. Has your Organization license ever been restricted, conditioned, suspended or terminated? ☐ Yes ☐ No

5. Does your Organization have any current state or federal sanctions or limitations? ☐ Yes ☐ No

6. **(For SNFs Only)** Has your organization been subject to any remedies? ☐ Yes ☐ No
*** If yes, please provide documentation of remedy being lifted**.

7. Does your organization have any, pending and/or settled, State Labor Law violation deemed willful? ☐ Yes ☐ No

8. Does your organization have any any other federal or state citations, notices, violations orders, pending administrative hearings or proceedings, or determinations of a violation of any labor law or regulation? ☐ Yes ☐ No

9. Does your organization have any civil or criminal investigation of the New York State Ethics Commission involving a violation(s) of Section 73 and Section 74 of the Public Office Law? ☐ Yes ☐ No

10. Does your organization have any investigation, indictment, or judgment of conviction for any business-related conduct constituting a crime under state or federal law? ☐ Yes ☐ No

## CONTACT INFORMATION

Please provide the important additional contacts at the facility below (required for SNFs):

| Position | Name | Telephone | Email |
|---|---|---|---|
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# ATTESTATION/RELEASE

I hereby affirm and represent all statements and information contained in this application are true to the best of my knowledge. I agree to inform VNSNY CHOICE, promptly of any change in the information provided in this application. I understand any false or misleading information, or the withholding of information deemed relevant by VNSNY CHOICE will disqualify this Membership Application from consideration as a VNSNY CHOICE participating provider.

In signing this application, I acknowledge this information is provided to VNSNY CHOICE for the purpose of developing a subcontract with the applicant organization. I further understand my completion and submission of this application only entitles the applicant organization to be considered as a participating provider. I understand that any decision with respect to my becoming a participating provider in the VNSNY CHOICE provider network remains the sole discretion of VNSNY CHOICE. VNSNY

CHOICE may, by means which it may choose, determine the truth or accuracy of all statements made herein.

In signing this application, I authorize VNSNY CHOICE to obtain any pertinent information needed to verify and credential my organization.

This attestation is granted with the understanding VNSNY CHOICE will take responsible measures to maintain the confidentiality of this information.

Print Officer Name _____ Signature of Officer _____

Title of Officer _____ Date _____

Completed application with all supporting documentation should be sent to:

**Mailing Address:**
VNSNY CHOICE Health Plans
Attention: Credentialing Department
220 East 42nd St, 3rd FL
New York, NY 10017
212-630-5303

**E-mail Address:**
CHOICECredentialing@vnsny.org

# ATTACHMENTS

**The following items must accompany your application:**

All Providers:
- General and Professional Liability Insurance Certificate copy and malpractice claims history
- IRS W-9 form
- Report from most recent site visit conducted by any City, County, State contracting authority (if applicable)
- Copy of OMIG Annual Compliance Certification Confirmation & status

Home Delivered Meals Providers:
- NYC Providers only: copy of current New York City Vendex rating letter
- Outside NYC Providers: copy of county or other governmental approval letter

Medical Adult Day Care Providers:
- Blank assessment and care plan
- Participant bill of rights
- Recent calendar of events
- Copy of Participant Eligibility Policy & Procedure Document
- Copy of Service Plan Policy & Procedure Document

Skilled Nursing Facility/Nursing Home:
- Copy of State Operating Certificate
- Statement of Deficiencies and plan of correction from Facility's most recent State survey OR Copy of letter from NYSDOH accepting plan of correction.
- Copy of any notice of sanctions imposed upon the nursing home by Medicare or Medicaid, or any disciplinary actions taken by the New York State Department of Health within the past five years
- Copy of accreditation documents
- Current Medicaid Rate Sheet

Laboratories:
- Copy of CLIA Certificate
- List of locations in New York State

Hospitals, Ambulatory Surgery Centers, D & TCs, Clinics, Health Centers, Radiology Centers, Dialysis Centers, Home Health Agencies, Outpatient Rehabilitation Centers, Hospice, etc.
- Copy of State Operating Certificate
- Copy of accreditation documents
- List of locations in New York State

## SADC CREDENTIALING REQUIRED DOCUMENTS

The following items must accompany your application:

- General/Professional/Automobile/Worker's Compensation Liability Insurance Certificate Copy
- IRS W-9 form, ADA Accessibility Attestation
- Liability Claims History Report
- SADC Policies and Procedures addressing:
  - a). Participant eligibility
  - b). Participant service plan (care plan)
  - c). Services delivery (services offered at the SADC)
  - d). Records and recordkeeping (including administrative and member records and confidentiality)
  - e). Admission and discharge
  - f). Program self-evaluation
  - g). Nutrition program
  - h). Organizational structure and staff functions
  - i). Orientation and training
- Completed Disclosure of Ownership and Interest Control Statement
- Copy of OMIG Certification Confirmation Notice and Approval
- Copy of current Certificate of Occupancy
- Copy of any materials showing the content of orientation training and any other trainings that are provided to staff (training manual, outlines, presentations, etc.)
- Participant Bill of Rights
- Blank participant assessment form (including medication form)
- Blank participant care plan form
- Blank participant attendance form
- Blank transportation documentation form (if transportation is provided)
- Sheet detailing emergency contact information
- Emergency preparedness program (fire, flood, choking, fainting)
- Copies of current insurance certificates for automotive liability insurance (if transportation is provided)
- Copy of any materials showing the content of any new trainings introduced over the past year that are provided to staff, as applicable (training manual, outlines, presentations, etc.)
- One year of training attendance sheets
- Current activity attendance roster
- Current calendar of events
- Current transportation log (if transportation services offered)
- Copies of contracts with third party vendors
- Copy of the SADC's current menu(s)

Copy of each of the following, if applicable:

- The current license of the Nutritionist or RN who provides oversight of the SADC's menu
- Proof of current participation in the USDA Child and Adult Care Food Program (CACFP)
- Proof of current participation in NYC DFTA Home Delivered Meals Program

Documents To Be Reviewed Obtained During Site Visit

- De-Identified health records of staff or attestation from supervisor on-site documenting annual assessment of staff health
- records and bi-annual PPD skin tests