Credentialing Application

Instructions:

Please type or legibly print in black ink and Fax, Mail, or E-mail Credentialing Application along with all required documentation to:

iCircle Care
860 Hard Road
Webster, NY 14580
Attn: Provider Network
Fax: (888) 519 - 2816
Email: ProviderNetwork@icirclecny.org

Credentialing Checklist:

Please utilize below checklist before sending to iCircle Care.

For questions please call: 1 (844) MY-iCare | 1.844.ICIRCLE(424.7253)TTY:711

- ☐ Signed and dated W-9
- ☐ Copy of Certificate of Liability Insurance - ***Certificate Holder*** *must be as follows:*
  iCircle
  860 Hard Road
  Webster, NY 14580
- ☐ National Provider Identification (NPI) number
- ☐ Copy of the Federal, State, and or/local License/Certificate
- ☐ Copy of Social Day Certification (Required for Social Day Programs ONLY)
- ☐ Copy of Medicaid ID number Certification
- ☐ Copy of FI Authorization Approval Letter (Required for CDPAS ONLY)
- ☐ Please check all pages are completed
- ☐ If any section does not apply to your organization please indicate by using “N/A”.
  Signatures or initials are required on each of the following pages: 9, 10, 11, 12, 13, 14, 15, 18 & 20
- ☐ For Transportation providers ONLY:
  - NYS DOT Certificate or Permit
  - Vehicle Registration from the Department of Motor Vehicles (for each vehicle)
  - Driver’s License (for each driver)
  - Certificate of Insurance (COI) for Automotive Liability (25k/50k) coverage; ***Certificate Holder*** *must be as follows:*
    iCircle
    860 Hard Road
    Webster, NY 14580

Contents

APP SECTION I. DEMOGRAPHIC and INSURANCE INFORMATION

License Information	List information related to the License
Provider Type	
Provider License #	
Provider Name	
Provider Address	
Location County	
Location Phone	
Location Fax	
Other Phone	
Contact Person And Title	
Contact's email	

Entity Information	List information related to the Entity, if different than License Info above
Entity Type	
Entity Name	
Entity Address	
Entity Phone	
Entity Fax	
Other Entity Phone	
Entity Contact And Title	
Contact's email	

If OTHER Identify	Make Checks Payable to: LICENSE NAME or ENTITY or OTHER
OTHER Name	
OTHER Address	
OTHER Phone	

Description	Number or Info applicable
National Provider Identifier (NPI) 10 digit number or declare you are "atypical" by writing that in the Number box.	
Medicaid Number	
Medicaid Encounter Data System (MEDS) Number (if different)	
Consumer-Directed Service Provider ID Number	
MEDICARE Number	
Employer Tax ID Number	

Provider Location

Actual operation hours each day at this location.	Hours of Operation / Office Hours	
Monday	From:	To:
Tuesday	From:	To:
Wednesday	From:	To:
Thursday	From:	To:
Friday	From:	To:
Saturday	From:	To:
Sunday	From:	To:

As a Provider, do you use Electronic Health Records?	**Yes or No** **If No, what year might you start?**
Is this location handicapped accessible? Circle all items accessible for people with physical disabilities.	**Building – Parking -- Office – Restroom Exam Rooms -- Equipment**
Is this location accessible to public transportation? Circle all that apply.	**Bus or Subway or Regional Train or None**
Do you have specialized options for Alzheimer enrollees?	**Yes or No**
Identify any Cultural or Religious Affiliations	

Contracting Contact :		
Phone:	Fax:	Email:
Credentialing Contact:		
Phone:	Fax:	Email:

Authorization Contact Name: Phone:	**Preferred Authorization Method** Fax ☐ or Email ☐ Please List Fax or email:

Circle to identify attributes of culturally appropriate services available to patients or members at this location or by this provider. Latin Meals or Kosher Meals Or, Identify other Ethnic Meals:
Diversity Training offered to Staff in the last 3 years? YES or NO Identify Program Name:

Please list any foreign language(s) or sign language that is spoken fluently when working with patients or members at this location:

_____

Are translation services available? YES or NO
Do you provide Text Telephony (TTY)? YES or NO (TTY # if YES _____)

Circle to identify Ethnicity of Provider or staff working with patients or members at this location.			
American Indian / Alaska Native	Asian	Black / African American	Hispanic
Native Hawaiian / Other Pacific Islander	White / Caucasian	Decline to State	Unknown

Circle to identify if this location is identified as one of these Essential Community Providers (ECP):		
Federally Qualified Health Center (FQHC)	Ryan White Provider	Family Planning Provider
Indian Provider	Hospital	Other ECP (identify)

Provider Location:

Circle to identify Provider or staff working with patients or members at this location with any special experience, skills and training including expertise in treating Persons and Individuals in these categories:

Physical disabilities	Chronic illness	HIV/AIDS	Serious Mental Illness
Co-occurring disorders	Homeless	Deaf or hard-of-hearing	Blind or Visually impaired
Other specialties (Identify)			

Insurance Information

Are you required to carry professional or malpractice insurance? If YES, enclose a copy of your current Policy Certificate or Declarations Page.	Yes or No
Are you required or do you carry general liability insurance? If YES, enclose a copy of your current Policy Certificate or Declarations Page.	Yes or No
Are you required to carry workers compensation insurance? If YES, enclose a copy of your current Policy Certificate or Declarations Page.	Yes or No
Did you advise your Agent to send Certificate of Insurance to: iCircle Care, 860 Hard Road, Webster, NY 14580	Yes or No

Insurance Agent	**Provide Information below**
Agent Name	
Agent Address	
Agent Phone	
Agent Contact person and email	

APP SECTION II. LICENSING/CERTIFICATION/ACCREDITATION

Identify all licenses used to operate your office or facility. Please return copies of each.

State of License	Provider License Type	Provider License Number (attach copy of the license)	Site Survey by License Authority?	Accreditation Evidence Attached?	Criminal Background Check Level 1, 2, or n/a
			Yes or No	Yes or No	1, 2, or n/a
			Yes or No	Yes or No	1, 2, or n/a
			Yes or No	Yes or No	1, 2, or n/a
			Yes or No	Yes or No	1, 2, or n/a
			Yes or No	Yes or No	1, 2, or n/a
			Yes or No	Yes or No	1, 2, or n/a

Long Term Care provider qualifications will often include a nurse for some services or a . For example: Medication Administration, Medication Management, Caregiver Training, and Behavior Management. Therefore, we are requesting the following information regarding nurses that may be on your staff.

State of License	Nurse Type	Nurse License Number (attach copy if available)	Minimum of 2 years direct experience working with adult populations diagnosed with Alzheimer's disease, other dementias or persistent behavioral problems
	RN or LPN		Yes or No
	RN or LPN		Yes or No
	RN or LPN		Yes or No
	RN or LPN		Yes or No

APP SECTION III. -- Application Disclosure Questions & Attestations

1. Has your Provider license ever been restricted, conditioned, suspended, terminated, or have you or your facility ever lost a licensure, certification, or accreditation?	Yes or No
2. Have you ever had loss or limitation of privileges, been sanctioned, reprimanded, disciplined, disqualified from participation or penalized in any way by a PSRO, PRO HCFA, or similar federal state agency including any with Medicaid or Medicare?	Yes or No
3. Do you or your facility have any current State or Federal sanctions or limits including any with Medicaid or Medicare?	Yes or No
4. Have there ever been or are there currently pending, any malpractice claims, suits, settlements or proceedings involving your professional practice?	Yes or No
5. Have you ever voluntarily relinquished or withdrawn, or failed to proceed with an application for any of the above in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to professional conduct?	Yes or No
6. Have you any history of felony convictions or has adjudication been withheld on a felony, pled nolo contendere to a felony, or entered into a pretrial for a felony?	Yes or No
7. Has any disciplinary action been taken against any business or professional license held in this or any other state or surrendered a license in this or any state?	Yes or No
8. Do you have, and will you maintain, liability insurance and workers compensation as required by rule and law?	Yes or No
9. If you are a “Chore” services provider, you attest staff providing these services will have appropriate training as may be required by your regulating Agency.	Yes or No
10. Have you been licensed for less than six months? If Yes provide relevant work history.	Yes or No

If you answered “YES” to #1 through #7 or #10 in the above questions, please provide a written explanation below. Additional documentation may be attached, if necessary. If attached, please annotate the enclosure here.

_____

_____

_____

_____

_____

_____

_____

_____

The undersigned, on behalf of the organization named above, hereby certifies that the above information is true and correct to the best of my knowledge. I further acknowledge, (i) that the organization will be bound by the terms of iCircle Care Network and affiliated MCO Health Plans Credentialing Plan; (ii) that iCircle Care Network and MCO may inquire of third party agencies for the purpose of verifying the information in this application; (iii) that any material misstatement in or omission from the Application may constitute grounds for denial or revocation of participation; and (iv) this is our attestation of compliance with all background screening laws and regulations applicable to our services, employees, and/or volunteers if any. More specifically, I attest compliance with Level II background screening in accordance with State requirements; and (v) iCircle Care and/or its MCO clients will be notified within ten (10) days of any material changes to the information in attestations.

Signature on next page. Please initial here _____ **Date:** _____

APP SECTION III continued. -- Attestations regarding Training – (Signature)
Abuse, Neglect, and Exploitation Training – Provider Attestation

All providers, who are mandated reporters of abuse, neglect, and exploitation, must attest that their staff has received the appropriate training. Please complete this Attestation by marking next to the applicable statement.

_____ We are a mandated reporter of Abuse, Neglect, and Exploitation. Our staff has received the appropriate training and update training as applicable. We are current with this requirement.

_____ We are NOT a mandated reporter of Abuse, Neglect, and Exploitation and will update this attestation should we become a mandated reporter.

Additionally, all providers and their employees with direct contact with enrollees must have completed Abuse, Neglect, and Exploitation Training. Please complete this Attestation as evidence of your compliance by marking next to the applicable statement.

_____ Our license requires that we provide Abuse, Neglect, and Exploitation training to our direct care staff upon orientation and annually. We are current with this requirement.

_____ Our licensure requires that we provide Abuse, Neglect, and Exploitation training to our direct care staff upon orientation only. We are current with the requirement.

_____ Our license does not require Abuse, Neglect, and Exploitation Training; however our policy and procedures require our staff to have this in-service training upon orientation. We are current with this requirement.

_____ Our license does not require Abuse, Neglect, and Exploitation Training and we request information or assistance to provide this annual training to our staff. We will complete this Provider Attestation again when we are current with this training requirement.

Provider Name: _____

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

Signature: _____ **Date:**_____

Print Name & Title: _____

APP SECTION III Continued – Social Adult Day Service Providers

Application Disclosure Questions & Attestations for Social Adult Day Service (SADS) providers not required to be licensed in the state of New York.

Provider has 501c (3) status (if yes please attach a copy of your IRS notification letter).	Yes	No
Provider is under contract with the NYS Office on Aging for the provision of Social Adult Day Services (if yes please attach a copy of an award letter).	Yes	No
Provider is under contract with the one or more health plans for the provision of Social Adult Day Services (if yes please attach a list of the health plans contracted with).	Yes	No
Provider is currently providing Social Adult Day Services to private pay individuals.	Yes	No
Provider is under contract with the local county, municipal or Area Agency on Aging for the provision of service(s) to the elderly; i.e. congregate senior centers, case management, home delivered meals, transportation, home care or other services (if yes please attach a copy of an award letter).	Yes	No
Provider is aware of the Social Adult Day Services Program Standards promulgated by the NYS Office on Aging (http://www.aging.ny.gov/LTC/SADS/NYSOFAAdultDayCareRegs.pdf).	Yes	No
Provider is a member of the New York State Adult Day Services Association (NYSADSA)	Yes	No
Provider site(s) have valid public assembly permits and/or certificates of occupancy (please provide a copy of the permit and/or certificate)	Yes	No
Provider Social Adult Day Service site(s) are ADA handicapped accessible.	Yes	No

The undersigned, on behalf of the organization named above, hereby certifies that the above information is true and correct to the best of my knowledge. I further acknowledge, (i) that the organization will be bound by the terms of iCircle Care Network and affiliated MCO Health Plans Credentialing Plan; (ii) that iCircle Care Network and MCO may inquire of third party agencies for the purpose of verifying the information in this application; and (iii) that any material misstatement in or omission from the Application may constitute grounds for denial or revocation of participation.

Provider Name: _____

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

Signature: _____ **Date:** _____

Print Name & Title_____

APP SECTION III continued. -- Attestations regarding Compliance – (Signature)

First-Tier, Downstream, and Related Entity Attestation Form

I hereby attest that my organization has read and understands the CMS Compliance and Fraud, Waste, and Abuse (FWA) Training and agrees to abide by the laws and regulations therein upon the initial term of my contractual status and annually thereafter.

I have read and agree to comply with all of the iCircle Care written compliance policies and procedures and Standards of Conduct, and will implement and distribute them to all employees and board members of my organization.

I, nor any employees of my organization, have not been convicted of, or charged with, a criminal offense related to health care, nor have I been listed by a federal agency as debarred, excluded or otherwise ineligible for participation in federally funded health care programs.

I, agree to review the HHS OIG List of Excluded Individuals & Entities list at http://oig.hhs.gov/exclusions/exclusions_list.asp and GSA Debarment list monthly for all employees and downstream entities of my organization. I agree to immediately disclose any exclusion, or other event that makes my organization ineligible to perform work related directly or indirectly to Federal health care programs, to iCircle Care.

I have effectively screened my organization's governing bodies and senior leadership for conflicts of interest.

I agree to report suspected violations of any laws and regulations to iCircle Care I understand that any violation of any laws and regulations is grounds for disciplinary action, up to and including termination of my contractual status. I am aware that I am protected from retaliation for False Claims Act complaints, as well as any other applicable anti-retaliation protections.

Unless otherwise noted in the space immediately below, I am not aware of any possible violations of any laws and regulations at this time.

Provider Name/City/State: _____

Signature: _____ **Date:** _____

Print Name & Title _____

APP SECTION IV. GENERAL PROVISIONS of Application– (Signature)

In order to evaluate this application for participation in and/or continued participation in the iCircle Care Network, the Provider hereby gives permission to the iCircle Care Network, their MCO client and/or agents, to request information regarding the Provider's credentials and qualifications. This includes consent to contact the Provider accreditation agencies, Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers.

The Provider understands that the iCircle Care Network and the MCO will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of iCircle Care Network and MCO credentialing policies.

The Provider certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Provider is selected or retained, after such selection or retention, the Provider agrees to inform iCircle Care Network in writing within fifteen (15) days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Provider agrees that submission of this application does not constitute selection or retention by iCircle Care Network on its own behalf or, if applicable, as an agent for one of its MCOs or affiliated Plans and if the Provider is initially applying for participation, grants this Provider no rights or privileges in any Plan programs or any program or one of its MCO affiliated Plans until such time as this Provider receives notice of selection.

The Provider is solely responsible for ensuring that any licensed practitioners under employment or working in association with Provider practice are fully qualified, comply with background screening laws/regulations, and have all necessary licenses required by all relevant laws to legally perform the assigned functions. It is the responsibility of your organization to conduct criminal background checks for all personnel or volunteers as required by applicable state law.

Provider shall not pay, employ or contract with individuals on the state or federal exclusions lists for services funded by Medicaid or Medicare.

The Provider applicant acknowledges that iCircle Care is organizing a network of Providers for bringing managed care opportunities to the Provider. Further, that the Provider chooses which programs, plans, and/or opportunities to participate with.

All information submitted in this application is true and complete to the best of our knowledge and belief. A Photostatic copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said Photostatic copy shall have the same force and effect as the signed original.

Signature on next page. Please initial here _____ **Date:** _____

The Provider applicant acknowledges, and attests will maintain compliance, including notice to the MCO contractor within twenty-four (24) hours when an enrollee dies, leaves the facility, or moves to a new residence; and that ALL direct service Providers complete an Abuse, Neglect & Exploitation Training. It is your responsibility as the Provider to use Abuse, Neglect and Exploitation training materials that have been approved, in advance if so required by the Program Authority Department; and to maintain necessary documentation of this training for the employees that have contact with the MCO (Managed Care Organization) enrollees; and make this documentation available to iCircle Care, the MCO, and the Program Authority Department as requested.

Residential Facilities attest compliance and agree to maintain a "Home-Like Environment" and “Community Integration” as may be defined by the State in which the Residential Facility is located. Further, that no resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law. Every resident of a facility shall have the right to:

- Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
- A notice of relocation or termination of residency from the facility will comply with State regulations unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at the number of State required days’ notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction

Provider applicant warrants they are eligible for participation in the Medicaid program; however, the Provider applicant "may" not be required to participate in the Medicaid program as a direct provider. Such requirement varies by program and/or state.

I agree that this authorization and consent shall remain valid and in full force and effect until specifically withdrawn by me in writing.

Provider Name: _____

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

Signature: _____

Print Name & Title:_____

Email:_____ **Date:**_____

APP SECTION V. OWNERSHIP DISCLOSURE FORM

Provider Entity Status	Check if Applicable	Minority & Ownership Characteristics	Check if Applicable
Sole Proprietorship		African American	
Professional Association		Hispanic American	
Partnership or Limited Liability Company		Asian American	
Corporation- For Profit		Native American	
Corporation- Not For Profit		American Women	
		Other Minority (Identify)	

List names and addresses of all Principals and indicate percent ownership, if applicable. ("Principal" means any shareholder, officer, partner, joint venturer or anyone else having an ownership in or managerial control over the PROVIDER. Attach additional sheets if necessary.)

Officer, Director, or Partner Name	Title	Address	Ownership Percentage

APP SECTION VI. EVACUATION PLANS OF RESIDENTIAL FACILITIES

If you are a "Residential Facility" such as ALF, AFCH, CLF, SLF, or SNF, please list those facilities that you have a mutual aid agreement so that Care Coordinators may access such information in the event of a natural disaster or state of emergency. Thank you.

Potential Evacuation Facility	Telephone	Address of Potential Evacuation Facility	Contact Person

APP SECTION VII. RESIDENTIAL FACILITIES – (Signature)

CMS technical guidance and State requirements recognizes the importance of ensuring that enrollees who reside in Residential Facilities reside in Home-Like Environments (HLE) and experience community inclusion to the fullest extent possible. There is specific provider contract language on this subject.

To access Medicaid Home and Community Based funding the Residential Facility Provider must assure that they maintain a home-like environment and community integration. Please document the HLE characteristics of your facility and the Community Integration Goal Planning below. Comment on any "NO" responses at the bottom.

Home-Like Environments (HLE) Characteristics	Answer
1. The unit/room should be a specific physical place that can be owned or rented by the person receiving services, and the person should have, at a minimum, the same protections from eviction that the state's tenants have under landlord/tenant law.	YES or NO
2. Privacy: Units should have lockable entrance doors, with appropriate staff having keys to doors.	YES or NO
3. Privacy: Residents should share units only at the residents' choice.	YES or NO
4. Privacy: Unless residents sharing a unit are spouses or partners, each resident should have an individual bedroom.	YES or NO
5. Privacy: Residents should have the freedom to furnish and decorate their living units.	YES or NO
6. Residents should have the freedom and support to control their own schedules and activities, and should have access to food at any time.	YES or NO
7. Residents should be able to have visitors of their choosing at any time.	YES or NO
Further information on any "NO" answers:	

Community Integration Goal Planning Documentation	Answer
1. **Are identified goals documented in the care plan in resident file?**	YES or NO
2. **Are identified barriers documented in the care plan in resident file?**	YES or NO
3. **Are interventions documented in the care plan in resident file?**	YES or NO
4. **Is progress documented in the care plan in resident file?**	YES or NO
Comment on any NO answers:	

I, attest, acknowledge, and agree that we are, and will maintain, compliance with the agreement language on Home-Like Environment characteristics, Community Integration, and the applicable Resident Bill of Rights.

Provider Name: _____

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

Signature: _____

Print Name & Title:_____

Email:_____ **Date:**_____

When used as part of a site review, the reviewer will complete the following: On this date I have found the Provider complies with HLE requirements. YES or NO and File Documentation: YES or NO

Signature: _____

Print Name & Title: _____

ATTACHMENT A - Covered Services and Service Area

Provider Name:	
Address:	

Covered Services: Provider agrees to provide the services indicated below for enrollees:

Please check all that apply:

	Adult Day Health Care		Nursing Services
	Audiology/Hearing Aids		Nutrition
	Care Management		Optometry/Eyeglasses
	CDPAS- Consumer Directed Personal Assistance		Personal Care
	Dental		Personal Emergency Response (PERS)
	Durable Medical Equipment (DME)		Occupation, Physical and Speech Therapy In Home
	Home Care		Occupation, Physical and Speech Therapy Outpatient
	Home Delivered Meals / Congregate Meals		Podiatry
	Home Health Aide		Private Duty Nursing
	Medical Social Services		Respiratory Therapy
	Non-Emergent Transportation See page 21		Social and Environmental Supports/Modifications https://www.emedny.org/ProviderManuals/HCBSWaiver/PDFS/HCBS_Policy_Section.pdf
	Nursing Home Care/Skilled Nursing Facility		Social Day Care
	CFCO ☐ Assistive/Adaptive Technology ☐ Vehicle Modifications ☐ Community Transitional Services ☐ Moving Assistance ☐ ADL, IADL Skills Acquisition, Maintenance and Enhancement (SAME)		
	Skilled Nursing Facility ☐ Do you offer services to the community (such as Occupational Therapy, Physical Therapy, Speech Therapy, etc.) - Y/N ☐ If YES, what services do you provide: _____ _____		

	_____ ▫ Do you offer respite services? – Y/N ▫ Do you offer specialty services (vent, neuro, etc.) – Y/N ▫ If YES, what services do you provide: _____ _____ _____

Service Area: Provider agrees to provide the services indicated herein for enrollees in the New York Statewide Program for the following counties. Facility based providers may be listed in Provider Directories for all adjacent state counties.

*Please check all that apply (**only counties that your organization services**):*

Albany	Cortland	Jefferson	Onondaga	Saratoga	Ulster
Allegany	Delaware	Kings	Ontario	Schenectady	Warren
Bronx	Dutchess	Lewis	Orange	Schoharie	Washington
Broome	Erie	Livingston	Orleans	Schuyler	Wayne
Cattaraugus	Essex	Madison	Oswego	Seneca	Westchester
Cayuga	Franklin	Monroe	Otsego	St. Lawrence	Wyoming
Chautauqua	Fulton	Montgomery	Putnam	Steuben	Yates
Chemung	Genesee	Nassau	Queens	Suffolk	
Chenango	Greene	New York	Rensselaer	Sullivan	
Clinton	Hamilton	Niagara	Richmond	Tioga	
Columbia	Herkimer	Oneida	Rockland	Tompkins	
☐ **All New York Counties**					

Print Name:	
Provider Signature:	
Date:	

TRANSPORTATION SERVICES PROVIDED* *TRANSPORTATION PROVIDERS ONLY
Provider Name:

TYPE OF SERVICE	YES	NO
Taxi/Livery		
Wheelchair Van		
Ambulance		
Stretcher Van		
Bariatric Wheelchair		
2-Man Assist		