Facility and Ancillary Enrollment Application

We appreciate your interest in providing care for our members as a contracted provider. Please use the following checklist to ensure you have provided all of the information and documentation required to process this application. If any section of the application does not apply to your organization please indicate that by using N/A. Once complete, please return this application with your signed contract to the address below.

Required Documentation:

☐ Copy of Federal, State, and/or Local License (OPCERT or License)

☐ Accreditation Certificate(s) as applicable (See below "Accreditations")

☐ Copy of any other State/Federal licensure (CLIA, DPS, DEA, etc.)

☐ Copy of Certificate of Insurance with General Liability coverage minimum amount $1M/$3M with current coverage dates

☐ Proof of enrollment in New York State Medicaid

☐ Proof of enrollment with Medicare

☐ W9. Please sign and date the form with the IRS registered legal entity name and billing address. Please only use your assigned TIN or SSN. This information MUST match the name on the Participating Provider Agreement

☐ Disclosure of Ownership and Control Interest statement (attached separately)

Applications may be returned to:

- Mail – iCircle, 860 Hard Road, Webster, New York 14580 Attention: Credentialing
- Email – Credentialing@iCircleCNY.org

Demographic Information

Legal Entity Name (line 1 W9):	DBA name (line 2 W9)	
Tax ID number:	Billing NPI:	Date of Application:
Additional NPI with service type (if applicable)	Additional NPI with service type (if applicable)	Additional NPI with service type (if applicable)
License #:	Medicaid ID # **(required)**:	Medicare ID # :

*Physical Address :	**Street Address** (*street level only, No PO Box)**:**			STE:
	City:	County:	State:	ZIP Code:
	Office Phone:	Office Fax:	Handicap accessible (**required**): ☐ Yes ☐ No	
	Email:		Public Transportation: ☐ Yes ☐ No	
Remit Address:	**Address:**			STE:
	City:	County:	State:	ZIP Code:
	Office Phone:	Office Fax:	Email:	
Billing Address:	**Address (**iCircle requests the billing address be populated here and on the W9)**:**			STE:
	City:	County:	State:	ZIP Code:
	Office Phone:	Office Fax:	Email:	

Credentialing Contact:	Name:	Telephone:	Email:
Billing Contact:	Name:	Telephone:	Email:
Authorization Contact:	Name:	Telephone:	Email:

Office Hours:	**From**	**To**
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

*If you have multiple locations please submit a roster of locations including all of the information requested above.

Facility and Ancillary Service Type (Please check all that apply)

	Type	Additional Information	Accreditation to Submit
☐	Adult Day Health Program		
☐	Ambulatory Surgery Center		JCAHO (TJC), HFAP, AAAHC, CMS or DOH review
☐	Community First Choice Option (CFCO)	☐ Assistive/Adaptive Technology (include type)_____ ☐ Environmental Modifications ☐ Vehicle Modifications ☐ Community Transitional Services ☐ Moving Assistance ☐ ADL, IADL Skills Acquisition, Maintenance and Enhancement (SAME) ☐ Home Delivered/Congregate Meals	
☐	Consumer Directed Personal Care Services(CDPAS)/Fiscal Intermediary		
☐	Durable Medical Equipment	☐ Diabetic Supplies ☐ Enterostomal Supplies ☐ Hospital Beds ☐ Incontinence Supplies ☐ Lift Chairs ☐ Oxygen/Respiratory Therapy ☐ Podiatry DME ☐ Prosthetics/Orthotics ☐ Other_____	ACHC DMEPOS Accreditation or letter from Palmetto GBA confirming DMEPOS
☐	Diagnostic and Treatment Center	☐ Federally Qualified Health Center (FQHC) ☐ Rural Health Center (RHC) ☐ Comprehensive Outpatient Rehab (CORF)	JCAHO (TJC), DNV, CMS or DOH review
☐	Free Standing Dialysis Center		AAHC, CMS or DOH review
☐	Free Standing Sleep Study Center		AASM, CMS or DOH review
☐	Free Standing Surgical Center/Ambulatory Care Organizations		JCAHO (TJC), AAAHC
☐	Free Standing Urgent Care Center		JCAHO (TJC), UCCA, CMS or DOH review
☐	Hemophilia Clinic/Clotting Factor Provider		
☐	Certified Home Health Agency (CHHA)	☐ Audiology ☐ In-home Physical Therapy ☐ In-home Occupational Therapy ☐ In-home Speech Language Pathology ☐ In-home Respiratory Therapy ☐ Medical Social Services ☐ DME/Medical Supplies ☐ Nursing ☐ Nutrition ☐ Home Health Aide ☐ Personal Care Services ☐ Telehealth	JCAHO (TJC), CHAP, ACHC, CMS or DOH review
☐	Licensed Home Health Services Agency (LHCSA)	☐ Audiology ☐ In-home Physical Therapy ☐ In-home Occupational Therapy ☐ In-home Speech Language Pathology ☐ In-home Respiratory Therapy ☐ Medical Social Services ☐ DME/Medical Supplies ☐ Nursing ☐ Nutrition ☐ Home Health Aide ☐ Personal Care Services ☐ Homemaker/Housekeeper ☐ Telehealth	JCAHO (TJC), CHAP, ACHC, CMS or DOH review
☐	Home Infusion		ACHC

☐	Hospice		CHAP, ACHC
☐	Laboratory		CLIA
☐	Organ Procurement Organization		FACT (Bone Marrow Transplants)
☐	Outpatient Diabetes Self-Management training		
☐	Outpatient Therapy Services:	☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Language Pathology ☐ Respiratory Therapy ☐ Pediatric Services Age range:_____	
☐	Personal Emergency Response System (PERS)		
☐	Portable X-Ray suppliers		ACR, IAC
☐	Skilled Nursing Facility	☐ Baseline ☐ Outpatient PT/OT/ST ☐ Adult Day Health Care ☐ Respite ☐ Assisted Living Program ☐ Specialty Unit: _____	JCAHO (TJC), CARF (rehabilitation), CCAC, CMS or DOH review
☐	Social Adult Day Program (MLTC only)		Annual Certification with NYS DOH/OMIG
☐	Social and Environmental Supports	☐ Pest Management ☐ Cleaning Services ☐ Other _____	NYSDEC Certification

Accreditations

Please attach a copy of any Accreditation Certificate(s) or:
Most recent NYSDOH onsite survey

Date of most recent full survey: _____

Please provide proof of survey and any corrective action plans as appropriate

Insurance/Professional Liability Coverage

☐ Attach a copy of the current Certificate of Insurance with detailed coverage amounts.

Additional Information

1. Has the practitioner completed cultural competence training? If so, please indicate type.
   - ☐ African American
   - ☐ Alaskan Native
   - ☐ American Indian
   - ☐ Asian
   - ☐ Hispanic/Latino
   - ☐ Pacific Islander
   - ☐ Other

2. Does your location offer Non-English languages on site by qualified health-care interpreters? If so, please indicate type.
   - ☐ American Sign Language (ASL)
   - ☐ Haitian
   - ☐ Hindi
   - ☐ Italian
   - ☐ Japanese
   - ☐ Korean
   - ☐ Polish
   - ☐ Portuguese
   - ☐ Russian
   - ☐ Spanish
   - ☐ Vietnamese
   - ☐ Other

3. Do you provide translation services for written materials? ☐ Yes ☐ No

4. Please specify what accessible types of options you have for individuals with physical disabilities:
   - ☐ Parking spaces, curb ramps, or loading zones at building entrance
   - ☐ Doorways wide enough to ensure safe-passage by individuals with mobility aids
   - ☐ Wheelchair accessible restrooms with grab bars
   - ☐ ASL signage and raised tactile text characters at office and/or elevator
   - ☐ Medical equipment accessible to patients using mobility aids
   - ☐ Exam rooms accessible to patients using mobility aids

Minority Owned Business

Are you designated as a Minority Owned Business? ☐ Yes ☐ No

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

If you do not provide all services in all counties selected above please provide further explanation:

_____

_____

_____

Attestation Questionnaire (any Yes responses should be fully explained with explanation attached separately)	
1. ☐ **Yes** ☐ **No**	Has the facility ever had or currently have pending any legal actions excluding medical malpractice?
2. ☐ **Yes** ☐ **No**	Has the facility ever been convicted of a crime, excluding misdemeanors?
3. ☐ **Yes** ☐ **No**	Has any government agency ever investigated, suspended, revoked, or taken other action against your license to conduct business?
4. ☐ **Yes** ☐ **No**	At any time, has any license or certification ever been revoked, denied, or suspended by others or voluntarily given up by the facility, or are any actions which may lead to such conclusions now under way?
5. ☐ **Yes** ☐ **No**	At any time, has the facility been assessed a penalty, conviction, or suspension or is the facility currently under investigation by the Medicaid or Medicare programs?
6. ☐ **Yes** ☐ **No**	At any time, has any third party payors ever revoked, reduced, denied, or suspended your facility's participation due to inappropriate utilization management or any quality of care issues?
7. ☐ **Yes** ☐ **No**	Has any managing employee or person with an ownership or control interest been excluded from participation in a government program (i.e. Medicaid/Medicare)?

I hereby certify that all responses and information provided pursuant to the above questions and requests are complete, accurate and current to the best of my knowledge and belief. I acknowledge that any misstatements in or omissions from this application constitute cause for denial or revocation of participation. Further, I give permission to verify the organizational providers credentials and by doing so hereby authorize release of the requested information concerning the organizational providers licensing, certification and accreditation. I further acknowledge, (i) that the organization will be bound by the terms of iCircle Services of the Finger Lakes, Inc. Credentialing plan; (ii) that 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 to compliance with Level II background screening in accordance with State requirements; and (iii) iCircle Services of the Finger Lakes, Inc. will be notified within ten (10) days of any material changes to the information in attestations. I also 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 warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

Provider Name/City/State: _____

Signature: _____ **Date:** _____

Print Name & Title _____