



## 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. 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](mailto:Credentialing@iCircleCNY.org)

**For any questions, please reach out to Provider Services at 1-844-283-2884.**



**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): <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Email:		Public Transportation: <input type="checkbox"/> Yes <input type="checkbox"/> 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:	<b>From</b>	<b>To</b>		
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)	<input type="checkbox"/> Assistive/Adaptive Technology (include type) _____ <input type="checkbox"/> Environmental Modifications <input type="checkbox"/> Vehicle Modifications <input type="checkbox"/> Community Transitional Services <input type="checkbox"/> Moving Assistance <input type="checkbox"/> ADL, IADL Skills Acquisition, Maintenance and Enhancement (SAME) <input type="checkbox"/> Home Delivered/Congregate Meals	
Consumer Directed Personal Care Services(CDPAS)/Fiscal Intermediary		
Durable Medical Equipment	<input type="checkbox"/> Diabetic Supplies <input type="checkbox"/> Enterostomal Supplies <input type="checkbox"/> Hospital Beds <input type="checkbox"/> Incontinence Supplies <input type="checkbox"/> Lift Chairs <input type="checkbox"/> Oxygen/Respiratory Therapy <input type="checkbox"/> Podiatry DME <input type="checkbox"/> Prosthetics/Orthotics <input type="checkbox"/> Other _____	ACHC DMEPOS Accreditation or letter from Palmetto GBA confirming DMEPOS
Diagnostic and Treatment Center	<input type="checkbox"/> Federally Qualified Health Center (FQHC) <input type="checkbox"/> Rural Health Center (RHC) <input type="checkbox"/> 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)	<input type="checkbox"/> Audiology <input type="checkbox"/> In-home Physical Therapy <input type="checkbox"/> In-home Occupational Therapy <input type="checkbox"/> In-home Speech Language Pathology <input type="checkbox"/> In-home Respiratory Therapy <input type="checkbox"/> Medical Social Services <input type="checkbox"/> DME/Medical Supplies <input type="checkbox"/> Nursing <input type="checkbox"/> Nutrition <input type="checkbox"/> Home Health Aide <input type="checkbox"/> Personal Care Services <input type="checkbox"/> Telehealth	JCAHO (TJC), CHAP, ACHC, CMS or DOH review
Licensed Home Health Services Agency (LHCSA)	<input type="checkbox"/> Audiology <input type="checkbox"/> In-home Physical Therapy <input type="checkbox"/> In-home Occupational Therapy <input type="checkbox"/> In-home Speech Language Pathology <input type="checkbox"/> In-home Respiratory Therapy <input type="checkbox"/> Medical Social Services <input type="checkbox"/> DME/Medical Supplies <input type="checkbox"/> Nursing <input type="checkbox"/> Nutrition <input type="checkbox"/> Home Health Aide <input type="checkbox"/> Personal Care Services <input type="checkbox"/> Homemaker/Housekeeper <input type="checkbox"/> Telehealth	JCAHO (TJC), CHAP, ACHC, CMS or DOH review
Home Infusion		ACHC

**Important Notice:** Failure to legibly complete all sections of this application or provide all documentation may result in delays.



Hospice		CHAP, ACHC
Laboratory		CLIA
Organ Procurement Organization		FACT (Bone Marrow Transplants)
Outpatient Diabetes Self-Management training		
Outpatient Therapy Services:	<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Language Pathology <input type="checkbox"/> Respiratory Therapy <input type="checkbox"/> Pediatric Services Age range: _____	
Personal Emergency Response System (PERS)		
Portable X-Ray suppliers		ACR, IAC
Skilled Nursing Facility	<input type="checkbox"/> Baseline <input type="checkbox"/> Outpatient PT/OT/ST <input type="checkbox"/> Adult Day Health Care <input type="checkbox"/> Respite <input type="checkbox"/> Assisted Living Program <input type="checkbox"/> 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	<input type="checkbox"/> Pest Management <input type="checkbox"/> Cleaning Services <input type="checkbox"/> 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.

- |   |   |
|---|---|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic/Latino  |
| <input type="checkbox"/> Alaskan Native   | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> American Indian  | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Asian            |   |

2. Does your location offer Non-English languages on site by qualified health-care interpreters? If so, please indicate type.

- |   |                                     |
|---|-------------------------------------|
| <input type="checkbox"/> American Sign Language (ASL) | <input type="checkbox"/> Polish     |
| <input type="checkbox"/> Haitian                      | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> Hindi                        | <input type="checkbox"/> Russian    |
| <input type="checkbox"/> Italian                      | <input type="checkbox"/> Spanish    |
| <input type="checkbox"/> Japanese                     | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Korean                       | <input type="checkbox"/> 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**

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

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

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**Attestation Questionnaire (any Yes responses should be fully explained with explanation attached separately)**

1.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the facility ever had or currently have pending any legal actions excluding medical malpractice?
2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the facility ever been convicted of a crime, excluding misdemeanors?
3.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has any government agency ever investigated, suspended, revoked, or taken other action against your license to conduct business?
4.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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** \_\_\_\_\_