Enrollment Application
(Non-Emergent Transportation)

Instructions:

Please type or legibly print in black ink and Fax, Mail, or E-mail Enrollment 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 checklist below before sending to iCircle Care.

- ☐ Signed and dated W-9
- ☐ Certificate of Liability Insurance – (COI) for Automotive Liability (25K/50K) coverage; Coverage dates must be current. Please inquire about additional requirements for Combined Single Limit (CSL) policies.

  Certificate Holder must be listed as follows:

  iCircle Care
  860 Hard Road
  Webster, NY 14580

- ☐ NYS DOT Certificate or Permit (when applicable)
- ☐ Signed Driver and Vehicle Attestation
- ☐ Copy of Medicaid ID Number Certification
- ☐ If any section does not apply to your organization please indicate by using “N/A”.
- ☐ Please check all pages are completed
- ☐ Disclosure of Ownership and Control Interest statement (attached separately)

We will notify you when your application has been approved. Upon notification, you will be considered a participating provider in our network. Prior to receiving this notification, you are **not** considered in-network.

Credentialing applications are usually processed within **90 days** of receipt. Please ensure that applications are completed in their entirety, signed, and all supporting documentation included.

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APP SECTION I. Demographic Information

Demographic Information

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

**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:			
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:*	
Service Authorization Contact:	Name:	Telephone:	*Email:*	
Contracting Contact:	Name:	Telephone:	*Email:*	
Customer Service Contact:	Name:	Telephone:	*Email:*	

Preferred Method to receive Service Authorizations

Fax ☐ or Email ☐

Please List Fax or Email:_____

Provider Operations: What hours are you available to transport members?

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

APP SECTION II. Additional Operational Information

Insurance Information

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

Operating License / Certification (if applicable)

Identify all licenses/certifications used to operate your business.
(i.e., DOT Certificate and/or Taxicab License)

DO NOT send copies of individual driver's licenses

State of License/Certification	Provider License/Certification Type	Provider License/ Certification Number (attach copy)

Special Expertise

A. Check 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			

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

_____

_____

C. Are translation services available? ☐ YES or ☐ NO

D. Diversity Training offered to Staff in the last 3 years? ☐ YES or ☐ NO
Identify Program Name:

E. Do you provide Text Telephony (TTY)? ☐ YES or ☐ NO
(TTY # _____)

Covered Services and Service Area

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

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

Service Area: Provider agrees to provide the services indicated herein for enrollees in the New York Statewide Program for the following counties. *Please check all that apply*

Counties served – Please check a box for only those counties that your organization services			
☐ 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**	

The undersigned, on behalf of the organization named below, 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.

Business Name: _____

Authorized Signature: _____ Date: _____

Print Name & Title: _____

APP SECTION III. Application Disclosure & Attestations

A. Disclosure

1. Has your Provider license ever been restricted, conditioned, suspended, terminated, or have you or your business ever lost a licensure or certification?	☐ Yes ☐ No
2. Have you or your business ever had loss or limitation of privileges, been sanctioned, reprimanded, disciplined, disqualified from participation or penalized in any way by state or federal agency, including Medicaid or Medicare?	☐ Yes ☐ No
3. Have there ever been or are there currently pending, claims, suits, settlements or proceedings involving your business?	☐ Yes ☐ No
4. 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 ☐ No
5. Has any disciplinary action been taken against any business operated by you or held by you in this or any other state?	☐ Yes ☐ No
6. Have you been licensed for less than six months? If Yes provide relevant work history.	☐ Yes ☐ No
7. Do you carry and maintain liability insurance as required by rule and law?	☐ Yes ☐ No

If you answered "YES" to #1 through #6 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: _____ Date: _____

B. Driver and Vehicle Attestation

I hereby attest to the following:

- All drivers operate with a valid NYS driver's license and are subject to annual driver's license checks.
- All drivers are subject to the Providers policies regarding drug and alcohol testing. These policies must be in line with NYS DOH and NYS DOT regulations.
- All vehicles are registered, in compliance with NYS inspection, have been properly maintained, and are in safe operating condition.
- The above information is on file with the Company and available on request by iCircle Care.
- iCircle will not be responsible for penalties incurred by the Company due to unmet licensure requirements or unsafe driving.
- The Company will comply with all standards detailed in the New York State Medicaid Program Transportation Policy Guidelines.

Signature: _____ Date: _____

C. 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.

Signature: _____ Date: _____

APP SECTION IV. General Provisions of Application

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: _____ 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.

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.

Signature: _____ Date: _____