Humana.

Home & Community-Based Services (HCBS)/Long Term Services & Supports (LTSS) Provider Assessment Form

Organization information		
Entity name:		
Doing business as (DBA) name or legal name (If applicable):		
Historic name(s) of the entity (if under same ownership):		
Management/ownership group name (if applicable):		
Is the entity enrolled in Medicare? ☐ Yes ☐ No Medicare number: _____	Is the entity enrolled with IHCP? ☐ Yes ☐ No IHCP provider ID: _____ State: IN	
Tax identification number (TIN):	Number if beds, as applicable by provider type:	
National provider identifier (NPI), as applicable: ☐ Check if the provider does not have an NPI.	Select one: ☐ For profit ☐ Nonprofit	
Ownership type (select one): ☐ Church related ☐ City/county owned ☐ Corporation ☐ Other (specify): ☐ Federally owned ☐ Hospital district ☐ Limited liability company ☐ Partnership ☐ Sole proprietorship ☐ State owned		
Physical location information		
Site-specific Medicare number:	Site-specific IHCP provider ID:	
Site-specific TIN:	Site-specific NPI, as applicable:	
Street address:		
City:	State:	
ZIP code:	County:	
Phone:	Fax:	
Mailing address		
Street address:		
Address line 2:		
City:	State:	ZIP code:
Phone:	Fax:	
Contact name:	Email:	
Contract Contact Information		
Contract Contact Name:	Contract Contact Phone:	
Contract Contact Email:		
Contract Signer:	Contract Signer Phone:	
Contract Signer Email:		

Humana.

Billing address (If different than mailing)		
Street address:		
Address line 2:		
City:	State:	ZIP code:
Phone:	Fax:	
Contact name:	Email:	

Hours of operation: ☐ **Check here if the organization operates 24 hours a day, 7 days a week.**

Day	Open	Close	Day	Open	Close
Monday:			Friday:		
Tuesday:			Saturday:		
Wednesday:			Sunday:		
Thursday:			☐ Telehealth services are available.		

Accessibilities	
☐ Americans with Disabilities Act (ADA) compliant	ADA access for: ☐ Building ☐ Parking ☐ Restroom
☐ Telecommunication device for the deaf (TTY) capability	☐ Interpreters available
☐ Answering service	☐ 24/7 phone coverage
☐ Is this location on a public transportation route?	☐ No ☐ Yes (explain) _____

Languages spoken by office personnel:

☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean
☐ German ☐ Dutch ☐ Other _____

Site survey

(Attach a copy of your most recent on-site survey or a cover letter from a government agency stating the facility is in substantial compliance.)

FSSA site survey is applicable for Assisted Living, Adult Day, and Adult Family Care Homes.
Health department site survey is applicable for Personal Care Service agencies.
Other HCBS provider types, please check the N/A option.

1. Has the facility had a post-licensing on-site visit by a government agency such as the Department of Health and Human Services or Centers for Medicare & Medicaid Services (CMS) within the past 36 months?
   - ☐ Yes – Date of most recent standard survey: _____
   - ☐ No – Successful completion of a health plan on-site visit may be required to complete credentialing.

2. Were any deficiencies cited during the last full survey?
   - ☐ Yes (If yes, attach documents defining deficiencies.)
   - ☐ No

☐ N/A – no recent survey

Licensure/Certification/Registration

Type of credential	**State**	**Number**	**Additional notes/info**
State license:			
State registration:			
State certification:			
CLIA:			
Other:			

Humana.

INDIANA LTSS SERVICES & COUNTIES

PLEASE COMPLETE ONE FORM PER LOCATION OR SUBMIT A ROSTER WITH SERVICES, LEVELS AND COUNTIES

SELECT ALL APPLICABLE SERVICES BELOW	
☐ **A07 Community Transition** **Service Counties:** _____	☐ **A10 Home-Delivered Meals** **Service Counties:** _____
☐ **A12 Nutritional Supplements** **Service Counties:** _____	☐ **A13 Pest Control** **Service Counties:** _____
☐ **A20 Home Modifications – Assessment** **Service Counties:** _____	☐ **A21, A00, A01, A02 Caregiver Coaching and Behavior Management** **Service Counties:** _____
Adult Day Service and Assisted Living providers: Please note your county selection (1 county/location) with the level/category selection above.	
A00 Adult Day Services ☐ Level 1 (Category 1) ☐ Level 1 (Category 2) **A01 Adult Day Services** ☐ Level 2 (Category 1) ☐ Level 2 (Category 2) **Facility Location County:** _____ ☐ **A09 Integrated Health Care Coordination** **Service Counties:** _____ **A02 Adult Day Services** ☐ Level 3 (Category 1) ☐ Level 3 (Category 2)	**A04 Assisted Living** ☐ Assisted Living – Level 1 ☐ Assisted Living – Level 2 ☐ Assisted Living – Level 3 **Facility Location County:** _____ ☐ **A09 Integrated Health Care Coordination** **Service Counties:** _____
A05 Attendant Care ☐ Attendant Care (Agency) ☐ Attendant Care (Non – Agency) **A15 Participant Directed Attendant Care** ☐ Attendant Care (Consumer- Directed) ☐ Attendant Care (Consumer- Directed Overtime) **Service Counties:** _____	**A21 Structured Family Caregiving** ☐ Structured Family Caregiving (Level 1) ☐ Structured Family Caregiving (Level 2) ☐ Structured Family Caregiving (Level 3) **Service Counties:** _____
A03 Adult Family Care ☐ Adult Family Care (Level 1) ☐ Adult Family Care (Level 2) ☐ Adult Family Care (Level 3) **Facility Location County:** _____	**A16 Specialized Medical Equipment Supplies** ☐ Specialized Medical Equipment – New DME ☐ Specialized Medical Equipment – Replacement or Repair **Service Counties:** _____
A14 Respite ☐ Respite (Unskilled) ☐ Respite (LPN) ☐ Respite (RN) **Service Counties:** _____	**A19 Personal Emergency Response System** ☐ Personal Emergency Response System – Install ☐ Personal Emergency Response System – Maintenance **Service Counties:** _____
A11 Home and Community Assistance ☐ Home and Community Assistance (Agency) ☐ Home and Community Assistance (Non-Agency) **Service Counties:** _____	**A17 Non-Medical Transportation** ☐ Nonmedical Transportation Non-assisted ☐ Nonmedical Transportation Assisted **Service Counties:** _____
A18 Vehicle modifications ☐ Vehicle Modifications ☐ Vehicle Modifications – Maintenance **Service Counties:** _____	

Humana.

HCBS certification from the appropriate division			
1. Have you received Department of Aging (DA) approval?:	☐ Yes	☐ No	
2. Do you have a DA Waiver Service Certification letter issued within the past 90 days?:	☐ Yes	☐ No	
3. Have you been licensed by the Indiana Professional Licensing Agency?	☐ Yes	☐ No	☐ N/A

Minority/Veteran Owned Status			
Minority Owned:	Yes ☐	No ☐	Minority Group (specify):
Minority Certified:	Yes ☐	No ☐	
Veteran Owned:	Yes ☐	No ☐	

Additional locations

If the organization operates multiple service locations, please complete the next section titled "Additional Location Addendum" for **each** service location. Meaning, if the organization operates 1 main service location and 4 additional service locations, please complete an "Additional Location Addendum" page for each of the 4 additional locations.

For each additional service location, please supply the demographic, licensure or registration, hours of operation, accessibilities, and languages spoken applicable to that specific location on the "Additional Location Addendum" page.

In the upper right-hand corner of the "Additional Location Addendum" page, please include the service location count. For example, if the organization operates 1 primary service location and 4 additional service locations, the 2nd location should be listed as "Service location 2 of 5". The 3rd location should be listed as "Service location 3 of 5", and so on. Please refer to the example below.

Service location 2 of 5
(If applicable)
Copy pages for each additional location

Service location 3 of 5
(If applicable)
Copy pages for each additional location

Service location 4 of 5
(If applicable)
Copy pages for each additional location

Service location 5 of 5
(If applicable)
Copy pages for each additional location

Humana.

Additional Location Addendum

Organization information		**Service location ___ of ___** (If applicable) Copy pages for each additional location
Demographics		
Location name:		
Location D/B/A name:	Location type:	
Site address:		
City, State, ZIP code:		
Phone:	Fax:	
Site's NPI, as applicable:	Site's Medicare number:	Site's IHCP provider ID:

Licensure/Certification/Registration

☐ Check here if this location is not required to be licensed, certified, or registered by a state agency. (Attach a copy of all.)

Type of credential	State	Number	Additional notes/info
State license:			
State registration:			
State certification:			
DEA:			
CLIA:			
Other:			

Hours of operation

Day	Open	Close	Day	Open	Close
Monday:			Friday:		
Tuesday:			Saturday:		
Wednesday:			Sunday:		
Thursday:			☐ The organization operates 24/7.		

☐ Telehealth services are available.

Accessibilities

☐ Americans with Disabilities Act (ADA) compliant	ADA access for	☐ Building	☐ Parking	☐ Restroom
☐ TTY capability	☐ Interpreters available			
☐ Answering service	☐ 24/7 phone coverage			
☐ Is this location on a public transportation route?	☐ No ☐ Yes (explain) _____			

Languages spoken by office personnel:

☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean
☐ German ☐ Dutch ☐ Other _____

Humana®

Organizational service provider screening

1. Select the method used to verify the license/certification of individuals rendering services for your organization:
   - ☐ Online directory with the appropriate state and/or federal licensure or certification board
   - ☐ Background check agency, contracted organization or vendor
   - ☐ Other process (please describe): _____

No process (please explain): _____

2. Indicate the method used to ensure that each license/certification (and all other credentials) of individuals rendering services for your organization is renewed before expiration:
   - ☐ Online directly with the appropriate state and/or federal licensure or certification board
   - ☐ Obtaining a current copy of the license/certification
   - ☐ Background check agency, contracted organization or vendor
   - ☐ Other process (please describe): _____
   - ☐ No process (please explain): _____

3. Indicate the method used to verify the identity of individuals rendering services for your organization:
   - ☐ Verification of a state driver's license or other government identification
   - ☐ Background check agency, contracted organization or vendor
   - ☐ Other process (please describe): _____
   - ☐ No process (please explain): _____

4. Indicate the method used to ensure criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service and that no individuals convicted of a felony for a healthcare-related crime (including, but not limited to, healthcare fraud, patient abuse and the unlawful manufacture, distribution, prescription or dispensing of a controlled substance) are rendering services:
   - ☐ Federal and/or state criminal background check(s)
   - ☐ Background check agency, contracted organization or vendor
   - ☐ Search a state "misconduct registry" or equivalent
   - ☐ Other process (please describe): _____
   - ☐ No process (please explain): _____

5. Has your organization or any of its authorized representatives ever been convicted of, pleaded guilty to or pleaded nolo contendere (no contest) to any legal actions (excluding medical malpractice and misdemeanors)?
   - ☐ No ☐ Yes (provide an explanation): _____
     _____
     _____

6. Does your organization or any of its authorized representatives currently have any pending legal actions (excluding medical malpractice and misdemeanors)?
   - ☐ No ☐ Yes (provide an explanation): _____
     _____
     _____

7. Has your organization at any time been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military or state department of health program?
   - ☐ No ☐ Yes (provide an explanation): _____
     _____

Humana.

8. Has any third-party payer ever revoked, reduced, denied or suspended your organization's participation due to inappropriate utilization management or quality-of-care issues?
   ☐ No ☐ Yes (provide an explanation): _____
   _____

9. Has any license or certification held by the organization or its branch locations ever been revoked, denied or suspended, or has the organization or its branch locations ever voluntarily surrendered any license or certification while under investigation or are any actions or investigations underway that may lead to one of these outcomes?
   ☐ No ☐ Yes (provide an explanation): _____
   _____

10. Has your organization's liability insurance coverage ever been restricted, limited, denied, not renewed or special-rated for any reasons other than the carrier's termination of operations in your state?
    ☐ No ☐ Yes (provide an explanation): _____
    _____

11. Does your organization currently employ any person who has been or is currently excluded from participation in a government program (e.g., Medicare, Medicaid)?
    ☐ No ☐ Yes (provide an explanation): _____
    _____

12. Does each service location associated with the facility follow the policies and procedures as defined by the facility's service location?
    ☐ No ☐ Yes (provide an explanation): _____
    _____

13. Does each service location associated with the facility follow the policies and procedures as defined by the facility's service location?
    ☐ No ☐ Yes (provide an explanation): _____
    _____

Restrictions

Provide any additional explanation or attach documents as needed for screening questions:

Humana.

DISCLOSURE OF OWNERSHIP, BUSINESS TRANSACTIONS & EXCLUSIONS STATEMENT FOR PROVIDERS

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to managed care entities that contract with the Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. **This statement must be completed whether or not you have any information to report.**

OWNERSHIP & CONTROL INTERESTS (42 CFR 455.104)

A. Please provide the following information for each Person with an Ownership or Control Interest in you as a Provider, or in any Subcontractor in which you, as a Provider, have direct or indirect ownership of 5% or more. If no such ownership exists, please indicate this with an "N/A."

☐ **N/A – Not applicable**

	Full legal name	Address	% of Owner	Interest	SSN or FEIN	Relationship
1						
2						
3						

B. If any Person with an Ownership or Control Interest listed in subsection IV (A) is related to another Person with an Ownership or Control Interest listed in section A as a spouse, parent, child or sibling, please complete the following section. If no such relationship exists, please indicate this with an "N/A."

☐ **N/A – Not applicable**

	Full legal name	Address	% of Owner	Interest	SSN or FEIN	Relationship
1						
2						
3						

C. For each Person with an Ownership or Control Interest listed in subsection IV (A) who also has an ownership or control interest in an organization other than those indicated in section A, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

☐ **N/A – Not applicable**

	Full name of business or organization	Name of other	Address	SSN or FEIN	% of Ownership Interest
1					
2					
3					

SIGNIFICANT BUSINESS TRANSACTIONS (42 CFR 455.405)

A. Please report your ownership of any Subcontractor with whom you as a Provider have had business transactions totaling more than twenty-five thousand dollars ($25,000.00) during the previous twelve (12) month period ending on the date of this request. If no such ownership exists please indicate this with an "N/A."

☐ **N/A – Not applicable**

	Full legal name	Address	SSN or FEIN	Reason
1				
2				
3				

B. Please report any Significant Business Transactions between you as a Provider and any Wholly Owned Supplier, or between you as a Provider and any Subcontractor, during the previous five (5) year period ending on the date of this request. If no such business transactions exist, please indicate this with an "N/A."

☐ **N/A – Not applicable**

	Name of Wholly Owned Supplier	Address	SSN or FEIN	Nature of Business Transactions
1				
2				
3				

Humana.

EXCLUDED INDIVIDUALS OR ENTITIES (42 CFR 455.106)

A. Are there any Persons with an Ownership or Control Interest in you as a Provider, or any type of your managing Employees, Agents or Subcontractors who have ever:

Been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid or other federally funded government healthcare programs in accordance with Sections 1128 and 1128A of the Social Security Act?

☐ Yes ☐ No

Been excluded from participation in Medicare, Medicaid or other federally funded government healthcare programs in accordance with Sections 1128 or 1128A of the Social Security Act?

☐ Yes ☐ No

B. Do you as a Provider have any agreements for the provisions of items or services related to the health plan's obligations under its contract with the Department of Human Services or the Centers for Medicare & Medicaid Services with an individual or entity who has been excluded from participation in Medicare, Medicaid or other federally funded government healthcare programs in accordance with Sections 1128 or 1128A of the Social Security Act?

☐ Yes ☐ No

If you answered "Yes" to any of the above questions, list the name and Social Security number or Tax ID of the individual or entity and reason for answering "Yes" (i.e., conviction of a criminal offense related to involvement in or exclusion from participation in Medicare, Medicaid or other federally funded government healthcare programs in accordance with Sections 1128 or 1128A of the Social Security Act).

	Full legal name	Address	SSN or FEIN	Reason
1				
2				
3				

Humana.

ATTESTATION AND RELEASE OF INFORMATION FORM

Modifications Will Not Be Accepted

RELEASE OF INFORMATION:
As part of the application process and for the purpose of verifying any information provided on this application, I, the undersigned authorized agent of the applicant facility/organization, grant the Managed Care Entity permission to contact any individual, institution, facility or agency identified on, or relative to, this application. Further, I hereby consent and authorize the Managed Care Entity to request, receive and inspect any and all records pertinent to consideration of this application.

As a health organizational facility/organization applicant, I, the undersigned authorized agent, acknowledge that I am required to supply the Managed Care Entity with verification of current malpractice coverage and any additional documentation necessary and relevant to the review of this application.

SITE REVIEW AUTHORIZATION:
I hereby grant permission for the Managed Care Entity to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support the Managed Care Entity's quality improvement and utilization review programs.

ATTESTATION:
I certify the information on this entire application is complete, accurate and current. I acknowledge that any misstatements in or omissions from this application constitute grounds for denial or summary dismissal. A copy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

I acknowledge that a decision about participation for the organization on this application will be delayed until all required information is received and/or verified. I acknowledge that acceptance of this application does not constitute approval or acceptance or participating status with the Managed Care Entity and does not grant this facility any rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this facility by the Managed Care Entity. All services rendered to its Members must be individually authorized until a written notice of participation and conditions of participation is issued by the Managed Care Entity.

This facility complies with all federal, state and local handicapped access requirements as well as the standards required by the 1990 federal Americans with Disabilities Act.

I certify that the appropriate state license or certification source is checked for all employees and direct service providers prior to the first provision of service. I certify that the appropriate state license or certification source is checked at least annually for employees and direct service providers to ensure that every licensed individual providing services as a representative of the applicant holds a current license, certification, and/or training, as applicable, to provide services. I certify that criminal background checks are conducted for all new employees and direct service providers prior to the first provision of service. I certify that the applicant does not employ or contract with any individual convicted of a felony for a healthcare-related crime, including, but not limited to, healthcare fraud, patient abuse, neglect or exploitation, and the unlawful manufacture, distribution, prescription or dispensing of a controlled substance. I certify that all employees and direct service providers have completed abuse, neglect, and exploitation training prior to the first provision of services.

I certify that the on-line exclusion lists for the (**http://oig.hhs.gov/exclusions/exclusions_list.asp**) and (**https://sam.gov/content/home**) are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthly basis to ensure that no state or federally excluded individuals perform any function related to any state or federal healthcare program. I certify that I will remove any employee or contracted service provider found on one of the above referenced federal exclusion lists from any functions related to a state or federal healthcare program.

The individual executing this Attestation is duly authorized and has the proper authority and proper authorization to execute this Attestation and does so with the intent to fully bind Facility to the truthfulness of its answers.

Authorized Signer: _____ Date: _____

Printed Name of Signer: _____

Authorized Signer Title: _____Signer's Email Address: _____

Printed Facility Name: _____