Map-811Checklist

NOTICE: Pursuant to 907 KAR 1:672 Section 2 1(c) (1), you must be enrolled as a participating provider prior to being eligible to receive reimbursement. **Enrollment in the program is not a guarantee; therefore, providing services to Kentucky Medicaid members prior to your effective date is at your own financial risk.**

A complete list of enrollment requirements for each provider type can be found on our website at the following link: http://www.chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm

Did you:

- Complete *all* questions? Questions not applicable should be completed with "N/A".
  (Applications will be rejected for any questions left blank.)
- Sign and date signature page (page 12) ***Electronic or stamped signatures are not accepted.***
- Attach appropriate licenses and/or certifications and all other required documents for requested effective date as well as current?
- Attach verification documentation for NPI and Taxonomy Code(s) from CMS NPI vendor or NPPES.
- Attach a MAP-347 if individual wants to be linked to group KY Medicaid provider number.
- Attach a copy of your Social Security card if you are enrolling as an individual. Attach your IRS verification letter if you are applying with a FEIN.
- If you are subject to an application fee, please attach a check payable to the KY State Treasurer. For more information on the application fee, please refer to your Provider Type Summary at **http://www.chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm.**
- Keep a copy of the application for your records.

Not completing these reminders will delay the processing of your application. Please ensure that all reminders above are completed. Other information not mentioned above may be requested during the processing of your application.

If you are completing this application for ENROLLMENT and you will not be participating with a MCO, please send this application to the following address:

Kentucky Medicaid
P.O. Box 2110
Frankfort, KY 40602

If you are completing this application for ENROLLMENT and you will be participating with a MCO, you will need to submit this application to the MCO of your choice.

Please do not send the application directly to the Department for Medicaid Services. This will delay the processing of your application.

If you have any questions regarding your enrollment, please call Kentucky Medicaid toll free at (877) 838-5085. A provider enrollment specialist will be available to help you between the hours of 8 am and 4:30 pm, EST, Monday through Friday.

Map-811 Provider Application Instructions

Section A: Administrative Information

Enrollment Block:

- If applying for a Kentucky Medicaid number for the first time, check first block.
- If reapplying as a Kentucky Medicaid number, check second block and enter your provider number in question #1.
- If a change in ownership has occurred, check third block.
- If applicant has been excluded from Medicare/Medicaid by Federal, State, or court sanction and has been terminated as a result, please declare "I am enrolling as a reinstatement" by checking fourth block.

MCO Participation: If you will be participating with a KY Managed Care Organization (MCO), please indicate.

Field #	Description
1	If a Kentucky Medicaid provider number has already been assigned to this provider, enter provider number.
2	Please mark the appropriate box. Indicate name of individual provider or if an entity/group is enrolling, please input entity/group name. For individual applicants, the name referenced in this field, must match all supporting documentation. Please include all suffixes in name if applicable. For entity/group applicants, the name referenced in this field and/or in question #3 must match all supporting documentation.
3	Enter the name the provider will be doing business as, if different than question #2. Otherwise, you may enter N/A. If you are applying for an individual provider number, do not enter your employer's name in this field.
4	Please mark the appropriate block.
5	Please mark the appropriate block.
6	Enter License/Certificate number for the applicant. Attach a copy of your license.
7	Enter provider type. (EXAMPLE: physician; dentist; etc.) A complete listing of provider types can be found at http://www.chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm.
8	Enter the type of service that will be provided. (EXAMPLE: Acute care; diabetic supplies; etc…)
9	Enter the date you wish your enrollment with Medicaid to be effective. Date must be in mm/dd/yyyy format.
10	Enter your National Provider Identifier (NPI). Include verification email or National Plan and Provider Enumeration System (NPPES) printout.
11	Enter your Taxonomy Code(s) associated with your NPI. (Attach extra sheet if necessary.) Include your email verification or NPPES printout.
12	Enter individual Social Security Number (SSN).
13	Enter FEIN only if you own the FEIN 100%.
14	Enter date of birth of applicant provider.
15	Please indicate which number will be used for reporting monies to you from Medicaid for 1099 purposes. Example: If you are an individual provider completing this question, please input your SSN or a FEIN if you own the FEIN 100%. If you are applying as an individual and want your monies to go to the entity/group, the individual must complete a MAP-347 form in order to be linked to the group setting under which they are reporting.
16	Please mark the appropriate box for tax structure.
17	Enter the first and last name of the person to sign for a summons in case of a lawsuit (N/A is not acceptable).
18	Enter telephone number of person named in question #17.
19	Enter Physical address, phone, fax, and physical county.
20	Enter Mailing address and credentialing contact information. The field must be completed with an email address.
21	Enter Pay-to/1099 address.
22	If you have held any Kentucky Medicaid group/facility numbers in the past three years, please enter on form. If not, please indicate with N/A.
23	Please list all Medicare numbers of applicant.
24	Please complete bed breakdown of facility.
25	Enter the Administrator's name with telephone and fax number.
26	Enter the Assistant Administrator's name, telephone number, and fax number.
27	Enter the Controller's name, telephone number, and fax number.
28	Enter the Accountant or CPA's name, telephone number, and fax number.
29	Enter the Fiscal Year End (FYE).
30	Complete if you wish to link to a group. Attach a MAP-347 for any additional group you wish to link to.

Section B: Disclosure of Ownership and Control Interest

Field #	Description
1	If there has been a change of ownership, list previous Medicaid provider number(s) and start and end dates for each.
2	Describe relationship or similarities between the provider disclosing information on this form and items "A" through "C".
3	Do you plan to have a change in ownership, management company or control within the next year? If so, when?
4	Do you anticipate filing bankruptcy? If so, when?
5	Enter the Federal Tax Identification Number (**if there is an affiliation with a chain**) along with name, address, city, state and zip code.
6	List name, address, SSN/FEIN of each person or organization having direct or indirect ownership or control interest in the disclosing entity. *Complete question #7 with the officers' and board members' information. If no one owns 5% or more of provider, check box and complete question #7 with the officers' and board members' information.* If you are applying as an individual and do not own a FEIN, please enter **your** name and information. In addition, all business locations of the corporate entity must be disclosed.

Indirect Ownership Interest - means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Ownership interest - means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest - means a person or corporation that:

- Has an ownership interest totaling 5% or more in a disclosing entity;
- Has an indirect ownership interest equal to 5% or more in a disclosing entity;
- Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity;
- Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity;
- Is an officer or director of a disclosing entity that is organized as a corporation; or,
- Is a partner in a disclosing entity that is organized as a partnership

7	List officers' and board members' information of disclosing entity. A social security number of officer or board member may be required.

Subcontractor- means an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients, OR an individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment or services provided under the Medicaid agreement

8	If applicant is related to persons listed in questions #6, #7, and #17, list the relationship.
9	List name of managing company, if not applicable enter N/A. A FEIN may be required.
10	List names of the disclosing entities in which persons have ownership of other disclosing entities.

Other Disclosing Entity- means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes:

- Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII).
- Any Medicare intermediary or carrier.
- Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX or the Act.

11	If entity engages with subcontractors (such as physical therapist, pharmacies, etc.,) which exceeds the lesser of $25,000 or 5% of applicant's operating expense, list subcontractor's name and address.

Significant Business Transaction- means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5% of applicant's operating expense.

12	List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. A SSN/FEIN may be required.
13	List name, SSN, address of any immediate family member who is authorized to prescribe drugs, medicine, devices or equipment.
14	List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more who have been convicted of a criminal offense related to the involvement of such persons or organizations in any problem established under Title 19 (Medicaid) or Title 20 (Social Services Block Grants) of the Social Security Act (SSA) or any criminal offense in this state or any other state since the inception of those programs. Please also indicate any KY Medicaid provider number(s) associated with individual or organization.
15	List any agent and/or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX or XX of the SSA or any criminal offense in this state or any other state since the inception of those programs. Indicate any KY Medicaid provider number(s) associated with individual or organization.

Agent- means any person who has been delegated the authority to obligate or act on behalf of a provider.

Managing Employee- means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

16	List the name, title, SSN, and business address of all managing employees as defined in 42 CFR 455.101.
17	List name, address and SSN/FEIN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.

Map-811 (Enrollment)
(Rev 7/2015)

For Kentucky Medicaid Use Only

ATN#_____
Identifier: _____
Provider Type _____
Reviewer's Initials: _____

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
SECTION A: ADMINISTRATIVE INFORMATION

I am enrolling as a: ☐ **New Provider** ☐ **Re-applicant** ☐ **Change of Ownership** ☐ **Reinstatement**

Will you be contracting with a KY Managed Care organization (MCO)? ☐ *Yes* ☐ *No* *If* **yes, please indicate which MCO?**
☐ Anthem ☐ Aetna Better Health of KY ☐ Humana CareSource ☐ Passport Health Plan ☐ WellCare of Kentucky

1. Kentucky Medicaid Provider Number: ☐ ***Check here for N/A***
(Complete only if you have indicated **Reapplicant**, or **Reinstatement** above.)

2. Applying As:
Please check only one box and print clearly. For individual applicants, please input any suffixes if applicable.

☐ **Individual**	☐ **Entity** ☐ **Group**
Last: **First:** **MI:**	**Name:**

3. Doing Business As (DBA):

4. Please select: ☐ **Public** ☐ **Private**	**5. Please select:** ☐ **Profit** ☐ **Non-Profit**
6. License/Certification #:	**7. Provider Type:**
8. Type of Service:	**9. Date Provider Requests Effective Enrollment: ____/____/_____** **(Date must be in mm/dd/yyyy format.)**
10. National Provider Identifier (NPI):	**11. Primary Taxonomy Code:** (Attach extra sheet if necessary.)

12. SSN:	**13. FEIN (Please list only if you own the FEIN 100%):**	**14. Date of Birth:**

15. DMS will report all monies paid to the IRS. Please indicate which number you use for tax reporting. (If you are enrolling as an individual and do not own a FEIN, please check SSN field). (Check one only.) ☐ **SSN** ☐ **FEIN**

16. Tax Structure: Please select only one structure.
☐ **Individual** ☐ **Partnership** ☐ **Corporation** ☐ **Government/Non-Profit**
☐ **Sole Proprietor** ☐ **Estate/Trust** ☐ **Public Service Corporation** ☐ **Limited Liability Company**

17. Agent of Service in Case of Summons (N/A not acceptable). **First Name:** **Last Name:**	**18. Telephone # of Agent of Service (N/A not acceptable).**

19. PRIMARY PHYSICAL BUSINESS LOCATION:
(If you have more than one physical location, attach a copy of items listing additional locations. If an entity/group is applying, each additional location may require separate enrollment.)

Street Address:

City:	**State:**	**Zip:**
Phone #: **Ext.** **Fax #:**	**County:**	

20. MAILING ADDRESS: ☐ **(Check here if same as primary physical business address)**

Address:

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

Credentialing Contact Information (Required)
(This individual will be contacted should any information be needed to process the application.) ***Note*: Your email address will not be given to any outside party for any reason. DMS may use provider email addresses to send provider letters/notices.**

Name:	**Email Address:**
Phone:	**Fax Number:**

21. PAY-TO/1099 ADDRESS: ☐ (Check here if same as primary physical business address)

Address :

City:	**State**:	**Zip**:
Contact First Name:	**Contact Last Name:**	**Phone #:**

22. List any Kentucky Medicaid *group/facility* numbers you have held in the past three years. ☐ ***Check here for N/A***

23. Please list all Medi*care* Provider Numbers. (Attach extra sheet if necessary.) ☐ ***Check here for N/A***

24. Bed Breakdown ☐ ***Check here for N/A***

_____ Acute	_____ TCU	_____ Hosp. Swing	_____ ICF/IID
_____ ICU	_____ Nursery	_____ Rehab. Hosp.	_____ Ventilator Unit
_____ Surgical ICU	_____ Neonatal ICU	_____ Psych. Hosp.	_____ Brain Injury Unit
_____ Burn ICU	_____ CCU	_____ PRTF	
_____ NF/Medicaid	_____ NF (Medicare/Medicaid)		
_____ Other /specify:			

25. Administrator: _____ **Phone:** _____ **Fax:** _____
☐ ***Check here for N/A***

26. Assistant Administrator: _____ **Phone:** _____ **Fax:** _____
☐ ***Check here for N/A***

27. Controller: _____ **Phone:** _____ **Fax:** _____
☐ ***Check here for N/A***

28. Accountant or CPA: _____ **Phone:** _____ **Fax:** _____
☐ ***Check here for N/A***

29. Fiscal Year End Date (FYE): ☐ ***Check here for N/A***

30. If you are applying as an *individual*, please complete if you wish to link to a Clinic Corporation or Facility.
☐ ***Check here for N/A***

I hereby declare that I _____
(Individual Provider Enrolling)

have entered into a contractual agreement with the following:

_____ _____
(Clinic/Corporation or Facility Name) (KY Medicaid Provider Number of Clinic/Corporation or Facility)

to provide professional services. I authorize payment including Medicaid/Medicare cross-overs, from the Kentucky Medicaid Program for covered services provided by me and specified by the criteria of our contract. I understand that I, personally shall not bill the Kentucky Medicaid Program for any service that is reimbursed as part of contractual agreement, and further that Clinic/Corporation or Facility Name listed above shall be responsible for refunding any overpayments made for services rendered. (Please note: If you choose to link to more than one group please attach a MAP-347).

SECTION B: DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST

SECTION B IS REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR 455.101, 455.104, 455.105 AND 455.106 and KRS CHAPTER 205, AS AMENDED).

Note: See the instructions for definitions of underlined terms per 42 CFR 455.101 and 455.104 and KRS Chapter 205, as amended. ***(Any attachments must be labeled referencing the question.)***

1. If there has been a change in ownership, enter the previous provider number(s) and their effective date(s):
☐ ***Check here for N/A***

Previous Medicaid Prov. #	**Start Date:**	**to End Date:**

2a. If you completed question #1 above, describe the relationship between the owner disclosing information on this form and the previous Medicaid owner. (Attach extra page if necessary.) ☐ ***Check here for N/A***

2b. If you completed question #1 above, describe the relationship between the corporate boards of disclosing provider and previous corporate boards of Medicaid provider. (Attach extra page if necessary.)

2c. Why did a change of ownership occur?

3. If you anticipate any change of ownership, management company or control within the year, state anticipated date of change and nature of the change. ☐ ***Check here for N/A***

Date: **Change:**

4. If you anticipate filing for bankruptcy within the year, enter anticipated date of filing. Date: ☐ ***Check here for N/A***

5. If this facility is a subsidiary of a parent corporation, enter corporate FEIN #: ☐ ***Check here for N/A***

Name:		
Box or Address:		
City:	State:	Zip:

6. List name, date of birth, SSN#/FEIN#, and address of each person or entity that owns 5% or more direct or indirect ownership or controlling interest in the applicant provider. (Attach extra page if necessary.) (N/A not acceptable.). ***If you are applying as an individual, list your information.*** ☐ ***Check here if no one owns 5% or more.***

Name:	SSN:	
Business Address:	FEIN:	DOB:
City:	State:	Zip:
P.O. Box:		
City:	State:	Zip:

****IF A CORPORATE ENTITY IS DISCLOSED IN QUESTION #6 ABOVE, THE BUSINESS LOCATIONS OF THE CORPORATE ENTITY MUST BE DISCLOSED. PLEASE ATTACH A SHEET TO DISCLOSE THIS INFORMATION.**

7. List officers' and board members' information of disclosing entity. (Attach extra sheet if necessary, listing same details below.) ☐ ***Check here for N/A*** ***The entire first name is required. Initials are not accepted.**

Name (a):	Title:	
Address:	SSN:	
City:	State:	Zip:
Name (b):	Title:	
Address:	SSN:	
City:	State:	Zip:

8. If any individuals listed in questions #6, #7, and #17 are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.) ☐***Check here for N/A***		
Name(a):	SSN:	
Relationship:	FEIN:	
Name(b):	SSN:	
Relationship:	FEIN:	
9. If this facility employs a management company, please provide following information: ☐***Check here for N/A***		
Name:		
Address:		
City:	State:	Zip:
10. List the name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.☐ ***Check here for N/A***		
Name:	Provider Number:	
Address:		
City:	State:	Zip:
11. List the names and addresses of all other Kentucky Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of $25,000 or 5% of your total operating expense. (Attach extra page if necessary.) ☐***Check here for N/A***		
Name:		
Address:		
City:	State:	Zip:
12. List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. (Attach extra page if necessary.) ☐***Check here for N/A***		
Name:		
Address:		
City:	State:	Zip:
13. List the name, SSN, and address of any immediate family member who is authorized under Kentucky Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment in accordance with KRS 205.8477. ☐***Check here for N/A***		
Name (a):	Credential (M.D., etc.):	
Address:	DOB:	SSN:
City:	State:	Zip:
Name (b):	Credential (M.D., etc.):	
Address:	DOB:	SSN:
City:	State:	Zip:
14. List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state, since the inception of those programs. (Attach extra page if necessary.) **If individual or organization is associated with a KY Medicaid provider number(s), please indicate below.** (Attach extra page if necessary.) ☐***Check here for N/A***		
NAME (a)/KY Medicaid Provider Number(s):		
NAME (b)/KY Medicaid Provider Numbers(s):		
15. List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) **If individual or organization is associated with a KY Medicaid provider number(s), indicate below.** (Attach extra page if necessary.) ☐***Check here for N/A***		
NAME (a)/KY Medicaid Provider Number(s):		
NAME (b)/KY Medicaid Provider Number(s):		

16. List the name, title, SSN, and business address of all managing employees below as defined in 42 CFR 455.101. ☐ ***Check here for N/A*** (Attach extra sheet if necessary listing same details below.)		
Name (a):	Credential (M.D., etc.):	
Box or Address:	DOB:	SSN:
City:	State:	Zip:
Name (b):	Credential (M.D., etc.):	
Box or Address:	DOB:	SSN:
City:	State:	Zip:

17. List name, address, SSN#, FEIN# of each person with an ownership or control interest in any SUBCONTRACTOR in which the provider applicant has direct or indirect ownership of 5% or more. (Attach extra page if necessary.) ☐ ***Check here for N/A***		
Name(a):	SSN:	
Box or Address:	FEIN:	
City:	State:	Zip:
Name(b):	SSN:	
Box or Address:	FEIN:	
City:	State:	Zip:

SECTION C: ATTESTATIONS

(TO BE COMPLETED IF ENROLLING AS AN INDIVIDUAL PROVIDER. DO NOT COMPLETE IF ENROLLING AS A GROUP OR ENTITY.)

Please answer all questions. For any "Yes" response, please attach an explanation.

1. LICENSURE		
☐YES ☐NO	**a.**	Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?
☐YES ☐NO	**b.**	Has there been any challenge to your licensure, registration or certification?
2. HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS		
☐YES ☐NO	**a.**	Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?
☐YES ☐NO	**b.**	Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?
☐YES ☐NO	**c.**	Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?
3. EDUCATION, TRAINING AND BOARD CERTIFICATION		
☐YES ☐NO	**a.**	Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign
☐YES ☐NO	**b.**	Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?
☐YES ☐NO	**c.**	Have any of your board certifications or eligibility ever been revoked?
☐YES ☐NO	**d.**	Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation
4. DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION		
☐YES ☐NO	**a.**	Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?
5. MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION		
☐YES ☐NO	**a.**	Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?
6. OTHER SANCTIONS OR INVESTIGATIONS		
☐YES ☐NO	**a.**	Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?
☐YES ☐NO	**b.**	To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?
☐YES ☐NO	**c.**	Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?
☐YES ☐NO	**d.**	Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?
☐YES ☐NO	**e.**	Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?

7. PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY		
☐YES ☐NO	a.	Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?
☐YES ☐NO	b	Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?
8. MALPRACTICE CLAIMS HISTORY		
☐YES ☐NO	a.	Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? * If yes, provide information for each case.
9. CRIMINAL/CIVIL HISTORY		
☐YES ☐NO	a.	Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?
☐YES ☐NO	b.	In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?
☐YES ☐NO	c.	Have you ever been court-martialed for actions related to your duties as a medical professional?
10. ABILITY TO PERFORM JOB		
☐YES ☐NO	a.	Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)
☐YES ☐NO	b.	Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?
☐YES ☐NO	c.	Do you have any reason to believe that you would pose a risk to the safety or wellbeing of your patients?
☐YES ☐NO	d.	Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?

MEDICAID RULES, REGULATION, POLICY AND 42USC 1320a-7b

1. Scope of Agreement:

This provider agreement sets forth the rights, responsibilities, terms and conditions governing the provider's participation in the Kentucky Medicaid Program and KCHIP and supplements those terms and conditions imposed by these programs.

2. **Medical Services to be Provided:**

The provider agrees to provide covered services to Medicaid and KCHIP recipients in accordance with all applicable federal and state laws, regulations, policies and procedures relating to the provision of medical services according to Title XIX, Title VI, the approved Waivers for Kentucky and policies and procedures duly adopted by the Department for Medicaid Services applicable to provider and recipients of Title XIX services.

3. Assurances:

The Provider:

(1) Agrees to maintain such records, including electronic storage media, as are necessary to document the extent of services furnished to KCHIP and Title XIX recipients for a minimum of five (5) years or as required by state and federal laws, and for such additional time as may be necessary in the event of an audit exception, quality of care issue, or other dispute and to furnish the state or federal agencies with any information requested regarding payments claimed for furnishing services.

(2) Agrees to permit representatives of the state and federal government, and, staff of the Department for Medicaid Services to have the unrestricted right to examine, inspect, copy and audit all records pertaining to the provision of services furnished to KCHIP and Title XIX recipients. Such examinations, inspections, copying and audits may be made without prior notice to the Provider. This right shall include the ability to interview facility staff during the course of any inspection, review, investigation or audit.

(3) Agrees to comply with the Civil Rights requirements set forth in 45 CFR Parts 80, 84, and 90 and the Americans with Disabilities Act (ADA), 42 USC 12101. Payments shall not be made to providers who discriminate on the basis of race, color, national origin, sex, disability, religion, age or marital status in the provision of services.

(4) Agrees to cooperate with applicable public health agencies to coordinate appropriate medical care for KCHIP and Title XIX recipients in order to ensure quality of care and avoid the provision of duplicate or unnecessary medical services.

(5) Assures awareness of the provisions of **42 USC 1320A-7B** reproduced on page 11 of this agreement and of the provisions of KRS 205.8451 to KRS 205.8483 relating to Medicaid Program Fraud and Abuse, and applicable Kentucky Administrative Regulations as specified in Title 907 relating to the Department for Medicaid Services and Provider Agreements.

(6) Agrees to inform the Cabinet for Health and Family Services, Department for Medicaid Services

A. within thirty-five (35) days of any change in the following:
   1. name;
   2. ownership;
   3. address; and,
   4. business transactions (or within 35 days of request by Secretary or Medicaid agency)

B. within five (5) days of information concerning the following:
   1. change in licensure/certification;
   2. regulation status;
   3. disciplinary action by the appropriate professional association; and,
   4. criminal charges

(7) Agrees to the following:

A. To assume responsibility for appropriate, accurate, and timely submission of claims and encounter data whether submitted directly by the provider or by an agent;

B. To use EMC submittal procedures and record layouts as defined by the Cabinet if submitting electronic claims;

C. That the provider's signature on this agreement constitutes compliance with the following: the transmitted information is true, accurate and complete and any subsequent correction which alters the information contained therein will be transmitted promptly;

D. Payment and satisfaction of claims will be from federal and state funds and that any false claims, statements, or documents or concealment of falsification of a material fact, may be prosecuted under applicable federal and state law.

(8) Agrees to participate in the quality assurance programs of the Department for Medicaid Services and understands that the data will be used for analysis of medical services provided to assure quality of care according to professional standards.

(9) A contract for the sale or change of ownership participating in the Medicaid Program shall specify whether the buyer or

seller is responsible for the amounts owed to the department by the provider, regardless of whether the amounts have been identified at the time of sale. In the absence of such specification in the contract for the sale or change of ownership, the owners or the partners at the time the department paid the erroneous payments have the responsibility for liabilities arising from those payments, regardless of when identified.

(10) Agrees to notify the Department for Medicaid Services in writing of having filed for protection from creditors under the Bankruptcy code within five (5) days of having filed a petition with the court. Notification shall include the number assigned the case by the court, and the identity of the court in which the petition was filed.

(11) Agrees to return any overpayment made by the Department for Medicaid Services resulting from agency error in calculation of amount or review of submitted claims.

(12) Agrees to comply with employee education for false claims recovery deficit reduction act (DRA) of 2005, Section 6032. More information can be found at http://chfs.ky.gov/dms/provider.htm.

4. ITEM # 4 APPLIES ONLY TO LONG TERM CARE FACILITES (NF, ICF/IID or Psychiatric Hospital), AND HOME COMMUNITY BASED Waiver SERVICES (HCB, SCL, Model Waiver II, Acquired Brain Injury, etc.)

As a result of the Medicare Catastrophic Coverage Act of 1988, each facility providing long term care services agrees to advise all new admissions of resource assessments to assist with financial planning performed by the Department for Community Based Services through a contractual arrangement with the Department for Medicaid Services. This requirement is a Condition of Participation in the Kentucky Medicaid Program, in accordance with 907 KAR 1:672 and is effective with new admissions on and after September 30, 1989. Each nursing facility agrees to comply with the preadmission screening and resident review requirement specified in Section 1919 of the Social Security Act, effective with regard to admissions and resident stays occurring on or after January 1, 1989.

5. Payment:

In consideration for the provision of approved Title XIX services rendered to Medicaid recipients and Title XXI services rendered to KCHIP recipients and subject to the availability of federal and state funds:

1) The Cabinet for Health and Family Services, Department for Medicaid Services agrees to reimburse the provider according to current applicable federal and state laws, rules and regulations and policies of the Cabinet for Health and Family Services for providers participating as direct Medicaid payment providers. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Health and Family Services, Department for Medicaid Services.
2) Department for Medicaid Services agrees to reimburse the provider according to the provisions of the agreement with the provider. Payments shall be made only upon receipt of appropriate encounter data, claims and reports as prescribed by the Department for Medicaid Services.
3) In accordance with 42 CRF 447.15, if the department makes payment for a covered service and the provider accepts this payment in accordance with the department's fee structure, the amounts paid shall be considered payment in full; a bill for the same service shall not be tendered to the recipient, and a payment for the same service shall not be tendered to the recipient, and a payment for the same service shall not be accepted from the recipient. A provider may not bill a Medicaid recipient for a bill that was denied due to incorrect billing. A provider may bill a Medicaid recipient under the following conditions:
   (1) Service not covered by Kentucky Medicaid, and member was previously informed of the non-covered service.
   (2) Provider is not enrolled in Kentucky Medicaid.
4) a. A provider may provide a service to a recipient on a non-Medicaid basis:
   (a) If the recipient agrees to receive the service on a non-Medicaid basis before the service begins; and
   (b) The service is not a Medicaid-covered service.

   b. If a provider renders a Medicaid-covered service to a recipient, regardless of if the service is billed through the provider's Medicaid provider number or any other entity including a non-Medicaid provider, the recipient shall not be billed for the service.

   c. The department shall terminate from Medicaid Program participation a provider who participates in an arrangement in which an entity bills a recipient for a Medicaid-covered service rendered by the provider

6. Provider Certification:

(1) If the provider is required to participate or hold certification under Title XVIII of the Social Security Act to provide Title XIX services, the provider assures such participation or certification is current and active.

(2) If the Provider is a specialty hospital providing psychiatric services to persons age twenty-one (21) and under, the Provider shall be approved by the Joint Commission on Hospitals or the Council on Accreditation of Services for Families and Children or any other accrediting body with comparable standards that are recognized by the state. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on the Accreditation of Health Care Organizations.

7. Lobbying Certification:

The provider certifies that to the best of one's knowledge and belief, that during the preceding contract period, if any, and during the term of this agreement:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influence or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee or Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL 'Disclosure Form to Report Lobbying' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

(4) This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into, submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352 Title 31. US code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

8. **Termination**

(1) The Department for Medicaid Services or provider shall have the right to terminate this agreement for any reason with up to thirty (30) days written notice served upon the other party by registered mail with return receipt requested. The Department for Medicaid Services may terminate this agreement immediately for cause, or in accordance with state or federal laws, upon written notice served upon the Provider by registered mail with return receipt requested.

(2) If Medicare or Medicaid terminates the provider, the Department for Medicaid Services shall also terminate the provider from participation.

(3) If there is a change of ownership of nursing facility, the Cabinet for Health and Family Services agrees to automatically assign this agreement to the new owner according to 42 CFR 442.14.

(4) Failure of a provider to comply with the terms of this agreement may result in the initiation of the following sanctions:

- Freezing member enrollment with the provider.
- Withholding all or part of the provider's monthly management fee.
- Making a referral to the Office of Inspector General for investigation of potential fraud or quality of care issues.

The Department will allow the provider two weeks to cure any violation that could result in the sanctioning of the provider. If the provider does not or refuses to cure the violation, the Department will proceed with action to impose sanctions on the provider. If sanctions are applied against the provider, the action will be reported to the appropriate professional boards and/or agencies. One or more of the above sanctions may be initiated simultaneously at the discretion of the Department based on the severity of the contraction violation. The Commissioner makes the determination to initiate sanctions against a provider. The provider will be notified of the initiation of a sanction by certified mail.

42USC Section 1320a-7b. Criminal Penalties for Acts Involving Federal Health Care Programs

(a) Making or causing to be made false statements or representations
Whoever-
(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f) of this section),
(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized.
(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,
(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not a licensed physician, or
(6) knowingly and willfully disposed of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under subchapter XIX of this chapter, if disposing of the assets in the imposition of a period of ineligibility for such assistance under section 1396p© of this title, shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which the payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement , representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such periods (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between the individual and such other person.
(b) Illegal remunerations
(1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind
(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.
(2) whoever knowingly and willfully offers or pays any remuneration (including kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person-
(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.
(3) Paragraphs (1) and (2) shall not apply to-
(A) a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program;
(B) any amount paid by an employer (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services;
(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under a Federal health care program if-
(i) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and
in the case of an entity that is a provider of services (as defined in section 1395x(u) of this title), the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;
(D) a waiver of any coinsurance under part B of subchapter XVIII of this chapter by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act {42 U.S.C.A. section 201 et seq.};
(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid patient and Program Protection Act of 1987; and
(F) any remuneration between an organization and an entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1395mm of this title or if the written agreement, through a risk-sharing arrangement, places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide.
(c) False statements or representations with respect to condition or operation of institutions
Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon rectification) as a hospital, rural primary care hospital, skilled nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity (including n eligible organization under section 1395mm(b) of this title) for which certification is required under subchapter XVIII of this chapter of a State health care program (as defined in section 1320a-7(h) of this title), or with respect to information required to be provided under section 1320-a-3a of this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.
(d) Illegal patient admittance and retention practices
Whoever knowingly and willfully-
(1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State, or
(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)-
(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or
(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.
(e) Violation of assignment terms
Whoever accepts assignments described in section 1395u (b) (3) (B) (ii) of this title or agrees to be a participating physician or supplier under section 1395u9h) (1) of this title and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.
(f) "Federal health care program" defined for purposes of this section, the term "Federal health care program" means-
(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United - 11 -States Government (other than the health insurance program under chapter 89 of Title 3); or
(2) any State health care program, as defined in section 1320a-7(h) of this title.

WHOEVER KNOWINGLY OR WILLFULLY MAKES, OR CAUSES TO BE MADE, A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT SHALL BE SUBJECT TO PROSECUTION UNDER APPLICABLE FEDERAL OR STATE LAWS. (42 USC 1320A-7B CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS IS PRINTED ON PAGE 11) FAILURE TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED SHALL RESULT IN A DENIAL OF A REQUEST TO PARTICIPATE IN OR TERMINATION OF THE CURRENT AGREEMENT WITH THE STATE AGENCY, AS REQUIRED BY 42 CFR 455.104 AND KRS CHAPTER 205 AS AMENDED.

Provider Authorized Signature: I certify, under penalty of law, that the information given in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or for prosecution for Medicaid fraud. I certify that I have read and understand the "Medicaid Rules, Regulation, Policy", 42 USC 1320A-7B" (pp. 8-11), 907 KAR 1:671, and 907 KAR 1:672 to the best of my ability. I agree to abide by the Medicaid Program terms and conditions listed in this document and aforementioned regulations, and I hold a license/certification to provide services corresponding to the information above and for which this agreement applies. I hereby authorize the Cabinet for Health and Family Services, the Department for Medicaid Services to make all necessary verification concerning me and/or my medical practice/facility, and further authorize each educational institute, medical/license board or organization to provide all information that may be needed in connection with my application for participation in the Kentucky Medicaid Program. I further certify that if I keep medical records in an electronic database, those records are confidential and patient privacy is protected (KRS 205.510).

Provider Signature	Transportation Broker Signature
Name: (Please Print): _____	Name: (Please Print): _____
Title: _____	Title: _____
Date: _____	Date: _____

NOTE: Please ensure that no questions were left blank before submitting application.

PLEASE MAKE A COPY OF COMPLETED PAGES FOR YOUR RECORDS. YOU WILL RECEIVE NOTIFICATION OF YOUR KENTUCKY MEDICAID PROVIDER NUMBER.

For Internal Use Only:

Department for Medicaid Services Signature: _____ **Date:** _____

Printed Name: _____ **Title:** _____

CLEAR FORM