COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Family Caregiver Training

VIRGINIA MEDICAID PROVIDER ENROLLMENT PACKAGE

Thank you for your interest in becoming a participating provider with the Virginia Medicaid program. Upon receipt of your completed Virginia Medicaid / Family Access to Medical Insurance Security Plan (FAMIS) enrollment application and any required documents, your application will be processed. Processing of your application may take up to ten business days. Completed paper enrollment applications can be faxed or mailed to Virginia Medicaid Provider Enrollment Services at the following fax number or address.

Toll free Fax 1-888-335-8476

Virginia Medicaid Provider Enrollment Services
PO Box 26803
Richmond, VA 23261-6803

If you have any questions regarding your paper enrollment application, you can contact Provider Enrollment Services toll-free at 1-888-829-5373 or local 1-804-270-5105.

Contents:

- Enrollment Form Instructions - Read all instructions to ensure your enrollment application is complete and that all necessary documentation has been attached prior to submission.
- Enrollment Application - Make sure all required fields are complete prior to submission.
- Participation Agreement - This must be signed by the provider.

SECTION I: PROVIDER DEMOGRAPHIC INFORMATION

1. Provider Identifier (API or NPI)

Atypical Provider Identifier (API)

Family and Caregiver Training provider category has been identified as an Atypical provider category. As such you will be assigned a ten digit Atypical Provider Identifier (API) for you to use when your application is approved. Your new ten digit API number is to be used on all Medicaid business transactions including electronic and paper claims, Automated Response System telephone service (ARS) and Prior Authorizations (PA).

National Provider Identifier (NPI)

Some Family and Caregiver Training Providers may have successfully obtained a National Provider Identifier (NPI) because they provide other services that qualify them as a healthcare provider according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules. If this is the case enter your ten digit NPI. If you are a business, enter your organization's NPI. More information about the NPI and how to obtain one can be found at http://www.cms.gov under Regulations and Guidance, HIPAA Administrative Simplification, National Provider Identifier Standard (NPI).

2. Individual Name (Required for an Individual enrolling) or Organization Name (Required for Organizations enrolling)

Enter the individual name or organization which identifies you to the public. This name will be used on the Virginia Medicaid Provider Search Directory.

3. Primary Servicing Address (Required)

Enter your Primary Servicing Address in this section.

- A Post Office Box address is not acceptable as a service location.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.
- Family and Caregiver Training providers must be located within the Commonwealth of Virginia.
- Out-of-state providers are not eligible for this program.

4. Correspondence Address (Required)

Enter the address to which you would like correspondence (Medicaid Manual updates, Medicaid memos, etc.) sent.

- A Post Office Box is acceptable for this type of address.
- Indicate whether or not you want Medicaid correspondence sent through the United States Post Office to this address.
- Only one Correspondence Address is allowed per NPI.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.
- If the Correspondence Address is the same as the Primary Servicing Address, write SAME on the Attention line.

5. Pay To Address (Optional)

Enter the address to which you would like payments sent for services rendered.

- Only one Pay To Address is allowed per NPI.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing, Correspondence, Pay To, or Remittance Advice addresses.
- If the Pay To Address is the same as the Correspondence Address, write SAME on the Attention line.

6. Remittance Advice Address (Optional)

Enter the address to which you would like Remittance Advice sent for services rendered.

- Only one Remittance Advice Address is allowed per NPI.
- The email address is required in order to receive important Medicaid information via our blast email system. The email address entered may differ between the Primary Servicing Correspondence, Pay To, or Remittance Advice addresses.
- If the Remittance Address is the same as the Pay To Address, write SAME on the Attention line.

7. IRS Name (Required)

Enter IRS name associated with the tax ID registered with the IRS.

8. Taxpayer Identification Number (TIN) OR Social Security Number (SSN) and Date of Birth (Required)

- If applying as an organization, enter your nine-digit Taxpayer Identification Number (TIN). This may also be called your Employer Identification Number (EIN), Federal Employer Identification Number (FEIN), or Federal Tax Identification Number (FTIN).
- If applying as an individual provider, billing and receiving payment under your Social Security Number, enter your SSN and Date of Birth.

9. Doing Business as (DBA) Name (Optional)

Enter the name under which the business or operation is conducted and presented to the community. This name will be used on the Virginia Medicaid Provider Search Directory.

10. Requested Effective Date of Enrollment (Required)

Enter the date that you are requesting your enrollment to begin.

- Effective date cannot be more than one year past the current date.
- Effective date will never be before the effective date of your license.

11. Family Caregiver Training License Requirements (Required)
(Required for Services Below)

Select the entity type providing services enter the license number, effective date and end date from your Licensing Board in the state where the services are being rendered. Please attach a copy of your license.

Community Developmental Disabilities Providers

Providers of this service who are licensed by DBHDS

Community Mental Health Centers

Providers of this service who are licensed by DBHDS

Developmental Disabilities Residential Providers

Providers of this service who are licensed by DBHDS

Health Department Clinics (Public Health Agency)

Providers of this service who are licensed by.

- Centers for Medicare and Medicaid Services (CMS) Certification
- Physician Directors Department of Health Professions (DHP) of Virginia License

Home Health Agencies

Home Care Organization license from Virginia Department of Health (HCO) or

- Accreditation Commission for Health Care, Inc. (ACHC) or
- Community Health Accreditation Program (CHAP) or
- Centers for Medicare/Medicaid Services (CMS) certification as a Home Health Agency or
- Joint Commission for Accreditation of Health Care Organizations (JCAHO) certification as a Home Health Agency or
- Virginia Department of Health (VDH) Centers for Quality Healthcare Services and Consumer Protection as a Home Health Agency

Hospitals

License information is accepted from the below organizations.

- American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP)
- Centers for Medicare and Medicaid Services (CMS) Certification
- Det Norske Veritus Healthcare (DNV) Inc.
- Joint Commission on Accreditation for Healthcare Organizations (JCAHO)

In-Home Rehabilitation Agencies

Providers of this service who are licensed through the following.

- American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP)
- Centers for Medicare and Medicaid Services (CMS) Certification
- Det Norske Veritus Healthcare (DNV) Inc.
- Joint Commission on Accreditation for Healthcare Organizations (JCAHO)

Licensed Clinical Social Workers

Providers of this service who are licensed through the DHP of Virginia

Licensed Nurse Practitioner

Providers of this service who are licensed through

- State Medical Board
- Virginia Department of Professional and Occupational Regulations (DPOR)

Licensed Practical Nurse

Providers of this service who are licensed through the Virginia Board of Nursing

Licensed Professional Counselors

Providers of this service who are licensed through the DHP of Virginia

Nurse Aide

Providers of this service who are licensed through the Virginia Board of Nursing

Occupational Therapist

Providers of this service who are licensed through DHP of Virginia

Physical Therapist

Providers of this service who are licensed through DHP of Virginia

Physician

Providers of this service who are licensed through

- State Medical Board
- Virginia Department of Professional and Occupational Regulations (DPOR)

Psychologist

Providers of this service who are licensed through the Board of Psychology

Registered Nurse

Providers of this service who are licensed through the Virginia Board of Nursing

Speech/Language Pathologist

Providers of this service who are licensed through the Virginia Board of Audiology and Speech-Language Pathology

Teacher

Providers of the service who are licensed through the Virginia Department of Education

12. Type of Applicant (Required)

Select the Type of Applicant: Corporation, Limited Liability Company, Partnership, Individual or Government Entity.

- Corporation is defined as a legal entity or structure under the authority of the laws of a state consisting of a person or group of persons who become shareholders.
- Limited Liability Company is defined as a business structure allowed by state statute whose owners have limited personal liability for the debts and actions of the Limited Liability Company.
- Partnership is defined as the relationship existing between two or more persons who join and carry on trade or business.
- Individual is defined as a single practitioner operating under his/her own SSN or TIN.
- Government Entity is defined as a “legally authorized or recognized agency, instrumentality, or other entity of Federal State, or local government (including multijurisdictional agencies, instrumentalities, and entities)”.

13. Languages Other Than English Spoken at Practice (Optional)

Select all that apply for languages that are spoken at your organization. If no language is selected, English only will be recorded.

14. Signature Waiver (Required)

Signature waiver allows for the submission of claim(s) which will contain the provider’s computer generated, stamped, or typed signature instead of a hand written signature.

SECTION II: DISCLOSURE OF OWNERSHIP AND CONTROL INFORMATION FOR DISCLOSING ENTITY, AUTHORIZED BY 42 C.F.R. §455.104 AND 42 C.F.R. §455.106

This section must be completed by an authorized representative. An authorized representative is defined as an individual with designated authority to act on behalf of the individual, group of practitioners, or disclosing entity. If not a solo practitioner, then the authorized representative must be a partner, president, or secretary of the group of practitioners or disclosing entity.

15. Ownership and Control Information for Disclosing Entity (Required)

List any managing employee and/or any individual(s) or organization(s) who has any ownership or controlling interest in this provider entity or in any subcontractor. The term “managing employee” means any person with management oversight, (i.e. general manager, business manager, administrator, director, or other individual) who exercises operational or managerial control over the day-to-day operations or administrative oversight of the provider/business office, as an employee, under contract with or through any other contractual arrangement. The ownership or controlling interest is an ownership interest of 5% or more in this provider entity.

Include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Type of ownership (Board of Directors, Controlling Interest, Managing Employee, Owner or Other)
- Address
- Percentage of ownership (Owners with 5% or greater ownership only)

If your organization is a non-profit or not-for-profit organization in accordance with IRS Section 501(c)(3):

- Enter 501(c)(3) under ownership
- Attach a list of your board of directors, including first name, last name or organization name, title (i.e. CEO, President), date of birth, SSN for individuals or Tax ID (TIN) for organizations, and address.

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

16. Relationships (Required)

List those individuals named in the previous question who are related to each other.

Include:

- Name from previous question
- Relationship, (spouse, parent, child, or sibling)
- Name of the person from previous question to whom they are related

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

17. Subcontractors (Required)

List any individuals with an ownership or controlling interest in any subcontractor that the disclosing entity has direct or indirect ownership of 5% or more.

Include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address
- Percentage of ownership

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

18. Other Disclosing Entity (Required)

List the name, title, SSN/TIN, address and percentage of ownership of any other disclosing entity in which a person, with an ownership or controlling interest in this disclosing entity, has an ownership or control interest of at least 5% or more.

Include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address
- Percentage of ownership

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

19. Criminal Offenses of Persons with Ownership or Controlling Interest (Required)

List any individual or organization listed previously who has any ownership or controlling interest in the applicant that has been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct.

Criminal offenses that must be included are:

- Convictions for any health related crimes or misconduct
- Assessment of fines or penalties for any health related crimes or misconduct
- Exclusion from any Federal or State healthcare program due to:
    - Fraud
    - Obstruction of an investigation
    - Controlled substance violation
    - Any other crime or misconduct

Include:

- First and last name or organization name
- Title (i.e. CEO, MD, Pres.), date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

Attach a copy of the final disposition.

20. Criminal Offenses of Any Other Connected Individuals or Organizations (Required)

If you check Yes, list any individual or contractor connected with your practice that has been convicted or assessed fines or penalties for any health related crimes or misconduct, or is excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct.

Criminal offenses that must be included are:

- Conviction for any health related crimes or misconduct
- Assessment of fines or penalties for any health related crimes or misconduct
- Exclusion from any Federal or State healthcare program due to:
    - Fraud
    - Obstruction of an investigation
    - Controlled substance violation
    - Any other crime or misconduct

Include:

- First and last name or organization name
- Date of birth and SSN for an individual or
- Tax ID (TIN) for an organization
- Address

If space is needed for additional individuals or organizations, attach paper listing all of the required information for each additional individual or organization.

Attach a copy of the final disposition.

21. Adverse Legal Actions (Required)

Check Yes if the applicant has had any adverse legal actions imposed by:

- Medicare
- Medicaid
- Federal agency or program
- Any state's agency or program
- Any licensing or certification agency

If Yes, attach a copy of the final disposition.

SECTION III: CLAIM PAYMENT AND PROCESSING INFORMATION

All Virginia Medicaid providers that enroll must submit all claims electronically by Electronic Data Interchange (EDI) through a clearing house, or Direct Data Entry (DDE) through the Virginia Medicaid web portal (www.virginiamedicaid.dmas.virginia.gov). Providers must also enroll to receive their payments via Electronic Funds Transfer (EFT) for payment of those services. Any provider who cannot comply with these requirements for good cause must request an exemption describing why they cannot comply.

22. Electronic Funds Transfer (Required)

If you select “Yes” to participate in the Electronic Funds Transfer (EFT) of payments directly deposited into your account, you must provide:

- The account type that will receive your EFT deposits
- The name of the financial institution that will receive your EFT deposits
- The routing or ABA number of the financial institution above. Your banking institution’s 9-digit routing number is sometimes called the ABA number. The routing number must begin with numbers that fall in the ranges 01-12, 1-32 or 61-72 (for example 079986597). Note the number on your deposit slip is not a valid routing number. Attach a voided check or ask your financial institution for a letter and attach a copy
- The account number is a code identifying the account that will be accepting your direct deposit

If you select “No”, you must apply for an exemption and show good cause.

- Good cause may include, but is not limited to the unavailability of a banking institution capable of transacting business via EFT.
- To apply for an exemption, attach to this application either a letter from the financial institution or a letter from the applicant for consideration. The letter must:
  - Be on letterhead, either a financial institution's or the applicant's
  - Be signed
  - Be dated
  - Include the applicant’s NPI
  - Include a description of the good cause

23. Electronic Claims Submission (Required)

For more information on how to submit claims through Electronic Data Interchange (EDI) through a clearing house or through Direct Data Entry (DDE) for no cost on the Virginia Medicaid Web Portal, visit www.virginiamedicaid.dmas.virginia.gov. This information is located in the Quick Links menu, Provider Services, EDI Support.

- Select “Yes” if you will submit claims using (EDI) through a clearing house or DDE through the Virginia Medicaid Web Portal, www.virginiamedicaid.dmas.virginia.gov.
- If you select “No", you must apply for an exemption and show good cause.
  - Good cause may include, but is not limited to:
    - Unavailability of necessary infrastructure in the geographic region
    - No mechanism to electronically submit for a particular claim type
    - Financial hardship
  - To apply for an exemption, attach a letter to this application for consideration. The letter must:
    - Be on the applicant’s letterhead
    - Be signed
    - Be dated
    - Include the applicant’s NPI
    - Include a description of the good cause

24. Electronic Remittance Advice (ERA) (Optional)

Select "Yes" if you would like to request participation in electronic remittance advices as part of your enrollment with Virginia Medicaid and FAMIS and enter the Service Center Name and ID Number.

SECTION IV HOME AND COMMUNITY BASED CARE SERVICES DEMOGRAPHICS

In accordance with federal requirements, all providers of Family and Care Giving Training services must submit the following information to DMAS.

25. Additional Provider Types Enrolled (Required)

If organization is currently a Medicaid enrolled provider, select type of provider and API or NPI number.

26. Administrator Name (Required)

Name of administrator for the organization.

27. Administrative Personnel (Required)

List administrative personnel

Enter the name, title, and telephone for all persons responsible for general management of your organization's program to include.

- Person responsible for signing contract
- Chief administrator on-site
- Other on-site contact person
- Chief corporate officer
- Other corporate contact person

28. Geographic Areas to be Served (Required)

List cities and counties in which you intend to service Medicaid eligible members.

29. Ownership Name and Percentage (Required)

Enter in Name and Address of all owners of organization and percentage of ownership. Total of the owner's percentages must equal 100 percent. If your organization is a non-profit or not-for-profit organization accordance with Section 501(c)(3) of the IRS code, a list of your organization's board of directors must be submitted.

30. Criminal Offence Disclosure (Required)

Federal requirements stipulate that disclosure must be made of any person (not limited to but including owner, operator, manager and /or employee) associated with the organization who has been convicted of a criminal offense (misdemeanor and/or felony). This disclosure must be made upon each submission of the provider agreement, or upon the provider receiving notice of the criminal offense, whichever is sooner. It is the duty of the provider organization to make inquiry and screen individuals at the point of application for employment to comply with this section.

If anyone associated with your organization (owner, operators, manager or employees) has been convicted of a criminal offense, attach a copy of the final disposition.

31. Family Caregiver Training Staffing Credentials (Required)

As a Family and Caregiver Training Services provider you are responsible for ensuring that all staff meets the qualifications guidelines in Chapter II of the Individual and Family Developmental Disabilities Support Services Waiver Services Manual.

As a Family and Caregiver Training Services provider it is your responsibility to assure that any new staff for the Family and Caregiver Training Services is oriented to the service and complies with all DMAS requirements including all policies, procedures and forms.

As a Family and Caregiver Training Services provider it is your responsibility to instruct all staff who provide Family Caregiver Training of the requirements related to the performance of their duties.

The only entities or qualified staff able to participate as a Family and Caregiver Training provider are the following

- Community Developmental Disabilities Providers
- Community Mental Health Centers
- Developmental Disabilities Residential Providers
- Health Department Clinics (Public Health Agency)
- Home Health Agencies
- Hospitals
- In-Home Rehabilitation Agencies
- Licensed Clinical Social Workers
- Licensed Nurse Practitioner
- Licensed Practical Nurse
- Licensed Professional Counselors
- Nurse Aide
- Occupational Therapist
- Physical Therapist
- Physician
- Psychologist
- Registered Nurse
- Speech/Language Pathologist
- Teacher

Person responsible for ensuring all professional staff are qualified, well-instructed, and comply with all DMAS regulations for providing Family Caregiver Training Services, (Required)

- Enter name
- Title
- Phone Number
- To whom they report (if applicable)

32. Compliance with Federal Regulations Regarding Rates for Services (Required)

An authorized administrator and signee of the Provider Participation Agreement attests that in order to comply with federal regulations, it will not charge DMAS a higher rate for Home and Community Based Care Services than is charged the private sector for the same services.

33. Insolvency or Bankruptcy Verification (Required)

An authorized administrator and signee of the Provider Participation Agreement attests that there is neither a judgment or pending action of insolvency or bankruptcy in a state or federal court. Further, the provider of services agrees to inform the DMAS immediately if court proceedings to make judgment of insolvency or bankruptcy are instituted with respect to the provider of services.

34. Validation of Program Description and Accurate Completion of Enrollment Application (Required)

An authorized administrator and signee of Provider Participation Agreement attests that the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community Based Care services, and that all information within this application is accurate, truthful, and complete.

35. Remarks (Optional)

Enter any additional information you would like to be considered as part of your enrollment application.

SECTION I: PROVIDER DEMOGRAPHIC INFORMATION

1. Provider Identifier (API or NPI)

Atypical Provider Identifier (API) _____

National Provider Identifier (NPI) _____

2. Individual Provider Name (Required for Individuals) or Organization Name (Required for Organizations)

Enter the name which identifies you or your organization to the public.

First _____ Middle Initial _____ Last _____ Suffix _____ Title _____

Organization Name _____

3. Primary Servicing Address (Required)

Attention _____

Address _____ _____ _____ _____

Street City State Zip

Office Phone **(Required)** _____ Ext. _____ 24 Hour Phone _____

TDD Phone _____ Fax Number _____ Email **(Required)** _____

Contact Name _____ Contact Phone _____

4. Correspondence Address (Required)

Attention _____

Address _____ _____ _____ _____

Street City State Zip

Office Phone _____ Ext. _____

TDD Phone _____ Fax Number _____ Email **(Required)** _____

Do you want to receive mailed Medicaid correspondence to this address? ☐ Yes or ☐ No

5. Pay To Address (Optional)

Attention _____

Address _____ _____ _____ _____

Street City State Zip

Office Phone _____ Ext. _____

TDD Phone _____ Fax Number _____ Email _____

Contact Name _____ Contact Phone _____

6. Remittance Advice Address (Optional)

Attention _____

Address _____ _____ _____ _____

Street City State Zip

Office Phone _____ Ext. _____

TDD Phone _____ Fax Number _____ Email _____

7. **IRS Name (Required)** _____

8. **Taxpayer Identification Number (TIN) OR Social Security Number (SSN) and Date of Birth (Required)**

   TIN or SSN _____ Date of Birth (if applicable) _____

9. **Doing Business as (DBA) Name (Optional)** _____

10. **Requested Effective Date of Enrollment (Required)** _____

11. **Family Caregiver Training License (Required)**

    Choose the entity providing the service and enter the license or certification information for each. Please attach a copy of your license.

    ☐ ***Community Developmental Disabilities Providers***

    DBHDS License #: _____ Begin Date: _____ End Date: _____

    ☐ ***Community Mental Health Centers***

    DBHDS License #: _____ Begin Date: _____ End Date: _____

    ☐ ***Developmental Disabilities Residential Providers***

    DBHDS License #: _____ Begin Date: _____ End Date: _____

    Health Department Clinics (Public Health Agency)

    ☐ ***Centers for Medicare and Medicaid Services (CMS) Certification***

    License #: _____ Begin Date: _____ End Date: _____ (Attach a copy)

    ☐ ***Physician Director's License***

    License #: _____ Begin Date: _____ End Date: _____ (Attach a copy)

    ☐ ***Home Health Agencies***

    License/Certification #: _____ Licensing Board: _____

    Begin Date: _____ End Date: _____

    Hospitals - (Select all that apply)

    ☐ ***American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP)***

    License #: _____ Begin Date: _____ End Date: _____ (Attach a copy)

    ☐ ***Centers for Medicare and Medicaid Services (CMS) Certification***

    License #: _____ Begin Date: _____ End Date: _____ (Attach a copy)

    ☐ ***Det Norske Veritus Healthcare (DNV) Inc.***

    License #: _____ Begin Date: _____ End Date: _____ (Attach a copy)

    ☐ ***Joint Commission on Accreditation for Healthcare Organizations (JCAHO)***

    License #: _____ Begin Date: _____ End Date: _____ (Attach a copy)

    ☐ ***In-Home Rehabilitation Agencies***

    DBHDS License #: _____ Begin Date: _____ End Date: _____ (Attach a copy)

    ☐ ***Licensed Clinical Social Workers***

    DHP License #: _____ Begin Date: _____ End Date: _____

☐ ***Licensed Nurse Practitioner***

State Medical Board License #: _____ Begin Date: _____ End Date: _____

DPOR License #: _____ Begin Date: _____ End Date: _____

☐ ***Licensed Practical Nurse***

VA Board of Nursing License #: _____ Begin Date: _____ End Date: _____

☐ ***Licensed Professional Counselors***

DHP License #: _____ Begin Date: _____ End Date: _____

☐ ***Nurse Aide***

VA Board of Nursing License #: _____ Begin Date: _____ End Date: _____

☐ ***Occupational Therapist***

DHP License #: _____ Begin Date: _____ End Date: _____

☐ ***Physical Therapist***

DHP License #: _____ Begin Date: _____ End Date: _____

☐ ***Physician***

State Medical Board License #: _____ Begin Date: _____ End Date: _____

DPOR License #: _____ Begin Date: _____ End Date: _____

☐ ***Psychologist***

Board of Psychology License #: _____ Begin Date: _____ End Date: _____

☐ ***Registered Nurse***

Board of Nursing License #: _____ Begin Date: _____ End Date: _____

☐ ***Speech/Language Pathologist***

Board of Audiology and Speech Pathology License #: _____ Begin Date: _____ End Date: _____

☐ ***Teacher***

Department of Education License #: _____ Begin Date: _____ End Date: _____

12. Type of Applicant - Check Only One (Required)

☐ Corporation ☐ Limited Liability Company

☐ Partnership ☐ Individual

☐ Government Entity

13. Languages Other Than English Spoken - Check All That Apply (Optional)

☐ Farsi ☐ Hindi ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Other: _____

14. Signature Waiver ☐ Yes ☐ No (Required)

I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.

SECTION II: DISCLOSURE OF OWNERSHIP AND CONTROL INFORMATION FOR DISCLOSING ENTITY, AUTHORIZED BY 42 C.F.R. §455.104. AND 42 C.F.R. §455.106.

15. Ownership and Control Information for Disclosing Entity (Required)

List any managing employee and/or any individual(s) or organization(s) that has any ownership or controlling interest in this provider entity. The term "managing employee" means any person with management oversight, (i.e. general manager, business manager, administrator, director, or other individual) who exercises operational or managerial control over the day-to-day operations or administrative oversight of the provider/business office, as an employee, under contract with or through any other contractual arrangement.

List the Individual Name or Organization Name, Title (i.e. CEO, MD, Pres.), Date of Birth, SSN/Tax ID (TIN), Type of Ownership, Address and Percentage of Ownership The ownership or controlling interest is an ownership interest of 5% or more in this provider entity.

Name/Organization _____ Title _____

Date of Birth _____ SSN/TIN _____ Ownership Type _____ Percent _____

Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____

Date of Birth _____ SSN/TIN _____ Ownership Type _____ Percent _____

Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____

Date of Birth _____ SSN/TIN _____ Ownership Type _____ Percent _____

Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____

Date of Birth _____ SSN/TIN _____ Ownership Type _____ Percent _____

Street Address _____ City _____ State _____ Zip _____

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

16. Relationships (Required)

List those individuals named in the previous question who are related to each other (spouse, parent, child, or sibling) and whom they are related to.

Name Listed Above _____

Relationship (i.e. spouse, parent, child, or sibling) _____

Is Related to (Name) _____

Name Listed Above _____

Relationship (i.e. spouse, parent, child, or sibling) _____

Is Related to (Name) _____

Name Listed Above _____

Relationship (i.e. spouse, parent, child, or sibling) _____

Is Related to (Name) _____

Name Listed Above _____

Relationship (i.e. spouse, parent, child, or sibling) _____

Is Related to (Name) _____

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

17. Subcontractors (Required)

List the Name, Title, Date of Birth, SSN/TIN, Address and Percentage of Ownership for any individual with an ownership or controlling interest in any subcontractor that the disclosing entity has direct or indirect ownership of 5% or more.

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

18. Other Disclosing Entity (Required)

List the name, title, Date of Birth, SSN/TIN, Percent Ownership and Address of any other disclosing entity in which a person, with an ownership or controlling interest in this disclosing entity, has an ownership or control interest of at least 5% or more.

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____
Date of Birth _____ SSN/TIN _____ Percent _____
Street Address _____ City _____ State _____ Zip _____

If more space is needed, attach additional paper listing all of the required information for the additional individual(s) or organization(s).

19. Criminal Offenses of Persons with Ownership or Controlling Interest (Required)

Has any individual or organization listed previously who has any ownership or controlling interest in the applicant that has been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?

☐ No ☐ Yes (if Yes please provide the Name, Title, Date of Birth, Address, and SSN/TIN information for individual(s) or organization(s). Attach copy of the final disposition.

Name/Organization _____ Title _____

Date of Birth _____ SSN/TIN _____

Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____

Date of Birth _____ SSN/TIN _____

Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____

Date of Birth _____ SSN/TIN _____

Street Address _____ City _____ State _____ Zip _____

Name/Organization _____ Title _____

Date of Birth _____ SSN/TIN _____

Street Address _____ City _____ State _____ Zip _____

If more space is needed, attach additional paper listing all of the required information for the additional individual or organization.

20. Criminal Offenses of Any Other Connected Individuals or Organizations (Required)

Has any individual or contractor connected with your practice ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or is excluded from any Federal or State healthcare program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?

☐ No ☐ Yes (if yes, please provide the Name, Date of Birth, Address, and SSN/TIN information for the individual(s) or contractors below. Attach a copy of the final disposition.

Name/Organization _____

Date of Birth _____ SSN/TIN _____

Street Address _____ City _____ State _____ Zip _____

Name/Organization _____

Date of Birth _____ SSN/TIN _____

Street Address _____ City _____ State _____ Zip _____

Name/Organization _____

Date of Birth _____ SSN/TIN _____

Street Address _____ City _____ State _____ Zip _____

Name/Organization _____

Date of Birth _____ SSN/TIN _____

Street Address _____ City _____ State _____ Zip _____

If more space is needed attach additional paper listing all of the required information for the additional individual or organization.

21. Adverse Legal Actions (Required)

Indicate if the applicant has ever had any adverse legal actions imposed by Medicare, Medicaid, any other Federal or State agency or program, or any licensing or certification agency.

☐ No ☐ Yes If Yes, attach a copy of any final disposition documentation.

SECTION III: CLAIM PAYMENT AND PROCESSING INFORMATION (Required)

22. Electronic Funds Transfer (Required)

☐ Yes, I will participate in EFT of payments directly deposited into my financial account. Complete the following:

Account Type ☐ Checking ☐ Savings ☐ Other

Name of Financial Institution _____

Routing or ABA number _____

Account Number _____

☐ No, I am filing for an exemption from participation in EFT for good cause.

☐ I am attaching a letter from my financial institution stating the inability of the institution to transact business using EFT.

☐ I am attaching a letter describing my good cause for exemption.

23. Electronic Claims Submission (Required)

☐ I will submit claim(s) through Electronic Data Interchange (EDI) or Direct Data Entry (DDE) on the Virginia Medicaid Web Portal as part of my enrollment with Virginia Medicaid and FAMIS.

☐ I am requesting an exemption from filing my claim(s) electronically at this time for the following reasons:

☐ Unavailability of the infrastructure necessary to support electronic claims submission in my geographic region. If checked attach supporting documentation.

☐ No mechanism for electronic submission for the particular claim types I bill Virginia Medicaid. If checked attach supporting documentation.

☐ Financial Hardship. If checked, attach supporting documentation.

☐ Other: _____

To be considered for an exemption, attach supporting documentation.

24. Electronic Remittance Advice (ERA) (Optional)

☐ Yes, I would like to request participation in electronic remittance advices as part of my enrollment with Virginia Medicaid and FAMIS. Complete the following:

Service Center Name _____

Service Center ID Number _____

SECTION IV HOME AND COMMUNITY BASED CARE SERVICES DEMOGRAPHICS

In Accordance with federal requirements, all providers of Home and Community Based Care services must submit the following information to DMAS.

25. Additional Provider Types Enrolled (Required)

Organization or individual is currently a Virginia Medicaid enrolled provider? ☐ Yes ☐ No

If Yes, select type of provider and enter NPIs under which your organization is currently enrolled.

☐ Clinic	NPI _____
☐ Home Health Agency	NPI _____
☐ Hospice	NPI _____
☐ Hospital	NPI _____
☐ Outpatient Rehabilitation Agency	NPI _____
☐ Nursing Facility	NPI _____

26. Administrator Name (Required) _____

27. Administrative Personnel (Required)

- Person Responsible for Signing Contract (Required) _____

  Office Phone _____

  Reporting to _____

  ☐ No ☐ Yes This person is responsible for general management of requested Medicaid programs.

- Name of Chief Administrator On-Site _____

  Office Phone _____

  Reporting to _____

  ☐ No ☐ Yes This person is responsible for general management of requested Medicaid Programs.

- Name of Other On-Site Contact Person _____

  Office Phone _____

- Name of Chief Corporate Officer _____

  Office Phone _____

- Name of Other Corporate Officer _____

  Office Phone _____

28. Geographic Areas To Be Served (Required)

_____

_____

_____

_____

29. Ownership Name and Percentage (Must Equal 100%) (Required)

Name	Address	% of Ownership

30. Criminal Offense Disclosure (Required)

Has anyone associated with organization (owner, operator, managers or employees) been convicted of a criminal offense?

☐ No ☐ Yes If Yes is checked, you must submit a copy of the final disposition.

31. Family Caregiver Training Staffing Credentials (Required)

- Person responsible for validating that all professional staff are qualified, well-instructed, and comply with all DMAS regulations for providing Family Caregiver Training Services.

Name _____

Title _____ Telephone _____

Reporting to _____

Qualifications

_____

_____

_____

_____

- Choose the qualification(s) for the Family and Caregiver Training professional staff.

☐ Community Developmental Disabilities Providers
☐ Community Mental Health Centers
☐ Developmental Disabilities Residential Providers
☐ Health Department Clinics (Public Health Agency)
☐ Home Health Agencies
☐ Hospitals
☐ In-Home Rehabilitation Agencies
☐ Licensed Clinical Social Workers
☐ Licensed Nurse Practitioner
☐ Licensed Practical Nurse
☐ Licensed Professional Counselors
☐ Nurse Aide
☐ Occupational Therapist
☐ Physical Therapist
☐ Physician
☐ Psychologist
☐ Registered Nurse
☐ Speech/Language Pathologist
☐ Teacher

32. Compliance with Federal Regulations Regarding Rates for Services (Required)

I certify as authorized administrator that the chief administrative agent of organization understands that in order to comply with Federal regulations, it will not charge DMAS a higher rate for Home and Community Based Care Services than is charged the private sector for the same services. ☐ **Yes**

33. Insolvency or Bankruptcy Verification (Required)

I certify as authorized administrator that there is neither a judgment or pending action of insolvency or bankruptcy in a state or federal court and that the provider of services agrees to inform the Department of Medical Assistance Services (DMAS) immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services. ☐ **Yes**

34. Validation of Program Description and Accurate Completion of Enrollment Application (Required)

I certify as authorized administrator that the chief administrative agent and professional staff have received and reviewed the program description materials of the Home and Community Based Care services, and that all information within this application is accurate, truthful, and complete. ☐ **Yes**

35. Remarks (Optional)

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services
Medical Assistance Program

Family Caregiver Training Participation Agreement

This is to certify:

Provider Name _____

NPI _____

On this _____ day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, and the legally designated State Agency for the administration of Medicaid.

1. The provider is authorized to practice under the laws of the state in which he is licensed and is not as a matter of state or federal law disqualified from participating in the Program.
2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in (Section 504 of the Rehabilitation Act of l973 29 USC.794) VMAP.
3. The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and federal personnel will be permitted upon reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a medical assistance recipient for any service provided under medical assistance is expressly prohibited.
6. The provider agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
9. The provider agrees to comply with 42 CFR §455.105. Disclosure by providers: Information related to business transactions within 35 days of request.
10. Except as otherwise provided by applicable state or federal law, this agreement may be terminated at will on thirty days' written notice by either party. This agreement may be terminated by DMAS if DMAS determines that the provider poses a threat to the health, safety or welfare of any individual enrolled in any program administered by the Department.
11. Except as otherwise provided by applicable state or federal law, all disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
12. The provider agrees that DMAS may disclose the provider's NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Insurance.
13. This agreement shall commence upon the approval date of your enrollment application. Your effective date of participation is listed on your approval letter which is sent to your correspondence address upon approval of your application. The provider shall retain a copy of this approval letter as part of the Participation Agreement. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

For Virginia Medicaid use only

Director, Division of Program Operations Date

Original Signature of Provider Date