



# COMMONWEALTH of VIRGINIA

## Department of Medical Assistance Services

### Private Duty Nursing Services

#### 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)**

Adult Day Health Care 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).

Some Atypical 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 10-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).

**National Provider Identifier (NPI) (Required for Private Duty Nursing Services)**

Private Duty Nursing Services must enter your organization's NPI (Required). To participate as a provider of medical or health services for the Department of Medical Assistance Services (DMAS), you are required to obtain an NPI. DMAS has adopted the NPI as the standard for identifying all providers on all transactions, including paper claims. 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. Organization Name (Required)**

Enter the organization name which identifies your organization 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.
- Adult Day Health Care and Private Duty Nursing providers must be located within the Commonwealth of Virginia. Out-of-State providers are not eligible for this Virginia Medicaid 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) (Required)**

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).

**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. Adult Day Health Care (ADHC) License**

A Virginia Department of Social Services (DSS) License as Adult Day Care is required. Enter the License number, effective date and end date. Attach a copy to your application.

**12. Private Duty Nursing (PDN) Services License**

Select the licensing board, enter the license number, effective date and end date. Attach a copy of your license to your application. (You must choose at least one)

- Accreditation Commission for Health Care, Inc. (ACHC)
- Community Health Accreditation Program (CHAP)
- Joint Commission (JCAHO) Accreditation
- Virginia Department of Health (VDH) certification as a Home Health Agency/Home Health Organization
- Virginia DSS License as Adult Day Care

**13. Type of Applicant (Required)**

Indicate the Type of Applicant: Corporation, Limited Liability Company, Partnership 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 a trade or business.
- 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)".

**14. 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.

**15. 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.

**16. 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.

**17. 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.

**18. 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.

**19. 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.

**20. 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:
  - o Fraud
  - o Obstruction of an investigation
  - o Controlled substance violation
  - o 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.

**21. 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:
  - o Fraud
  - o Obstruction of an investigation
  - o Controlled substance violation
  - o 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.

**22. 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.viriniamedicaid.dmas.virginia.gov](http://www.viriniamedicaid.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.

**23. 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:
  - o Be on letterhead, either a financial institution's or the applicant's
  - o Be signed
  - o Be dated
  - o Include the applicant's NPI
  - o Include a description of the good cause

**24. 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.viriniamedicaid.dmas.virginia.gov](http://www.viriniamedicaid.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.viriniamedicaid.dmas.virginia.gov](http://www.viriniamedicaid.dmas.virginia.gov).
- If you select "No", you must apply for an exemption and show good cause.
  - o 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
  - o 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

**25. 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 Home and Community Based Care services must submit the following information to DMAS.

**26. Additional Provider Types Enrolled (Required)**

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

**27. Administrator Name (Required)**

Name of administrator for the organization.

**28. Administrative Personnel (Required)**

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

**29. Geographical Areas to be Served (Required)**

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

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

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

**31. 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.

List anyone associated with your organization (owner, operators, manager or employees) who have been convicted of a criminal offense.

**32. Staffing Credentials (Required)**

It is the provider's responsibility to assure that all staff is oriented with all policies, procedures and forms necessary to comply with DMAS requirements that relate to performance of duties.

**Adult Day Health Care (ADHC)**

- As an ADHC provider, you are responsible for assuring that all program staff meets the qualifications detailed in Chapter II of the Commonwealth Coordinated Care (CCC) Plus Waiver Provider Manual, located on the Virginia Medicaid Web Portal, [www.viriniamedicaid.dmas.virginia.gov](http://www.viriniamedicaid.dmas.virginia.gov).
- All ADHC providers that perform supervisory and/or coordination activities for the ADHC program are expected to be knowledgeable of the ADHC criteria definitions for the completion of the functional status assessments and all other program requirements.

**Private Duty Nursing (PDN)**

- As a PDN provider, you are responsible for assuring that RN supervisory and private duty nursing staff meets the qualifications detailed in Chapter II of CCC Plus Waiver and Private Duty Nursing Services provider manual, located on the Virginia Medicaid web portal, [www.viriniamedicaid.dmas.virginia.gov](http://www.viriniamedicaid.dmas.virginia.gov).
- All PDN RN staff that performs supervisory activities for the PDN program are expected to be knowledgeable of the program eligibility criteria (i.e., CCC Plus Waiver, and Community Living Waiver) and all other program requirements.

For each program staff

- Enter name
- Full or part-time status
- License number
- Degree type (if applicable)
- Amount and type of clinical experience

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

Authorized administrator must certify that the chief administrative agent of the 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.

**34. 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 DMAS immediately if any court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of these services.

**35. 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.

**36. Remarks (Optional)**

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

# VIRGINIA MEDICAID ENROLLMENT FORM

## SECTION I: PROVIDER DEMOGRAPHIC INFORMATION

### 1. Provider Identifier (NPI or API)

Atypical Provider Identifier (API) (Leave blank until assigned) \_\_\_\_\_

National Provider Identifier (NPI) (Required for Private Duty Nursing Services) \_\_\_\_\_

### 2. Organization Name (Required)

\_\_\_\_\_  
*Enter the name which identifies your organization to the public*

### 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 at 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) (Required)

\_\_\_\_\_

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

\_\_\_\_\_

### 10. Requested Effective Date of Enrollment (Required)

\_\_\_\_\_

**11. Adult Day Health Care (ADHC) License (Required)**

☐ Virginia Department of Social services (DSS) License

License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_ (Attach Copy)

**12. Private Duty Nursing (PDN) Services License (Required)**

Select all that apply:

☐ Accreditation Commission for Health Care, Inc. (ACHC)

License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_ (Attach Copy)

☐ Community Health Accreditation Program (CHAP)

License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_ (Attach Copy)

☐ Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Accreditation

License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_ (Attach Copy)

☐ Virginia Department of Health (VDH) certification

License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_ (Attach Copy)

☐ Department of Social Services (DSS)

License # \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_ (Attach Copy)

**13. Type of Applicant - Check Only One (Required)**

☐ Corporation ☐ Limited Liability Company

☐ Partnership ☐ Government Entity

**14. Languages Other Than English Spoken - Check All that Apply (Optional)**

☐ Farsi ☐ Hindi ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Other: \_\_\_\_\_

**15. 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.**

**16. 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).

**17. 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).

**18. 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.

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

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

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

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

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

**19. 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.

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

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

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

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

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

**20. 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.

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Name/Organization \_\_\_\_\_ Title \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Name/Organization \_\_\_\_\_ Title \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Name/Organization \_\_\_\_\_ Title \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Name/Organization \_\_\_\_\_ Title \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

**21. 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.

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Name/Organization \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Name/Organization \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Name/Organization \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Name/Organization \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN/TIN \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

**22. 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)

#### 23. 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.

#### 24. 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.

#### 25. 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.

### 26. Additional Provider Types Enrolled (Required)

Organization is currently a Virginia Medicaid enrolled Provider ☐ Yes ☐ No

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

<input type="checkbox"/> Clinic	NPI	_____
<input type="checkbox"/> Home Health Agency	NPI	_____
<input type="checkbox"/> Hospice	NPI	_____
<input type="checkbox"/> Hospital	NPI	_____
<input type="checkbox"/> Outpatient Rehabilitation Agency	NPI	_____
<input type="checkbox"/> Nursing Facility	NPI	_____

### 27. Administrator Name (Required)

\_\_\_\_\_

### 28. Administrative Personnel (Required)

- Person Responsible for Signing Contract (Required) \_\_\_\_\_  
Office Phone \_\_\_\_\_  
Name of Person you report to \_\_\_\_\_  
☐ No ☐ Yes This person is responsible for general management of requested Medicaid Programs.
- Name of Chief Administrator On-site \_\_\_\_\_  
Office Phone \_\_\_\_\_  
Name of Person you report 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 \_\_\_\_\_

### 29. Geographical Areas To Be Served (Required)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 30. Ownership Name and Percentage (Must equal 100 )

Name	Address	% of Ownership
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**31. Criminal Offense Disclosure (Required)**

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

☐ No ☐ Yes If Yes is checked, you must submit final relevant disposition .

**32. Staffing Credentials for Adult Day Health Care (ADHC) Staffing Credentials (Required)**

• Name \_\_\_\_\_  
License ☐ No ☐ Yes # \_\_\_\_\_ ☐ Full Time ☐ Part Time  
Degree ☐ No ☐ Yes (if Yes, provide degree type) \_\_\_\_\_  
Amount/Type of Clinical Experience \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

• Name \_\_\_\_\_  
License ☐ No ☐ Yes # \_\_\_\_\_ ☐ Full Time ☐ Part Time  
Degree ☐ No ☐ Yes (if Yes, provide degree type) \_\_\_\_\_  
Amount/Type of Clinical Experience \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

• Name \_\_\_\_\_  
License ☐ No ☐ Yes # \_\_\_\_\_ ☐ Full Time ☐ Part Time  
Degree ☐ No ☐ Yes (if Yes, provide degree type) \_\_\_\_\_  
Amount/Type of Clinical Experience \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

• Name \_\_\_\_\_  
License ☐ No ☐ Yes # \_\_\_\_\_ ☐ Full Time ☐ Part Time  
Degree ☐ No ☐ Yes (if Yes, provide degree type) \_\_\_\_\_  
Amount/Type of Clinical Experience \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**33. Compliance with Federal Regulations Regarding Rates (Required)**

I certify as authorized administrator that the chief administrative agent of the organization that in order to comply with federal regulations, this provider 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**

**34. 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 DMAS immediately if court proceedings to make a judgment of insolvency or bankruptcy are instituted with respect to the provider of services. ☐ **Yes**

**35. 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**

**36. Remarks (Optional)**

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## COMMONWEALTH of VIRGINIA

### Department of Medical Assistance Services Medical Assistance Program

#### Private Duty Nursing Services 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 1973 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