Summit COMMUNITY CARE

Health Care Delivery Organization and Ancillary Application

Please submit all applicable documents from the list below with your completed and signed application. Failure to submit a complete application and all applicable documents will result in the application being returned and will prohibit Summit Community Care from completing the credentialing and/or contracting process.

Note: Submission of a completed application does not guarantee approval as a participating provider as additional information and/or documentation may be required by Summit Community Care.

Required attachments:

- Copy of all federal, state and/or local licenses required to operate as a health care facility (by location)
- Copy of *Accreditation Certificate* or letters
- Copy of most recent CMS or state survey (with deficiencies) including cover letter from CMS or state agency stating facility is in substantial compliance or *Corrective Action Plan* if deficiencies were cited
- Copy of Medicaid and Medicare certification(s) or certificate numbers on the application
- *W-9*
- Current copy of professional liability insurance and general liability insurance (must indicate coverage limits, policy number, effective date and expiration date)
- Proof of established Quality Improvement Program
- Current copy of *Pharmacy License* in state where contracting (for ambulatory and home infusion therapy providers)
- *Clinical Laboratory Improvement Act Certificate(s)* for each location (for dialysis and laboratory providers)

As requested by our Network Provider Solutions and Credentialing department, additional paperwork or addendums to this application may need to be completed.

Instructions: Complete the following pages and return to Summit Community Care with the required attachments.

Provider type		
☐ Ambulatory surgery center	☐ Home health agency	☐ Outpatient rehab center/hospital
☐ Birthing center	☐ Home infusion therapy	☐ Portable X-Ray supplier
☐ Clinical laboratories	☐ Hospice facility	☐ Rural health clinic (RHC)
☐ Dialysis center/ESRD	☐ Hospital	☐ Skilled nursing facility
☐ Federally qualified health center (FQHC)	☐ Inpatient rehab hospital	

Behavioral health	
☐ Ambulatory detox	☐ Partial hospitalization — psychiatric
☐ Community mental health center	☐ Partial hospitalization — substance abuse
☐ Crisis stabilization unit	☐ Psychiatric inpatient rehabilitation
☐ Hospital — inpatient detox	☐ Psychiatric residential treatment facility
☐ Hospital — psychiatric	☐ Residential treatment center — substance abuse
☐ Intensive outpatient — psychiatric	☐ Substance abuse — inpatient rehabilitation
☐ Intensive outpatient — substance abuse	☐ Substance abuse clinic — outpatient services
☐ Mental health clinic — outpatient services	
☐ Methadone maintenance clinic	

Provider identification		
Legal business name:		
Doing business as (if applicable):		
Primary contact person:		
Title:		
Email:		
Primary contact address:		
City:	State:	ZIP code:
Phone:	Fax:	

Credentialing information		
Credentialing contact name:		
Title:		
Email:		
Credentialing address:		
City:	State:	ZIP code:
Phone:	Fax:	

Primary office/service address		
Does the facility have multiple locations? ☐ Yes ☐ No (If yes, attach a separate sheet for other locations.)		
Address line 1:		
Address line 2:		
City:	State:	ZIP code:
County:		

Primary office/service address (cont.)			
Phone:		Fax:	
Primary contact:			
Primary contact email:			
Phone:		Website:	
Administrator (full name):			
Medicaid #:		Medicare #:	
TIN/EIN:		NPI #:	
Taxonomy code(s):			
Does provider bill from this address? ☐ Yes ☐ No			
Does this office meet *ADA* accessibility requirements? ☐ Yes ☐ No			
Check all that apply:			
Handicap accessible:	☐ Building ☐ Parking ☐ Restroom		
Services for disabled:	☐ TTY ☐ American Sign Language ☐ Mental/physical impairment		
Accessible by public transportation:	☐ Bus ☐ Subway ☐ Regional train		
Billing information			
Contact name (billing contact):			
Title:			
Address line 1:			
Address line 2:			
City:	State:	ZIP code:	
Phone:		Fax:	
Email:			
Website:			
Preferred method of communication: ☐ Email ☐ Fax ☐ Mail			

Licensure/operating certificate			
State:	Date of license:	License number:	Expiration date:
State:	Date of license:	License number:	Expiration date:
CLIA certificate #:			

Accreditation/certification (Attach a copy of current accreditation certificate or survey)			
A.			
☐ AAAASF ☐ AAAHC ☐ AAPSF ☐ ACHC ☐ ACR ☐ BOC INTL	☐ CABC ☐ CAHC ☐ CCAC ☐ CHAP ☐ CIHQ ☐ COA	☐ COLA ☐ CTEAM ☐ DNV/NIAHO ☐ HFAP ☐ HQAA ☐ IMQ	☐ TJC ☐ AIUM ☐ FDA ☐ _____ ☐ Not accredited (If not accredited, please complete Section B below.)
Date of initial accreditation:		Date of next survey:	
Date of last survey:			

Accreditation/certification (cont.)							
B.							
Has provider had an onsite survey by CMS or state? ☐ Yes ☐ No*							
Date of last recertification/annual state survey program review report:							
* If no, successful completion of an onsite visit is required to complete credentialing. You will be contacted to schedule the visit. Nonaccredited providers must provide a copy of their most recent government agency survey (may not be older than 36 months) along with the *Corrective Action Plan* (if deficiencies were cited) or attach the letter from the government agency stating facility is in substantial compliance with most recent survey standards. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.							
General and professional liability insurance							
General liability coverage (Attach copy of current insurance face sheet/declaration page)							
Carrier name:							
Policy #:							
Effective date:				Expiration date:			
Coverage per incident: $				Coverage aggregate: $			
Professional liability insurance							
Carrier name:							
Policy #:							
Effective date:				Expiration date:			
Coverage per incident: $				Coverage aggregate: $			
Provider directory							
The following information will be used for your provider directory listing.							
Office hours							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open:							
Close:							
About the facility							
1. Does the facility have experiences and skills in treating persons with:							
A. Physical disabilities?				☐ Yes ☐ No ☐ N/A			
B. Chronic illness?				☐ Yes ☐ No ☐ N/A			
C. HIV/AIDS?				☐ Yes ☐ No ☐ N/A			
D. Serious mental illness?				☐ Yes ☐ No ☐ N/A			
2. Do you have experience and skills in treating individuals who are:							
A. Homeless?				☐ Yes ☐ No ☐ N/A			
B. Deaf or hard of hearing?				☐ Yes ☐ No ☐ N/A			
C. Blind or visually impaired?				☐ Yes ☐ No ☐ N/A			
What languages (other than English) are spoken by you/facility staff fluently enough to treat patients who only speak that language?							

Disclosure questions	
• **If you answer yes to any of the following questions, attach a detailed explanation.** • **If any question does not apply, please answer no.** • Failure to answer or provide an explanation may result in a delay in processing the application. • Do not use whiteout to correct/change answers; if you need to correct/change an answer, cross out the incorrect answer, initial it and then mark the correct answer.	
1. Does the business have evidence of:	
A. Professional liability claims history for each subcontractor?	☐ Yes ☐ No
B. Disciplinary action taken against any business or professional license held in this or any other state or surrender of a license in this or any state?	☐ Yes ☐ No
C. Any history of loss or limitation of privileges or disciplinary activity?	☐ Yes ☐ No
2. Has the business' general or professional liability insurance ever been denied, cancelled, nonrenewed or refused upon application for any reason other than by the facility's request?	☐ Yes ☐ No
3. Has the business, under any current or former name or business entity, ever:	
A. Had licensure to do business in any applicable jurisdiction ever been denied, revoked, reduced, suspended or not renewed?	☐ Yes ☐ No
B. Been suspended or excluded from receiving payment under Medicare or Medicaid?	☐ Yes ☐ No
C. Had accreditation status reduced, terminated, suspended or revoked?	☐ Yes ☐ No
D. Been under investigation by any government agency?	☐ Yes ☐ No
4. Is the business' professional liability insurance provided through a self-insurance trust or program?**	☐ Yes ☐ No

Disclosure questions (cont.)

****** If yes, an officer of the company (for example, president, vice president, chief financial officer or chief operating officer) must sign the following attestation.

On behalf of the applicant, I represent and warrant the following with respect to the self-insurance program maintained by the applicant or which provides professional liability insurance for the applicant:

1. The self-insurance program is adequately funded to provide the minimum required limits of liability as required by the plan.
2. The self-insurance program has an actuarially validated reserve adequate for incurred claims, for incurred but not reported claims, and future claims based on past experience.
3. The self-insurance program has a designated third-party administrator or other appropriately licensed claims professional or attorney serving the program.
4. The self-insurance program has a designated medical malpractice defense firm or more than one designated medical malpractice defense firm.
5. The self-insurance program maintains excess insurance/reinsurance above the self-funded level if the self-insured level alone is insufficient to meet required limits of the plan.
6. The self-insurance program maintains evidence of a surety bond or letter of credit as collateral to the self-insured limit or a captive, self-management of a large retention through a trust.
7. The self-insurance program maintains a total value of the program that at a minimum meets the required limit of liability as set forth by the plan.
8. I have confirmed the foregoing with my auditor or the actuary for the self-insurance fund.

Attestation signature:	Date:
Printed name:	Title:

Note: Summit Community Care reserves the right to request documentation from the applicant to confirm the information disclosed in this attestation.

Attestation

I, the undersigned authorized agent, hereby attest that the information submitted in or in support of this application is true, accurate and complete to the best of my knowledge and belief and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of application or termination of privileges, employment or participating practitioner agreement.

A photocopy of this document shall be as effective as the original.

Preparer's name:	Title:
Signature:	Date: