Hennepin Health

☐ **Initial Credentialing** ☐ **Recredentialing**

Please follow the Instructions on Page 8.

1. PROVIDER IDENTIFICATION

CORPORATE IDENTIFICATION INFORMATION

Legal Business Name (as assigned on W-9):	Federal Tax Identification Number (TIN): ___ ___ ___ ___ ___ ___ ___ ___ ___ (Application **cannot** be processed without a valid 9-digit TIN)
Corporate Address (if different than facility address):	NPI for facility being credentialed: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (Application **cannot** be processed without a valid 10-digit NPI)
☐ Corporation ☐ Partnership ☐ Not-For-Profit Corp. ☐ Other (specify) ☐ Sole Proprietorship _____	Length of time in business with this name and Tax ID: _____Years _____Months

Is facility owned in whole or in part or managed by a hospital or health care system/organization?

☐ Yes, owned in whole or in part by _____

☐ Yes, managed by _____

☐ No, not affiliated with a hospital or health care system/organization

FACILITY INFORMATION

Facility DBA Name:			
Street Address:			
City:	State:	Zip:	County:
Phone:	Fax:	Website:	
Administrator:	Email:		
Application Contact Person:	Title:		
Phone:	Fax:	Email:	

MAILING/CORRESPONDENCE ADDRESS

Must be an address where provider can be contacted directly. PAYMENTS / REMITS WILL BE DIRECTED TO THIS ADDRESS.

☐ Check here if all correspondence can be directed to the facility location directly above. Otherwise, complete the section below.

Name:			
Mailing Address:			
City:	State:	Zip:	Phone:

FACILITY TYPE
One box must be checked. If your provider type is not listed below, do NOT complete this application.

MEDICAL

☐ Hospital

☐ Skilled Nursing Facility/Nursing Home

☐ Free-Standing Surgical Center

☐ Home Health Care Agency

BEHAVIORAL HEALTH

☐ Inpatient Services

☐ Outpatient Services

☐ Ambulatory Services

Must complete Section 11 if agency is not Medicare certified.

2. MEDICAL DIRECTOR

A specific physician Medical Director must clearly be identified and must be licensed in good standing.

Name:_____ MD☐ DO☐ Specialty: _____

License #:_____ State:_____ Phone: ( )_____-_____

Email Address:_____ NPI: _____

3. FACILITY LICENSURE

Attach a copy of each Facility license for this facility. Do not submit Practitioner licenses.
Residential BH facilities must submit both DHS license and Board & Lodging/Supervised Living license.

License Number	Licensing Agency	Effective Date	Expiration Date
		____/____/____	____/____/____
		____/____/____	____/____/____
		____/____/____	____/____/____

4. MEDICARE STATUS

Is this facility/program/agency Medicare certified? ☐ YES ☐ NO
If Yes: Medicare number:_____ Date of initial Certification:_____/_____/_____

☐ Check here if facility is not eligible for Medicare certification.

5. ACCESSIBILITY STATUS

Does this facility meet applicable standards for accessibility of the Americans with Disabilities Act?

☐ YES ☐ NO ☐ N/A - Home Care Agency only

6. ACCREDITATION

Indicate which accreditation the facility holds and attach a copy of all applicable certificates/letters. The facility being credentialed must be listed as included in the accreditation.

- ☐ **AAAASF** - American Association for Accreditation of Ambulatory Surgery Facilities
- ☐ **AAAHC** - Accreditation Association for Ambulatory Health Care
- ☐ **AASM** - American Academy of Sleep Medicine
- ☐ **ACHC** - Accreditation Commission for Health Care
- ☐ **CABC** – Commission for the Accreditation of Birth Centers
- ☐ **CARF** - Commission on Accreditation of Rehabilitation Facilities
- ☐ **CCAC** - Continuing Care Accreditation Commission
- ☐ **CHAP** - Community Health Accreditation Program
- ☐ **COA** - Council on Accreditation
- ☐ **DNV / NIAHO** - Det Norske Veritas / National Integrated Accreditation for Healthcare Organizations
- ☐ **HFAP** – Healthcare Facilities Accreditation Program
- ☐ **TJC** – The Joint Commission (Formerly known as JCAHO)

1. Date of last full survey:_____/_____/ _____
2. Effective date of accreditation:_____/_____/_____through_____/_____/_____

☐ **Facility is not currently accredited.** ***Complete Non Accredited Facility Section below.***

7. NON ACCREDITED FACILITY

Complete this section if facility is not accredited.

Medical Facility: Has the Department of Health completed an onsite licensing review or CMS certification survey within the past 36 months?

Behavioral Health Facility: Has the Department of Human Services completed an onsite licensing review within the past 36 months?

☐ YES – Date of most recent onsite survey:_____/_____/_____

Attach copy of the most recent onsite licensing/certification survey along with your Corrective Action Plan (CAP), if deficiencies were cited; OR attach a letter or email from the licensing/certification agency stating that the facility is in substantial compliance with the most recent survey standards.

☐ NO – ***Successful completion of a Hennepin Health onsite visit will be required to complete re/credentialing.*** You will be contacted by Hennepin Health to schedule the visit.

8. CREDENTIALING PROGRAM

Indicate how proper credentialing is ensured for all health care professionals employed or contracted at the facility:

- ☐ Credentialing procedures are performed internally.
- ☐ Credentialing procedures are outsourced/delegated to _____

_____

- ☐ Other, explain: _____

_____

_____

9. INSURANCE COVERAGE

1. Is this facility covered by **Commercial General** liability insurance in the minimum amount of $1 million per occurrence and $3 million aggregate? (Excess liability/Umbrella coverage can count toward the $3 million aggregate amount.)
   - ☐ YES – *Attach copy of insurance certificate.* We prefer the Acord® Certificate of Liability Coverage form.
   - ☐ NO - *Please obtain the required amount of coverage before submitting this application.*
   - ☐ Facility is covered by Government insurance. – *Attach documentation detailing coverage.*

2. Is facility covered by **Professional** liability insurance in the minimum amount of $1 million per occurrence and $3 million aggregate? Policy must state it covers all facility employees. (Excess liability/Umbrella coverage can count toward the $3 million aggregate amount.)
   - ☐ YES - *Attach copy of insurance certificate.* We prefer the Acord® Certificate of Liability Coverage form.
   - ☐ NO - *Please obtain the required amount of coverage before submitting this application.*
   - ☐ Facility is covered by Government insurance. - *Attach documentation detailing coverage.*

10. ATTACHMENTS

Indicate all documents included with this application.

THE PROCESSING OF YOUR APPLICATION WILL BE DELAYED IF ALL REQUIRED INFORMATION IS NOT SUBMITTED.

- ☐ Copy of all State and/or local licenses required to operate as a health care facility
- ☐ Copy of Medicare certification documentation from CMS
- ☐ Copy of facility's Commercial General liability insurance certificate
- ☐ Copy of facility's Professional liability insurance certificate covering all facility employees
- ☐ Copy of most recent accreditation letter or certificate
- ☐ Copy of most recent onsite governmental licensing agency survey including facility's corrective action plan if deficiencies were cited, OR cover letter/email from licensing agency stating facility is in substantial compliance with licensing standards from most recent survey
- ☐ Other: _____

11. NON MEDICARE CERTIFIED HOME CARE AGENCY SECTION

Complete this section ONLY for Home Care Agency that is not Medicare (CMS) certified. Answer ALL questions.

1. Indicate the number of hours and days per week agency is available to serve clients.
   Hours per day:_____Days per week: _____

2. List states and years agency has been in business.
   State:_____Year(s):_____- _____

   State:_____Year(s):_____- _____

3. Indicate number of clients agency has served.
   This year: _____
   Last year: _____
   Two years ago: _____

4. Indicate the age range of clients accepted.
   _____to _____

5. Number of agency employees in each category.
   Registered Nurses (RN): _____
   Licensed Practical Nurses (LPN): _____
   Home Health Aide: _____
   Other _____ _____

6. Percentage of clients in the past year through present who primarily received **skilled nursing services, physical (PT), occupational (OT), and/or speech-language therapy** rather than home health aide
   _____**%**

7. Give reason(s) this home care agency has not pursued/been granted Medicare certification.
   _____
   _____
   _____

12. PROVIDER INTEGRITY ATTESTATION

Answer all questions with YES or NO.
Provide an explanation below for all questions answered YES. Use a separate sheet if necessary.
A written signature is required; do not submit a typed signature. Form must be dated.

☐ YES ☐ NO	1. Within the past five years, has this facility had or does it currently have pending any legal actions against it, excluding medical malpractice and/or frivolous law suits?
☐ YES ☐ NO	2. Within the past five years, has this facility been convicted of a crime, excluding misdemeanors or have any of its employees ever been convicted of a felony offense?
☐ YES ☐ NO	3. Within the past five years has this facility been found liable for the death of a patient or resident or been cited for by its licensing/certification agency for a substantiated determination of maltreatment of a child or vulnerable adult?
☐ YES ☐ NO	4. Within the past five years, has any government licensing agency restricted, conditioned or taken any other action against this facility's license to operate?
☐ YES ☐ NO	5. Within the past five years has this facility's accreditation or certification been revoked, denied, suspended or been voluntarily surrendered by the facility, or are any actions now underway which may lead to such conclusions?
☐ YES ☐ NO	6. Within the past five years, has this facility/organization been assessed a penalty or fined by a government agency, or is the facility currently under investigation by the Medicaid or Medicare programs or any other government agency?
☐ YES ☐ NO	7. Has any third party payor ever revoked, reduced, denied, or suspended this facility's network participation due to inappropriate utilization management or any quality of care issues?

Provide details that include: 1) pertinent facts, 2) dates, and 3) current status/disposition for all questions answered YES. The application cannot be processed without all of this information. Use a separate sheet if necessary.

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire Application are true, accurate and complete to the best of my knowledge. I fully understand that any falsification of information or omissions from this Application may be grounds for denial of this Application as a Hennepin Health participating provider.

I further understand, as an authorized agent of the applicant, that I and the organization have the burden of producing adequate information for the proper evaluation of the organization's competence, character, and ethics in resolving doubts about such qualifications.

I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

_____ _____
Signature of Authorized Representative **Printed Name of Authorized Representative**

_____/_____/_____ _____
Date Signed **Authorized Representative's Title**

FACILITY CREDENTIALING APPLICATION

CLINICAL SPECIALTIES

Check only those clinical areas for which your facility currently provides services and staff have the required education and/or training to provide.

- ☐ Acupuncture (ACUP)
- ☐ Addictions (ADCT)
- ☐ ADD/ADHD (ADDA)
- ☐ Adjustment Disorders (ADJD)
- ☐ Adoption (ADPT)
- ☐ Anger Management (ANGM)
- ☐ Anxiety Disorder (ANXD)
- ☐ Applied Behavioral Therapy (ABTH)
- ☐ Arthroscopic Surgery (ARTH)
- ☐ Autism (ATSM)
- ☐ Bariatric Surgery (BARI)
- ☐ Behavior Modification (BHMD)
- ☐ Biofeedback (BIOF)
- ☐ Bipolar Disorder (BIPO)
- ☐ Blended Families (BLND)
- ☐ Brief Solution Focused (BSOL)
- ☐ Burn Unit (BURN)
- ☐ Cataract Laser Surgery (CATL)
- ☐ Chemical Dependency (CDEP)
- ☐ Child Abuse (CHLD)
- ☐ Christian Counseling (CHRS)
- ☐ Chronic Mental Illness (CHMI)
- ☐ Compulsive Gambling (CGAM)
- ☐ Conduct-Disruptive Disorders (CNDT)
- ☐ Co-Dependency (CODE)
- ☐ Couples/Marriage Therapy (CPLT)
- ☐ Cornea Specialists (CORN)
- ☐ Crisis Intervention Services (CRIS)
- ☐ Critical Incident Debriefing (CIDB)
- ☐ Cultural/Ethnic Issues (CULT)
- ☐ Depressive Disorder (DPDS)
- ☐ Developmental Disabilities (DVDS)
- ☐ Dialectical Behavioral Therapy (DIAL)
- ☐ Dissociative Disorder (DISD)
- ☐ Divorce (DVRC)
- ☐ Domestic Violence (DOMV)
- ☐ Dual Dx - Dev. Disab./MH (DDMH)
- ☐ Dual Dx - Sub. Abuse/MH (SAMH)
- ☐ Eating Disorders (EATD)
- ☐ Electroconvulsive Therapy (ELCT)
- ☐ Emergency Dr (EMDR)
- ☐ End of Life Issues (ENDL)
- ☐ Epilepsy (EPIL)
- ☐ Family Therapy (FAMT)
- ☐ Fitness For Duty Assessments (FDYT)
- ☐ Forensic/Sex Offenders (FORN)
- ☐ Gastric Banding (GASB)
- ☐ Gay/Lesbian/Bisexual (GYLB)
- ☐ Gender Identity (GENI)
- ☐ Geriatric Medicine (GERM)
- ☐ Glaucoma Specialist (GLAU)
- ☐ Grief Counseling (GRFC)
- ☐ Group Therapy (GRPT)
- ☐ Head Injury Patients (HDIN)
- ☐ Hearing Impaired Issues (HEAR)
- ☐ Hip Surgery (HIPS)
- ☐ HIV/AIDS Related Issues (HIVA)
- ☐ Holistic Medicine (HOLM)
- ☐ Home Based Services (HBSR)
- ☐ Home Care Home Visits (HCHV)
- ☐ Homeopathic Medicine (HMED)
- ☐ Hypnosis (HYPN)
- ☐ Infertility (INFR)
- ☐ Joint Replacement (JRPL)
- ☐ Knee Surgery (KNEE)
- ☐ Lasik Surgery (LSIK)
- ☐ Learning Disabilities (LRND)
- ☐ Medical Stress/Behavioral Mod (MSBM)
- ☐ Medication Management (MEDI)
- ☐ Men's Issues (MENS)
- ☐ Mohs Only (MOHS)
- ☐ Mood Disorders (MOOD)
- ☐ Multicultural Issues (MLTC)
- ☐ Naturopathic Medicine (NATM)
- ☐ Neuropsychological Assessment (NEUR)
- ☐ Nutrition (NTRN)
- ☐ Obesity Assessment/Counseling (OBES)
- ☐ Obsessive Compulsive Disorder (OBCD)
- ☐ Oculoplastics (OCUL)
- ☐ Open Heart Surgery (OHRT)
- ☐ Orbit Specialist (ORBT)
- ☐ Organic Brain Syndrome (ORGB)
- ☐ Organic Disorders (ORGD)
- ☐ Pain Management (PAIN)
- ☐ Panic Disorder (PNIC)
- ☐ Parenting Skills (PRNT)
- ☐ Pastoral Counseling (PAST)
- ☐ Pediatric Skilled Nursing (PDSN)
- ☐ Personality Disorder (PRSN)
- ☐ Phobias (PHOB)
- ☐ Physical Abuse/Violence (PHYA)
- ☐ Physically Impaired Patients (PHYI)
- ☐ Play Therapy (PLAY)
- ☐ Police Personnel (POLC)
- ☐ Post-Traumatic Stress Dis. (PTSD)
- ☐ Postpartum Issues (PSTP)
- ☐ Prenatal Issues (PREN)
- ☐ Psych Disability Eval/Mgmt (PDEM)
- ☐ Psychological Testing (PSYT)
- ☐ Psychosomatic (PSMT)
- ☐ Psychotic Disorders (PSCD)
- ☐ Rape Victims (RAPE)
- ☐ Retinal Specialist (RETN)
- ☐ Schizophrenic Disorders (SCHZ)
- ☐ Sex Offender (SEXO)
- ☐ Sexual Abuse/Violence (SXAV)
- ☐ Sexual Dysfunction (SXDY)
- ☐ Sexual Harassment (SXHA)
- ☐ Shoulder Surgery (SHOU)
- ☐ Sleep Studies (SLPD)
- ☐ Somatoform Disorders (SOMD)
- ☐ Sports Medicine (SPTM)
- ☐ Spine Surgery (SPNS)
- ☐ Strabismus Specialists (STRB)
- ☐ Terminally Ill Patients (TERM)
- ☐ TMJ (TMJO)
- ☐ Transplant (TRNS)
- ☐ Urodynamics (UROD)
- ☐ Venous Closures (VENC)
- ☐ Visually Impaired (VISI)
- ☐ Women's Issues (WMNI)
- ☐ Workers' Compensation (WORK)

FACILITY CREDENTIALING APPLICATION

LANGUAGES

- ***Check all languages spoken by facility/agency/program staff fluently enough to treat patients/clients who speak only that language.***
- ***If none of these languages are spoken at your facility, check None of These.***
- ***Indicate if Sign Language and/or an Interpreter Service is available at your facility.***

☐	AFRIKAANS	☐	HILIGAYNON	☐	OROMO
☐	AKAN	☐	HINDI	☐	PAKASTANI
☐	AMHARIC	☐	HINDU	☐	PERSIAN
☐	ARABIC	☐	HMONG	☐	POLISH
☐	ARABIC NORTH LEVAN	☐	HUNGARIAN	☐	PORTUGUESE
☐	ARMENIAN	☐	IBO OF NIGERIA	☐	PUNJABI
☐	ASSAMESE	☐	ICELANDIC	☐	ROMANIAN
☐	BENGA	☐	INDONESIAN	☐	RUSSIAN
☐	BENGALI	☐	IOLOCANO	☐	SERBIAN
☐	BOSNIAN	☐	ITALIAN	☐	SINDHI
☐	BULGARIAN	☐	KANNADA	☐	SINHALA
☐	BURMESE	☐	KAREN	☐	SLAVIC
☐	CAMBODIAN	☐	KASHMIRI	☐	SLOVENIAN
☐	CANTONESE	☐	KISII	☐	SOMALI
☐	CHILEAN	☐	KISWAHILI	☐	SPANISH
☐	CHINESE	☐	KONKANI	☐	SWAHILI
☐	CHINESE MANDARIN	☐	KOREAN	☐	SWEDISH
☐	CROATIAN	☐	KUNIAN	☐	TAGALOG
☐	CZECH	☐	KURDISH	☐	TAIWANESE
☐	DANISH	☐	LATIAN	☐	TAMIL
☐	DUTCH	☐	LAOTIAN	☐	TELUGU
☐	EGYPTIAN	☐	LATVIAN	☐	THAI
☐	ESAN	☐	LIINGALA	☐	TIGRIGNA
☐	ESTONIAN	☐	LITHUANIAN	☐	TSWANA
☐	FARSI	☐	LUGANDA	☐	TURKISH
☐	FILIPINO	☐	LUO	☐	TURKMEN
☐	FINNISH	☐	MALAY	☐	UKRANIAN
☐	FLEMISH	☐	MALAYALAM	☐	URDU
☐	FRENCH	☐	MANDARI	☐	VIETNAMESE
☐	GERMAN	☐	MANDINKA	☐	WELSH
☐	GREEK	☐	MARATHI	☐	WOLOF
☐	GUJARATI	☐	NEPALI	☐	YIDDISH
☐	HAITIAN CREOLE FRENCH	☐	NORWEGIAN	☐	YORUBA
☐	HEBREW	☐	OJIBWE	☐	NONE OF THESE

☐ AMERICAN SIGN LANGUAGE ☐ INTERPRETER SERVICE UTILIZED BY FACILITY

APPLICATION INSTRUCTIONS

(The term "facility" used throughout this application is inclusive of home care agencies and behavioral health programs.)

- This application should be completed **only** for facility types listed on Page 2.
- Applications should be typed or legibly block printed in black or dark blue ink.
- ALL fields must be completed unless otherwise directed.
- Additional instructions are ***bolded*** in *italics* on the application.
- A separate application is required for EACH facility location. Facility providers cannot be "branched" or added to an existing contract.
- If you have any questions, please send an email message to *hhcredentialing@hennepin.us.*
- Submit completed application along with **all** required documentation by one of these methods:

EMAIL: **hhcredentialing@hennepin.us** (Preferred Method)

FAX: **612-677-6264**

MAIL: **Hennepin Health**
Provider Credentialing
Minneapolis Grain Exchange Building
400 S 4th St STE 201
Minneapolis MN 55415