Hennepin Health

☐ **Initial Credentialing** ☐ **Re-Credentialing**

CREDENTIALING CONTACT *(Name, Email, Phone)*	**DATE OF COMPLETION**

CORPORATE IDENTIFICATION INFORMATION

LEGAL BUSINESS NAME *(as reflected on W-9)*

DOING BUSINESS AS NAME *(as reflected on W-9)*	**FEDERAL EIN/TAX ID**
ORGANIZATIONAL NPI	**LENGTH OF TIME TAX ID HAS BEEN IN BUSINESS**

ORGANIZATION CLASSIFIED AS:

☐ Corporation ☐ Partnership

☐ Not-For-Profit Corp ☐ Sole Proprietorship

☐ Other (Specify) ______________________

FACILITY TYPE:

Free Standing Surgical Center

☐ Skilled Nursing Facility ☐ Home Health Agency

Out Patient Behavioral Health

☐ Nursing Home ☐ In Patient Behavioral Health

☐ Hospital ☐ Chemical Dependency

☐ Ambulatory Services

IS THE ENTITY WHOLLY OR PARTIALLY OWNED OR MANAGED BY A HOSPITAL OR HEALTH CARE SYSTEM?

☐ Wholly owned by ____

☐ Partially owned by ____

☐ Managed by ____

☐ Not affiliated with a hospital or health care system

IS THE ENTITY MEDICARE CERTIFIED? ☐ Yes ☐ No

If Yes, complete the following: Medicare PTAN number _______________________ Date of last Certification ___________________

IS THE ENTITY ELIGIBLE FOR MEDICARE CERTIFICATION? ☐ Yes ☐ No

Non-Medicare certified Home Care Agencies MUST complete the Non-Medicare Certified Home Care Agency portion of the application.

PLEASE LIST YOUR PROVIDER TYPE(S) AND SPECIALTIES:

DO YOU HAVE ADDITIONAL LOCATIONS? ☐ No ☐ Yes *(Please complete the attached roster template)*

FACILITY INFORMATION

FACILITY DOING BUSINESS AS NAME *(as reflected on W-9)*

STREET ADDRESS		**CITY**	**STATE**	**ZIP CODE**
COUNTY	**PHONE**	**FAX**	**WEBSITE**	

OFFICE ADMINISTRATOR *(Name, Title, Email, Phone)*

Hennepin Health

FACILITY LICENSING Attach a copy of each facility license including DHS and Board & Lodging/Supervised Living licenses when applicable			
LICENSING AGENCY	**LICENSE NUMBER**	**EFFECTIVE DATE**	**EXPIRATION DATE**
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INSURANCE COVERAGE

Attach a copy of Certificate of Insurance for General, Professional and or Government Liability policies

MINIMUM COVERAGE AMOUNTS OF $1 MILLION PER OCCURRENCE AND $3 MILLION AGGREGATE (includes umbrella policy)

Professional Liability Coverage MUST list all facilities and/or practitioners covered under the policy

☐ Yes ☐ No Commercial General Liability

☐ Yes ☐ No Professional Liability

☐ Yes ☐ No Are you covered under TORT or other Government insurance

SERVICE ACCESSIBILITY INFORMATION

Does this facility meet applicable Americans with Disabilities Act standards for accessibility? ☐ Yes ☐ No

Do you offer flexible appointment hours at this location? ☐ Yes ☐ No

Is this location wheelchair accessible? ☐ Yes ☐ No

Is transfer assistance available? ☐ Yes ☐ No

Are private waiting areas available? ☐ Yes ☐ No

Is there parking lot or ramp access for this location? ☐ Yes ☐ No

What is the approximate distance from this location to public transportation?

☐ 1 to 2 blocks ☐ 3 to 5 blocks (1/4 mile) ☐ 6 to 8 blocks (1/2 mile)

☐ 9 to 10 blocks (3/4 mile) ☐ 11-13 blocks (1 mile) ☐ More than 2 miles

CREDENTIALING INFORMATION

MEDICAL DIRECTOR (OR EQUIVALENT) NAME		**PROVIDER TYPE**	**SPECIALITY**
NPI	**LICENSE STATE**	**LICENSE NUMBER**	**LICENSE EXPIRATION**
PHONE		**EMAIL ADDRESS**	

HOW ARE THE PRACTITIONERS CREDENTIALED WITHIN YOUR ORGANIZATION?

Please provide a roster of practitioners including Name, Provider Type and Specialty

☐ Credentialing is performed internally

☐ Credentialing is outsourced or delegated to the following third-party or CVO ________________________________

☐ Credentialing is not performed internally

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ACCREDITATION

Attach a copy of the most recent Certification. The facility must be specifically listed within the Accreditation Certification.

☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
☐ Accreditation Association for Ambulatory Health Care (AAAHC)
☐ American Academy of Sleep Medicine (AASM)
☐ Accreditation Commission for Health Care (ACHC)
☐ Commission on Accreditation of Birth Centers (CABC)
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)
☐ Continuing Care Accreditation Commission (CCAC)
☐ Community Health Accreditation Program (CHAP)
☐ Council on Accreditation (COA)
☐ Det Norske Veritas/National Integrated Accreditation for Healthcare Organization (DNV/NIAHO)
☐ Healthcare Facilities Accreditation Program
☐ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ Utilization Review Accreditation Commission (URAC)

Non-Accredited organizations complete the Non-Accredited Facility portion of this application.

DATE OF LAST FULL SURVEY	EFFECTIVE AND EXPIRATION DATES OF ACCREDITATION

NON-ACCREDITED FACILITY

Attach copy of the most recent licensing or survey results

☐ Yes ☐ No The Department of Health completed an onsite licensing review or CMS survey within the past 36 months?
☐ Yes ☐ No The organization was issues a Corrective Action Plan (CAP) for deficiencies cited?
If Yes, attach a copy of the CAP and if applicable, the verification of CAP being completed or in compliance

Site Visits will be required for all facilities that are not accredited and/or do not have a current CMS survey or licensing review by the Department of Health. This is required for participation with Hennepin Health.

DATE OF LAST FULL SURVEY	EFFECTIVE AND EXPIRATION DATES OF ACCREDITATION

NON-MEDICARE CERTIFIED HOME CARE AGENCY

Indicate the number of hours per week the agency is available to serve clients: ________________________________
Indicate the date per week the agency is available to serve clients: ____
Indicate the age range of clients accepted: ____

STATES IN WHICH YOU ARE LICENSED	YEARS IN BUSINESS

Hennepin Health

NUMBER OF CLIENTS SERVED: ☐ Current Year ____________________ ☐ Previous Year ___________________ ☐ Two Years Ago __________________	**% OF CLIENTS WHO RECEIVED THE FOLLOWING SERVICES:** ☐ Skilled Nursing Services _________________________ ☐ Physical Therapy ___________________ ☐ Occupational Therapy ___________________ ☐ Speech Language Therapy ___________________
STATES LICENSE TO PRACTICE AND # OF YEARS OPEN: ☐ ____________________ ☐ ___________________ ☐ __________________	**NUMBER OF AGENCY EMPLOYEES:** ☐ Registered Nurse _________________________ ☐ Licensed Practical Nurse ___________________ ☐ Home Health Aide ___________________ ☐ Other ___________________

PROVIDE A REASON FOR NOT PURSUING/BEING GRANTED MEDICARE CERTIFICATION OR LICENSING REVIEW:

ATTACHMENTS (COPIES ONLY)

Below listed attachments not received by Hennepin Health will delay the Credentialing and Contracting processes.

☐ Roster of additional locations using the Hennepin Health Organizational Roster template

☐ State and Local licenses required to operate as a health care facility

☐ DHS and Board & Lodging/Supervised Living licenses, if applicable

☐ W-9

☐ Commercial General Liability insurance certificate, TORT or other Government insurance verification

☐ Professional insurance certificate, TORT or other Government insurance verification

☐ Accreditation Certification or confirmation letter

☐ Most recent Government licensing agency survey results

☐ Government licensing agency corrective action plan(s), if applicable

☐ Det Norske Veritas/National Integrated Accreditation for Healthcare Organization (DNV/NIAHO)

☐ Healthcare Facilities Accreditation Program

☐ National Committee for Quality Assurance (NCQA)

☐ The Joint Commission (TJC)

☐ Utilization Review Accreditation Commission (URAC)

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PROVIDER DISCLOSURE AND ATTESTATION FOR RELEASE Please provide a written explanation for all YES responses	
☐ Yes ☐ No	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	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	Within the past five years, has this facility been found liable for the death of a patient/resident or been cited for by a licensing/certification agency for a substantiated determination of maltreatment of a child or vulnerable adult?
☐ Yes ☐ No	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	Within the past five years has this facility's accreditation/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	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	Has any third-party payer ever revoked, reduced, denied, or suspended this facility's network participation due to inappropriate utilization management or any quality of care issues?

WRITTEN EXPLANATION SHOULD INCLUDE DATES, DETAILS OF CASE, CURRENT STATUS AND DISPOSITION:

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**