Dear Provider,

Thank you for your interest in joining Integrated Home Care Services, Inc. (IHCS). Our mission is to provide compassionate care to patients in need of our services and connecting them with qualified resources to improve the delivery of care in the home setting.

IHCS is pleased to contract with network providers who share our commitment in offering compassionate, high-quality care to patients in the comfort of their homes.

Attached, you will find the IHCS credentialing application for your completion. In order to expedite the process, please ensure that all sections of the application are complete and copies of the items on the checklist are provided. If a section is not applicable, please indicate N/A.

Most states have regulatory requirements for how providers like you can deliver services and seek reimbursement for health care claims. These include requirements related to coverage and reimbursement under state Medicaid programs as well as regulatory requirements issued by state departments of insurance. You are responsible for ensuring that you understand and comply with all applicable state laws, regulations, and guidance regarding the delivery of care in the home setting. You can find contact information for each state's relevant Medicaid agency (**https://www.medicaid.gov/about-us/contact-us/contact-your-state-questions/index.html)** and insurance department **(https://www.iii.org/services/directory/company-categories/state-insurance-departments)** with questions on state specific requirements.

We appreciate your time and effort in completing this credentialing application as it is an important step in becoming part of our network. In order to qualify as a participating ancillary provider for Integrated Home CareServices, Inc. and its affiliates, a provider must meet the requirements which include, but are not limited to theattached requests.

For Florida, Credentialing Application may be returned to:

- **Mail:** Integrated Home Care Services, ATTN: Credentialing/Provider Relations Dept, 3700 Commerce Parkway, Miramar, FL 33025
- **Email: ProviderNetwork.Credentialing@ihcscorp.com**
- Fax: 954-624-8744

For any questions, please contact the Credentialing/Provider Network Department at (844)215-4264 Extension 7534.

For all other States, Credentialing Application may be returned to:

- **Mail:** Integrated Home Care Services, ATTN: Credentialing/Provider Relations Dept, 3700 Commerce Parkway, Miramar, FL 33025
- **Email: ProviderNetworkSupport@ihcscorp.com**
- Fax: 570-300-3318

For any questions, please contact the National Team at (844)215-4264 Extension 7705.

Thank you- Credentialing Department

PROVIDER'S RIGHTS DURING CREDENTIALING

- The right to review information submitted to support their credentialing application.
- The right to correct erroneous information.
- The right to verify the status of Credentialing/Re-Credentialing application upon request, within 60 days of the Committee meeting.
- The right to be notified about these rights.
- The right to appeal decision made by the Credentials Committee by written request.
- The right to contact the Credentialing Department to receive further information
- To initiate these rights for the state of **Florida** you may contact Lazara Barreto, Manager of the Credentialing/Provider Network Department at (844)215-4264 Ext. 7409 or email at **Lbarreto@ihcscorp.com**
- For all other states you may contact the Ferne Dorn , Executive Director Market Development at (844)215-4264 Ext. 7705 or email at **Fdorn@ihcscorp.com**

PROVIDER'S ONGOING CREDENTIALING OBLIGATIONS

- Providers are obligated to notify **Integrated Home Care Services, Inc**. of any changes regarding the following: Medicaid/Medicare Status, Change of Name, Ownership, NPI number, Tax ID number, Address, Telephone number, Fax number, Billing Address, State License, Occupational or Certifications, Accreditation, Liability and Workers Compensation insurance.
    - All requested changes must be made on a company letterhead.
    - Note: For Name or Ownership changes additional documents may be requested by **Integrated Home Care Services, Inc**.
- Providers who no longer wish to maintain credentialing obligations may request termination of their contract/LOA in writing.

Initial Application Credentialing Document Request Check List

Please provide copies of the following:

	*Credentialing Application for each location included under this contract
	*Signed and dated attestation on page two and three of credentialing application
	*Copy of current State license, certification, or registration. Current DEA or CDS Certificate. Oxygen permits as applicable.
	Occupational Business License per location included under this contract
	**Attach a copy of the letter or documentation from Centers for Medicare and Medicaid Services (CMS) and AHCA (as applicable) which verifies your Medicare and/or Medicaid effective date and provider number. *The verification will be enough to present to committee.
	Copy of provider valid National Provider Identifier (NPI) and taxonomy number letter.
	*Copy of Accreditation and last survey report. . If not accredited, Copy of Emergency Action Plan approved by the State and one of the following: most recent State Survey, Federal Survey, or Inspection report
	*Current Professional Liability Insurance & General Liability Insurance certificate for each of your locations, with limits of no less than $1,000,000 per occurrence and 3,000,000 annual aggregate at a minimum
	*Worker' Compensation – With state law required amounts If exempt, please provide a copy of exemption
	Liability Claims History (Minimum of five years) (Please send details for any OPEN Claims) If there aren't any please send a statement from insurance carrier that there's no claims history for the past five years.
	*Copy of W-9 for tax identification number (IRS requirement). The provider name and address used for payment must be the same as what is used for IRS purposes. Billing address must be a physical location
	Please provide the Table of Contents from your Policy and Procedure Manual, for quality management program including, at a minimum. Policy & Procedure Manual (If Applicable) Pediatric Manual (If Applicable) Quality Improvement Plan Utilization review Plan Personnel Policy and procedures On-Call Emergency Procedures Client Satisfaction Measurement Tool Yearly Review Emergency Preparedness / Disaster Recovery Plan Copies of the above items will be requested upon Auditing.
	*Disclosure of Ownership Form ATTACHED
	*FDR / Affiliate Compliance ATTACHED
	Provide a staff roster of RN, LPN, MSW, PT, ST, OT, and RT staff e.g. Full names, Specialty, State License, and State License Expiration Date). Only applicable to HH providers and IV providers as applicable.
	*DME providers must provide us with a $50,000 surety bond.

PROVIDER CREDENTIALING APPLICATION

TYPE OF ORGANIZATION			
□ Home Health Agency □ Nurse Registry □ Homemaker & Companion □ Durable Medical Equipment, Medical Supplies, Respiratory Equipment □ Home Infusion			
Provider Legal Name:			
Provider d.b.a. Name (if applicable):			
Physical Business Address:			
City, State, Zip Code: County/Parish:			
Billing Address, if different from physical address:			
City, State, Zip Code: County/Parish:			
Hours of Operations:		On Call Phone Number:	
Please indicate your staff's multilingual and multicultural capabilities (e.g. languages spoken) other than English: Spanish / Creole / Portuguese / Other: _____			
Email Address:		Credentialing Email Address:	
Office Phone Number:		Office Fax Number:	
Credentialing Phone Number:		Credentialing Fax Number:	
Name of Administrator:		Name of Director of Nursing:	
Federal Tax I.D. Number:		N.P.I. Number:	
To better assist with staffing, please list the counties on a separate attachment that your company covers and the Zip Codes within those counties/parishes for the above location (provide additional pages as needed). Zip codes are only required if your company does not service an entire county. This requirement will ensure appropriate referral activities to your company.			
Age Range of Patients Treated:			

Check all that apply for Home Health Services

Provider Services:	***Yes***	***No***	**Provider Services:**	***Yes***	***No***	**Provider Services:**	***Yes***	***No***
Pediatrics	□	□	Wound Care	□	□	Home Health Aide Hourly Visit	□	□
Private Duty Nursing	□	□	Wound Vac	□	□	Live-In	□	□
Pediatric Occupational Therapy	□	□	RN Evaluation	□	□	Respiratory Therapy Visit	□	□
Pediatric Physical Therapy	□	□	RN Visit	□	□	Intrastromal Skilled Visit	□	□
Pediatric Speech Therapy	□	□	LPN Visit	□	□	Blood and Blood Product Administration	□	□
Pediatric Respiratory Therapy	□	□	RN Hourly Shifts	□	□	Durable Medical Equipment	□	□
Adult Occupational Therapy	□	□	LPN Hourly Shifts	□	□	Home Infusion	□	□
Adult Physical Therapy	□	□	Hi-Tech RN Visit	□	□	Medical Supplies	□	□
Adult Speech Therapy	□	□	Midline Insertion	□	□	Respiratory Equipment	□	□

Adult Respiratory Therapy	□	□	Medical Social Worker Visit	□	□	Transportation	□	□
PICC Line Insertion	□	□	Obstetrical Skilled Visit	□	□	Adult Companion	□	□
High Tech Nursing for IV	□	□	Home Health Aide Visit	□	□	Adult Day Care (Adult DayHealth Care)	□	□
Assisted Living Facility Services	□	□	Assistive Care Services	□	□	Attendant Care	□	□
Behavior Management	□	□	Caregiver Training	□	□	Case Management	□	□
Home Accessibility Adaptation	□	□	Home Delivered Meals	□	□	Hospice	□	□
Intermittent and Skilled Nursing	□	□	Medicaid Administration	□	□	Medication Management	□	□
Nutritional Assessment and Risk Reduction	□	□	Nursing Facility Care	□	□	Personal Care	□	□
Personal Emergency Response System	□	□	Respite Care	□	□	Other	□	□

Check all that apply for DME Services

Provider Services:	***Yes***	***No***	**Provider Services:**	***Yes***	***No***	**Provider Services:**	***Yes***	***No***
Durable Medical Equipment	□	□	Support Surfaces: Pressure Reducing Beds/Mattresses/Overlays/Pads-New	□	□	Ostomy Supplies	□	□
Home Infusion	□	□	Traction Equipment	□	□	Tracheostomy Supplies	□	□
Medical Supplies	□	□	Transcutaneous Electrical Nerve Stimulators (TENS)	□	□	Urological Supplies	□	□
Transportation	□	□	Ultraviolet Light Devices	□	□	Voice Prosthetics	□	□
Commodes/Urinals/Bedpans	□	□	External Infusion Pump Supplies	□	□	Enteral Nutrients	□	□
Continuous Passive Motion (CPM) Devices	□	□	Surgical Dressings	□	□	Enteral Equipment and/or Supplies	□	□
Blood Glucose Monitors and Supplies (Non-Mail Ord)	□	□	Canes and Crutches	□	□	Parenteral Nutrients	□	□
Gastric Suction Pumps	□	□	Patient Lifts	□	□	Parenteral Equipment and/or Supplies	□	□
Heat & Cold Applications	□	□	Power Operated Vehicles (Scooters)	□	□	Continuous Positive Airway Pressure (CPAP) Devices	□	□
Hospital Beds (Electric)	□	□	Seat Lift Mechanisms	□	□	High Frequency Chest Wall Oscillation HFCWO Devices	□	□
Hospital Beds (Manual)	□	□	Walkers	□	□	Mechanical In-Exsufflation Devices	□	□
Infrared Heating Pads Systems	□	□	Wheelchairs-Standard Manual	□	□	Nebulizer Equipment and Supplies	□	□
External Infusion Pumps	□	□	Wheelchairs-Standard Manual Related Accessories and Repairs	□	□	Oxygen Equipment and Supplies	□	□
Negative Pressure Wound Therapy Pumps and Supplies	□	□	Wheelchairs-Standard Power	□	□	Respiratory Assist Devices	□	□
Neuromuscular Electrical Stimulators (NMES)	□	□	Wheelchairs-Standard Power Related Accessories and Repairs	□	□	Respiratory Suction Pumps	□	□

Osteogenesis Stimulators	□	□	Wheelchair Seating/Cushions	□	□	Ventilators: All Types- Not CPAP or RAD	□	□
Pneumatic Compression Devices	□	□	Penile Pumps	□	□		□	□
Speech Generating Devices	□	□	Neurostimulators	□	□	Other	□	□

LICENSURE

State License / Business License / Registration Number:_____Expiration Date: / / _

Have there been any restrictions, actions or sanctions on your licensure, certification, or registration in the past five (5) years? Yes / No

*** If the answer to the above question is yes, please provide details on a separate sheet**

DEA Number:_____DEA Expiration Date: _____

CDS Number:_____CDS Expiration Date: _____

Oxygen Certificate Number:_____ Oxygen Expiration Date:_____

Are you certified/ participating as a provider in the Medicare program? Yes/ No Medicare Provider Number: _____

Are you certified/ participating as a provider in the Medicaid program? Yes/ No Medicaid Provider Number: _____

Do you have a Medicaid Waiver? Yes/ No Medicaid Waiver Number: _____

Please provide a letter or other applicable documentation for the above waiver for each office/location. (Not required for Tennessee providers)

ACCREDITATION:

Accrediting Organization: Accreditation Number:_____

Effective Date: / / Expiration Date: / /

Other Accrediting Organization: Accreditation Number:

Effective Date: / / Expiration Date: / /

Has your organization lost its accreditation, been denied accreditation, or otherwise been sanctioned by the accrediting body within the lastfive (5) years?

□ Yes

□ No

*** If the answer to the above questions is yes, please provide details on a separate sheet**

INSURANCE COVERAGE

Professional Liability Carrier:_____Pol Eff. Date:_____Exp. Date: _____

Policy Number:_____Occurrence Amount:_____Aggregate Amount:_____

General Liability Carrier: _____Pol Effective Date:_____Exp.Date: _____

Policy Number: **:**_____Occurrence Amount:_____Aggregate Amount:_____

Worker's Compensation Carrier:_____Pol Eff. Date:_____Exp.Date: _____

Policy Number: **:**_____Occurrence Amount:_____Aggregate Amount: _____

* Please submit a copy of each insurance policy declaration page (Face sheet) indicating current status and coverage amounts.

QUESTIONNAIRE

*** If the answer to any of the following questions is yes, please provide details on a separate sheet**

Have criminal proceedings ever been initiated against your Company or its authorized representative(s)?

□ Yes

□ No

In the last five years, have there been any liability claims history or law suits, or are there currently any pending or potential suits againstyour Company, or have any judgments been made or settlements paid on its behalf?
□ Yes
□ No

Providers must be in compliance with all Federal and State licensure, regulatory and accreditation requirements. Has there been any disclosure ofcomplaints or adverse action reports files with a local, state or national professional society or licensing board?
□Yes
□No
Has there been any disclosure of refusal, restriction, or cancellation of professional liability insurance?
□Yes
□No
<u>Initial Credentialing Purposes:</u>
Owners, Director, Officers of the company cannot have any felony convictions or fraud convictions and may not be on any Medicare or Medicaid Pre-Payment Review. List any sanctions or notifications from Medicare or Medicaid regarding overpayments within the last 5years. If overpayments exist, please provide supporting documentation that the overpayment was not due to fraud, waste or abuse. Has your Company ever been the subject of an investigation, suspended, sanctioned, loss of license, has had limitations of privileges or disciplinary actions, and/or otherwise restricted from participating in any private, state or federal health insurance program (for exampleMedicare or Medicaid)?
□Yes
□No
<u>Re-credentialing Purposes:</u>
Since your last credentialing cycle with **Integrated Home Care Services, Inc.** or in the last three years since you've been in Network with **Integrated Home Care Services, Inc.** has your Company been the subject of an investigation, suspended, sanctioned, loss oflicense, has had limitations of privileges or disciplinary actions, and/or otherwise restricted from participating in any private, state or federal health insurance program (for example Medicare or Medicaid)?
□Yes □No □N/A
Providers may not be on any Medicare or Medicaid Pre-Payment Review. List any sanctions or notifications from Medicare or Medicaid regarding overpayments within the last 5 years. If over payments exist, please provide supporting documentation that the overpayment was not due to fraud, waste or abuse.

Additional Information:
Do you allow the release of your Company's Liability Claims History and Liability Insurance Certificate to **Integrated Home CareServices, Inc.?**
□Yes
□No
Do you or Company's staff, per diem and/or contractors presently or have a history of any physical, mental health or other conditions including illegal substance abuse, and/or chemical, and/or alcohol abuse dependency that may affect your/their ability to perform your professional duties appropriately?
□Yes
□No
Any DME companies must have a licensed Respiratory Therapist on staff if CPAP, BiPAP, Ventilator, Apnea Monitor, Phototherapy andSuction equipment is a listed service as these must be delivered by a Licensed Respiratory Therapist.
Provider will not market or solicit a Physician's Office, Case Managers, Discharge Planners or any other referral source to obtainbusiness.
All referrals/prescriptions must be sent to IHCS from the referral source and NOT from Provider.
Provider must be able to provide every item on the Medicare / Medicaid Fee Schedule directly. Provider may not sub-contract for anyservices authorized by IHCS.
Provider may not be related or have any family members related to any referring physician or other referral source.
In the event that Provider violates any of these requirements, IHCS has the right to immediately terminate Provider from theNetwork

All providers must have an internal system for measuring quality. As a provider, you must have procedures for evaluating patient satisfaction. I release from liability that **Integrated Home Care Services, Inc.** and all representative of **Integrated Home Care Services, Inc.** for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations that provide information to **Integrated Home Care Services, Inc.** in good faith without malice or negligence concerning my professional competence, character and ethics. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension or curtailment or participation status, membership from **Integrated Home Care Services, Inc.**

I attest and certify that I have completed the above application truthfully and that information given in or attached to this application are true, correct, and complete to the best of my knowledge. I authorize and hereby give my consent to the Company to collect any information necessary to verify the information provided in this credentialing application. I have acknowledged that I have received a copy of my rights as a Provider during credentialing.

I understand that, as a condition to signing this attestation, any misrepresentations or misstatements in, or omission of any of these answers, whether intentional or not shall constitute grounds for rejection of my request for participation with Integrated Home Care Services, Inc.…

Print Name	Signature
Title	Date

I hereby attest and certify to the following:

☐ **COMPLIANCE WITH FRAUD, WASTE & ABUSE TRAINING**

My agency/business practices have met the, Fraud, Waste and Abuse (**FWA**) certification requirements through enrollment into the Medicare program or accreditation as a (circle one) DME/HHA/IV provider and is deemed to have met the training and education requirements for fraud, waste and abuse per 42 C.F.R. S423.504(b)(4)(vi)(C).

☐ **ATTESTATION OF COMPLIANCE HIPAA TRAINING**

My agency/business conducts HIPPA training within 30 days of hire, or prior to exposure to PHI, whichever is sooner. Thereafter, employees receive additional HIPAA training by way of an annual Code of Conduct training that includes a discussion regarding the importance of protecting patient information and compliance with HIPAA, periodic webinars focused on compliance issues, newsletter articles, and emails from the legal and/or compliance department and/or management staff.

☐ **ATTESTATION OF COMPLIANCE STANDARDS OF CONDUCT TRAINING**

My agency/business attests to the completion of annual training of all staff to our Standards of Conduct and have read Integrated Home Care Services Standards of Conduct located in the Provider Training Manual. Every staff member has completed training on the company's Standards of Conduct and has signed an acknowledgement of the training and their responsibilities. Documentation of the training will be made available upon request. When applicable, all employees or contractors that will enter a patient's property or residence have completed the annual training on "Abuse, Neglect and Exploitation".

☐ **COMPLIANCE WITH STATE LAWS AND REGULATIONS**

My agency/business practices comply with all applicable state laws, regulations, and guidance regarding the delivery of home health services and the submission of claims for reimbursement of home health services. I understand that my agency/business is responsible for accessing, understanding, and complying with all relevant state laws, regulations, and guidance, including conducting relevant training of employed and contracted staff.

☐ **VERIFICATION OF THE ELIGIBILITY FOR EMPLOYMENT ATTESTATION**

My agency/business has verified employment eligibility for all my employees using the *E-Verify* database and/or by approved documents per Form I-9 they are all eligible to work in the United States. *E-Verify* is an Internet-based system that allows businesses to determine the eligibility of their employees to work in the United States. **www.uscis.gov** U.S. law requires companies to employ only individuals who may legally work in the United States – either U.S. citizens, or foreign citizens who have the necessary authorization

☐ **BACKGROUND SCREENING**

My agency/business is compliant with state and contractual requirements for background screening.
(For Florida, a level 2 background with the Agency for Health Care Administration (AHCA) is required).
(For Pennsylvania, requirements for Criminal history checks and all hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 relating to protective services for older adults) and will produce these clearances upon request).

☐ **OIG/SAM/GSA SCREENING**

My agency/business is compliant with federal requirements to provide documentation of employee screening against the OIG and GSA listing prior to hire and monthly thereafter, and will retain for a minimum of 10 years. A provider must produce these clearances upon request.

☐ **PROVISION OF DOCUMENTATION AS REQUESTED BY IHCS**

My agency/business will document, implement and maintain policies and/or procedures in compliance with Federal, State and Local regulatory or network participation requirements. My agency/business agrees to comply with any requests made by Integrated Home Care Services, Inc. for copies of any policy and/or procedure to support regulatory and quality improvement related audits.

_____

Name of the Agency/Contractor

_____ _____ _____

Name of the person attesting **Title** **Signature** **Date of Attestation**