SKILLED NURSING FACILITY CREDENTIALING APPLICATION

INSTRUCTIONS

- Applications not completed online should be typed or legibly printed in black or dark blue ink. ALL fields are required to be completed unless otherwise directed.
- Separate applications are required for EACH facility location. Facility providers cannot be "branched" or added to an existing facility contract.
- See shaded areas of each section for any further instructions.
- If you have questions, please send an email message to *credentialing@commongroundhealthcare.org*. Put "Facility Question" in the subject line.
- Submit completed application along with **all** required documentation by one of these methods:

EMAIL: *credentialing@commongroundhealthcare.org*

FAX: **262-754-9690**
ATTENTION: CREDENTIALING/PROVIDER RELATIONS

MAIL: **COMMON GROUND HEALTHCARE COOPERATIVE - PROVIDER RELATIONS**
PO BOX 78553
MILWAUKEE WI 53278-8553

PLEASE NOTE:

Initial Credentialing

- Failure to legibly complete all sections of this application and submit current copies of all required documentation will result in processing delays. Priority status is given to fully completed applications.

Recredentialing

- Submission of recredentialing information is a contractual obligation.
- Failure to complete all sections of this application and submit current copies of all required documentation *in a timely manner* will be considered a request to terminate the facility's participation in our networks.

FACILITY CREDENTIALING APPLICATION

☐ **INITIAL CREDENTIALING** ☐ **RECREDENTIALING**

Please read Instructions on Page 1 before completing.

IDENTIFICATION

CORPORATE IDENTIFICATION INFORMATION

Legal Business Name: (As reported to the IRS)	Federal Tax Identification Number (TIN):
Doing Business As (DBA) Name (if applicable):	NPI for facility being credentialed: (Application **cannot** be processed without a valid 10-digit NPI)
Corporate Name + Address (if different than above): --- ---	Length of time in business with this name and tax ID: __________ Years (or) __________ Months

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

☐ Yes, owned in whole or in part by ____

☐ Yes, managed by ____

☐ Not affiliated with a hospital or health care system/organization

FACILITY INFORMATION

Facility Name:			
Street Address:			
City:	State:	Zip:	County:
Phone:	Fax:	Website:	

Administrator Name:	Email:	Phone:
Business Office Contact:	Email:	Phone:
Director of Nursing	Email:	Phone:
Social Worker	Email:	Phone:

MAILING/CORRESPONDENCE ADDRESS

Check here if all correspondence can be directed to the facility location above. If not, complete below.

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

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

HEALTH CARE LICENSURE/CERTIFICATION

***Attach** a copy of each license for this facility.*

License Number	Licensing Agency	Initial Issue Date	Renewal Date	Expiration Date
		____/____/___	____/____/___	____/____/___
		____/____/___	____/____/___	____/____/___
		____/____/___	____/____/___	____/____/___

Is this facility participating in the Medicare program? YES NO PENDING

Medicare number: ______________________ Date of initial certification: ______/______/______

Check here is facility is not eligible for Medicare certification.

MEDICARE STATUS

ACCREDITED FACILITIES

Complete this section and attach copy of current accreditation certificate or letter.

Certificate/letter should list this facility location as being included in the accreditation.

☐ **CARF** - Commission on Accreditation of Rehabilitation Facilities

☐ **TJC** – The Joint Commission (Formerly known as JCAHO)

1. Date of last full survey: ______ / ______ / ______
2. Effective dates of accreditation: ______ / ______ / ______ through ______/______/______

NON ACCREDITED FACILITIES

Complete this section and attach copy of the most recent on-site government licensing agency survey along with your Corrective Action Plan (CAP), if deficiencies were cited; OR attach a letter or email from the licensing agency stating the facility is in substantial compliance with the most recent survey standards.

Has this facility completed an onsite licensing/certification survey by the Department of Health or CMS within the past 36 months?

☐ YES – Date of most recent onsite survey: ______/______/______ ***See instructions above.***

☐ NO - ***Successful completion of a health plan onsite visit will be required to complete credentialing.*** You will be contacted by the health plan to schedule the visit.

INSURANCE

Complete this section and attach a copy of the facility's insurance certificate(s) that include:

- ***Insurer(s) Affording Coverage***
- ***Policy Number***
- ***Effective Date and Expiration Date***
- ***Amounts of Coverage***
- ***This facility listed as covered by the policy***
- ***Name and phone number of agency issuing policy***

We prefer the "Acord Certificate of Liability Coverage" form.

Facilities covered by government insurance should attach documentation detailing coverages.

1. Is this facility covered by commercial general liability insurance in the amount of $1 million per occurrence and $3 million aggregate? (Excess liability/umbrella coverage can be counted toward the $3 million aggregate amount.)

☐ Yes

☐ No - ***Please obtain the above amount of required coverage before submitting application.*** Facility is covered by government insurance.

2. Is facility covered by professional liability insurance in the amount of $1 million per occurrence and $3 million aggregate? Must be a facility/organizational policy, not an individual only policy. (Excess liability/umbrella coverage can be counted toward the $3 million aggregate amount.)

☐ Yes

☐ No - ***Please obtain the above amount of required coverage before submitting application.*** Facility is covered by government insurance.

3. Has this facility's commercial general or professional liability insurance ever, for any reason, been denied, cancelled, non-renewed, or initially refused upon application?

☐ Yes – *Explain below.*

☐ No

____

____

____

____

ATTACHMENTS

Have you attached all required documents? If not, the processing of your application will be delayed.

Check all documents included with this application.

☐ Copy of all state and/or local licenses required to operate as a health care facility
Do not attach practitioner licenses.

☐ Copy of facility's commercial general liability insurance certificate

☐ Copy of facility's professional liability insurance certificate covering all facility employees

☐ Copy of accreditation certificate or letter

☐ 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: ____

____

ATTESTATION

Answer all eight questions with YES or NO.
Provide a detailed explanation below for all questions answered YES. Use a separate sheet if necessary.
Do not submit a typed signature; a written signature is required. Be sure the attestation is dated.

☐ **YES** ☐ **NO**	*1. Has this facility ever had or currently have pending any legal actions against it excluding medical malpractice and frivolous law suits?*
☐ **YES** ☐ **NO**	*2. Has this facility ever been convicted of a crime, excluding misdemeanors?*
☐ **YES** ☐ **NO**	*3. Has any government agency ever investigated, suspended, revoked, or taken other action against this facility/organization's license to conduct business?*
☐ **YES** ☐ **NO**	4. At any time has any license or certification been revoked, denied, or suspended by others or voluntarily given up by the facility, or are any actions now underway which may lead to such conclusions?
☐ **YES** ☐ **NO**	5. At any time, 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**	6. At any time, has any third party payor ever revoked, reduced, denied, or suspended this facility's network participation due to inappropriate utilization management, quality of care issue, or for any other reason?
☐ **YES** ☐ **NO**	7. Has any managing employee or person with an ownership or controlling interest in this facility/organization been excluded from participation in any government health care program?
☐ **YES** ☐ **NO**	8. Has this facility, under any current former name or business identity, ever had its accreditation revoked or suspended?

Explanation ***including dates and outcome*** *for question(s) answered YES:*

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 health plan participating provider or cause for summary dismissal from the health plan.

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.

____
Printed Name of Authorized Representative

____
Authorized Representative's Title

________/________/________
Date Signed

____
Signature of Authorized Representative

FACILITY CREDENTIALING APPLICATION CLINICAL

AREAS OF INTEREST

- ***Check only those clinical areas of interest for which your facility currently provides services and staff has the necessary education and/or training to provide.***
- ***This information will be used to update our provider directories.***

☐ Behavioral issues
☐ Complex Wound Care Management
☐ Hospice
☐ IV Therapies
☐ Memory Care
☐ Short-Term Rehabilitation

Facility Name: ______________________________

City, State: ______________________________ TIN: ____________________