Keystone First

Community HealthChoices

Home- and Community-Based Services (HCBS)/ Long-Term Services and Supports (LTSS)

Provider Credentialing/Recredentialing Application

Entire application must be completed. If entire application is not completed, it will be returned to sender as incomplete. If a question does not apply, please use N/A. Fax this application, the Home- and Community-Based Services (HCBS)/Long-Term Services and Supports (LTSS) checklist, and all applicable items on the checklist to the Keystone First Credentialing department at **1-717-651-1673**. **Or, you may scan your signed documents and submit them by secure e-mail to: keystonefirstntchc@keystonefirstchc.com.**

General information			
Corporate name (as assigned on IRS Form W-9):			
Doing business as (if applicable):			
Practice/facility name to appear in directory:			
Primary street address:			
City:	County:	State:	ZIP+4 code:
Phone number:		Fax number:	
Credentialing contact name:		Email address:	
Credentialing street address (if different from primary address):			
City:	County:	State:	ZIP+4 code:
Phone number:		Fax number:	
National Provider Identifier (NPI) (if applicable):			
Business type: ☐ For-profit ☐ Not-for-profit ☐ Sole proprietorship ☐ Estate/trust ☐ Partnership ☐ Government-owned ☐ Public service corporation			
Primary taxonomy code:		Secondary taxonomy code:	
Payment/remittance information			
Check payable to:			
Taxpayer Identification Number (TIN):			
Street address:			
City:		State:	ZIP+4 code:
Billing contact name:			
Email address:			
Phone number:		Fax number:	
Document needed: Please provide a copy of the IRS W-9 form.			
Document needed: Are Clinical Laboratory Improvement Amendments (CLIA) certificate and Pennsylvania Department of Health lab permit associated with this service location? If yes, please provide a copy of both with this application. ☐ Yes ☐ No			
Document needed: Drug Enforcement Administration (DEA) number (include a legible copy of DEA certificate, if applicable)			
Individual practitioner name (if applicable):			
Individual practitioner gender (if applicable):			
Individual practitioner Social Security number (if applicable):			
Individual practitioner date of birth (if applicable):			
Title/degree as it appears on the license:			
Handicap accessible? ☐ Yes ☐ No			
1. Does the office have exterior or interior steps leading to the main entrance doorway? ☐ Yes ☐ No If yes, please check which type applies. ☐ Interior ☐ Exterior			
2. If yes to question 1, does the office have a permanent or portable wheelchair ramp? ☐ Yes ☐ No If yes, please check which type applies. ☐ Permanent ☐ Portable			
3. If yes to question 1, is there an alternate entrance that has no exterior or no interior steps or has a wheelchair ramp? ☐ Yes ☐ No If yes, please check which type applies. ☐ No interior ☐ No exterior ☐ Permanent ramp ☐ Portable ramp			

General information (continued)

In addition to English, do you or your staff communicate in any other language? If yes, list languages:

Office hours (use HH:MM format)

Day	Start	a.m./p.m.	End	a.m./p.m.	Day	Start	a.m./p.m.	End	a.m./p.m.
Monday					Saturday				
Tuesday					Sunday				
Wednesday					☐ 24/7				
Thursday									
Friday									

Licensure/certification/accreditation

Documents needed: Please provide a copy of all licenses, accreditation, and certificates, including city or state.

State license number (if applicable):	Issue date:	Expiration date:
Additional license number (if applicable):	Issue date:	Expiration date:
Title/degree as it appears on license:		
Is the facility accredited? ☐ Yes ☐ No	Accreditation name:	
Effective date:	Expiration date:	
Is the practitioner/facility/contractor certified? ☐ Yes ☐ No	Certification name:	
Effective date:	Expiration date:	
Medicare number:		
Is the practitioner/facility/contractor a participating Medicare provider? ☐ Yes ☐ No		
PROMISe™ Provider Identification Number (PPID) or Medicaid number (9 digits + 4-digit extension) _____ **or** **Document needed:** Copy of PPID application (first page and signature pages only) ☐ Application attached		

Liability insurance

Document needed: Please provide a copy of your current professional or general liability insurance.

Insurance carrier name:	Policy number:
Effective date:	Expiration date:
Dollar amount per occurrence:	Dollar amount aggregate:
Site visit requirements (if applicable):	

Document needed: Attach a copy of most recent onsite survey for each location (with Corrective Action Plan [CAP] if citations were issued) **or** attach cover letter from government agency stating facility is in substantial compliance for each location.

Do you have a Home Health Agency license from the Pennsylvania Department of Health? ☐ Yes ☐ No

If enrolling as an individual **only**, do you have a license from the Department of State for an individual specialty? ☐ Yes ☐ No
If yes, please select the service(s). ☐ Home health ☐ Personal assistance services (PAS) ☐ Therapy and counseling ☐ Respite

Do you have an Adult Day Care license from the Pennsylvania Department of Human Services (DHS) or the Department of Aging?
☐ Yes ☐ No
If yes, please select the service(s). ☐ Adult daily living

Does the agency specialize in services that assist consumers with obtaining new skills in order to be a part of their community? ☐ Yes ☐ No
If yes, please select the service(s). ☐ Employment supports ☐ Community integration

Liability insurance

Does the agency specialize in a vendor service? ☐ Yes ☐ No
If yes, please select the service(s).
☐ Assistive technology ☐ Community transition services ☐ Home adaptations ☐ Home-delivered meals
☐ Non-medical, non-emergency transportation ☐ Personal Emergency Response System (PERS)
☐ Specialized medical equipment and supplies ☐ TeleCare services ☐ Vehicle modifications

Has your agency achieved Commission on Accreditation of Rehabilitation Facilities (CARF) Brain Injury Home and Community Services accreditation? ☐ Yes ☐ No

Provider type

☐ Durable medical equipment (DME) ☐ Home health ☐ Hospice ☐ Skilled nursing facility
☐ HCBS facility (59) ☐ County nursing home

Select the counties where your agency is willing to provide services for your **primary** location only.

☐ All counties in Pennsylvania
☐ Adams
☐ Allegheny
☐ Armstrong
☐ Beaver
☐ Bedford
☐ Berks
☐ Blair
☐ Bradford
☐ Bucks
☐ Butler
☐ Cambria
☐ Cameron
☐ Carbon
☐ Centre
☐ Chester
☐ Clarion
☐ Clearfield
☐ Clinton
☐ Columbia
☐ Crawford
☐ Cumberland
☐ Delaware
☐ Dauphin
☐ Elk
☐ Erie
☐ Fayette
☐ Forest
☐ Franklin
☐ Fulton
☐ Greene
☐ Huntingdon
☐ Indiana
☐ Jefferson
☐ Juniata
☐ Lackawanna
☐ Lancaster
☐ Lawrence
☐ Lebanon
☐ Lehigh
☐ Luzerne
☐ Lycoming
☐ McKean
☐ Mercer
☐ Mifflin
☐ Monroe
☐ Montgomery
☐ Montour
☐ Northampton
☐ Northumberland
☐ Perry
☐ Philadelphia
☐ Pike
☐ Potter
☐ Schuylkill
☐ Snyder
☐ Somerset
☐ Sullivan
☐ Susquehanna
☐ Tioga
☐ Union
☐ Venango
☐ Warren
☐ Washington
☐ Wayne
☐ Westmoreland
☐ Wyoming
☐ York

Types of services provided at primary location only (please check all that apply)

- ☐ Adult Daily Living/Adult Day Services – Full Day (410)
- ☐ Adult Daily Living/Adult Day Services – Half Day (410)
- ☐ Adult Daily Living Enhanced (staff to individual ratio is 2:1) – Full Day (411)
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- ☐ Community Transition Services – Household Supplies (551)
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- ☐ Exceptional Durable Medical Equipment and Supplies
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- ☐ Home Health Aide
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- ☐ Home Health Services Occupational Therapy (171)
- ☐ Home Health Services Occupational Therapy Assistant (171)
- ☐ Home Health Services Physical Therapy (170)
- ☐ Home Health Services Physical Therapy Assistant (170)
- ☐ Home Health Services Speech and Language Therapy (173)
- ☐ Hospice

1. Has the facility had a post-licensing onsite visit by a government agency such as the Department of the Health or CMS within the past 36 months?
   - ☐ Yes. Date of most recent standard survey (MM/DD/YYYY): _____ (Please submit copy with application.)
   - ☐ No. Successful completion of a health plan onsite visit will be required to complete credentialing.

2. Were any deficiencies cited during the last full survey? ☐ Yes ☐ No ☐ N/A — no recent survey
   If yes, have all deficiencies been corrected?
   - ☐ Yes. Provide evidence of state acceptance of your CAP. **Note**: Please submit with application.
   - ☐ No. Provide explanation and your plan to correct all deficiencies.

If no deficiencies were cited during the last full survey, please submit verification of no deficiencies.

Responses are required. If no responses are given, the application will be returned.

Disclosure questions: For any "Yes" answers, please provide (on page 8) a detailed explanation of the cause, any action you may have taken, and the results.

Licensure

1. ☐ Yes ☐ No ☐ N/A Has your license to practice ever been restricted, reduced, or revoked in this or any state or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to license or certification or the quality of services provided, or entered into a Consent Order issued by a licensing, certifying, or professional standards board or agency?
2. ☐ Yes ☐ No ☐ N/A Has there been any challenge to your licensure, registration, or certification?

Medicare, Medicaid, or other governmental program participation

3. ☐ Yes ☐ No ☐ N/A Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?

Other sanctions or investigations

4. ☐ Yes ☐ No ☐ N/A Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined, or resigned in exchange for no investigation or adverse action within the past year for sexual harassment or other illegal misconduct?
5. ☐ Yes ☐ No ☐ N/A Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or health care facility of any military agency?
6. ☐ Yes ☐ No ☐ N/A Has the practitioner/facility ever been convicted of a crime, excluding misdemeanors?
7. ☐ Yes ☐ No ☐ N/A At any time, has any third-party payer ever revoked, reduced, denied, or suspended your or the facility's participation due to inappropriate utilization management or any quality of care issues?
8. ☐ Yes ☐ No ☐ N/A To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?
9. ☐ Yes ☐ No ☐ N/A Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agency (e.g., CLIA, OSHA, etc.)?

Professional liability insurance information and claims history

10. ☐ Yes ☐ No ☐ N/A Has your professional liability coverage ever been canceled, restricted, declined, or not renewed by the carrier, based on your individual liability history?
11. ☐ Yes ☐ No ☐ N/A Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your liability history?

Malpractice claims history

12. ☐ Yes ☐ No ☐ N/A Have you had any professional liability actions (pending, settled, arbitrated, mediated, or litigated) within the past five years? If yes, provide information for each case.

Criminal/civil history

13. ☐ Yes ☐ No ☐ N/A Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?
14. ☐ Yes ☐ No ☐ N/A In the past 10 years, have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct?
15. ☐ Yes ☐ No ☐ N/A Have you ever been court martialed for actions related to your duties as a medical professional?

Disclosure questions (continued)

Ability to perform job

16. ☐ Yes ☐ No ☐ N/A Are you currently engaged in the illegal use of drugs? ("Currently" refers to sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice Medicine. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Dangerous Act, 21 U.S.C. § 812.22.)
17. ☐ Yes ☐ No ☐ N/A Do you use any chemical substances that would in any way impair or limit your ability to practice medicine or perform the functions of your job with reasonable skill and safety?
18. ☐ Yes ☐ No ☐ N/A Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?
19. ☐ Yes ☐ No ☐ N/A Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?

Staffing

Does the facility validate the credentials for each licensed practitioners and/or staff member employed or contracted at the facility?

☐ Yes ☐ No

If yes, indicate how the facility validate the credentials for each staff member employed or contracted at the facility:

☐ Validations are performed internally.

☐ Validations are outsourced to: _____

☐ Other, specify: _____

If no, please explain: _____

Exclusion certification

I hereby certify that the online exclusion lists for the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) and the General Services Administration (GSA) are checked for all new hires and monthly for existing employees to ensure that no excluded employees work on any jobs related to any federal health care programs. I also hereby certify that I will remove any employee found on one of the above-referenced lists from any work related to a federal health care program. The OIG exclusion list is available at **http://exclusions.oig.hhs.gov/**. The GSA exclusion list is available at **www.sam.gov/**.

Authorized signature for facility:	Date:
Print name:	Title:

Release of information, including background checks and authorization

I hereby certify that, to the best of my knowledge, the responses and information contained in this application are complete, correct, and current. I acknowledge that any misstatements or omissions constitute cause for denial of admission to, or summary dismissal from, membership in the Keystone First Community HealthChoices provider network.

I hereby authorize Keystone First Community HealthChoices and its designated agents and representatives to conduct a comprehensive review of the background and credentials of those named on this application. I acknowledge that such review may cause a consumer report and/or an investigative consumer report to be generated. I understand that the scope of the consumer report/investigative consumer report may include, but is not necessarily limited to, the following areas: verification of Social Security number/taxpayer identification number; credit reports; current and previous residences; employment history; education background; character references; drug testing; civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records; birth records; and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me and any others I have presented on this application, to Keystone First Community HealthChoices and its agents. I further authorize the complete release of any records or data pertaining to me or others I have presented on this application which the individual company, firm, corporation, or public agency may have to include information or data received from other sources. Keystone First Community HealthChoices and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicant's personal information, including, but not limited to, addresses, Social Security numbers, and dates of birth.

I warrant that I have the authority to sign this authorization and to thereby authorize the release of information and the performance of a background check, on behalf of all parties named on this application.

Signature:	Date:
Print name:	Title:

Disclosure question explanations for malpractice claims

For any "Yes" answers to Disclosure Questions **10**, **11**, and **12** on page 5, please provide the date of occurrence, status of claim, detailed explanation of the claim, any action you may have taken, and the results. Please indicate "N/A" if not applicable.

Date of occurrence (MM/DD/YYYY):
Status of claim (**Note:** If case is pending, select Open.) ☐ Open ☐ Close
Explanation:

Date of occurrence (MM/DD/YYYY):
Status of claim (**Note:** If case is pending, select Open.) ☐ Open ☐ Close
Explanation:

Date of occurrence (MM/DD/YYYY):
Status of claim (**Note:** If case is pending, select Open.) ☐ Open ☐ Close
Explanation:

Additional disclosure question explanations

For any other "Yes" answers to Disclosure Questions on pages 5 and 6, please provide a detailed explanation of the cause, any action you may have taken, and the results. Please indicate "N/A" if not applicable.

Question number:
Explanation:

Question number:
Explanation:

Question number:
Explanation:

Question number:
Explanation:

Attachment A: LTSS/HCBS Health Services Addendum

Please copy this page, prior to completing, for all additional sites. (Note: This is for sites under the same license as the primary location. For locations under a different license, please submit another full application.)

Additional location/site information			
Practice/facility name to appear in directory:			
NPI or additional NPI (if applicable):		PPID + location 4 digits:	
Taxpayer Identification Number (TIN) (**Note**: If different than primary location, a separate application is needed):			
Street address:			
City:	County:	State:	ZIP+4 code:
Remittance address (if different from primary location/site):			
Phone number:		Fax number:	

Is the office wheelchair accessible? ☐ Yes ☐ No

1. Does the office have exterior or interior steps leading to the main entrance doorway? ☐ Yes ☐ No
   If yes, please check which type applies. ☐ Interior ☐ Exterior

2. If yes to question 1, does the office have a permanent or portable wheelchair ramp? ☐ Yes ☐ No
   If yes, please check which type applies. ☐ Permanent ☐ Portable

3. If yes to question 1, is there an alternate entrance that has no exterior or no interior steps or has a wheelchair ramp? ☐ Yes ☐ No
   If yes, please check which type applies. ☐ No interior ☐ No exterior ☐ Permanent ramp ☐ Portable ramp

In addition to English, do you or your staff communicate in any other language? If yes, list languages:

Office hours (use HH:MM format)

Day	**Start**	**a.m./p.m.**	**End**	**a.m./p.m.**	**Day**	**Start**	**a.m./p.m.**	**End**	**a.m./p.m.**
Monday					Saturday				
Tuesday					Sunday				
Wednesday					☐ 24/7				
Thursday									
Friday									

Select the counties where your agency is willing to provide services for this location.

☐ All counties in Pennsylvania	☐ Clinton	☐ Lancaster	☐ Schuylkill
☐ Adams	☐ Columbia	☐ Lawrence	☐ Snyder
☐ Allegheny	☐ Crawford	☐ Lebanon	☐ Somerset
☐ Armstrong	☐ Cumberland	☐ Lehigh	☐ Sullivan
☐ Beaver	☐ Delaware	☐ Luzerne	☐ Susquehanna
☐ Bedford	☐ Dauphin	☐ Lycoming	☐ Tioga
☐ Berks	☐ Elk	☐ McKean	☐ Union
☐ Blair	☐ Erie	☐ Mercer	☐ Venango
☐ Bradford	☐ Fayette	☐ Mifflin	☐ Warren
☐ Bucks	☐ Forest	☐ Monroe	☐ Washington
☐ Butler	☐ Franklin	☐ Montgomery	☐ Wayne
☐ Cambria	☐ Fulton	☐ Montour	☐ Westmoreland
☐ Cameron	☐ Greene	☐ Northampton	☐ Wyoming
☐ Carbon	☐ Huntingdon	☐ Northumberland	☐ York
☐ Centre	☐ Indiana	☐ Perry	
☐ Chester	☐ Jefferson	☐ Philadelphia	
☐ Clarion	☐ Juniata	☐ Pike	
☐ Clearfield	☐ Lackawanna	☐ Potter	

Types of services provided at this location (please check all that apply):

- ☐ Adult Daily Living/Adult Day Services – Full Day (410)
- ☐ Adult Daily Living/Adult Day Services – Half Day (410)
- ☐ Adult Daily Living Enhanced (staff to individual ratio is 2:1) – Full Day (411)
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- ☐ Home Health Services Physical Therapy Assistant (170)
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- ☐ Hospice

Application submission instructions

Please use the application checklist as a fax cover sheet.

Fax all applicable items to the Keystone First Credentialing department at **1-717-651-1673**.

Or, you may scan your signed documents and submit them by secure email to **keystonefirstntchc@keystonefirstchc.com**.

Please be sure to email or fax the checklist, application, attachments, and contract in one submission.