VNS Health

Facility/Ancillary/Organizational Provider Credentialing Application

T. 866-783-0222 F. 212-609-1780

Instructions: Please complete all sections of this application. Please indicate if a question is not applicable to your organization or facility, or if the answer is none. All payments will be issued in the provider's legal business name in compliance with IRS regulations.

ORGANIZATION INFORMATION

Facility/Provider Type: _____

Legal Name (as listed on W-9): _____

DBA/Directory Name: _____

NPI #: _____ TAX ID #: _____

Medicaid #: _____ Medicare #: _____

LOCATION INFORMATION *(if more than one location, please supply list of servicing locations, hours, PFI, Op Cert, M)*

Street Address: _____

City, State Zip Code: _____

Directory Telephone: _____ Directory Fax: _____

Contact Name/Title: _____ Contact Email: _____

Contracted Service Counties: _____

Capacity (if applicable): _____

Languages (other than English): _____

ACCESS INFORMATION

1. Do you provide 24 hours/day, 365 days/year service? ☐ Yes ☐ No

If no, please fill in the table below with regular operation hours.

Day	Hours	
Monday	From:	To:
Tuesday	From:	To:
Wednesday	From:	To:
Thursday	From:	To:
Friday	From:	To:
Saturday	From:	To:
Sunday	From:	To:

BILLING/REMITTANCE ADDRESS ☐ *Same as service location*

Street Address _____

City, State Zip Code _____

CORRESPONDENCE ADDRESS ☐ *Same as service location*

Street Address _____

City, State Zip Code _____

LICENSURE & ACCREDITATION

2. Is the organization licensed by the New York State Dept of Health? ☐ Yes ☐ No ☐ Not Applicable

Type of Op License/Cert: _____ Op License/Cert #: _____

Effective Date: _____ Expiration Date: _____

Date of Recent Survey: _____ PFI #: _____

3. Were there any deficiencies? ☐ Yes ☐ No

(if Yes, attach copy of corrective action plan with letter of acceptance)

4. Is the organization accredited? ☐ Yes ☐ No

Effective Date: _____ Expiration Date: _____

Date of Recent Survey: _____

VNS Health

Facility/Ancillary/Organizational Provider Credentialing Application

T. 866-783-0222 F. 212-609-1780

SCOPE OF SERVICES/PROGRAMS *CHECK CONTRACTED SERVICES ONLY*

Hospital

- ☐ Inpatient Acute Rehab
- ☐ Transplant Surgery
- ☐ Cardiac Catheterization
- ☐ Dental
- ☐ Methadone Clinic
- ☐ Outpatient Rehab OT/PT/ST
- ☐ Ambulatory Surgery
- ☐ Cardiac Surgery
- ☐ Renal Dialysis
- ☐ Other: _____
- ☐ Renal Dialysis
- ☐ Chemical Dependence
- ☐ Radiology
- ☐ Maternity

Skilled Nursing Facility/Nursing Homes

- ☐ AIDS Beds
- ☐ Outpatient Physical Therapy
- ☐ Respite Care
- ☐ Bariatric Program
- ☐ Alzheimer's/Dementia Program
- ☐ Respiratory Treatment
- ☐ Vent Beds
- ☐ Outpatient Occupational Therapy
- ☐ Transfusion Services
- ☐ Younger Adults Program
- ☐ Chemotherapy
- ☐ Other: _____
- ☐ Clinical Laboratory Service
- ☐ Outpatient Speech Therapy
- ☐ Traumatic Brain Injury Program
- ☐ Wandering Unit
- ☐ Radiation Therapy

LHCSA/CHHA/CDPAS (FI)

- ☐ Nursing Care
- ☐ Medical Social Services
- ☐ Speech Therapy
- ☐ Private Duty Nursing
- ☐ Cardiac Care
- ☐ Pediatric Care
- ☐ Traumatic Brain Injury
- ☐ Wound Care
- ☐ Physical Therapy
- ☐ Home Health Aides
- ☐ Nutrition
- ☐ Live-In Services
- ☐ Difficult to Serve Client
- ☐ Other: _____
- ☐ Home Infusion
- ☐ Occupational Therapy
- ☐ Personal Care Workers
- ☐ Alzheimer's
- ☐ Behavioral Health
- ☐ Rehab Services

Radiology

- ☐ MRI
- ☐ PET
- ☐ EMG
- ☐ EKG
- ☐ MRA
- ☐ Bone Densitometry
- ☐ Fluoroscopy
- ☐ Echocardiography
- ☐ Mammography
- ☐ Ultrasound
- ☐ Breast MRI
- ☐ Other: _____
- ☐ Nuclear Cardiography
- ☐ CT
- ☐ CTA
- ☐ X-Ray
- ☐ Myelography

Chores/Environmental/Meals/CFCO

- ☐ Light duty cleaning
- ☐ Carpet cleaning
- ☐ Furniture cleaning
- ☐ Extermination
- ☐ Assisted Living Technology
- ☐ Heavy duty cleaning
- ☐ Mattress cleaning
- ☐ Furniture removal
- ☐ Bed bug treatment
- ☐ Other: _____
- ☐ Chores/Shopping
- ☐ Laundry
- ☐ Furniture disposal
- ☐ E-Mod/V-Mod

Durable Medical Equipment

- ☐ Prosthetics
- ☐ Respiratory Therapy
- ☐ Orthotics
- ☐ Other: _____
- ☐ Medical Supply

Additional Services/Certification Programs

- ☐ HCBS Palliative Care: _____
- ☐ OASAS-Specializing in: _____
- ☐ Telehealth
- ☐ Traumatic Brain Injury Program
- ☐ OMH-Specializing in: _____
- ☐ Other: _____

VNS Health

Facility/Ancillary/Organizational Provider Credentialing Application

T. 866-783-0222 F. 212-609-1780

ACCREDITING AGENCY NAME

☐ **ACHC**- Accreditation Commission for Health Care
☐ **ABCOP**- American Board for Certification in Orthotics & Prosthetics, Inc.
☐ **AOHA**- American Osteopathic Hospital Association
☐ **AAAASF**- American Association for Accreditation of Ambulatory Surgery Facilities, Inc.
☐ **NCQA**- National Committee for Quality Assurance
☐ **NABP**- National Association of Boards of Pharmacy
☐ **HRSA**- *Health Resources & Services Administration*
☐ **DNV/NIAHO**- Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations
☐ **CARF**- Commission on Accreditation for Rehab Facilities
☐ **NYS Article 28 Facility**
☐ **ACR**- American College of Radiology
☐ **AAAHC**- American Association of Ambulatory Health Centers
☐ **CLIA**- Clinical Laboratory Improvement Act
☐ **CHAP**- Community Health Accreditation Program
☐ **TJC**- The Joint Commission
☐ **BOCUSA**- Board of Orthotist / Prosthetist Certification
☐ **HQAA**- Healthcare Quality Association on Accreditation
☐ **NBAOS**- The National Board of Accreditation for Orthotic Suppliers
☐ **URAC**- Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc.
☐ **Other:** _____

ADDITIONAL CERTIFICATIONS

☐ N/A-NOT APPLICABLE

5. Does your facility hold any certifications in any state programs/services? _____ ☐ Yes ☐ No ☐ Not Applicable

6. Certification Type: _____ ☐ OMH ☐ OASAS ☐TBI ☐HCBS-Palliative Care ☐ CLIA
If OMH/OASAS, specializing: _____
Certificate #: _____ Effective Date: _____
Expiration Date: _____

7. Certification Type: _____ ☐ OMH ☐ OASAS ☐TBI ☐HCBS-Palliative Care ☐ CLIA
If OMH/OASAS, specializing: _____
Certificate #: _____ Effective Date: _____
Expiration Date: _____

DIRECTORY INFORMATION

8. Does the staff have the ability to communicate with the visually impaired? ☐ Yes ☐ No ☐ N/A

9. Does the staff have the ability to communicate with the hearing impaired? ☐ Yes ☐ No ☐ N/A

10. Is the facility wheelchair accessible? ☐ Yes ☐ No ☐ N/A

11. Does your facility offer American Sign Language (ASL) services? ☐ Yes ☐ No

12. Does your facility offer Non-English Medical Interpreters? ☐ Yes ☐ No

13. Is your facility accessible by public transportation? ☐ Yes ☐ No ☐ N/A

14. Does your facility offer accessible equipment? ☐ Yes ☐ No ☐ N/A

15. Does your facility offer accessible exam room? ☐ Yes ☐ No ☐ N/A

16. Does your facility offer electronic prescribing? ☐ Yes ☐ No ☐ N/A

If no, please provide brief explanation: _____

ORGANIZATION BACKGROUND

17. Does your organization have any financial interest in the Visiting Nurse Service of NY? ☐ Yes ☐ No

If Yes, please provide explanation below:

_____
_____
_____
_____
_____

18. Please indicate the facility's organization type by checking all terms applicable: ☐ N/A

☐ Non-profit ☐ Minority Business ☐Small Business ☐ Women-Owned Business

19. Is the facility a participating provider in the NY State Medicaid program? ☐ Yes ☐ No ☐N/A

20. Is the facility a participating provider with Medicare? ☐ Yes ☐ No ☐N/A

21. Does the organization subcontract any of its services to another entity? ☐ Yes ☐ No

If yes, please list the subcontracted services and the name of the organization(s) providing those services:

_____
_____
_____
_____
_____

STAFF HEALTH/SCREENING

22. At least annually, do you assess and document the health status of each staff person who may or will have contact with participants to ensure he or she is free from any health impairment potentially risking others or may interfere with the performance of his or her duties? ☐ Yes ☐ No

23. Do you require each staff person who may or will make contact with members/patients to have a PPD (Mantoux) skin test for tuberculosis prior to employment and no less than every two (2) years, thereafter? ☐ Yes ☐ No

24. Does your facility conduct employee/staff drug and background screenings? ☐ Yes ☐ No

If no, please provider brief explanation:

_____
_____
_____
_____
_____

DISCLOSURE QUESTIONS

Applicable to organization, any affiliate (including a wholly or partially owned subsidiary), any predecessor company or entity, any owner of 5.0% or more of the firm's shares, any director, officer, partner or proprietor or any employee alleged to have been acting on the part of the organization. If yes to any questions below, please attach brief explanation.

25. Have there been any settled malpractice claims, suites, settlements or proceedings involving your organization?	☐ Yes	☐ No
26. Has your organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted regarding participation in the Medicare or Medicaid program, or regarding other federal or state government health care plans or programs?	☐ Yes	☐ No
27. Has an officer of your organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?	☐ Yes	☐ No
28. Has your organization license ever been restricted, conditioned, suspended or terminated?	☐ Yes	☐ No
29. Does your organization have any current state or federal sanctions or limitations?	☐ Yes	☐ No
30. Does your organization have any, pending and/or settled, State Labor Law violation deemed willful?	☐ Yes	☐ No
31. Does your organization have any other federal or state citations, notices, violations orders, pending administrative hearings or proceedings, or determinations of a violation of any labor law or regulation?	☐ Yes	☐ No
32. Is there any special transportation available to the facility for visitors?	☐ Yes	☐ No
33. Does your organization have any civil or criminal investigation of the New York State Ethics Commission involving a violation(s) of Section 73 and Section 74 of the Public Office Law?	☐ Yes	☐ No
34. Does your organization have any investigation, indictment, or judgment of conviction for any business-related conduct constituting a crime under state or federal law?	☐ Yes	☐ No

ATTESTATION/RELEASE

I hereby affirm and represent all statements and information contained in this application are true to the best of my knowledge. I agree to inform VNS Health-Health Plans, promptly of any change in the information provided in this application. I understand any false or misleading information, or the withholding of information deemed relevant by VNS Health-Health Plans will disqualify this Membership Application from consideration as a VNS Health-Health Plans participating provider.

In signing this application, I acknowledge this information is provided to VNS Health-Health Plans for the purpose of developing a subcontract with the applicant organization. I further understand my completion and submission of this application only entitles the applicant organization to be considered as a participating provider. I understand that any decision with respect to my becoming a participating provider in the VNS Health-Health Plans provider network remains the sole discretion of VNS Health-Health Plans. VNS Health-Health Plans, may, by means which it may choose, determine the truth or accuracy of all statements made herein.

In signing this application, I authorize VNS Health-Health Plans to obtain any pertinent information needed to verify and credential my organization. This attestation is granted with the understanding VNS Health-Health Plans will take responsible measures to maintain the confidentiality of this information.

Print Officer Name _____ Signature of Officer _____

Title of Officer _____ Date _____

Completed application with all supporting documentation should be sent to:
VNS Health-Health Plans
Attention: Credentialing Department
Credentialing@vnshealth.org