Arizona Priority Care

Ancillary Facility Application

This application is submitted to _____, herein, this Healthcare Organization. [1]

I. INSTRUCTIONS

This form should be typed or legibly printed in black or blue ink. If more space is need the provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with this application:**

- Accreditation
- Current License
- Medicare Acceptance Letter (HCFA) (if applicable)
- Sanction Information (if applicable)
- Face Sheet of General & Professional Liability Insurance
- Advanced Directives (if applicable)
- Latest DHS Site Survey-CAP & Acceptance Letter (if applicable)
- Latest CLIA Waiver/PPMP (if applicable)

II. IDENTIFYING INFORMATION

Please select the type the facility.

- ☐ Ambulatory Surgery Center
- ☐ Behavioral Health Organization
  - ☐ Inpatient ☐ Ambulatory ☐ Outpatient
- ☐ Clinical Laboratories
- ☐ Comprehensive Outpatient Rehabilitation Facility
- ☐ Federally Qualified Health Center
- ☐ Home Health Agency
- ☐ Hospice
- ☐ Other: _____
- ☐ Hospital
- ☐ Outpatient Diabetes Self-Management Training
- ☐ Outpatient Physical Therapy Facility
- ☐ Outpatient Speech Pathology Facility
- ☐ Portable X-Ray Supplier
- ☐ Renal Dialysis Facility
- ☐ Rural Health Clinic
- ☐ Skilled Nursing Facility

Facility Name:	
Facility Address:	City:
	State:
	Zip:
Telephone:	E-Mail Address:
Fax:	Pager Number:
Chief Administrative Officer:	Chief Medical Officer:

Please attach a sheet containing additional affiliated entity/locations you wish to include under this application.

III. ACCREDITATION & CERTIFICATIONS

(Remember to attach copies of documents)

Is Facility Medicare Certified? ☐ Yes ☐ No	Medicare Provider No:
Is Facility Medi-Cal Certified? ☐ Yes ☐ No	Medi-Cal Provider No:
Is Facility Champus Contracted? ☐ Yes ☐ No	NPI Number:

Accredited: ☐ Yes ☐ No

☐ JCAHO/JC ☐ AOA ☐ CCAC ☐ Other: _____

☐ AAAHC ☐ CARF Expiration Date:

1 - As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

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IV. SANCTIONS (Remember to attach copies of documents)

Has the institution been sanctioned, placed on probation or lost accreditation, licensure or certification status during the last five (5) years by any of the following:

	Yes	No	N/A
JCAHO/AAAHC/CLIA/CARF/AOA/CCAC	☐	☐	☐
Medicare	☐	☐	☐
Medicaid	☐	☐	☐
State License	☐	☐	☐
Professional Review Organization (PRO)	☐	☐	☐
Other:_____	☐	☐	☐

If you answered **YES** to any of the above, please describe the nature, reason, and date of the sanction on an attached sheet.

V. TAX IDENTIFICATION NUMBER

In order to ensure that our files contain accurate information for reporting on IRS Form 1099 payments made to your organization, please provide your Tax Identification Number and your reporting Name and Address as they appear on you W-9 IRS Form.

Tax Identification Number:	
State/Local Operating License:	
Business Reporting Name:	
Address:	City:
	State:
	Zip:
Telephone:	E-Mail Address:

VI. PROFESSIONAL & GENERAL LIABILITY (Remember to attach copies of documents)

Professional Liability Insurance

Current Insurance Carrier:	Policy Number:
Mailing Address:	City:
	State:
	Zip:
Per Claim Amount:	Per Aggregate Amount:
Original Effective Date:	Expiration Date:

General Liability Insurance

Current Insurance Carrier:	Policy Number:
Mailing Address:	City:
	State:
	Zip:
Per Claim Amount:	Per Aggregate Amount:
Original Effective Date:	Expiration Date:

For each of the last five (5) years, please provide a confidential listing of each general liability and each malpractice claim filed against the facility, which resulted in either a settlement or court disposition adverse to the facility, in the format below.

Claims Type	Description	Status	Incident Date	Settlement Date	Settlement Amount

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VII. ADDITIONAL QUESTIONS

1 Do you have a Quality Assurance Program ? ☐Yes ☐No

2 Please show number of licensed beds, staffed beds and occupancy rate during the most recent fiscal year for the following services: ☐ N/A

Specify Time From(mm/yy): _____ To(mm/yy):_____

Service	Licensed Bed (Total)	Staffed Bed (Total)	Licensed Bed Occupancy Rate
Skilled Nursing Facility			
Rehabilitation			
In-Patient Hospice			
Total			

3 Please indicate overall occupancy for the fiscal year indicated above: Occupancy Rate:_____

I attest that this facility complies with Federal requirements prohibiting employment contracts with individuals excluded from participation under either Medicare or Medicaid.

☐Yes ☐No

I attest that this facility complies with State, Federal and Local requirements for handicap access, as well as the standards required by the 1992 Federal American Disability Act.

☐Yes ☐No

I attest to the fact that all of the information submitted by me in this document is true, correct and complete to the best of my knowledge and belief. I fully understand that any significant mis-statement in, or omission from, this application may constitute cause for denial of participation or cause for summary dismissal from Heritage Provider Network, or be subject to applicable State or Federal penalties for perjury. 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 | **Date**

Print Name of Authorized Representative | **Telephone Number**

Name and Title of Credentialing Contact Person

Telephone Number | **Fax Number**