

## Ancillary Facility Application

This application is submitted to \_\_\_\_\_, herein, this Healthcare Organization. <sup>1</sup>

### 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.

- |  |   |
|--|---|
| <input type="checkbox"/> Ambulatory Surgery Center<br><input type="checkbox"/> Behavioral Health Organization<br><input type="checkbox"/> Inpatient <input type="checkbox"/> Ambulatory <input type="checkbox"/> Outpatient<br><input type="checkbox"/> Clinical Laboratories<br><input type="checkbox"/> Comprehensive Outpatient Rehabilitation Facility<br><input type="checkbox"/> Federally Qualified Health Center<br><input type="checkbox"/> Home Health Agency<br><input type="checkbox"/> Hospice<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Hospital<br><input type="checkbox"/> Outpatient Diabetes Self-Management Training<br><input type="checkbox"/> Outpatient Physical Therapy Facility<br><input type="checkbox"/> Outpatient Speech Pathology Facility<br><input type="checkbox"/> Portable X-Ray Supplier<br><input type="checkbox"/> Renal Dialysis Facility<br><input type="checkbox"/> Rural Health Clinic<br><input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
State License	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional Review Organization (PRO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

<u>Claims Type</u>	<u>Description</u>	<u>Status</u>	<u>Incident Date</u>	<u>Settlement Date</u>	<u>Settlement Amount</u>
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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): \_\_\_\_\_
- | <u>Service</u>           | <u>Licensed Bed (Total)</u> | <u>Staffed Bed (Total)</u> | <u>Licensed Bed Occupancy Rate</u> |
|--------------------------|-----------------------------|----------------------------|------------------------------------|
| Skilled Nursing Facility |                             |                            |                                    |
| Rehabilitation           |                             |                            |                                    |
| In-Patient Hospice       |                             |                            |                                    |
| <b>Total</b>             |                             |                            |                                    |
- 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**