

On behalf of ODJFS, Submit completed signed application/agreement with required attachments to:

Margie Herrel, Program Administrator  
Ohio Department of Mental Health  
30 E. Broad St., 7<sup>th</sup> Floor  
Columbus, OH 43215

(For State Use Only)

## Ohio Health Plans Provider Enrollment Application/Time Limited Agreement for Organizations (Medicaid Program)

Complete all applicable items if you plan to bill Medicaid as a sole proprietor of a business, or if you are a publicly or privately held business with more than one owner. (This does not apply to individual practitioners or practitioner groups.)

### Organizational Provider Types: - Required

 Mark the **ONE** appropriate type

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Ambulance (82)                               | <input type="checkbox"/> Home Health Agency (JC/CHAPS) (16)                  | <input type="checkbox"/> PACE (08)                                 |
| <input type="checkbox"/> Ambulatory Surgery Center (46)               | <input type="checkbox"/> Hospice (44)  | <input type="checkbox"/> Pharmacy (70)                             |
| <input type="checkbox"/> Ambulette (83)                               | <input type="checkbox"/> Independent Diagnostic Testing Facility (IDTF) (79) | <input type="checkbox"/> Portable X-ray Laboratory 81)             |
| <input type="checkbox"/> Assisted Living Waiver Provider (74)         | <input type="checkbox"/> Independent Laboratory (80)                         | <input type="checkbox"/> Primary Care Clinic (50)                  |
| <input type="checkbox"/> Durable Medical Equipment (76)               | <input type="checkbox"/> Medicaid School Program (28)                        | <input type="checkbox"/> Professional Dental School Clinic (56)    |
| <input type="checkbox"/> End-Stage Renal Disease Dialysis Clinic (59) | <input type="checkbox"/> Mental Health Clinic (51)                           | <input type="checkbox"/> Professional Optometry School Clinic (55) |
| <input type="checkbox"/> Family Planning Clinic (54)                  | <input type="checkbox"/> Mental Hospital (02)                                | <input type="checkbox"/> Public Health Department Clinic (52)      |
| <input type="checkbox"/> Federally Qualified Health Center (12)       | <input type="checkbox"/> Optician (75)                                       | <input type="checkbox"/> Rural Health Clinic (05)                  |
| <input type="checkbox"/> General Hospital (01)                        | <input type="checkbox"/> Outpatient Health Facility (04)                     | <input type="checkbox"/> Targeted Case Management (85)             |
| <input type="checkbox"/> Hearing and Speech Clinic (58)               | <input type="checkbox"/> Outpatient Rehabilitation Clinic (53)               | <input type="checkbox"/> Waiver Service Provider (45)              |
| <input type="checkbox"/> Home Health Agency (Medicare Cert.) (60)     | <input type="checkbox"/> ODADAS Certified/Licensed Treatment Program         | <input type="checkbox"/> ODMH Certified Comm Mental Hlth Agency    |

### Provider Identification: - Required

 (Print or type entries)

Organization Name	
Abbreviated Organization Name (If your name exceeds 30 spaces, indicate preferred abbreviation.)	
Employer Identification Number	<b><u>You must attach a signed W-9 form</u></b>

### Address Information: - Required

Physical Location of Business (Applicants: If more than one location, list Primary. Required field)

Building Name / <b>OR</b> / Department / <b>OR</b> / In care of			
Business Address (Number, Street, Avenue, Route, etc: P.O. and Drop Boxes are not acceptable)			Suite Number
City	County	State	Zip Code (Zip +4, if possible)
Telephone Number	Fax Number	Email Address	

"Pay to" Address (Name & Address to which Payment and/or Remittance Advice is to be mailed)

(If Address is not different from "Physical Location of Business" address, leave blank)

Building Name / <b>OR</b> / Department / <b>OR</b> / In care of			
Address			Suite Number
City	State	Zip Code (Zip + 4, if possible)	

Mailing/Correspondence Address (Name & Address to which all other material is to be mailed)

(If Address is not different from "Physical Location of Business" address, leave blank)

Building Name / <b>OR</b> / Department / <b>OR</b> / In care of			
Address (P.O. and Drop Boxes are not acceptable)			Suite Number
City	State	Zip Code (Zip + 4, if possible)	

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### National Provider Identifier:

<b>If you have received your National Provider Identifier (NPI) number, please report it here:</b>	<b>If you had a previous NPI number, please report it here:</b>
NPI number **	NPI number

\*\* You must attach a copy of the notice from the NPI Enumerator to verify the National Provider Identifier Number.

### Medicare Identification Information: - Required if applicable

PIN number*	PIN number*	DMERC number*
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\*You must attach copy of CMS Approval Letter.

### Clinical Laboratory Improvement Act Information - REQUIRED FOR ALL HOSPITALS AND ALL LABORATORIES

CLIA number*	CLIA number*	CLIA number*
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\* You must attach copy of CLIA Certificate

\* You must attach copy of CLIA Certificate

\* You must attach copy of CLIA Certificate

### Optional Categories of Service:

Check your Provider Type, and any other Categories of Service you are licensed and/or authorized to provide.

Provider Type	Optional Category of Service	Provider Type	Optional Category of Service
<input type="checkbox"/> Ambulance (82)	<input type="checkbox"/> Ambulette Services (38)	<input type="checkbox"/> Outpatient Rehabilitation Clinic (53)	<input type="checkbox"/> Supplies & Med Equip (32)
<input type="checkbox"/> End-Stage Renal Disease Dialysis Clinic (59)	<input type="checkbox"/> Prescribed Drugs (30) <input type="checkbox"/> Supplies & Med Equip (32)	<input type="checkbox"/> Primary Care Clinic (50)	<input type="checkbox"/> Dental Services (45) <input type="checkbox"/> Optometric Services (47) <input type="checkbox"/> Advanced Practice Nurse (21) <input type="checkbox"/> Supplies and Medical Equip (32) <input type="checkbox"/> Physician Services (43) <input type="checkbox"/> EPSDT Services (40)
<input type="checkbox"/> Family Planning Clinic (54)	<input type="checkbox"/> Supplies & Med Equip (32)	<input type="checkbox"/> Professional Optometry School Clinic (55)	<input type="checkbox"/> Supplies & Med Equip (32)
<input type="checkbox"/> General Hospital (01)	<input type="checkbox"/> Ambulance Services (37) <input type="checkbox"/> Ambulette Services (38)	<input type="checkbox"/> Public Health Department Clinic (52)	<input type="checkbox"/> Dental Services (45) <input type="checkbox"/> Optometric Services (47) <input type="checkbox"/> Supplies & Medical Equip (32)
<input type="checkbox"/> Mental Health Clinic(51)	<input type="checkbox"/> Supplies & Medical Equip(32)		

### Federally Qualified Health Centers, Rural Health Facilities, Outpatient Health Facilities

Providers may be enrolled as only one type of alternative payment clinic. An "alternative payment clinic" shall be defined as an FQHC, rural health clinic (RHC), or outpatient health facility (OHF). Check the appropriate box:

Section 330 of Public Health Service Act grants – recipient or under a contract with the recipient  
(include documentation from CMS that identifies the specific service site(s) included in the 330 public health services project)

Health and Human Services Certification as a Federally Qualified Health Center  
(include documentation from US secretary of health and human services confirmation letter that the service site(s) is/are considered an FQHC look-alike with respect to Medicaid coverage)

(For State Use Only)

## Medicaid School Program

Ohio Department of Education Information Retrieval Number:	Information Retrieval Number*	* You must attach a copy of the Information Retrieval Number notification.
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**Clinics** Check the applicable Clinic Provider Type , and attach a copy of the required documentation as indicated for your Provider Type

<u>Provider Type</u>	<u>Required documentation (to be submitted with application)</u>
<input type="checkbox"/> 59 - End-Stage Renal Dialysis Clinic	<input type="checkbox"/> Medicare Certification as a Dialysis Clinic <input type="checkbox"/> Licensure by the Ohio Department of Health as a dialysis provider
<input type="checkbox"/> 54 - Family Planning Clinic	<input type="checkbox"/> Affiliation with the Planned Parenthood Federation of America (PPFA) <input type="checkbox"/> Grant award for the provision of family planning services under Title X of the Public Health Services Act <input type="checkbox"/> Grant award through the Ohio Department of Health for family planning services under the Child and Family Health Services program <input type="checkbox"/> Grant award through the Ohio Department of Health's Women's Health Services, in accordance with rule 3701-68-01 of the Administrative Code
<input type="checkbox"/> 58 - Hearing and Speech Clinic	<input type="checkbox"/> Specialize in either speech language/audiology services or diagnostic imaging services
<input type="checkbox"/> 51 - Mental Health Clinic	<input type="checkbox"/> Ohio Department of Health Recognition as an Alcoholism Outpatient and After-care Services Program. <input type="checkbox"/> Ohio Department of Mental Health Certification as an Outpatient Mental Health Facility.
<input type="checkbox"/> 53 – Outpatient Rehabilitation Clinic	<input type="checkbox"/> Medicare Certification as an Outpatient Rehabilitation Clinic OR <input type="checkbox"/> Medicare Certification a Comprehensive Outpatient Rehabilitation Clinic
<input type="checkbox"/> 50 - Primary Care Clinic	<input type="checkbox"/> Joint Commission Accreditation <input type="checkbox"/> Accreditation Association for Ambulatory Health Care (AAAHC) <input type="checkbox"/> Healthcare Facilities Accreditation Program of the American Osteopathic Association <input type="checkbox"/> Community Health Accreditation Program (CHAP) <input type="checkbox"/> Receipt of state or federal grant funds for the provision of health services
<input type="checkbox"/> 56 – Professional Dental Dental Clinic	<input type="checkbox"/> Accreditation by the Council on Dental Education (CODA) of the American Dental Association (ADA)
<input type="checkbox"/> 55 – Professional Optometry School Clinic	<input type="checkbox"/> Accreditation by the Council on Optometry Education (ACOE) of the American Optometric Association
<input type="checkbox"/> 52 - Public Health Department Clinic	<input type="checkbox"/> Legal Status as a County Health Department, City Health Department, or Combined Health District

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### Hospitals - Required

Hospital License Registry Number\*

License Registry Date (mm/dd/yyyy)

Current License Registry Expiration Date\* (mm/dd/yyyy)

\*You must attach copy of License

**Hospital Beds - You must attach a copy of the letter from Department of Health with Your Bed Certification.**

TOTAL HOSPITAL BEDS \_\_\_\_\_

**Please check all that apply and attach supporting documentation for each block checked**

- Children's Hospital
- Hospital has a Distinct Part Psychiatric Unit
- Major Teaching Hospital  
(Submit intern to bed ratio from fiscal intermediary)
- Rural Referral Center
- For hospitals in Ohio, please specify Nursery Level (Submit documentation from Ohio Dept. of Health)
  - Level 1
  - Level 2
  - Level 3
- Rehabilitation Hospital
- Long Term Acute Care Hospital
- Cancer Hospital
- HMO owned Hospital
- Specialty Hospital  
(Please Specify) \_\_\_\_\_

*If you provide Pharmacy and/or Ambulance/Ambulette services you must also complete the Pharmacy and Transportation sections of this application*

### National Provider Identifier: Secondary NPIs

Psychiatric Unit NPI

Rehabilitation Unit NPI

### Hospital Cost Report Contact- Required

Name/Title			
Address			Suite Number
City		State	Zip Code (Zip + 4, if possible)
Phone Number	Fax Number	E-Mail Address	

### Hospital Care Assurance Program (HCAP) Contact

(If contact is not different from "Hospital Cost Report Contact," leave blank.)

Name/Title			
Address			Suite Number
City		State	Zip Code (Zip + 4, if possible)
Phone Number	Fax Number	E-Mail Address	

### Upper Payment Limit (UPL) Program Contact

(If contact is not different from "Hospital Cost Report Contact," leave blank.)

Name/Title			
Address			Suite Number
City		State	Zip Code (Zip + 4, if possible)
Phone Number	Fax Number	E-Mail Address	

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**Pharmacies - Required**

State Pharmacy Board License Number*	DEA Registration Number*
*You must attach a copy of license.	
*You must attach a copy of Controlled Substance Registration Certificate	
Name of Licensed, Registered Pharmacist (In full and actual charge of the Pharmacy)(print or type.)	
Pharmacist's License Number*	Pharmacist's Signature
Date of Signature (mm/dd/yyyy)	
*You must attach a copy of license.	

**Medical Suppliers - Required**

State Vendor's License Number*	or	Orthotics / Prosthetics License Number*	or	State Tax Exemption Certificate Number*
*You must attach a copy of license.		*You must attach a copy of license.		*You must attach a copy of Certificate.
Do you have a Respiratory Board license? <input type="checkbox"/> YES <input type="checkbox"/> NO (This is required to bill for respiratory services)				
State Respiratory Board License Number*	Date license was issued (mm/dd/yyyy)	Date license expires (mm/dd/yyyy)		
*You must attach a copy of license.		*You must attach a copy of license.		
Are you dispensing hearing aids? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please enter the appropriate License Number below.				
Hearing Aid Dispenser License Number*	or	Audiologist License Number*		
*You must attach a copy of license.		*You must attach a copy of license.		

**Independent Diagnostic Testing Facilities - Required**

**Physician's Certification:** I certify that (check one):

I own or partially own the facility and employ the operating personnel.

I am a part-time employee or an employee under contract whose responsibilities include checking the procedural and quality control manuals, observing the operator's or technician's performance, verifying that the equipment and personnel meet applicable federal, state, and local licensure and registration requirements, and assuring that safe operating procedures and quality control procedures are used.

Physician's Name (print)	Physician's Signature	Date of Signature (mm/dd/yyyy)
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**Eligible Medicaid providers of Independent Diagnostic Testing Facility services must meet the following criteria:**

- Possess a current unrevoked or unsuspended Medicare Provider Number as an Independent Diagnostic Testing Facility.
- Be in conformity with all applicable federal, state, and local laws and regulations.
- Provide nonradiological services under the general supervision of a physician who is certified or meets the requirements and/or training in the performance and interpretation of diagnostic testing procedures.
- Provide radiological services under the following conditions:
  - The services are performed under the general supervision of a licensed doctor of medicine or licensed doctor of osteopathy who is qualified by advanced training and experience in the use of x-rays as defined below:
    - The physician is certified in radiology by the American Board of Radiology or by the American Osteopathy Board of Radiology or possesses qualifications which are equivalent to those required for such certification;
    - The physician is certified or meets the requirements for certification in a specialty in which the physician has become qualified by experience and/or training in the use of x-rays for diagnostic purposes.
  - All operators of the x-ray equipment must meet the following requirements:
    - Successful completion of a program of formal training in x-ray technology of not less than 24 months duration in a school approved by the Council on Education of the American Medical Association, or have earned a bachelor of science degree or associate degree in radiology technology from an accredited college or university.
    - For those whose training was completed prior to July 1, 1966, but on or after July 1, 1960, successful completion of 24 full months of training under the direct supervision of a physician who meets the definition of a qualified physician.
- Radiology procedures are conducted in compliance with radiology safety standards which assure that the equipment and the operating procedures used minimize the radiation exposure and hazards for patients, personnel, and other persons in the immediate environment. X-ray equipment and shielding are inspected by qualified individuals at intervals not greater than every 24 months.

### Ambulance/Ambulette Transportation Services

Are you publicly owned and operated? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, enter your <i>State Medical Transportation Board Service Number*</i> here	Medicare Certification Number (Ambulance Provider Applicants only)*
<b>* You must attach a copy of the State Medical Transportation Board Certificate of Licensure</b>	<b>* You must attach a copy of the Medicare Certification</b>

### Ambulance/Ambulette Personnel

(This page may be copied as needed to list all drivers.)

Ambulance providers: All drivers must have EMT certification (include a copy of EMT card for each driver with the application)

A copy of each driver's driving record from the Bureau of Motor Vehicles to be submitted with the application.

Ambulette providers:

Each driver and each attendant must have a current card as proof of successful completion of the

"American Red Cross" (or equivalent certifying organization) basic course in first aid and a CPR certification

Each card must be signed and a copy of each driver's card, front and back, must be included with the application

OR EMT certification for each driver/attendant (include a copy of each driver's/attendant's EMT card with the application)

**List the driver/attendant information below. Be sure to include the appropriate certification cards with the application for each driver/attendant. Please print or type all responses.**

Driver/Attendant's Name	EMT Card Number Required for Ambulance Drivers	American Red Cross Basic/Community First Aid and CPR	EMT Expiration Date or Completed Date of American Red Cross Basic/Community First Aid Training/CPR (mm/dd/yyyy)
Driver      Attendant		First Aid:	EMT expiration date or First Aid completion date
		CPR:	CPR completion date
Driver      Attendant		First Aid:	EMT expiration date or First Aid completion date
		CPR:	CPR completion date
Driver      Attendant		First Aid:	EMT expiration date or First Aid completion date
		CPR:	CPR completion date
Driver      Attendant		First Aid:	EMT expiration date or First Aid completion date
		CPR:	CPR completion date
Driver      Attendant		First Aid:	EMT expiration date or First Aid completion date
		CPR:	CPR completion date
Driver      Attendant		First Aid:	EMT expiration date or First Aid completion date
		CPR:	CPR completion date

## Requirements for Ambulette Vehicle Providers Documents to be included with the application

You must include, with your application, copies of documents for each item listed on this page. In addition, all ambulette vehicle providers must have documented proof on file of compliance with the following requirements, to be available upon request from the Department of Job and Family Services.

### Check each block to certify compliance and include required documentation

<input type="checkbox"/> Currently, the ambulette service is operating _____ vehicles. The provider maintains a valid current vehicle license registration with the Ohio Bureau of Motor Vehicles for each vehicle. Include a copy of the vehicle registration for each vehicle.
<input type="checkbox"/> Each vehicle displays the company logo, insignia, or name on both sides and rear of the vehicle. Include photos of each vehicle for verification.
<input type="checkbox"/> The provider maintains liability insurance coverage in the amount of not less than five hundred thousand dollars per occurrence and not less than five hundred thousand dollars in the aggregate, for any cause for which the provider would be liable. Include proof of insurance.
<input type="checkbox"/> The provider maintains bodily injury and property damage insurance with solvent and responsible insurers licensed to do business in this state for any loss or damage resulting from any occurrence arising out of or caused by the operation or use of any ambulette vehicle. The insurance plan shall insure each vehicle for the sum of not less than one hundred thousand dollars for bodily injury to or death of more than one person in any one accident and for the sum of fifty thousand dollars for damage to property arising from any one accident. Include proof of insurance.
<input type="checkbox"/> Each driver and attendant must submit himself or herself for criminal background checks in accordance with section 109.572 of the Revised Code. Any applicant or employee who has been indicted, convicted, or pleaded guilty to violation cited in divisions (A)(1)(a), (A)(2)(a), (A)(4)(a), and/or (A)(5)(a) of section 109.572 of the revised code shall not provide services to medicaid patients unless the exceptions set forth in paragraphs (A) and (B) of rule 3701-13-06 of the Administrative Code apply. Include a copy of the BCI criminal background check results.
<input type="checkbox"/> Each driver and each attendant has current cards issued as proof of successful completion of the "American Red Cross" (or equivalent) basic or community course in first aid and CPR. Each card must be signed on the back by the driver or attendant who completed the course. Include a copy of each card for each driver and attendant with the application.
<input type="checkbox"/> Each driver must have a copy of his or her driving record provided from the Bureau of Motor Vehicles. The date of the driving record submitted at the time of the application must be no more than fourteen days prior to the date of application for employment. Persons with six or more points on their driving record in accordance with section 4507.02 of the Revised Code cannot be an ambulette driver. Include a copy of each driver's driving record with the application.
<input type="checkbox"/> The qualifications of each driver and each attendant must comply with local, state, and federal laws and regulations, including a valid driver's license and be eighteen years or older. Include a copy of a valid driver's license for each driver.

## Requirements for Ambulette Vehicle Providers

All ambulette providers must certify that they operate vehicles that meet the following standards and have documentation to verify compliance that is available upon request.

### Check each block to certify compliance

<input type="checkbox"/>	Each vehicle is specifically designed to transport one or more patients sitting in wheelchairs and has fasteners to secure the wheelchair to the floor or side of the vehicle to prevent wheelchair movement. In addition, the vehicle is equipped with restraints to secure the patient in the wheelchair.
<input type="checkbox"/>	Each vehicle has a minimum ceiling to floor height of fifty-six inches.
<input type="checkbox"/>	Each vehicle is equipped with a communication system capable of two-way communication.
<input type="checkbox"/>	Each vehicle is equipped with a stable access ramp or hydraulic lift.
<input type="checkbox"/>	The provider must conduct daily inspection and testing of the hydraulic lift or access ramp.
<input type="checkbox"/>	Each vehicle is equipped with, at a minimum, a fire extinguisher and an emergency first-aid kit.
<input type="checkbox"/>	Each vehicle has provisions for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and driver in the event of an accident.
<input type="checkbox"/>	The provider must complete vehicle inspection documentation in the form of a checklist to include at a minimum wheelchair restraints, wheelchair lifts, lights, windshield wipers/washers, emergency equipment, mirrors, and brakes.
<input type="checkbox"/>	The provider maintains on file evidence that at least an annual vehicle inspection was completed by the Ohio State Highway Patrol Safety Inspection Unit, or a certified mechanic and each vehicle has been determined to be in good working condition.
<input type="checkbox"/>	Each ambulette driver and each attendant has an identification card available to the patient identifying his or her complete name and company affiliation.
<input type="checkbox"/>	The provider maintains on file a signed statement from a licensed physician for each driver and attendant declaring that they do not have physical, including vision and hearing, or mental limitation likely to interfere with safe driving, passenger assistance, or emergency activity and does not have a communicable disease that could jeopardize the health or welfare of patients being transported.
<input type="checkbox"/>	Each ambulette driver has undergone testing for alcohol and controlled substances in accordance with 49 CFR 382.
<input type="checkbox"/>	Each ambulette and each attendant has completed a passenger assistance training course to include at a minimum the basic characteristics of major disabling conditions affecting ambulation, basic considerations for functional factors, management of wheelchairs, assistance and transfer techniques, environmental considerations, and emergency procedures.

# Disclosure and Ownership/Control Interest Statement

Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations in spaces provided. List any additional names and addresses on the proper section of the sheet provided.

**1. A.** Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organization, agency, or practice that have been indicted or convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

YES    NO

Name	When? Give date (mm/dd/yyyy)	SSN/EIN
Name	When? Give date (mm/dd/yyyy)	SSN/EIN

**1. B.** Are there any directors, officers, agents, or managing employees of the institution, agency, organization, or practice who have ever been indicted or convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

YES    NO

Name	When? Give date (mm/dd/yyyy)	SSN/EIN
Name	When? Give date (mm/dd/yyyy)	SSN/EIN

**2. A.** List names, addresses, and SSNs for individuals, and the names, addresses, and Employer Identification Numbers (EIN) for organizations having direct or indirect ownership or a controlling interest in the entity or practice. Place an "X" in the box labeled Related for all names listed who are related to each other.

Name	Related	Address	SSN/EIN
Name	Related	Address	SSN/EIN
Name	Related	Address	SSN/EIN
Name	Related	Address	SSN/EIN

**2. B.** Type of Entity or Practice:    Sole Proprietorship    Partnership    Corporation    Unincorporated Associations  
 Other (specify) \_\_\_\_\_

**2. C.** If the disclosing entity or practice is a corporation, list names, addresses, and SSNs of the Directors and the name, address, and EIN of the parent corporation, if applicable.

Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN

**2. D.** Have you ever been issued an Ohio Medicaid 7-digit Provider Number?  
 YES    NO   If YES, you must list them in the boxes below.

7-digit Provider Number	7-digit Provider Number	7-digit Provider Number	7-digit Provider Number
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**2.E.** Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership, or Members of the Board of Directors.) If yes, list names, addresses of individuals, and provider numbers. If under Title XIX, list vendor number.  
 YES  NO

Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number

**3.A.** Has there been a change in ownership or control within the last year? If yes, when? (mm/dd/yyyy)  
 YES  NO **ATTACH EXPLANATION**

**B.** Do you anticipate any change in ownership or control within the year? If yes, when? (mm/dd/yyyy)  
 YES  NO **ATTACH EXPLANATION**

**4.** Is this entity operated by a management company, or leased in whole or part by another organization?  
If yes, give date of change in operations.(mm/dd/yyyy)  
 YES  NO

**5.** Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?  
 YES  NO

**6.** Is this entity chain affiliated? (If yes, list name, address of Corporation, and EIN number.)  
 YES  NO

Name	Address	EIN
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**7.** Are there any Directors, Officers, Agents, or Managing Employees of the Institution, Agency, Organization, or Practice who have ever been indicted or convicted of a violation of State or Federal Law?  
 YES  NO

Name	Type of offense?	When, give date? (mm/dd/yyyy)	SSN/EIN
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Hospitals, only:  
**8.** Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?  
 YES  NO If yes, give year of change. Current Beds Prior Beds

**Disclosure statement: Additional Names, Addresses, and Numbers by section.**

**Section: 1.A.**

Who was it? Give name.	When? Give date (mm/dd/yyyy)	SSN/EIN
Who was it? Give name.	When? Give date (mm/dd/yyyy)	SSN/EIN
Who was it? Give name.	When? Give date (mm/dd/yyyy)	SSN/EIN

**Section: 1.B.**

Who was it? Give name.	When? Give date (mm/dd/yyyy)	SSN/EIN
Who was it? Give name.	When? Give date (mm/dd/yyyy)	SSN/EIN
Who was it? Give name.	When? Give date (mm/dd/yyyy)	SSN/EIN

**Section: 2.A.**

Name	Related	Address	SSN/EIN
Name	Related	Address	SSN/EIN
Name	Related	Address	SSN/EIN
Name	Related	Address	SSN/EIN
Name	Related	Address	SSN/EIN
Name	Related	Address	SSN/EIN
Name	Related	Address	SSN/EIN
Name	Related	Address	SSN/EIN
Name	Related	Address	SSN/EIN
Name	Related	Address	SSN/EIN

**Section: 2.C.**

Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN

**All providers must read the statements below, print name, initial, and date.**

In accordance with Executive Order 2007-01S, Vendor or Grantee, by signature on this document, certifies: (1) it has reviewed and understands Executive Order 2007-01S, (2) has reviewed and understands the Ohio ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Vendor or Grantee understands that failure to comply with Executive Order 2007-01S is, in itself, grounds for termination of this contract or grant and may result in the loss of other contracts or grants with the State of Ohio.

Authorized Representative Name and Title (please print) :

\_\_\_\_\_

Authorized Representative Initial: \_\_\_\_\_ Date: \_\_\_\_\_

A copy of Executive Order 2007-01S can be found at: <http://www.dot.state.oh.us/clc/governor.asp>

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the State agency or the Secretary, as appropriate.

Authorized Representative Name and Title (please print) :

\_\_\_\_\_

Authorized Representative Initial: \_\_\_\_\_ Date: \_\_\_\_\_

**For all Ambulatory Health Care Clinics Only:**

All Ambulatory Health Care Clinics must provide documentation indicating the facility:

- \* Is Free Standing – no administrative, organizational, financial, or other connection with a hospital or long term care facility;
- \* Furnishes outpatient (non-institutional) health care by or under the direction of a physician or dentist;
- \* Has a fixed location or specifically designed mobile unit;
- \* Does not provide overnight accommodations;
- \* Is not eligible as a Medicaid provider as a professional association of physicians, dentists, optometrists, opticians, podiatrists, or limited practitioners such as physical therapists, psychologists, or chiropractors enrolled as a Medicare provider.

### OHIO MEDICAID PROVIDER AGREEMENT

(For all providers except Medicaid Managed Care Plans and Long-Term Care Facilities)

This provider agreement is a contract between the Ohio Department of Job and Family Services (the Department) and the undersigned provider of medical assistance services in which the Provider agrees to comply with the terms of this provider agreement, state statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies to:

1. Render medical assistance services as medically necessary for the patient and only in the amount required by the patient without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap, submit claims only for services actually performed, and bill the Department for no more than the usual and customary fee charged other patients for the same service.
2. Ascertain and recoup any third-party resource(s) available to the recipient prior to billing the Department. The Department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in Chapter 5101:3 of the Administrative Code.
3. Accept the allowable reimbursement for all covered services as payment-in-full and, except as required in paragraph 2 above, will not seek reimbursement for that service from the patient, any member of the family, or any other person.
4. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer.
5. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Ohio Medicaid fraud control unit or their designees any information maintained under paragraph 4 above for audit or review purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of Medicaid or Disability Assistance Medical payments and may result in termination from the Medicaid and Disability Assistance Medical programs.
6. Inform the Department within thirty days of any changes in licensure, certification, or registration status; ownership; specialty; additions, deletions, or replacements in group membership and hospital-based physicians; and address;
7. Disclose ownership and control information, and disclose the identity of any person (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5101:3-1-17.3 of the Administrative Code) who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX services.
8. Neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, or any independent contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title X beneficiaries.
9. To follow the regulations and policies set forth in the appropriate edition of the Medicaid Handbook.
10. Provide to ODJFS, through the court of jurisdiction, notice of any action brought by the provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to: "Office of Legal Services, Ohio Department of Job and Family Services, 30 East Broad Street - 31st Floor, Columbus, Ohio 43215".
11. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d).

This provider agreement may be canceled by either party upon 30 days written notice prior to termination date.

I further certify that I am the individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive officer, or general partner of the business organization that is applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.

Certain provider agreements may be made retroactive (up to 12 months) to encompass dates on which the provider furnished covered services to a Medicaid consumer and the service has not been billed to Medicaid. **If you meet this provision, please check this box.**   
A failure to check this box shall be taken by ODJFS to mean that you waive your rights to a retroactive period of up to 12 months prior to the date ODJFS approves your application.

Authorized Representative Name and Title (please print) : \_\_\_\_\_

Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)

For State Use Only

Signature of Authorized Agent: \_\_\_\_\_ Date: \_\_\_\_\_ (mm/dd/yyyy)

(For State Use Only)

**For State Use Only**

Date Received(1)	Date Received(2)	Date Received(3)	Date Received(4)
Date Returned(1)	Date Returned(2)	Date Returned(3)	Date Returned(4)

Date Processed	Effective Date	Provider Number
Operator's Number		