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: _____

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: _____

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

10. Does the staff have the ability to communicate with the visually impaired?	☐ Yes ☐ No ☐ N/A
11. Does the staff have the ability to communicate with the hearing impaired?	☐ Yes ☐ No ☐ N/A
12. Is the facility wheelchair accessible?	☐ Yes ☐ No ☐ N/A
13. Does your facility offer American Sign Language (ASL) services?	☐ Yes ☐ No
14. Does your facility offer Non-English Medical Interpreters?	☐ Yes ☐ No
15. Is your facility accessible by public transportation?	☐ Yes ☐ No ☐ N/A
16. Does your facility offer accessible equipment?	☐ Yes ☐ No ☐ N/A
17. Does your facility offer accessible exam room?	☐ Yes ☐ No ☐ N/A
18. Does your facility offer electronic prescribing?	☐ Yes ☐ No ☐ N/A

If no, please provide brief explanation: _____

CREDENTIALING PROGRAM

19. Does the facility validate for each licensed provider employed or contracted at the facility the credentials necessary to perform health care services? ☐ Yes ☐ No

If yes, indicate how the facility conducts the credentialing process for each provider:

☐ Credentialing procedures are performed internally

☐ Credentialing procedures are outsourced or delegated to _____

If no, please provide brief explanation:

ORGANIZATION BACKGROUND

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

(if Yes, please provide explanation below)

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

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

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

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

24. 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

25. 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

26. 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

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

If no, please provider brief explanation:

FACILITY/ORGANIZATION PROVIDES MEALS ☐ N/A-NOT PROVIDED

28. What meals/snacks are provided? _____

29. Are meals prepared onsite/offsite? _____

If no, indicate name of caterer: _____

30. Special/Dietary Meals Provided, e.g. Kosher, vegetarian? ☐ Yes ☐ No
If yes, please specify: _____

31. Does a nutritionist or dietician oversee and approve the menu? ☐ Yes ☐ No ☐ N/A

32. Do you participate in the USDA Child and Adult Care Food Program? ☐ Yes ☐ No

33. For NYC providers, is the food program funded by the NYC Department for the Aging (DFTA)? ☐ Yes ☐ No

If yes, how many slots are funded by DFTA? _____

34. For NYC providers, are you in compliance with DFTA's Quality Assurance Guidelines? ☐ Yes ☐ No ☐ N/A

35. Is the program in the facility funded by City Meals on Wheels? ☐ Yes ☐ No

36. NYC providers, do you have a NYCDOH Food Service Establishment Permit? ☐ Yes ☐ No

37. Does the program have other funding sources? ☐ Yes ☐ No
If yes, please list:

_____

_____

_____

TRANSPORTATION SERVICES (DIRECTLY/INDIRECTLY) ☐ N/A-NOT PROVIDED

38. Transportation is provided by? ☐ This organization ☐ Subcontractor
If provided by a subcontractor, specify name and address: _____

39. Can wheelchairs be accommodated in transportation? ☐ Yes ☐ No

40. Is an escort provided to accompany attendees on transport? ☐ Yes ☐ No

41. Do participants go on program-sponsored off-site trips? ☐ Yes ☐ No

42. How do you track patients who use transportation to/from your site? _____

***If Transportation Provider Only** (please answer questions 33 through 37 as well)*

43. NYC Only: Are you registered with the NYC Taxi & Limousine Commission? ☐ Yes ☐ No ☐ N/A
If no, please explain: _____

44. Base License #: _____

45. Are you registered with the NYS Dept. of Transportation (DOT)? ☐ Yes ☐ No DOT #_____

46. Vehicle are: ☐ Company Owned ☐ Driver Owned ☐ Other: _____
Number of Vehicles: _____

47. Vehicles Types: _____

Ambulettes must be participating with Medicaid Program

SOCIAL ADULT DAY CARE/MEDICAL ADULT DAY CARE PROVIDERS ONLY ☐ N/A-Skip Pg. 6-7

S1-Is the Adult Day Care program conducted: ☐ On-Site ☐ Off-Site
If off-site, provider address: _____

S2-If applicable, is there a current Certificate of Occupancy which follows all applicable city, town, and state building and fire codes? *(If no, credentialing may not proceed.)* ☐ Yes ☐ No

S3- Is the Adult Day Care currently open and operating? ☐ Yes ☐ No
If no, scheduled opening date: _____

S4-Total number of members per day, the program can accommodate: _____

S5-Current attendees per shift/day _____

S6-Number of hours of structured programming per day _____

STAFF COMPOSITION *including paid, non-paid, full/part time (description should include types of positions, not names)*

Job Title	Full Time/Part Time	Responsibilities

S7-Staff (including paid, non-paid, full and part time) to Participant Ratio: _____

S8-List of staff trainings conducted: _____

_____

_____

S9-How many staff members are involved in the coordination of this program? _____

S10-What is the minimum number of staff with the participants during the program session? _____

S11-What is the maximum ratio of staff to participants during the program session? _____

SERVICES

S12- Program serves clients with: (check all that apply) ☐ Physically Frail
☐ Dementia (indicate level) ☐ Severe ☐ Moderate ☐ Mild

S13-List specific conditions that are accepted, e.g. incontinence, wheelchair-bound, etc.:

_____

_____

S14-What type of personal care do you provide? ☐ Toileting ☐ Ambulation ☐ Transferring ☐ Feeding/Eating
☐ Prompting participants for self-administration of medications ☐ Bathing ☐ Dressing ☐ Grooming ☐ Routine Skin Care
☐ Using supplies & adaptive assistance devices ☐ Changing-simple dressing

Please attach copy of recent Calendar of Events (minimum of 2 structured activities per day)

S15-Number of hours of structured programming per day _____

POLICIES & PROCEDURES

S16-Does the facility have a bill of rights or similar document? (attach a copy) ☐ Yes ☐ No

S17-Do you have a written Policy & Procedure Manual? (attach a copy) ☐ Yes ☐ No

S18-Do you conduct a self-evaluation at least annually of your administrative, fiscal, and program operations? ☐ Yes ☐ No

RECORD KEEPING

S19-Does your record keeping documentation include?

☐ Administrative and financial records

☐ Participant personal records, including identifying emergency, and medical information including physician name, diagnosis, and medications

☐ Service records for each participant, including the individual assessment, the service plan and documentation of the delivery of services

S20-Are participant records maintained in a secure place? ☐ Yes ☐ No

Please attach a copy of a blank assessment and care plan.

S21-How do you track participant attendance/transportation at your site? _____

S22-Do you provide any additional services for caregivers? ☐ Yes ☐ No

If yes, please describe: _____

SKILLED NURSING FACILITIES/NURSING HOMES ONLY

☐ N/A

10. Has your organization been subject to any remedies? (e.g. DPNA) ☐ Yes ☐ No

11. Are there transfer agreements with hospitals? ☐ Yes ☐ No
If so, which hospitals: _____

12. Are there any religious affiliations and/or services at the facility? ☐ Yes ☐ No
If so, please list: _____

13. Is there resident council? ☐ Yes ☐ No

14. Is there family member sleepover allowed? ☐ Yes ☐ No

15. Is there family council or caregiver support group? ☐ Yes ☐ No

16. Is there any special transportation available to the facility for visitors? ☐ Yes ☐ No

45.Are there any Ambulette/Ambulance providers utilized? ☐ Yes ☐ No

17. List any medical service vendor, or other contract arrangements the facility maintains (e.g. radiology, laboratory): _____

FACILITY CONTACT INFORMATION (REQUIRED)

Position	Name	Telephone/Fax	Email
Administrator			
Director, Admissions			
Director, Social Work			
Director, Patient Accounts			
Director, Nursing			
Director, Quality Management			
Responsible for Medicaid Recertification			
Credentialing			

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.

48. Have there been any settled malpractice claims, suites, settlements or proceedings involving your organization?	☐ Yes	☐ No
49. 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
50. 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
51. Has your Organization license ever been restricted, conditioned, suspended or terminated?	☐ Yes	☐ No
52. Does your Organization have any current state or federal sanctions or limitations?	☐ Yes	☐ No
53. Does your organization have any, pending and/or settled, State Labor Law violation deemed willful?	☐ Yes	☐ No
54. 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
55. Is there any special transportation available to the facility for visitors?	☐ Yes	☐ No
56. 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
57. 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

CREDENTIALING SUPPLEMENTAL DOCUMENTATION

The following items must accompany your application:

All Providers

- ☐ General and Professional Liability Insurance Certificate copy (incl. Worker's Comp, Automobile)
- ☐ IRS W-9 form
- ☐ State Operating License/Certificate(s)
- ☐ Accreditation Documents/Certificates (if applicable)
- ☐ Copy of OMIG Annual Compliance Certification Confirmation & Certification status
- ☐ Current Medicaid/Medicare Enrollment Status
- ☐ Claims Loss Report-last 5 yrs (from insurance carrier)
- ☐ ADA Questionnaire
- ☐ Report from most recent site visit conducted w/ Approval of Deficiencies/POC (by any City, County, State contracting authority (if applicable)

Home Delivered Meals Providers

- ☐ NYC Providers only: Copy of current New York City Vendex rating letter
- ☐ Outside NYC Providers: copy of county or other governmental approval letter

Medical Adult Day Care Providers

- ☐ Blank assessment and care plan
- ☐ Recent calendar of events
- ☐ Participant Bill of Rights

LHCSA/CHHA/CDPAS (FI)

- ☐ Subcontracts for administrative, health, prescription services (if applicable)
- ☐ Code of Conduct
- ☐ Conflict of Interest Policy
- ☐ Training logs, sign-in sheets, program materials
- ☐ General Medicare Compliance Program Training Materials
- ☐ LHCSA VNSNY Attestation
- ☐ Non-Retaliation Policy
- ☐ Fraud, Waste, Abuse training materials/certificates

Laboratories

- ☐ Copy of CLIA Certificate
- ☐ List of locations in New York State

Hospitals, Ambulatory Surgery Centers, D&TCs, Clinics, Health Centers, Radiology Centers, Dialysis Centers, Outpatient Rehabilitation Centers, Hospice

- ☐ List of locations in New York State

Transportation

- ☐ New York City Taxi and Limousine Commission (TLC) base license (if operating within New York City) or New York State Department of Transportation (NYS DOT) Contract Carrier Permit
- ☐ Another jurisdiction license if operating outside NYC
- ☐ List of all Drivers, Driver's License Number, DOB, SSN

SOCIAL ADULT DAY CARE (SADC) CREDENTIALING SUPPLEMENTAL DOCUMENTATION

The following items must accompany your application:

Facility Documents

- ☐ General and Professional Liability Insurance Certificate copy (incl. Worker's Comp, automobile)
- ☐ ADA Accessibility Attestation
- ☒ Certificate of Occupancy
- ☐ Completed Disclosure of Ownership and Interest Control Statement
- ☐ Certificate of Occupancy
- ☐ Training Materials (Presentations/Manual)
- ☐ Current transportation log (if transportation services offered)
- ☐ Current activity attendance roster
- ☐ Sheet detailing emergency contact information
- ☐ Copy of OMIG Annual Compliance Certification Confirmation & Certification status
- ☐ IRS W-9 form
- ☐ Claims Loss Report-last 5 years (insurance carrier)
- ☐ Copy of OMIG SADC Certification Confirmation Notice and Approval
- ☐ Participant Bill of Rights
- ☐ Training Attendance Sheets (past year)
- ☐ Emergency preparedness program (fire, flood, choking, fainting)
- ☐ Current calendar of events
- ☐ Copy of the current menu(s)
- ☐ Copies of contracts with third party vendors

SADC Policies and Procedures

- ☐ Participant eligibility
- ☐ Participant service plan (care plan)
- ☐ Services delivery
- ☐ Nutrition program
- ☐ Records and recordkeeping
- ☐ Admission and discharge
- ☐ Program self-evaluation
- ☐ Organizational structure and staff functions
- ☐ Orientation and training

Sample (Blank) Copies of the following:

- ☐ Participant assessment form (incl. medication form)
- ☐ Participant Attendance Form
- ☐ Care Plan Form
- ☐ Transportation Attendance/Documentation (if appl.)

Copy of each of the following, if applicable:

- ☐ Proof of current participation in NYC DFTA Home Delivered Meals Program
- ☐ Proof of current participation in the USDA Child and Adult Care Food Program (CACFP)
- ☐ Nutritionist or RN License (oversees menu)