Dear Provider:

Enclosed is the District of Columbia Medicaid provider enrollment application. Please complete the application packet in its entirety including the Required Documents Checklist. Failure to include signatures on all forms and copies of all necessary attachments will delay the processing of your application.

Return the completed application to:

Xerox Provider Enrollment
Post Office Box 34761
Washington, DC 20043-4761

After receipt and approval of your application, you will be notified by mail of your District of Columbia Medicaid provider number. If you have any questions regarding this packet, please call Provider Enrollment toll free at 1-866-752-9231.

Sincerely,

Provider Enrollment and Outreach Branch
Division of Public and Private Provider Services
Health Care Operations Administration
DEPARTMENT OF HEALTH CARE FINANCE
PROVIDER APPLICATION FORM

Please type or print. Do not staple application packet. Incomplete applications will not be processed.

SECTION I   APPLICANT INFORMATION

If re-enrolling enter your existing DC Medicaid ID ________________

Check only one.

☐ Individual

  o As an individual applicant and you are to be affiliated with a member of a group provider, enter the group affiliations in Section XX.

☐ Group Practice

  o A group must have members affiliated with this group. The group must be enrolled first before members can be affiliated with the group. If this is a new group provider, enter the names of the members to be added after approval and their Medicaid provider IDs in Section XX.

  o When submitting claims for a group, the group’s NPI and Taxonomy code will be entered for the billing and the pay-to provider.

  o The rendering provider on the CMS 1500 or 837P and the treating provider on the Dental claim or 837D, will be the individual provider’s NPI and Taxonomy code that are affiliated with the group.

☐ Clinic Provider

  o A Clinic is not a group practice. A clinic does not have members affiliated with the clinic.

  o The billing, pay-to and rendering/treating providers are all the same on the professional CMS 1500 or 837P and dental claim forms ADA2006 or 837D.

☐ Facility – A Hospital, LTC, Hospital Based Outpatient facility, etc.

  o There are no members affiliated with a Hospital, LTC, Hospital Based Outpatient facility, etc.

☐ Waiver Provider

  o MRDD professional services and EPD service providers only. Other non-medical MRDD service providers must go to www.dds.dc.gov to download an application

DME Provider

Do not use this form. Go to www.dc-medicaid.com to download the DME Application.

Crossover/QMB Only

Do not use this form. Go to www.dc-medicaid.com to download the Crossover/QMB Only application.
SECTION II   APPLICANT’S NAME & ADDRESS

Individual Last Name: ___________________________  First: _________________________ MI _____
Organization Name: ______________________________________________________________
Doing Business As: _______________________________________________________________
(If this is an individual applicant, do not place the group or facility’s name here. Only enter the
DBA name if you registered with IRS with a DBA name.)

Applicant’s NPI: _________________________  Taxonomy: ___________________________
(Required for all Health Care providers – refer to the NPI supplement document within this application.)

Addresses

Primary Service Address  ___________ ___________________________________________
(Must be a street address – no PO Box)
Primary Service Address  (L2) _______ _______________________________________________
    City/State/Zip  ______________________________________________________
    If DC Address  Quadrant: _______    Ward _________
Office Telephone(s) _________________________  Office Fax __________________________
Contact Name ______________________________ Contact Phone ____________________
Contact Email _______________________________________________

If any address below is the same as the Primary Service Address, indicate Same for the address.

Correspondence Name   __________________________________________________
    Address  _____________________________________________________________
    Address L2  __________________________________________________________
    City/State/Zip  _______________________________________________________

Billing/Payment Name   ______________________________________________________
    Address  _____________________________________________________________
    Address (L2)  _________________________________________________________
    City/State/Zip  _______________________________________________________

Remittance Advice (RA) Name ________________________________________________
Remittance Address _______________________________________________________
Remittance Address L2 ______________________________________________________
City/State/Zip  __________________________________________________________
**SECTION III PROVIDER TYPE**

Select only one. To apply for more than one provider type, separate applications must be submitted. 
*If a Group – Choose the provider type that best represents your group.*

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Provider Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Substance Abuse – Adult Clinic</td>
<td>Hospital - Psychiatric Private</td>
</tr>
<tr>
<td>Alcohol and Substance Abuse – Youth Clinic</td>
<td>Hospital - Psychiatric Public</td>
</tr>
<tr>
<td>Adult Day Care</td>
<td>Home Community Based Waiver</td>
</tr>
<tr>
<td>Ambulance Transportation</td>
<td>Home Health Agency</td>
</tr>
<tr>
<td>Ambulatory Surgery Center</td>
<td>Hospice</td>
</tr>
<tr>
<td>Assisted Living (Pending)</td>
<td>ICF/MR</td>
</tr>
<tr>
<td>Audiologist</td>
<td>Independent Lab</td>
</tr>
<tr>
<td>Birthing Center</td>
<td>Independent Lab and XRay</td>
</tr>
<tr>
<td>Case Manager</td>
<td>Mental Health Clinic</td>
</tr>
<tr>
<td>Community Residential Facility</td>
<td>MRDD Waiver</td>
</tr>
<tr>
<td>Day Treatment</td>
<td>Nurse Midwives</td>
</tr>
<tr>
<td>DC Public Schools</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>DC Public Charter Schools</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>Dentist*</td>
<td>Optician</td>
</tr>
<tr>
<td>Dentist Waiver</td>
<td>Optometrist</td>
</tr>
<tr>
<td>DHS Dental Clinic</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Emergency Access Hospital</td>
<td>Physician DO*</td>
</tr>
<tr>
<td>EPD (Elderly Waiver)</td>
<td>Physician MD*</td>
</tr>
<tr>
<td>Early Intervention - EPSDT Services</td>
<td>Podiatrist</td>
</tr>
<tr>
<td>Family Planning Clinic</td>
<td>Psychiatric Residential Treatment Facility (PRTF)</td>
</tr>
<tr>
<td>Federal Qualified Health Center</td>
<td>Public Charter Schools</td>
</tr>
<tr>
<td>Hearing Aid Dispenser</td>
<td>Public Health Center</td>
</tr>
<tr>
<td>Hemodialysis Center - Freestanding</td>
<td>Radiology - Freestanding</td>
</tr>
<tr>
<td>HMO</td>
<td>Radiation Therapy Center</td>
</tr>
<tr>
<td>Hospital - General</td>
<td>Rehabilitation Center</td>
</tr>
<tr>
<td>Hospital - LTAC</td>
<td>Transportation Broker Private Clinic</td>
</tr>
</tbody>
</table>

**SECTION IV SPECIALTIES**

*If you are a Medical doctor, a doctor of Osteopathic Medicine, a Dentist, MRDD Waiver – Professional Services, EDP Waiver, or an institution that renders such services, please review and check the applicable specialty from the following lists.

<table>
<thead>
<tr>
<th>MD and DO Specialties</th>
<th>MD and DO Specialties</th>
<th>MD and DO Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy</td>
<td>Infectious Disease</td>
<td>Otolaryngology</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>Internal Medicine</td>
<td>Pathology</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Mental Health Case Mgmt</td>
<td>Pediatrics</td>
</tr>
<tr>
<td>Colon and Rectal Surgery</td>
<td>Neonatal</td>
<td>Physical Medicine &amp; Rehab</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Nephrology</td>
<td>Plastic Surgery</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>Neurosurgery</td>
<td>Preventive Medicine</td>
</tr>
<tr>
<td>Family Practice</td>
<td>Neurology</td>
<td>Psychiatry</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Nuclear Medicine</td>
<td>Pulmonary Disease</td>
</tr>
<tr>
<td>General Surgery</td>
<td>OB/GYN</td>
<td>Radiology</td>
</tr>
<tr>
<td>Genetics</td>
<td>Obstetrics</td>
<td>Rheumatology</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>Ophthalmology</td>
<td>Thoracic Surgery</td>
</tr>
<tr>
<td>Gynecology</td>
<td>Ortho Surgery</td>
<td>Urology</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>Osteopathy</td>
<td>Vascular Surgery</td>
</tr>
</tbody>
</table>
Dental Specialties

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Specialty</th>
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</thead>
<tbody>
<tr>
<td>Endodontist</td>
<td>Pedodontist</td>
</tr>
<tr>
<td>General Dentistry</td>
<td>Periodontist</td>
</tr>
<tr>
<td>Oral Surgery*</td>
<td>Prosthodontist</td>
</tr>
<tr>
<td>Orthodontist</td>
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</tbody>
</table>

*Please note Oral Surgeons must complete an application for Dentist (specialty: General Dentistry) as well as Physician (specify oral surgery).

MRDD – Home Community Based Waiver Specialties

<table>
<thead>
<tr>
<th>Professionals*</th>
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</thead>
<tbody>
<tr>
<td>Acupuncturist</td>
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<tr>
<td>Art Therapy</td>
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<tr>
<td>Dance Therapy</td>
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<tr>
<td>Drama Therapy</td>
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<tr>
<td>Family Training</td>
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<tr>
<td>Fitness Trainer</td>
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<tr>
<td>Massage Therapy</td>
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<tr>
<td>Music Therapy</td>
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<tr>
<td>Nutritionist</td>
</tr>
<tr>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Sexuality Education Training</td>
</tr>
<tr>
<td>Speech, Hearing and Language Therapy</td>
</tr>
</tbody>
</table>

*Please note that you must complete a separate application if applying for more than one specialty.

EPD - Home Community Based Waiver Specialties

<table>
<thead>
<tr>
<th>Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistive Living*</td>
</tr>
<tr>
<td>Case Management</td>
</tr>
<tr>
<td>Chore Aid*</td>
</tr>
<tr>
<td>Homemaker Services*</td>
</tr>
<tr>
<td>Personal &amp; Emergency Response*</td>
</tr>
<tr>
<td>Personal Care Aide*</td>
</tr>
<tr>
<td>Respite Services*</td>
</tr>
</tbody>
</table>

*Must be an existing home health agency to provide these services.

SECTION V      SPECIALTY INFORMATION

Primary Specialty ________________________________  ☐Qualified ☐Certified ☐Not Applicable

State Certified __________________  Board Name __________________

Date of initial certification ____________________ Expires __________________

Sub Specialty ________________________________  ☐Qualified ☐Certified ☐Not Applicable

State Certified __________________  Board Name __________________

Date of initial certification ____________________ Expires __________________

Sub Specialty ________________________________  ☐Qualified ☐Certified ☐Not Applicable

State Certified __________________  Board Name __________________

Date of initial certification ____________________ Expires __________________
SECTION VI REQUIRED DOCUMENTATION

Please see Appendix A for the Required Documents by Provider Type.
**SECTION VII  APPLICANT’S SSN & TAX ID**

<table>
<thead>
<tr>
<th>Applicant’s SSN</th>
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</table>

*If the applicant is an individual,* the EIN / Tax ID is the applicant’s EIN / Tax ID. *It is not to be the EIN or Tax ID of the group, clinic, hospital or facility for an individual applicant. It is the individual applicant’s tax information. Only the Billing/Pay-to provider on the claim receives the payments.*

*Otherwise if the applicant is a group, clinic, facility or hospital enter their EIN*

<table>
<thead>
<tr>
<th>Applicant’s EIN or TAX ID</th>
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</table>

**SECTION VIII  OFFICE HOURS & INFORMATION**

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
</table>

Do you currently:

- Accept new patients into your practice? Y N
- Accept new patients from referral only? Y N

Does the office:

- Have 24-hour telephone coverage? Y N
- Have capability for electronic billing? Y N
- Meet Americans with Disabilities Act accessibility standards? Y N

**SECTION IX  CLINICAL LABORATORY CLIA INFORMATION**

Do you bill for diagnostic radiology or clinical laboratory services under your supervision? □ Yes □ No

If Yes, please indicate the following:

- ? Radiology or ionizing services? Clinical laboratory services

  CLIA # ____________________________________________________

**SECTION X  PROFESSIONAL LICENSURE**

*List all current professional licenses. Please attach copies.*

<table>
<thead>
<tr>
<th>State</th>
<th>Type</th>
<th>Number</th>
<th>Issue Date</th>
<th>Expiration Date</th>
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<th>Expiration Date</th>
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</tbody>
</table>
SECTION XI  CERTIFICATIONS/REGISTRATION

Please attach copies of any of the following certifications if held. Attach a separate sheet if necessary.

Federal DEA Registration Number ________________________________________________________
  Date Issued ____________________  Expiration Date ______________________

State CDS Number __________________________  State _____________________________________
  Date Issued _________________    Expiration Date ______________________

CPR certified?    ? Yes  ? No  Expiration Date _____________________________
  If Yes, list classifications
  ______________________________________________________
  ______________________________________________________

International Graduates: Are you ECFMG certified?  ? Yes  ? No
  USMLE/ECFMG Number ____________________  Issue Date ______________________

Nursing Professionals: Please list any certifications held

<table>
<thead>
<tr>
<th>Certification ID or Name</th>
<th>Received From</th>
<th>Expiration (MM/YYYY)</th>
</tr>
</thead>
<tbody>
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</table>

SECTION XII  BEHAVIORAL HEALTH PROVIDERS/PRACTITIONERS

If you practice Behavioral Health, please complete this section.
  Please attach copies of any certifications held.

Do you offer emergency appointments (within 24 hours of call)?  □ Yes  □ No
Do you treat younger children (age 0-5)?  □ Yes  □ No
Do you treat older children (age 6-12)?  □ Yes  □ No
Do you treat adolescents (age 13-17)?  □ Yes  □ No
Do you treat adults (age 18-65)?  □ Yes  □ No
Do you treat geriatric patients (age 65 and older)?  □ Yes  □ No
Do you provide family therapy?  □ Yes  □ No
Do you provide group therapy?  □ Yes  □ No
Do you provide crisis evaluation/intervention services?  □ Yes  □ No
Are you available to see clients at least 4 full days a week?  □ Yes  □ No
What is the average waiting time to obtain an appointment?  ______________________
**SECTION XIII  DENTAL PROVIDERS / PRACTITIONERS**

*If you are a Dental Provider, please complete this section. Please attach copies of any licenses held.*

Licensure Status (please check all that apply and indicate licensure information in Section V)

- [ ] General dental license
- [ ] Limited dental license
- [ ] Teacher’s dental license
- [ ] Inactive dental license
- [ ] Other _____________________________________________

Are you recognized as a Specialist by the Dental Board?  
[ ] Yes  [ ] No

If Yes, please specify ___________________________________________________________________

Do you hold a permit to administer general anesthesia?  
[ ] Yes  [ ] No

Do you hold a permit to administer conscious sedation?  
[ ] Yes  [ ] No

Do you utilize nitrous oxide in your practice?  
[ ] Yes  [ ] No

**SECTION XIV  VISION PROVIDERS/PRACTITIONERS**

*If you are a vision provider, please complete this section. Please attach copies of any certifications held.*

Which of the following are you certified to use or prescribe?

- [ ] Topical Ocular Diagnostic Pharmaceutical Agents
- [ ] Therapeutic Pharmaceutical Agents
- [ ] Diagnostic Pharmaceutical Agents
- [ ] Does your office have an on-site lab?  [ ] Yes  [ ] No
If you are a hospital or facility, please complete this section.

Name of Facility/Institution ______________________________________________________________

Type of Facility/Institution ______________________________________________________________

Name of Administrator _________________________________________________________________

Telephone Number _____________________________________________________________________

Name of Medical Director _______________________________________________________________

Telephone Number _____________________________________________________________________

Licensed Bed Capacity (if applicable) ______________________________________________________

Name of Comptroller (if applicable) _______________________________________________________

Telephone Number _____________________________________________________________________

Facility/Institution License Number _______________________________________________________

State ____________________________________  Effective Date _______________________________

Tax Identification Number _______________________________________________________________

Drug Enforcement Agency (DEA) Number _________________________________________________

Is the facility/institution Medicare certified?  □ Yes  □ No

Accreditation Date (if applicable) _________________________________________________________

Medicare Provider Number _________________________  Medicare Effective Date ________________

UPIN (if applicable) ____________________________________________________________________

Please enter 1 for services provided by staff and enter 2 for services provided under contract.

___ Clinical Laboratory  ___ Dentistry  ___ Diagnostic Radiology

___ Educational  ___ Nursing  ___ Occupational Therapy

___ Outpatient Speech Pathology  ___ Pharmacy  ___ Physical Therapy

___ Podiatry  ___ Psychological Services  ___ Recreational Activities

___ Speech Pathology  ___ Other Services

Name of Peer Review Organization (PRO) services organization ________________________________

_____________________________________________________________________________________

Address ______________________________________________________________________________

Telephone Number _____________________________________________________________________
### SECTION XVI  OUT OF STATE HOSPITALS/FACILITIES

*If you are an out-of-state hospital or facility, please complete this section in addition to Section IX.*

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Percent of Charges</th>
<th>Per Diem or Visit All-Inclusive</th>
<th>Fee for Service</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Are physician services and components included in your cost?  □ Yes  □ No
Separately?  □ Yes  □ No

### SECTION XVII  PHARMACY PROVIDERS

*If you are a pharmacy provider, please complete this section.*

Name of Pharmacy ________________________________________________
Doing Business As ________________________________________________
Chief Pharmacist ________________________________________________
Title ____________________________________ Phone ___________________

Please list information for all pharmacists providing services at your location.

<table>
<thead>
<tr>
<th>Name of Pharmacist</th>
<th>License Number</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Occupancy Permit Number __________________________________________
NABP Number ________________________________ NABP Effective Date __________

Please list any additional services, excluding drugs that are provided to the District Medicaid recipient.

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
If you are a transportation provider, please complete this section.

Check one or more of the following boxes to indicate whether your company has obtained authority to transport passengers for hire from any federal or state agency.

- Provider has not obtained authority to transport passengers for hire with any agency.
- Provider has obtained authority from the Washington Metropolitan Area Transit Commission (WMATC).
- Provider has obtained authority from the Maryland Public Service Commission (MDPSC).
- Provider has obtained authority from the State of Virginia Department of Motor Vehicles.

Check the box that corresponds to the amount of automobile insurance currently in force for your company.

- $1.5 million
- $5 million
- Other ($ ____________)
- Uninsured

Does your company have a current safety rating from the United States Department of Transportation (USDOT) or the Federal Highway Administration?  

Yes  No

If Yes, what is the rating? _______________________________________________________________

If the rating was satisfactory or conditional, please attach the notice of safety rating.

Check all that apply.

- Ambulance
- Wheelchair Equipped Van
- Stretcher
- Taxicab
- Other, please describe

Please complete the table below for all vehicles in your fleet. Attach additional pages if necessary.

Maximum seating capacity should include driver and assistant and include ambulatory (A) vs. non-ambulatory (W) wheelchair loads (i.e., 3 wheelchairs and 6 ambulatory).

<table>
<thead>
<tr>
<th>Fleet Vehicle Number</th>
<th>Type of Vehicle as defined above</th>
<th>Vehicle Identification Number</th>
<th>Make and Model of Vehicle</th>
<th>License Plate Number</th>
<th>Maximum Seating Capacity</th>
<th>Is vehicle owned or leased?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Please list all motor vehicle operators who will be employed in the transporting of DC Medicaid patients – not applicable to air transportation providers. Attach additional pages if necessary.

<table>
<thead>
<tr>
<th>Full legal name of operator</th>
<th>Age of operator</th>
<th>Driver’s License Number &amp; jurisdiction issued</th>
<th>Vehicle number in which operator will be assigned</th>
<th>Background check performed?</th>
<th>Drug screening performed?</th>
<th>Is vehicle owned or leased by carrier?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Facility Name</td>
<td>Street Address</td>
<td>City/State/Zip</td>
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<tr>
<td>Staff Category</td>
<td>Status of Privileges</td>
<td>Dates of Affiliation</td>
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Any past or present restriction of privileges? (If Yes, explain on next page)

Is this your Primary Facility?

Facility Name

Street Address

City/State/Zip
SECTION XX  GROUP AFFILIATIONS

☐ If you selected Individual in Section I, list the Group(s) you are currently a member.
  
  ☐ If the Group you are to be a member is a new Group that does not have a DC Medicaid ID#, the group must be enrolled first. Then the members enrolled and any new providers being enrolled into the DC Medicaid program can be added to the group provider.

☐ If you selected Group in Section I, please list your active member providers below. Attach additional sheets if necessary.

*Special note: If you are enrolling as a Clinic, Hospital or as a Facility in Section I, then there are no members to be affiliated with these facilities.*

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>DC Medicaid Provider Number</th>
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14
SECTION XXI  PROFESSIONAL LIABILITY INSURANCE COVERAGE

Please provide information on professional liability insurance for the past five (5) years.

Carrier Name ___________________________________________
Carrier Address __________________________________________
Agent Name ____________________________ Policy Number ____________________________
Policyholder ____________________________________________
Amount of Coverage ______________________________________
| Coverage amount per occurrence | Coverage amount per aggregate |
Dates of Coverage from ______ to ______
Type of Coverage □Claims Made □Occurrence

Carrier Name ___________________________________________
Carrier Address __________________________________________
Agent Name ____________________________ Policy Number ____________________________
Policyholder ____________________________________________
Amount of Coverage ______________________________________
| Coverage amount per occurrence | Coverage amount per aggregate |
Dates of Coverage from ______ to ______
Type of Coverage □Claims Made □Occurrence

Carrier Name ___________________________________________
Carrier Address __________________________________________
Agent Name ____________________________ Policy Number ____________________________
Policyholder ____________________________________________
Amount of Coverage ______________________________________
| Coverage amount per occurrence | Coverage amount per aggregate |
Dates of Coverage from ______ to ______
Type of Coverage □Claims Made □Occurrence
SECTION XXII MALPRACTICE CLAIMS HISTORY

Please provide information for all cases occurring in the past ten (10) years, beginning with the most recent. Attach additional sheets if necessary.

☐ None

Date of Occurrence __________________________  Date Claim Filed __________________________

Professional liability carrier involved ______________________________________________________

You were: ☐ Primary Defendant ☐ Co-Defendant

Other Defendants (if any) _______________________________________________________________

Describe the allegations against you ______________________________________________________

Describe the alleged injury to the patient __________________________________________________

Claimant/Plaintiff filed suit in court? ☐ Yes ☐ No  If Yes, Date Filed ________________________

State Court Case Number ____________________ State _______________ County ________________

Federal Court (U.S. District Court) Case Number ______________________ District _______________

Present status of the claim/case
☐ Pending  ☐ Settled  ☐ Arbitrated  ☐ Awarded
☐ In Appeal  ☐ Adjudicated  ☐ Withdrawn  ☐ Other ________

Please provide additional information/explanation (e.g., the condition/diagnosis of the patient at the time of the incident, treatment rendered and the condition of the patient subsequent to treatment)

Date of Occurrence __________________________  Date Claim Filed __________________________

Professional liability carrier involved ______________________________________________________

You were: ☐ Primary Defendant ☐ Co-Defendant

Other Defendants (if any) _______________________________________________________________

Describe the allegations against you ______________________________________________________

Describe the alleged injury to the patient __________________________________________________

Claimant/Plaintiff filed suit in court? ☐ Yes ☐ No  If Yes, Date Filed ________________________

State Court Case Number ____________________ State _______________ County ________________

Federal Court (U.S. District Court) Case Number ______________________ District _______________

Present status of the claim/case
☐ Pending  ☐ Settled  ☐ Arbitrated  ☐ Awarded
☐ In Appeal  ☐ Adjudicated  ☐ Withdrawn  ☐ Other ________

Please provide additional information/explanation (e.g., the condition/diagnosis of the patient at the time of the incident, treatment rendered and the condition of the patient subsequent to treatment).
## SECTION XXIII  ADDITIONAL QUESTIONS

1. Have any of your board certifications ever been suspended, revoked, or voluntarily surrendered? □ Yes □ No

2. Have any of your professional licenses, in any state, ever been limited, sanctioned, voluntarily/involuntarily restricted, denied, revoked, suspended, surrendered, subjected to a consent order, placed on probation or cancelled? □ Yes □ No

3. Has your DEA license or state CDS certification ever been voluntarily or involuntarily suspended, restricted, revoked, surrendered, denied, or otherwise limited? □ Yes □ No

4. Have your privileges at any hospital, facility, HMO, or health plan been voluntarily or involuntarily surrendered, denied, suspended, revoked, restricted, limited, or placed on probation? □ Yes □ No

5. Have you ever been placed on probation or asked to resign from an internship, residency or other training program? □ Yes □ No

6. Have you ever been named a Defendant in any criminal case, other than misdemeanor traffic violation? □ Yes □ No

7. Has your malpractice insurance ever been cancelled, suspended, restricted, limited, special rated, or not renewed? □ Yes □ No

8. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified (terminated, suspended, restricted, revoked, limited, cancelled)? □ Yes □ No

9. Has information pertaining to you ever been reported to the National Practitioner Data Bank? □ Yes □ No

10. Have you ever been sanctioned or otherwise disciplined for a violation of ethical standards by a professional organization and/or a licensing board? □ Yes □ No

11. Are you engaged in the illegal use of drugs? □ Yes □ No

12. Within the last five (5) years, have you been sanctioned, reprimanded or otherwise disciplined in any manner by any state licensing authority or other professional board or peer committee for conduct related to the use of alcohol or the use of drugs? □ Yes □ No

13. Have you ever been the subject of a focused review by a peer review organization or similar agency including, but not limited to, Medicare, Medicaid, etc.? □ Yes □ No

14. Have you ever received sanctions from a regulatory agency (e.g., CLIA, OSHA, etc.)? □ Yes □ No

15. Do you, or your business entity, own, have an investment in, manage, own stock in, participate in a joint venture, or act as a partner, contract consultant or medical/dental advisor in any medical/dental enterprise or medical/dental supplier outside of your direct practice where you would financially benefit directly or indirectly? □ Yes □ No

If so, please provide the following information:

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>Type of Organization</th>
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<tbody>
<tr>
<td>Mailing Address of Organization</td>
<td></td>
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<tr>
<td>Telephone Number</td>
<td>Tax ID Number</td>
</tr>
<tr>
<td>Percent of Business Owned/Invested by You</td>
<td>Nature of Business Investment (owner, partner, investor, etc.)</td>
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IF YOU ANSWERED “YES” TO ANY OF THE ABOVE, PLEASE PROVIDE AN EXPLANATION FOR EACH AFFIRMATIVE RESPONSE IN SECTION XIX.

SECTION XXIV   EXPLANATION

Please use this space to provide any necessary explanation from previous sections. Please indicate the Section and question number.

_____________________________________________________________________________________
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I authorize the DC Department of Health Care Finance and its affiliates, subsidiaries or related entities to consult with hospital administrators, members of medical staffs of hospitals, malpractice carriers, licensing boards, professional organizations, and other persons to obtain and verify information and I release the carrier and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application; and,

I consent to the release by any person to the carrier of all information that may be reasonably relevant to an evaluation of my professional competency, character, and moral and ethical qualification, including any information relating to any disciplinary action, suspension or limitation of privileges, and hereby release any such person providing such information from any and all liability for doing so.

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I further agree to notify the carrier of any change to the information provided in this application within thirty (30) days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by the carrier.

________________________________________      __________________________________________
Applicant Signature     Date

________________________________________      __________________________________________
Applicant’s Printed Name    Telephone

Mailing Address
DEPARTMENT OF HEALTH CARE FINANCE

MEDICAID PROVIDER AGREEMENT

Name of Provider ________________________________________________________________

Address _________________________________________________________________________

Title XIX Provider Number __________________________________________________________

This Agreement made and entered into this _____ day of ______________, 20 ___, by and between the District of Columbia Department of Health Care Finance, hereinafter designated as the Department, and the above-named, a Provider of Services, whose address is, as stated above, hereinafter designated as the Provider.

Witnesseth:

WHEREAS, persons receiving public assistance payments from the Department of Health Care Finance and other persons eligible for care and under the Medical Assistance Program operating under Title XIX of the Social Security Act, are in need of medical care;

WHEREAS, Section 1902(a)(27) of Title XIX of the Social Security Act requires the District of Columbia to enter into written agreement with every person or institution providing services under the State’s Plan for Medical Assistance (Title XIX);

WHEREAS, pursuant to Commissioner’s Order 70-83 and PL-90-227 which makes the DC Department of Health Care Finance the agency responsible for administering the Medical Assistance Program (Title XIX) in the District of Columbia, and authorize the Department of Health Care Finance to take all necessary steps for the proper and efficient administration of the District of Columbia Medical Assistance Program;

WHEREAS, to participate in the District of Columbia Medical Assistance Program, the provider when applicable, must: (1) be licenses in the jurisdiction where located and/or the District of Columbia; (2) be currently in compliance with standards for licensure; (3) services be administered by a licensed or certified practitioner; and, (4) comply with applicable Federal and district standards for participation in Title XIX of the Social Security Act, and;

WHEREAS, prospective provider has filed an application with the Department to provide medical services to persons eligible under the Medical Assistance Program operated under Title XIX of the Social Security Act and said application is incorporated by reference into this Agreement and made a part hereof the same as if it were written herein.
The Provider agrees:

I. GENERAL PROVISIONS

A. To provide to Medicaid patients, services as covered in Title XIX of the Social Security Act and the State Plan of Medical Assistance.

B. To accept as payment for supplying the services in “A” above, a reimbursement rate calculated in accordance with the District State Plan for Medical Assistance;

   1. The provider’s payment shall be accepted as payment in full for the care of the patient, and;

   2. No additional charge shall be imposed on the patient, member of his family or to another source for any supplementation for any time except as allowed within Federal and District regulation.

C. To satisfy all requirements of the Social Security Act, as amended, and be in full compliance with the standards prescribed by Federal and State standards.

D. To accept such amendments, modifications or changes in the program made necessary by amendments, modifications or changes in the Federal or State standards for participation.

E. To comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, 42 CFR Parts 80, 84 and 90, the Americans with Disabilities Act, P.L. 101-336, any amendments thereto and the rules and regulations there under.

F. To maintain all records relevant to this Agreement at his/her cost, for a period of six years or until all audits are completed, whichever is longer. Such records shall include all physical records originated or prepared pursuant to performance under this Agreement, including but not limited to, financial records, medical records, charts and other documents pertaining to costs, payments received and made, and services provided to covered Medicaid recipients.

G. To provide full access to these records to authorized personnel of the Department, the United States Department of Health and Human Services, the Comptroller General of the United States or any of their duly authorized representatives for audit purposes.

H. To furnish upon request to the Medicaid agency, the Federal Government or their designees, information related to business transactions in accordance with 42 CFR & 455.105(b);

I. To hold harmless the District of Columbia Government, the Department and Medicaid recipients against any loss, damage, expense and liability of any kind arising out of any action of the provider or its subcontractors arising out the performance of this agreement.

J. To comply with the advance directive requirements contained in 42 CFR, Part 489, Subpart I, as appropriate.
K. To complete and sign a Provider Application to participate in the Medical Assistance Program (Title XIX), and to keep the information in the application current with the understanding that the application becomes a part of this agreement and that each succeeding change in the application constitutes an amendment to the Agreement and failure to keep the information current constitutes a breach of the Agreement.

   a. To provide assurances of compliance with:

D.C. Law 12-238 which prohibits Medicaid providers from offering employment or contracting with any person who is not a licensed healthcare professional until a criminal background check has been conducted for the person and also prohibits any facility from employing or contracting with any person who has been convicted of certain criminal offenses specified in the law;

42 USC § 31306 and 49 CFR 382 which requires employers of commercial drivers to conduct pre-employment, reasonable suspicion, and post-accident testing for controlled substances; and, The Drug-Free Work Place Act of 1988 (21 USC § 701 et seq.), which requires the implementation of an alcohol and drug-testing program.

   b. That any breach of violation of any one of the above provisions shall make this entire Agreement, at the Department’s option, subject to immediate cancellation or imposition of enforcement remedies in conformance with Federal and District laws and regulations.

II. REQUIRED INFORMATION

A. A description of ownership and a list of major owners (stockholders owning or controlling five percent or more outstanding shares);

B. A list of Board members and their affiliations;

C. A roster of key personnel, their qualifications and a copy of their position descriptions. Key personnel including: the President and Vice-President, Chief Executive Officer, Chief Medical Officer, Chief Financial Officer, Director of Nursing, Director of Quality Improvements/Quality Assurance;

D. Copies of licenses and certifications for all staff providing medical services;

E. The address of all sites at which services will be provided to Medicaid recipients;

F. Copy of the most recent audited financial statement of the organization;

G. A completed provider application;

H. A copy of the basic organizational documents of the provider, including an organizational chart and current articles of incorporation;

I. A copy of the by-laws or similar documents regulating conduct of the provider’s internal affairs;
J. A copy of the business license;

K. A copy of Joint Commission on Accreditation of Health Care Organization’s certification;

L. A copy of Certificate of Need approval; and,

M. The submission of any other documentation deemed necessary the Department for the approval process as a Medicaid Provider.

III. CONTRACT AND SUBCONTACTS

A. The Department or the provider may terminate this Agreement for convenience by giving 90 days written notice or intent to terminate the Agreement to the party.

B. The provider shall be legally responsible for all activities of its contractor and subcontractors and for requiring that they conform to the provisions of this Agreement. Subject to such conditions any service or function required by the provider pursuant to this Agreement may be subcontracted to any person or organization who/which meets all Federal and District requirements for participation in Medicaid, whether or not they are enrolled as Medicaid providers.

C. Sub-contractual agreement with providers who have been convicted of certain crimes or received certain sanctions as specified in Section 1128 of the Social Security Act is prohibited. Services provided to Medicaid eligible recipients through such subcontracts shall not be eligible for reimbursement by the Department.

D. The Department reserves the right to require the Provider to furnish information relating to the ownership of the subcontractor, the subcontractor’s ability to carry out the proposed obligations, assurances that the subcontractor shall comply with all applicable provisions of Federal and District law, and regulations pertaining to Title XIX of the Social Security Act and the State Plan for Medical Assistance and with all Federal and District laws and regulations applicable to the service or activity covered by the contract; the procedures to be followed by the provider in monitoring or coordinating the subcontractor’s activities and such other provisions as the Department or the Federal Government may reasonably require.

E. Each subcontract shall contain a provision that the subcontractor shall look solely to the provider for payment of covered services rendered.

IV. PAYMENT TO PROVIDER

A. The Department shall reimburse providers for services to eligible Medicaid recipients in accordance with the District’s State Plan of Medical Assistance.

B. The provider shall submit invoices for payment according to the Department’s requirements.

C. The Department shall make payments to the provider in accordance with applicable laws, as promptly and as feasible after a proper claim is submitted and approved.
D. The Department shall notify the provider of any major changes in Title XIX rules and regulations and in the State Plan of Medical Assistance.

V. THIRD PARTY LIABILITY RECOVERY

A. The provider shall utilize and require its subcontractors to utilize, when available, covered medical and hospital services or payments from other public or private sources, including Medicare.

B. The provider shall attempt to recover, and shall require its subcontractors to attempt to recover, monies from third party liability cases involving workers’ compensation, accidental injury insurance and other subrogation of benefit settlements.

C. The Department shall notify the provider of any reported third party payment sources.

D. The provider shall verify third party payment sources directly, when appropriate.

E. Payment of State and Federal funds under the District’s State Plan for Medical Assistance to the provider shall be conditional upon the utilization of all benefits available from such payment sources.

F. Each third party collection by a provider for a Medicaid recipient shall be reported to the Department and all recovered monies shall be returned to the Department immediately upon recovery.

VI. SANCTIONS FOR NON-COMPLIANCE

If the Department determines that a provider has failed to comply with the applicable Federal or District law or rule, or any law or order that prohibits discrimination on the basis of race, age, sex, national origin, marital status or physical or mental handicap, the Department may do all of the following:

A. Withhold all or part of the providers’ payments; and/or,

B. Terminate the Agreement within 30 days from date of notice to the provider

C. Before taking action described in VI, A & B, the Department shall provide written notice to the provider which shall include:

1. Identification of the sanction to be applied;

2. The basis for the Department’s determination that the sanction should be taken;

3. The effective date of the sanction; and,

4. The timeframe and procedure for the provider to appeal the Department’s determination.

D. The termination of the Agreement shall not discharge the responsibilities of either party with respect to services or items furnished prior to termination, including retention of records and verification of overpayment or underpayment.
E. Upon termination, the provider shall submit to the Department all outstanding invoices for allowable services rendered prior to the date of termination in the form prescribed by the Department. Invoices submitted not later than thirty (30) days following the termination date shall be paid.

F. The provider also shall submit to the Department all financial performance and other reports required as a condition to this Agreement within ninety (90) days of the termination date.

G. The Department reserves the right to terminate this Agreement immediately if:
   
   1. The United States Department of Health withdraws Federal financing participation in all or part for the cost of covered services;

   2. District funds are unavailable for the continuation of the Agreement;

   3. The Department is notified by the appropriate District agencies, or other appropriate licensing or certifying bodies that the licenses and/or certification under which it operates have been revoked, expired and/or will not be renewed; or,

   4. The owners, officers, managers or other persons with substantial contractual relationships have been convicted of certain crimes or received certain sanctions as specified in Section 1128 of the Social Security Act.

H. The Department reserves the right to terminate this Agreement or take some other enforcement act consistent with Federal and District law and regulation in the event of default of the provider.

I. The following shall trigger use of an enforcement action against a provider:
   
   1. Inability of the provider to provide the services described in this Agreement;

   2. Insolvency of the provider;

   3. Failure of the provider to maintain its licensure or accreditation;

   4. Violation of any provision of applicable Federal or District law or implementing rules.

J. The provider shall be responsible for providing written notice to recipients thirty (30) days prior to the effective date of the termination in the form prescribed by the Department and shall be responsible for notifying the Department of those recipients who are undergoing treatment of an acute condition.

K. The Department may, at its sole discretion, offer to re-negotiate any provision of this Agreement if such re-negotiation would mitigate or eliminate any of the causes of termination specified.
VII. ASSIGNMENT OF RIGHTS

The rights, benefits and duties included under this Agreement shall not be assignable by the provider without receiving the written approval of the Department. The Department, as a condition of granting such approval, shall require that such assignees be subject to all conditions and provisions of this Agreement and all Federal laws and rules governing the assigned Agreement.

VIII. TERMINATION OR REDUCTION OF THE DEPARTMENT’S SOURCE OF FUNDING

The Department’s obligation to pay funds for the purpose of this Agreement is limited solely to availability of Federal and District funds for such purposes. No commitment is made by the Department to continue or expand such activities.

IX. CONFIDENTIALITY OF INFORMATION

A. All information, records and data collected and maintained by the provider or its subcontractor relating to eligible Medicaid recipients shall be protected by the provider from unauthorized disclosure;

B. Except as otherwise provided in Federal law or rules, use or disclosure of information concerning recipients shall be restricted to purposes directly related with the administration of the Medicaid program;

C. Purpose directly related to the Medicaid program shall include the following:
   1. Establishing eligibility;
   2. Providing services; and,
   3. Conducting or assisting in an investigation, prosecution, civil or criminal proceeds relating to the administration of the Medicaid program.

D. The type of information to be safeguarded shall include all information listed in 42 CFR 431.305.
X. EFFECTIVE DATE

The effective date of agreement for provider payments shall be on the date the provider attains participating status as determined by the Department under Federal and District regulations, and that such determination shall be made a part of this Agreement.

I/We agree that the receipt by the D.C. Medicaid program of the first and each succeeding claim for payment from me/us will be the Medicaid program’s understanding of my/our declaration that the provisions of this Agreement and supplemental providers manuals and instructions have been understood and complied with:

_________________________________________________________________________________
Provider’s Signature __________________________

_________________________________________________________________________________
Corporate Name of the Group, Institute, Medical Facility, Firm or Government
(i.e., the Provider Entity)

Address __________________________

Phone Number

Signature of individuals responsible to enforce compliance with these conditions

_________________________________________________________________________________
Chief Executive Officer (if applicable) __________________________

Date

_________________________________________________________________________________
Chief Medical Officer (if applicable) __________________________

Date

_________________________________________________________________________________
Principal Corporate Officer (if applicable) __________________________

Date

Accepted by:

_________________________________________________________________________________
Provider Enrollment __________________________

Health Care Operations Administration

Department of Health Care Finance

Date

For Official Use Only

D.C. Medicaid Provider Number Assigned: ________________________________
General Instructions
For definitions, procedures and requirements, refer to the appropriate Regulations:

<table>
<thead>
<tr>
<th>Title</th>
<th>Regulation</th>
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</thead>
<tbody>
<tr>
<td>V</td>
<td>42CFR 51a.144</td>
</tr>
<tr>
<td>XVIII</td>
<td>42CFR 420.200-206</td>
</tr>
<tr>
<td>XIX</td>
<td>42CFR 455.100-106</td>
</tr>
<tr>
<td>XX</td>
<td>45CFR 228.72-73</td>
</tr>
</tbody>
</table>

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original copy to the State agency: retain the photocopy for your files.

DETAILED INSTRUCTIONS
These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

Item I — Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

Item II- Self-explanatory

Item III- List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined, as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A’s interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity, which may be maintained, by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV-VII- Changes in Provider Status
Change in provider status is defined as any change in management control.

Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the ownership partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation or any change of ownership.

For Items IV-VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV - (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate that date in the appropriate space.

Item V - If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VII- A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII - If yes, list the actual number of beds in the facility now and the previous number.
DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

II. 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 under Remarks on page 2. Identify each item number to be continued.

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

☐ Yes ☐ No

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

☐ Yes ☐ No

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution’s organization’s, or agency’s fiscal intermediary or carrier within the previous 12 months? (Title XVII providers only)

☐ Yes ☐ No

III. (a.) List names, addresses for individuals, or the EIN for organization having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under “Remarks” on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

<table>
<thead>
<tr>
<th>Name</th>
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(b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation
☐ Unincorporated Associations ☐ Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions
(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

☐ Yes ☐ No

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Provider Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### IV. (a) Has there been a change in ownership or control within the last year?
- Yes □  No □
  
  If yes, give date ____________________

### (b) Do you anticipate any change of ownership or control within the year?
- Yes □  No □
  
  If yes, when? ____________________

### (c) Do you anticipate filing for bankruptcy within the year?
- Yes □  No □
  
  If yes, when ____________________

### V. Is this facility operated by a management company, or leased in whole or part by another organization?
- Yes □  No □
  
  If yes, give date of change in operations _______________________________

### VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year?
- Yes □  No □

### VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)
- Yes □  No □
  
  Name
  
  EIN#
  
  Address

### VIII. 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 change _____________
  
  Current Beds ____________  Prior beds _______________

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF 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 D. C. STATE AGENCY AS APPROPRIATE.

<table>
<thead>
<tr>
<th>Name of Authorized Representative (Type)</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Remarks
The National Provider Identifier (NPI) final rule, Federal Register 45CFR Part 162, was published on January 23, 2004 by the Department of Health Care Finance (DHCF) as part of the Health Insurance Portability and Accountability Act (HIPAA). The rule established the NPI as the standard unique identifier for health care providers to be used in HIPAA-covered transactions. The rule requires covered health care providers, clearinghouses, and health plans to use this identifier in HIPAA-covered transactions.

All DC Medicaid healthcare providers must provide DHCF with their NPI information. Please complete the below information and return with your Medicaid Enrollment Application. If you do not have an NPI yet, you may obtain one at https://nppes.cms.hhs.gov/NPPES/Welcome.do. If you do not meet the definition of ‘healthcare provider’ as defined under HIPAA, this form is not required.

If you are a healthcare provider please provide your NPI that was issued by National Plan & Provider Enumeration System (NPPES) in the space below. Please also provide your taxonomy code that is currently on file with NPPES.

NPI

Taxonomy Code

If this application is for an organization, please supply additional NPIs and taxonomy codes on a separate sheet.

I certify this information to be true and accurate.
Dear Provider:

The Department of Health Care Finance (DHCF) is pleased to announce a new initiative to increase the number of Medicaid providers enrolled in the EFT/ACH program via the National Automated Clearinghouse Association (NACHA) network. DHCF is committed to achieving the goal of 100 percent of Medicaid providers enrolled in the EFT/ACH program by the end of FY 2012. The EFT/ACH program eliminates the possibility of lost checks as well as allows for faster access to funds. The enrollment process is easy and only takes a few minutes.

In order to enroll:

1. Complete Section A on the enclosed ACH Vendor Payment Enrollment form.
2. Forward or take the enrollment form to the branch manager or banking official at your depository bank/financial institution for verification of your company's ACH account information. Have the bank complete and sign Section B on the enrollment form.
3. Complete the Supplier/Vendor Information form (new EFT/ACH applicants ONLY).
4. Attach a signed W-9 form (new Medicaid providers ONLY).

Completed enrollment forms should be sent directly to:

Department of Health Care Finance  
Attn: Division of Public and Private Provider Services  
609 H Street, NE  
Second Floor  
Washington, DC  20020

Please allow four to six weeks to establish your direct deposit account. Questions should be directed to the Division of Public and Private Provider Services at 202-698-2000.

Sincerely,

Division of Public and Private Provider Services  
Health Care Operations Administration

Enclosures:  
EFT/ACH Enrollment Form  
Supplier/Vendor Information Form  
Frequently Asked Questions (FAQs)
**Section A**

**ACH VENDOR PAYMENT ENROLLMENT FORM**

<table>
<thead>
<tr>
<th>New Form</th>
<th>Correction/Change</th>
<th>Cancellation</th>
</tr>
</thead>
</table>

**Vendor/Payee/Company Information**

<table>
<thead>
<tr>
<th>Vendor Name*</th>
<th>EIN or SSN*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vendor Number*</td>
<td></td>
</tr>
<tr>
<td>Address*</td>
<td>Vendor Contact</td>
</tr>
<tr>
<td>Name*</td>
<td>Phone Number*</td>
</tr>
<tr>
<td>Alternative Phone Number</td>
<td></td>
</tr>
</tbody>
</table>

*Required

I (we) hereby authorize the District of Columbia to initiate credit entries to my (our) account. If funds to which I am not entitled to are deposited to my account, I (we) authorize the District of Columbia to direct the financial institution to return said funds. This authorization is to remain in effect until the District of Columbia receives written notification of revocation.

Name & Title of Authorizing Official for Vendor (Please type or print)

Signature of Authorizing Company Official for Vendor

Date

**Section B**

**Payments should be made to the depository account named below**

<table>
<thead>
<tr>
<th>Bank/Financial Institution Information (to be reviewed and signed by Vendor's Financial Institution)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank/Financial Institution Name</td>
</tr>
<tr>
<td>Branch Address</td>
</tr>
</tbody>
</table>

9-digit Transit Routing Number

<table>
<thead>
<tr>
<th>Account Number</th>
</tr>
</thead>
</table>

Bank's ACH Coordinator

<table>
<thead>
<tr>
<th>Telephone Number</th>
</tr>
</thead>
</table>

Type of Account

- [ ] Checking
- [ ] Savings

Signature & Title of Banking Official

Print Name & Title

Notice: All vendors must have a W-9 on file with the District of Columbia
GOVERNMENT OF THE DISTRICT
OF COLUMBIA

SUPPLIER/VENDOR INFORMATION FORM

New Vendor [ ] CHECK
New Payment Address [ ] ONLY
New Business Address [ ] ONE
Deactivation [ ]

Business Entity
V/N

Supplier/Vendor
Type: ______
(From Page 2)

Ownership Code: ______
(From Page 2)

Individual
V/N

Supplier/Vendor
Type: ______
(From Page 2)

Ownership Code: ______
(From Page 2)

Payment Address

One Time Payment: [ ]

3. To which all payments will be sent:
Suite/Room: __________________________
Street: __________________________
City: _______ State: _______ Zip: _______
Telephone __________________________
Fax: __________________________

Additional Payment Address

4. New additional payment address:
Suite/Room: __________________________
Street: __________________________
City: _______ State: _______ Zip: _______
Telephone __________________________

Authorization

5. INFORMATION PROVIDED BY: __________________________
Print or Type Name of Requestor

Date Faxed ______/____

URGENT: Court Order: [ ]

Title __________________________
Phone __________________________
Fax __________________________

3 digit Agency Code

DCGR 1710 Emergency: [ ]

Agency Chief Contracting Officer (ACCO) __________________________
Date __________________________

Agency Chief Financial Officer (ACFO) __________________________
Date __________________________

(FMS Form 710R (REV. 3/02)

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## VENDOR INFORMATION FORM

**FAX OR DELIVER TO:**
DIVISION OF VENDOR ENTRIES
810 FIRST STREET, N.E.
SUITE 200
WASHINGTON, DC 20002
FAX: (202) 442-8217
For Assistance, call Division of Vendor Entries at (202) 442-8269

<table>
<thead>
<tr>
<th>Vendor Type</th>
<th>6. (Please circle one):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Employee</td>
</tr>
<tr>
<td></td>
<td>2. Federal Agency</td>
</tr>
<tr>
<td></td>
<td>3. State Agency</td>
</tr>
<tr>
<td></td>
<td>4. Local Government</td>
</tr>
<tr>
<td></td>
<td>5. Vendor-business</td>
</tr>
<tr>
<td></td>
<td>6. Vendor-Individual</td>
</tr>
<tr>
<td></td>
<td>7. Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ownership Code</th>
<th>7. (Please circle one):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. State Corporation</td>
</tr>
<tr>
<td></td>
<td>B. Professional Corporation</td>
</tr>
<tr>
<td></td>
<td>C. State Employee</td>
</tr>
<tr>
<td></td>
<td>D. Financial Institution</td>
</tr>
<tr>
<td></td>
<td>E. Government Entity</td>
</tr>
<tr>
<td></td>
<td>F. Individual Recipient</td>
</tr>
<tr>
<td></td>
<td>G. Local Small Disadvantage Business Enterprises</td>
</tr>
<tr>
<td></td>
<td>H. Medical Corporation</td>
</tr>
<tr>
<td></td>
<td>I. Out of State Corporation</td>
</tr>
<tr>
<td></td>
<td>J. Professional Association</td>
</tr>
<tr>
<td></td>
<td>K. Foreign</td>
</tr>
<tr>
<td></td>
<td>L. Sole Ownership</td>
</tr>
<tr>
<td></td>
<td>M. Partnership</td>
</tr>
</tbody>
</table>

FMS Form 710R (REV. 3/02)
ELECTRONIC PAYMENTS INITIATIVE

FREQUENTLY ASKED QUESTIONS

How do I benefit from receiving Electronic Payments?
Electronic payments allow you to 1) eliminate the risk of mailing delays, 2) have immediate availability to funds 3) avoid the hassle of travel time to deposit checks and 4) avoid having to wait for clearance.

How can I eliminate waste and save time and money?
Automated Clearinghouse (ACH) payments are deposited directly into your bank account electronically.

How can I enroll in the Automated Clearinghouse (ACH) Program?
To enroll in the ACH program, complete Section A of the enclosed ACH Enrollment form. Forward the enrollment form to your branch manager or other banking official at your financial institution to verify the ACH account information for your company and complete Section B. Return the completed and signed form to the same agency that currently receives your invoices. If you maintain more than one bank account that receives deposits from the District of Columbia, a separate form must be completed for each account.

What is the ACH Process?
When a completed and signed application is received by the District agency, your company’s information will be updated to include your banking data and change your payment method from check to ACH.

How do I change my ACH information?
To change account information, simply complete an ACH Vendor Payment Enrollment form, indicating in Section A “Correction/Change.” Forward the document to your financial institution for completion and return it to your paying agency for processing.

How do I cancel ACH participation?
To cancel your ACH participation, complete an ACH Vendor Payment Enrollment form, indicating in Section A "Cancellation" or send a letter to your paying agency.

Who do I contact with questions?
Contact the Department of Health Care Finance at 202-698-2000 between the hours of 8 a.m. and 5 p.m., Monday through Friday, excluding holidays or send any written correspondence to:

Division of Public and Private Provider Services
Department of Health Care Finance
609 H Street, NE
2nd Floor
Washington, DC 20002