Dear Provider:

Enclosed is the District of Columbia Medicaid provider enrollment application. Please complete the application packet in its entirety. 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:

ACS 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, and are in the in the DC Metro area, please call Provider Enrollment at 202-906-8318. If you are outside the DC Metro Area, please call Provider Enrollment toll free at 1-866-752-9231.

Sincerely,

Office of Program Operations
Department of Health
Medical Assistance Administration
REQUIRED ATTACHMENTS

All Providers
- W-9 Form
- Disclosure of Ownership Form
- NPI Supplement Attachment *(healthcare providers only)*

Clinics
- Current License
- Certificate of Need (CON) license or exception letter

Day Treatment Centers
- Certificate of Need (CON) License

DC Charter Schools
- Copies of job descriptions, resumes, license & certifications of all staff providing services
- Copy of Bylaws regarding conduct of the provider’s internal affairs
- Business license or Certificate
- Certificate of Need or exception letter
- Certificate of Occupancy
- Program policies & procedures
- Quality Management plan

Dental Providers
- Current License
- Malpractice Insurance Certificate of Coverage
- DEA License

Home Health Providers
- Current License
- Certificate of Need (CON) license

Hospitals & Residential Treatment Centers
- Current Certification/Licensure in Local Jurisdiction
- Liability Insurance
- Current JCAHO Accreditation Letter
- Residential Treatment for Children and Adolescents Supplement (not applicable for hospitals)

Independent Labs
- List of Category/Sub-Category Tests and/or Procedures which the lab is certified to render under Medicare (Title XVIII)
- List of Usual and Customary Charges for each Test/Procedure certified by Medicare (Title XVIII)
- Most recent CLIA Certificate
- Current Licenses for all clinicians

Pharmacists
- State Controlled Substance
- DEA License
- State Pharmacy License
- CMS Letter

Physicians/Opticians
- Current License

Optional
- Direct Deposit Application
- EDI Application (electronic billing) – available upon request
Please check (4) your provider type. **This application is limited to one provider type.** To apply for more than one provider type, separate applications must be submitted.

<table>
<thead>
<tr>
<th>Alcohol and Substance Abuse Clinic</th>
<th>Independent Lab</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Transportation</td>
<td>LTAC Hospital</td>
</tr>
<tr>
<td>Ambulatory Surgery Center</td>
<td>MCO</td>
</tr>
<tr>
<td>Audiologist</td>
<td>Mental Health Clinic</td>
</tr>
<tr>
<td>Birthing Center</td>
<td>Mental Health Rehab Services (MHRS)</td>
</tr>
<tr>
<td>Day Treatment</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>DC Public Chartered Schools</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>Dental Clinic</td>
<td>Optician</td>
</tr>
<tr>
<td>Dentist*</td>
<td>Optometrist</td>
</tr>
<tr>
<td>Emergency Access Hospital</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Family Planning Clinic</td>
<td>Physician DO*</td>
</tr>
<tr>
<td>Federal Quality Health Center</td>
<td>Physician MD*</td>
</tr>
<tr>
<td>Freestanding Radiology</td>
<td>Podiatrist</td>
</tr>
<tr>
<td>General Hospital</td>
<td>Private Clinic</td>
</tr>
<tr>
<td>Hearing Aid Dispenser</td>
<td>Psychiatric Hospital Private</td>
</tr>
<tr>
<td>Hemodialysis Center – Freestanding</td>
<td>Psychiatric Hospital Public</td>
</tr>
<tr>
<td>Home Community Based Waiver*</td>
<td>Public Health Center</td>
</tr>
<tr>
<td>Home Health Agency</td>
<td>Radiation Therapy Center</td>
</tr>
<tr>
<td>Hospice</td>
<td>Rehabilitation Center</td>
</tr>
<tr>
<td>ICF/MR</td>
<td>Residential Treatment Center</td>
</tr>
</tbody>
</table>

*If you are a medical doctor, a doctor of osteopathic medicine, a dentist, or an institution that renders such services, please review and check the applicable specialty from the list provided on the next page.

**Specialties:**

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

**Dental Specialties**

<table>
<thead>
<tr>
<th>General Dentistry</th>
<th>Orthodontist</th>
<th>Endodontist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Surgery</td>
<td>Periodontist</td>
<td>Prosthodontist</td>
</tr>
</tbody>
</table>
### Mental Retardation Developmental Disabilities (MRDD) Waiver Specialties

<table>
<thead>
<tr>
<th>Consultants &amp; Professionals</th>
<th>Hands-On Direct Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>Personal Care Aide</td>
</tr>
<tr>
<td>Speech, Hearing &amp; Language Therapy</td>
<td>Homemaker</td>
</tr>
<tr>
<td>Nutrition Counselor</td>
<td>Respite</td>
</tr>
<tr>
<td>Caregiver Education/Family Training</td>
<td>Attendant Care Aide</td>
</tr>
<tr>
<td>Preventive &amp; Consultative Crisis Intervention</td>
<td>Chore Aide</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>Companion</td>
</tr>
<tr>
<td>Dental</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Residential Habilitation</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>Day Habilitation</td>
</tr>
<tr>
<td>Assistive Adaptive Services</td>
<td></td>
</tr>
<tr>
<td>Personal Emergency Response</td>
<td>Prevocational Habilitation</td>
</tr>
<tr>
<td>Environmental Accessibility Adaptation</td>
<td>Supportive Employment Habilitation</td>
</tr>
<tr>
<td>Adaptive Equipment</td>
<td></td>
</tr>
</tbody>
</table>

**Habilitation Services**

### Elderly and Persons with Disabilities (EPD) Waiver

<table>
<thead>
<tr>
<th>Case Management</th>
<th>Environmental Accessibility &amp; Adaptation Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Care Aide</td>
<td>Respite Service</td>
</tr>
<tr>
<td>Homemaker Services</td>
<td>Assisted Living</td>
</tr>
<tr>
<td>Chore Service</td>
<td>Consumer Directed Care</td>
</tr>
<tr>
<td>Personal and Emergency Response</td>
<td></td>
</tr>
</tbody>
</table>

### HIV-1915C Waiver

| Water Filter |
 SECTION 1
APPLICANT INFORMATION

Check the appropriate box below and complete the associated information.

ο Individual
Name (Last, First, Middle) _______________________________________________________________
Doing Business as _________________________________________________________________
Telephone ___________________________ Fax _______________________________________
Email _____________________________________________________________________________

ο Group
Group Name _________________________________________________________________________
Doing Business as _________________________________________________________________
Contact Name _________________________________________________________________
Telephone ___________________________ Fax _______________________________________
Email _____________________________________________________________________________

ο Facility
Facility Name _______________________________________________________________________
Doing Business as _________________________________________________________________
Contact Name _________________________________________________________________
Telephone ___________________________ Fax _______________________________________
Email _____________________________________________________________________________

Have you or your organization ever enrolled in DC Medicaid?  o Yes  o No
If Yes, please complete the following:
DC Medicaid Provider Number _________________________________________________________
SECTION II
OFFICE INFORMATION

Primary Office Street Address ____________________________________________________________
City/State/Zip _______________________ Ward ___________________
Office Telephone(s) ______________________________ Office Fax __________________________
Office Email __________________________ Office Manager _____________________________
Correspondence Address ________________________________________________________________
City/State/Zip _________________________________________________________________________
Type of Practice (L.L.C., Corp., etc.) ______________________________________________________
Group/Corporate Name __________________________ Federal Tax ID _______________________
Medicare # __________________________ Medicaid # ________________________________
Please list other licensed/certified professional members of your practice:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Office Hours:

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

Do you currently: (circle one)

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

Does the office: (circle one)

Have 24-hour telephone coverage? Y N
Have capability for electronic billing? Y N
Does this location have TDD? Y N
Have public transportation access? Y N
Meet Americans with Disabilities Act accessibility standards? Y N
Please complete this page if you have an additional office.

Primary Office Street Address ____________________________________________________________
City/State/Zip ___________________________ Ward __________________________
Office Telephone(s) ___________________________ Office Fax __________________________
Office Email ___________________________ Office Manager __________________________
Correspondence Address ________________________________________________________________
City/State/Zip _______________________________________________
Type of Practice (L.L.C., Corp., etc.) ______________________________________________________
Group/Corporate Name _______________________________ Federal Tax ID ________________________
Medicare # ___________________________ Medicaid # ______________________________
Please list other licensed/certified professional members of your practice:
_____________________________________________________________________________________
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_____________________________________________________________________________________
Office Hours:

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<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
</table>

Do you currently: (circle one)

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

Does the office: (circle one)

Have 24-hour telephone coverage?  Y    N  Have public transportation access?  Y    N
Have capability for electronic billing? Y    N  Meet Americans with Disabilities
Does this location have TDD?  Y    N  Act accessibility standards?  Y    N
SECTION III
BILLING INFORMATION

Payment Address ____________________________________________________________
City/State/Zip _____________________________________________________________
Remittance Address _________________________________________________________
City/State/Zip _____________________________________________________________

What type of media are you using for billing today (i.e., electronic, manual, etc.)?

____________________________________________________________________________

Do you bill for diagnostic radiology or clinical laboratory services under your supervision? o Yes o No
If Yes, please indicate the following:
ο Radiology or ionizing services ο Clinical laboratory services
CLIA # _________________________________________________________________

SECTION IV
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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<tbody>
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<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>
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?  o Yes  o No  Expiration Date ____________________________
If Yes, list classifications ________________________________________________________________

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

**Nursing Professionals:** Please list any certifications held

<table>
<thead>
<tr>
<th>Certification</th>
<th>Received From</th>
<th>Expiration (MM/YY)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
SECTION VI
SPECIALTY INFORMATION

Primary Specialty ____________________________ o Qualified  o Certified  o Not Applicable
Board Name ________________________________ Date of initial certification ____________
Board Certification expires?  o Yes  o No  If Yes, date of expiration? ______________________
Have you been recertified?  o Yes  o No  If Yes, date of recertification? ______________________
If Qualified, when does status expire? (MM/YY) ___________________________________________
Board certification results pending?  o Yes  o No

Sub-Specialty ________________________________ o Qualified  o Certified  o Not Applicable
Board Name ________________________________ Date of initial certification ____________
Board Certification expires?  o Yes  o No  If Yes, date of expiration? ______________________
Have you been recertified?  o Yes  o No  If Yes, date of recertification? ______________________
If Qualified, when does status expire? (MM/YY) ___________________________________________
Board certification results pending?  o Yes  o No

Sub-Specialty ________________________________ o Qualified  o Certified  o Not Applicable
Board Name ________________________________ Date of initial certification ____________
Board Certification expires?  o Yes  o No  If Yes, date of expiration? ______________________
Have you been recertified?  o Yes  o No  If Yes, date of recertification? ______________________
If Qualified, when does status expire? (MM/YY) ___________________________________________
Board certification results pending?  o Yes  o No
SECTION VII
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)?  o Yes  o No
Do you treat younger children (age 0-5)?  o Yes  o No
Do you treat older children (age 6-12)?  o Yes  o No
Do you treat adolescents (age 13-17)?  o Yes  o No
Do you treat adults (age 18-65)?  o Yes  o No
Do you treat geriatric patients (age 65 and older)?  o Yes  o No
Do you provide family therapy?  o Yes  o No
Do you provide group therapy?  o Yes  o No
Do you provide crisis evaluation/intervention services?  o Yes  o No
Are you available to see clients at least 4 full days a week?  o Yes  o No
What is the average waiting time to obtain an appointment? ____________________________

SECTION VIII
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)
  o General dental license  o Limited dental license  o Teacher’s dental license
  o Inactive dental license  o Other ____________________________

Are you recognized as a Specialist by the Dental Board?  o Yes  o No
If Yes, please specify ________________________________________

Do you hold a permit to administer general anesthesia?  o Yes  o No
Do you hold a permit to administer conscious sedation?  o Yes  o No
Do you utilize nitrous oxide in your practice?  o Yes  o 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? o Yes  o 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 X
**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>
<td></td>
<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>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

### SECTION XI
**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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<td></td>
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</tr>
</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.

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

9
SECTION XII
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
SECTION XIII
HEALTH CARE FACILITY AFFILIATIONS

List all health care facilities where you currently have privileges, beginning with the most recent. Please attach a separate sheet if necessary.

Facility Name _________________________________________________________________________
Street Address ________________________________________________________________________
City/State/Zip _________________________________________________________________________
Staff Category _______________________________  Status of Privileges ________________________
Dates of Affiliation     From __________ to __________
Any past or present restriction of privileges? (If Yes, explain in Section XVI)        o Yes  o No
Is this your Primary Facility?        o Yes  o No

Facility Name _________________________________________________________________________
Street Address ________________________________________________________________________
City/State/Zip _________________________________________________________________________
Staff Category _______________________________  Status of Privileges ________________________
Dates of Affiliation     From __________ to __________
Any past or present restriction of privileges? (If Yes, explain in Section XVI)        o Yes  o No
Is this your Primary Facility?        o Yes  o No

Facility Name _________________________________________________________________________
Street Address ________________________________________________________________________
City/State/Zip _________________________________________________________________________
Staff Category _______________________________  Status of Privileges ________________________
Dates of Affiliation     From __________ to __________
Any past or present restriction of privileges? (If Yes, explain in Section XVI)        o Yes  o No
Is this your Primary Facility?        o Yes  o No
Is this your Primary Facility?

SECTION XIV
GROUP AFFILIATIONS

Group Name __________________________________________
Doing Business As _______________________________________
Address ______________________________________________
Telephone Number _______________________________________
As a group practice, please list providers below. Attach additional sheets if necessary.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Current Provider Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Group Name __________________________________________
Doing Business As _______________________________________
Address ______________________________________________
Telephone Number _______________________________________
As a group practice, please list providers below. Attach additional sheets if necessary.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Current Provider Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
SECTION XV
PROFESSIONAL LIABILITY INSURANCE COVERAGE

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

<table>
<thead>
<tr>
<th>Carrier Name</th>
<th>Carrier Address</th>
<th>Agent Name</th>
<th>Policy Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Policyholder

Amount of Coverage

<table>
<thead>
<tr>
<th>Coverage amount per occurrence</th>
<th>Coverage amount per aggregate</th>
</tr>
</thead>
</table>

Dates of Coverage From _______ to _______

Type of Coverage  o Claims Made  o Occurrence

<table>
<thead>
<tr>
<th>Carrier Name</th>
<th>Carrier Address</th>
<th>Agent Name</th>
<th>Policy Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Policyholder

Amount of Coverage

<table>
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<tr>
<th>Coverage amount per occurrence</th>
<th>Coverage amount per aggregate</th>
</tr>
</thead>
</table>

Dates of Coverage From _______ to _______

Type of Coverage  o Claims Made  o Occurrence

<table>
<thead>
<tr>
<th>Carrier Name</th>
<th>Carrier Address</th>
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Policyholder

Amount of Coverage

<table>
<thead>
<tr>
<th>Coverage amount per occurrence</th>
<th>Coverage amount per aggregate</th>
</tr>
</thead>
</table>

Dates of Coverage From _______ to _______

Type of Coverage  o Claims Made  o Occurrence
Please provide information for all cases occurring in the past ten (10) years, beginning with the most recent. Attach additional sheets if necessary.

<table>
<thead>
<tr>
<th>Date of Occurrence</th>
<th>Date Claim Filed</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
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</table>

Professional liability carrier involved

<table>
<thead>
<tr>
<th>You were:</th>
<th>Primary Defendant</th>
<th>Co-Defendant</th>
</tr>
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</tbody>
</table>

Other Defendants (if any)

Describe the allegations against you

Describe the alleged injury to the patient

Claimant/Plaintiff filed suit in court?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>If Yes, Date Filed</th>
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State Court Case Number | State | County |
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Federal Court (U.S. District Court) Case Number | District |
|                                                  |         |
|                                                  |         |

Present status of the claim/case

<table>
<thead>
<tr>
<th>Pending</th>
<th>Settled</th>
<th>Arbitrated</th>
<th>Awarded</th>
<th>In Appeal</th>
<th>Adjudicated</th>
<th>Withdrawn</th>
<th>Other</th>
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</thead>
<tbody>
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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) in Section XIX.

<table>
<thead>
<tr>
<th>Date of Occurrence</th>
<th>Date Claim Filed</th>
</tr>
</thead>
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Describe the alleged injury to the patient

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</tr>
</tbody>
</table>
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) in Section XIX.

### SECTION XVII
### ADDITIONAL QUESTIONS

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Have any of your board certifications ever been suspended, revoked, or voluntarily surrendered?</td>
</tr>
<tr>
<td>2.</td>
<td>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?</td>
</tr>
<tr>
<td>3.</td>
<td>Has your DEA license or state CDS certification ever been voluntarily or involuntarily suspended, restricted, revoked, surrendered, denied, or otherwise limited?</td>
</tr>
<tr>
<td>4.</td>
<td>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?</td>
</tr>
<tr>
<td>5.</td>
<td>Have you ever been placed on probation or asked to resign from an internship, residency or other training program?</td>
</tr>
<tr>
<td>6.</td>
<td>Have you ever been named a Defendant in any criminal case, other than misdemeanor traffic violation?</td>
</tr>
<tr>
<td>7.</td>
<td>Has your malpractice insurance ever been cancelled, suspended, restricted, limited, special rated, or not renewed?</td>
</tr>
<tr>
<td>8.</td>
<td>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)?</td>
</tr>
<tr>
<td>9.</td>
<td>Has information pertaining to you ever been reported to the National Practitioner Data Bank?</td>
</tr>
<tr>
<td>10.</td>
<td>Have you ever been sanctioned or otherwise disciplined for a violation of ethical standards by a professional organization and/or a licensing board?</td>
</tr>
<tr>
<td>11.</td>
<td>Are you engaged in the illegal use of drugs?</td>
</tr>
<tr>
<td>12.</td>
<td>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?</td>
</tr>
</tbody>
</table>
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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Mailing Address of Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone Number</th>
<th>Tax ID Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent of Business Owned/Invested by You</th>
<th>Nature of Business Investment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Owner, partner, investor, etc.)</td>
</tr>
</tbody>
</table>

**IF YOU ANSWERED “YES” TO ANY OF THE ABOVE, PLEASE PROVIDE AN EXPLANATION FOR EACH AFFIRMATIVE RESPONSE IN SECTION XIX.**
Please use this space to provide any necessary explanation from previous sections. Please indicate the Section and question number.
SECTION XIX
AUTHORIZATION TO RELEASE INFORMATION
AND AFFIRMATION

I authorize the DC Medical Assistance Administration 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
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, 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 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 the agency responsible for administering the Medical Assistance Program (Title XIX) in the district of Columbia, and authorize the Department of Health 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 cover 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 by the Department for the approval process as a Medicaid Provider.

III. CONTRACT AND SUBCONTRACTS

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      Date

_________________________________________________________________________________
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:

______________________________________________________  __________________________
Authorized Signature by:       Date

Department of Health
Medical Assistance Administration

For Official Use Only

D.C. Medicaid Provider Number Assigned: ________________________________
Form W-9

Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

<table>
<thead>
<tr>
<th>Part I</th>
<th>Taxpayer Identification Number (TIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 2.</td>
<td></td>
</tr>
<tr>
<td>Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part II</th>
<th>Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under penalties of perjury, I certify that:</td>
<td></td>
</tr>
<tr>
<td>1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and</td>
<td></td>
</tr>
<tr>
<td>2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and</td>
<td></td>
</tr>
<tr>
<td>3. I am a U.S. person (including a U.S. resident alien).</td>
<td></td>
</tr>
</tbody>
</table>

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here

<table>
<thead>
<tr>
<th>Signature of U.S. person</th>
<th>Date</th>
</tr>
</thead>
</table>

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

Note: If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments after December 31, 2001 (20% after December 31, 2003). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return. Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions on page 2 and the separate instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.
Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Som propietario. Enter your individual names as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as [DBA]" name on the "Business name" line.

Limited liability companies (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner’s name on the "Name" line. Enter the LLC’s name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Exempt from backup withholding. If you are exempt, enter your name as described above, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Individuals (including sole proprietors) are not exempt from backup withholding. Corporate are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payers, see the Instructions for the Requester of Form W-9.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-9.

Note: If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Part I—Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see the instructions for a TIN below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an LLC that is disregarded as an entity separate from its owner (see Limited liability company [LLC] above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded entity is a corporation, partnership, etc., enter the owner’s EIN.

Note: See the chart on this page for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for it immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office. Get Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN.

If you are applying for an ITIN for an individual, you will need to show your IRS identifying number (ITIN) or get Form W-7, Application for Individual Taxpayer Identification Number, to apply for an ITIN. You can get Form W-7, Application for ITIN, SS-4, and SS-5 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at www.irs.gov.

If you are required to complete Form W-9 but do not have an EIN, enter a "pseudonym" for the business, trade, or DBA name, and the name of the entity described in the space for the TIN. Sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to realizable income, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until your TIN is provided to the requester.

Note: Writing Applied For means that you have already applied for a TIN or that you intend to apply for one soon. Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II—Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be required to sign by the withholding agent even if items 1, 2, and 3 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see Exempt from backup withholding above.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. Other payments include payments made in the course of the requester’s trade or business for rents, royalties, goods (other than for merchandise, medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fisherman, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA or Archer MSA contributions or distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice
Section 6109 of the Internal Revenue Code requires you to give your TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account: Give name and SSN of:

1. Individual

2. Two or more individuals (joint accounts)

3. Creditor account of a minor (gift account)

4. A. The usual revocable savings trust (grantor is also trustor)

5. B. A. So-called trust account that is not a legal or valid trust under state law

6. Sole proprietorship

7. A valid trust, estate, or pension trust

8. Corporate

9. Association, club, religious, charitable, educational, or other tax-exempt organization

10. Partnership

11. A broker or registered nominee

12. Account with the Department of Agriculture in the name of a governmental unit, such as a state or local government, school district, or person who receives agricultural program payments

1. Individual

2. Two or more individuals (joint accounts)

3. A valid trust, estate, or pension trust

The individual

The trustor

The grantor

The trustee

1. Individual

2. Legal entity

3. The corporation

4. The organization

1. The partnership

2. The broker or nominee

3. The public entity

1. List first and circle the number of the person whose name is the person whose number you furnish. If only one person on a joint account has an SSN, that number must be furnished

2. Circle the minor’s name and furnish the minor’s SSN.

3. You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or TIN if you have one.

4. List first and circle the name of the legal trust, estate, or pension trust. Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is designated in that account number.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first listed name.
INSTRUCTION FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT (DC-1513)

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Titles V, XVIII, XIX, AND XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the District of Columbia state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the D.C. State Agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete Part II (a) and (b) of this form. Only those Title XX providers rendering medical, remedial, or health related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III.

General Instructions

For definitions, procedures and requirements, refer to the appropriate Regulations:

<table>
<thead>
<tr>
<th>Title</th>
<th>Regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title V</td>
<td>42CFR 51a.144</td>
</tr>
<tr>
<td>Title XVIII</td>
<td>42CFR 420.200-206</td>
</tr>
<tr>
<td>Title XIX</td>
<td>42CFR 455.100-106</td>
</tr>
<tr>
<td>Title XX</td>
<td>42CFR 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. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI- If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

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**

**Identifying Information**

<table>
<thead>
<tr>
<th>(a) Name of Entry</th>
<th>D/B/A</th>
<th>Provider No.</th>
<th>Vendor No.</th>
<th>Telephone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>City, County, State</td>
<td>Zip Code</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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>
<th>Address</th>
<th>EIN</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

(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>
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</tr>
</tbody>
</table>

30
IV.  (a) Has there been a change in ownership or control within the last year?  
If yes, give date ____________________  □ Yes  □ No

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

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

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

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)  
Name  EIN#  □ Yes  □ No

Address

VIII.  Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?  
If yes give year change ______________  □ Yes  □ No

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.

Name of Authorized Representative (Type
Title

Signature  Date

Remarks
The National Provider Identifier (NPI) final rule, Federal Register 45CFR Part 162, was published on January 23, 2004 by the Department of Health and Human Services (DHHS) 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 MAA 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 NPI’s and taxonomy codes on a separate sheet.

I certify this information to be true and accurate.

_______________________________  ________________________ _________
Provider Signature or Authorized Representative                      Printed Name        Date
MEDICAL ASSISTANCE ADMINISTRATION
RESIDENTIAL TREATMENT FOR CHILDREN AND ADOLESCENTS
SUPPLEMENTAL APPLICATION

Complete the information below and submit to the Medical Assistance Administration for enrollment as a provider of Residential Treatment. Please check one of the following.

___ Intermediate Residential Treatment
___ Intensive Residential Treatment
___ Other (please specify) ______________________________________________________________

An agency may apply to be a Medical Assistance Administration Residential Treatment Provider by completing this form and submitting required documentation. Separate applications are to be submitted for each site. Where the space allotted for any response is inadequate, please attach an additional sheet.

1. Name of provider agency ______________________________________________________________

2. Address __________________________________________________________________________
   ___________________________________________________________________________________

3. Name and title of administrator _________________________________________________________
   Telephone __________________________________________________________________________

4. Description of service(s) provided _______________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

5. Licenses and accreditations (list all that are applicable and attach copy of verification)
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

6. Describe the physical facility, including location, buildings, grounds and how they are used by the children served.
   ___________________________________________________________________________________
7. Program description

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

8. Treatment philosophy

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

9. Treatment modalities used

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

10. Provide a description of the education program in which the children participate.
Do children participate in local public school program? _________________________________
Is there an on-campus school program? _________________________________
If so, how is it certified or accredited? _________________________________

_____________________________________________________________________________________

How will children be assessed for the appropriate educational experience?

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Additional information regarding educational program

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

11. Attach data regarding all treatment and direct care staff. List staff according to categories (suggested categories are direct care, treatment, medical, etc.) Show for each staff member position held, educational qualifications, gender and ethnicity.

12. Attach a count by residential unit of the gender and ethnicity of each child in placement at the time of the application (cumulative count of children, not individually identified).

13. Provide a description of the process by which children are considered for admission.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

34
14. Describe behavior management and discipline used.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

15. Describe community activities and community involvement for children served.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

16. List methods used to ensure that services are provided in a manner which is sensitive to the cultural diversity of the population served.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

17. Describe methods used to assure maximum involvement of the families of children in treatment.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

18. Describe procedures used to investigate and report any allegation of maltreatment made by or on behalf of any child in the program.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

19. Provide characteristics of children appropriately served in the program.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

20. Provide characteristics of children who are not appropriately served.

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
21. List the criteria used to determine when a child’s treatment is successfully completed.

_____________________________________________________________________________________

_____________________________________________________________________________________

22. List the criteria for discharge in addition to successful completion of treatment.

_____________________________________________________________________________________

_____________________________________________________________________________________

How much notice is given? ______________________________________________________________

Describe any provision for services to children who experience crises, such as additional or supplemental services to prevent negative emergency discharges.

_____________________________________________________________________________________

_____________________________________________________________________________________

23. Describe the discharge planning process and the after care service provided.

_____________________________________________________________________________________

_____________________________________________________________________________________

Number of children in the program at the date of application __________________________________

Total number served for the last fiscal year _______________________________________________

For the last two fiscal years (including current year), how many children were discharged?

_____________________________________________________________________________________

Attach the length of stay for each discharge, reason for discharge, and placement outcome upon discharge.

24. How is the program evaluated? Describe the methodology used and give data regarding results.

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

36
Dear Medicaid Provider:

As an added service for our Medicaid providers, the Medical Assistance Administration (MAA) is offering the direct deposit option for your Medicaid claims payments. MAA implemented the direct deposit program for all Medicaid providers in 2003. As a result, this program enabled the District of Columbia to realize cost savings and increase efficiencies by replacing claims payment checks with electronic transfer of funds to Medicaid providers.

Your money will be credited directly to your account within 48 hours after the District’s Office of Finance and Treasury (OFT) releases payment to all vendors. You will continue to receive the standard Medicaid remittance advice informing you of each direct deposit transaction.

To take advantage of the convenience and speed of direct deposit, please complete the enclosed (4) forms, make a copy for your records and return the originals to the following address. Enclosed are instructions to follow for completing the forms.

ACS
P.O. Box 34761
Attn: Provider Enrollment
Washington, DC 20043

To ensure timely processing, the enclosed forms listed below need to be completely filled out.

- Medicaid Provider ACH/Direct Deposit Enrollment Form
- W-9 Form – Request for Taxpayer Identification & Certification
- Direct Deposit Authorization Form
- Supplier/Vendor Information Form

Please allow four to six weeks to establish your direct deposit account. If you have any questions regarding this option, please call 202-698-2000.

Sincerely,

Office of Program Operations
Medical Assistance Administration
INSTRUCTIONS
For
Completing Direct Deposit Enrollment Forms (4)

The following instructions will assist you in completing the four (4) forms listed below. It is necessary to give full and accurate information for each question to ensure enrollment in the District of Columbia Medical Assistance Administration’s (MAA) Direct Deposit Plan. If you have more than one Medicaid provider number (assigned by ACS), you will need to complete a complete packet (4 forms) for each Medicaid provider number.

Return all completed forms to ACS as soon as possible. Please direct all questions regarding these four (4) forms to the Provider Services Unit at 202-906-8318 or the Office of Program Operations on 202-698-2000. Allow 6-8 weeks processing time.

1. Medicaid Provider ACH/Direct Deposit Enrollment Form
(Please complete all fields)

Please complete all fields and have this signed by the Chief Financial Officer or authorized representative.

- Name of Provider – actual provider name
- Medicaid Provider Number – 9-digit number assigned by ACS
- Federal Tax Identification Number
- ABA/Routing Transit Number – checking account information from bank
- Address, City, State, Zip – address of provider
- Point of Contact – person to contact for additional information
- Section 2 – have CFO print and sign this section

2. W-9 Form – Request for Taxpayer Identification & Certification
(Provide “either” your Employer Tax ID number or Social Security number – do not provide both!)

Detailed instructions are on pages 2, 3, and 4 of the form. Enter information that is on file with the Internal Revenue Service (IRS).

- Name – enter your “company name” or the name of your organization as registered on file with the IRS on Line #1; only complete Line #2 if the “company name” is different.
- Business Name – list trade names used, if any
- Type – if incorporated, select “Corporation”
- Address – enter address on file with the IRS
- Part I – enter employer identification number (i.e., TAX ID); only provide your Social Security number if you do not have an employer identification number
- Part II – have appropriate official (i.e., CEO, CFO, VP) sign and date form
- Print the name of the person signing the form directly below the signature line
3. Direct Deposit Authorization Form
(Your bank must complete and sign this form)

Complete Sections 1 and 2. Your BANK must complete, verify, and sign Sections 1 and 3. An official bank representative must sign and date the form. You can also include a “voided” deposit slip for the account that claims payments should be transmitted to.

- Name of Person entitled to Payment – enter name of organization
- Government Agency Name – agency name and/or department
- Government Agency Address – address of agency and/or department
- Name and Address of Financial Institution – enter bank name and branch
- Type of Depositor – select “Checking”
- Depositor Account Number – enter checking account number
- ABA/Routing Transit Number – have bank complete this section

4. Supplier/Vendor Information Form
(Complete Sections 1 and 3)

Column 1, Row 1 – select “New Vendor
Business Entity Section
- Attorney – select “N” for no
- Supplier Vendor Type – select 5 for vendor-business and circle (5) on page 2, question #6
- Ownership Code – select “N” for medical corporation and circle (N) on page 2, question #7 Note: If address in question #1 is out of the District of Columbia, select “O” for out of state corporation
- Enter address information provided on all forms
- 1099 – circle “N” for no

Payment Address
- One Time Payment – leave this blank
- Question 3 – enter address and telephone number of your banking institution (branch level or main office; cannot be a P.O. box)

Section 5 – leave blank. The Medical Assistance Administration will complete this section.
Section 6 – circle “5” for vendor-business
Section 7 – circle “N” for medical corporation

MAA must receive “original” copies and signatures so they may be placed in your permanent file. Please review your completed form prior to submission and return all four (4) original forms together as soon as possible to:

ACS
P.O. Box 34761
Attn: Provider Enrollment
Washington, DC 20043

Questions – contact Provider Services at 202-906-8318
MEDICAID PROVIDER
ACH/DIRECT DEPOSIT ENROLLMENT FORM

SECTION 1
(All fields must be completed)

Name of Provider ______________________________________________________________________

Medicaid Provider Number (9-digit number assigned by ACS) ________________________________

Federal Tax Identification Number ________________________________________________________

Bank Account Number __________________________________________________________________

ABA/Routing Transit Number ____________________________________________________________

Address _________________________________________  State __________  Zip _________________

Point of Contact _______________________________  Telephone Number _____________________

SECTION 2
(To be completed by the Chief Financial Officer or Authorized Representative)

CERTIFICATION

I confirm the identity of the above Medicaid provider, name, provider number, federal tax identification number, bank account number, and routing number. As a representative of the above named Medicaid Provider, I certify that the information is correct and the provider approves of the direct deposit option.

CFO or Authorized Representative _______________________________________________________

(print or type)

Signature of Representative ___________________________________________________________

TelephoneNumber ______________________________ Date ______________________________
Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Name

Business name, if different from above

Check appropriate box:  [ ] Individual  [ ] Sole proprietor  [ ] Corporation  [ ] Partnership  [ ] Other  [ ] Exempt from backup withholding

Address (number, street, and apt. or suite no.)

City, state, and ZIP code

Requestor’s name and address (optional)

List account number(s) here (optional)

Part I  Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 2.

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II  Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Signature of U.S. person

Date

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding,
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding Tax on Nonresident Aliens and Foreign Entities.

Note: If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester’s form if it is substantially similar to this Form W-9.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments after December 31, 2001 (29% after December 31, 2003). This is called “backup withholding.” Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding:

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1985 only).

Certain payees and payments are exempt from backup withholding. See the instructions on page 2 and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.
# Direct Deposit Authorization Form

**Government of the District of Columbia**
**Office of the Chief Financial Officer**
**Office of Finance and Treasury**

(Please read the reverse side carefully before completing this form)

## SECTION 1

(TO BE COMPLETED BY PAYEE)

<table>
<thead>
<tr>
<th>A. NAME OF PAYEE (last, first, middle initial)</th>
<th>B. ORGANIZATION CODE ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDRESS (street, route, P.O. Box, APO/FPO)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HOME</th>
<th>WORK</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NAME OF PERSON(S) ENTITLED TO PAYMENT</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>GOVERNMENT AGENCY NAME</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>D. TYPE OF DEPOSITOR ACCOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Checking</td>
</tr>
<tr>
<td>o Savings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GOVERNMENT AGENCY ADDRESS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>E. DEPOSITOR ACCOUNT NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>F. ABA/ROUTING TRANSIT NUMBER</th>
</tr>
</thead>
</table>

## SECTION 2

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
</table>

JOINT ACCOUNT HOLDERS CERTIFICATION (optional)

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
</table>

## SECTION 3

(TO BE COMPLETED BY FINANCIAL INSTITUTION)

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above named payee(s) and the account number, routing number and title. As a representative of the above named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above.

<table>
<thead>
<tr>
<th>PRINT OR TYPE REPRESENTATIVE’S NAME</th>
<th>SIGNATURE OF REPRESENTATIVE</th>
<th>TELEPHONE NUMBER</th>
<th>DATE</th>
</tr>
</thead>
</table>
# GOVERNMENT OF THE DISTRICT OF COLUMBIA

## SUPPLIER/VENDOR INFORMATION FORM

### Business Entity

1. As information appears in official records: (ALL FIELDS MUST BE COMPLETED)

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Taxpayer ID</td>
<td></td>
</tr>
<tr>
<td>Social Security Number</td>
<td></td>
</tr>
<tr>
<td>Corporate Name</td>
<td></td>
</tr>
<tr>
<td>Suite/Room</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
</tr>
<tr>
<td>Contact</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
</tbody>
</table>

### Individual

2. In an individual rather than a business entity: (ALL FIELDS MUST BE COMPLETED)

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number</td>
<td></td>
</tr>
<tr>
<td>Individuals Name</td>
<td></td>
</tr>
<tr>
<td>Suite/Room</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
</tbody>
</table>

### Payment Address

3. To which all payments will be sent:

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suite/Room</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Payment Address

4. New additional payment address:

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suite/Room</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
</tr>
</tbody>
</table>

### Authorization

5. INFORMATION PROVIDED BY:

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print or Type Name of Requestor</td>
<td></td>
</tr>
</tbody>
</table>

### Other Information

**URGENT: Court Order:**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td>3 digit Agency Code</td>
<td></td>
</tr>
</tbody>
</table>

**DCMR 1710 Emergency:**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Chief Contracting Officer (ACCO)</td>
<td>Date</td>
</tr>
<tr>
<td>Agency Chief Financial Officer (ACFO)</td>
<td>Date</td>
</tr>
</tbody>
</table>

---

FMS Form 710R (REV. 3/02)
## 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>C. Professional Corporation</td>
</tr>
<tr>
<td></td>
<td>E. State Employee</td>
</tr>
<tr>
<td></td>
<td>F. Financial Institution</td>
</tr>
<tr>
<td></td>
<td>G. Government Entity</td>
</tr>
<tr>
<td></td>
<td>I. Individual Recipient</td>
</tr>
<tr>
<td></td>
<td>L. Local Small Disadvantage Business Enterprises</td>
</tr>
<tr>
<td></td>
<td>N. Medical Corporation</td>
</tr>
<tr>
<td></td>
<td>O. Out of State Corporation</td>
</tr>
<tr>
<td></td>
<td>P. Professional Association</td>
</tr>
<tr>
<td></td>
<td>R. Foreign</td>
</tr>
<tr>
<td></td>
<td>S. Solo Ownership</td>
</tr>
<tr>
<td></td>
<td>T. Partnership</td>
</tr>
</tbody>
</table>

FMS Form 710R (REV. 3/02)