UnitedHealthcare Community Plan

Instructions for Ohio Home- and Community-Based Services Provider Credentialing Application

To participate in the Medicaid Managed Long Term Services and Supports (MLTSS) program, providers who participate with UnitedHealthcare Community Plan must complete and return the Ohio Home- and Community-Based Services Provider Credentialing Application. Please note that all fields require a response, even if it is N/A. Incomplete applications will delay processing.

Send your completed application and attachments (W-9 form, certificates, etc.) to:

UnitedHealthcare Community Plan
Attn: HCBS Credentialing
9200 Worthington Road 3rd Floor
Westerville, OH 43802

SECTION TITLE	SECTION INSTRUCTIONS
Provider/Corporate Owner	Complete section using your provider demographic information.
Business Operations	Enter appropriate Federal Tax ID, Medicaid and Medicare number (if applicable) on the lines provided. Answer questions as appropriate. **A Medicaid provider number is required to participate with UnitedHealthcare as a home- and community-based provider.**
Primary Business Address	Complete primary business information for agency. Independent providers should use personal provider demographic information.
Other Address	Complete information as appropriate; address may be the same for both mailing and billing/remit locations.
Contacts	Provide contact information for provider.
Services	Select services supported by accreditation documentation.
Services Counties	Select service counties; if services are provided for all counties, select all counties.
Languages	Complete information as appropriate.
Licensure/Certifications	Provide applicable licenses and/or certifications for the services you are rendering per location.
Accreditation	Provide documentation supporting your accreditations.
Insurance	Please attach all applicable insurance forms per location.
Questionnaire	Complete information as appropriate.
Provider Attestation/Consent and Release Form	Complete information as appropriate.

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Ohio Home- and Community-Based Services Provider Credentialing Application

PROVIDER/CORPORATE OWNER:

Name: _____

DBA Name: _____

Street: _____

City: _____ **ST:** _____ **ZIP Code:** _____

Phone: _____ **Fax**: _____

BUSINESS OPERATIONS:

		Used for All Locations
Federal Tax ID Number:	_____	☐ Yes ☐ No
National Provider Identifier (NPI) Number:	_____	☐ Yes ☐ No
Atypical Provider Identifier Number:	_____	☐ Yes ☐ No

**If you checked no for any of the above, please list on a separate sheet of paper all addresses, Tax ID, NPI/API numbers and the Legal Name for each listing/location.*

Do you participate with the Ohio Medicaid Plan? ☐ Yes ☐ No _____ Ohio Medicaid Number

Are you Medicare certified? ☐ Yes ☐ No _____ Medicare Certification Number

Are you American with Disabilities Act (ADA) compliant? ☐ Yes ☐ No ☐ N/A

Effective date of training: _____ Expiration date: _____

Does your staff have any training in cultural competency? ☐ Yes ☐ No ☐ N/A

Do you provide accommodations for cultural preferences? ☐ Yes ☐ No ☐ N/A

Are you a registered small, women-owned, minority-owned, or disabled-owned business?

☐ Yes ☐ No If yes, indicate _____

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How many clients/members can you accommodate? _____

PRIMARY BUSINESS ADDRESS:

If there are additional office location(s), please attach a separate page with the following information.

**Please select if the primary address is the same as the following; otherwise, complete additional address sections. ☐ Corporate Address ☐ Billing/Remittance Address ☐ Mailing address

Street: _____

City: _____ **ST:** _____ **ZIP Code:** _____

Phone: _____ **Fax:** _____

Is this location on a public transportation route? ☐ Yes ☐ No

Other transportation available to members: _____

Does this location have any accommodations for ADA?

☐Yes ☐No ☐N/A

☐ Parking ☐ Exterior Building

☐ Restroom Valid Values ☐ Interior Building

☐ Exam Room Valid Values ☐ Exam Table/Scale Valid Values

Office Hours	*From*	*To*
Sun		
Mon		
Tues		
Wed		
Thur		
Fri		
Sat		

OTHER ADDRESS:

Mailing Address:

Street: _____

City: _____ **ST:** _____ **ZIP Code:** _____

Phone: _____ **Fax:** _____

Billing/Remit Address:

Street:

City: _____ **ST:** _____ **ZIP Code:** _____

Phone: _____ **Fax:** _____

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CONTACTS:

	Primary	Secondary	Credentialing	Billing
Name:				
Title:				
Phone:				
Fax:				
Email:				

SERVICES:

Please check the type of home- and community-based service(s) you are licensed/certified or state approved to provide:

☐ Adult Day Health	☐ Home Maker Services
☐ Assisted Living Services	☐ Independent Living Services
☐ Home Care Attendant	☐ Alternative Meal Services
☐ Enhanced Community Living Services	☐ Pest Control
☐ Nutritional Consultation	☐ Out of Home Respite Services
☐ Chore Services	☐ Personal Care Services: Agency
☐ Emergency Response Services	☐ Personal Care Services: Independent
☐ LTSS Independent Waiver Nursing	☐ Home-Delivered Meals
☐ Community Transitions	☐ Social Work Counseling
☐ Home Medical Equipment Supplemental and Adaptive Services	☐ Home Modification and Repair Services
☐ Respite	

Are you affiliated with a Skilled Nursing Facility?

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☐ **No** ☐ **Yes** Name: _____

SERVICES COUNTIES:

Please indicate which counties you provide services in:

☐ Adams	☐ Allen	☐ Ashland	☐ Athens
☐ Auglaize	☐ Belmont	☐ Brown	☐ Butler
☐ Carroll	☐ Champaign	☐ Clark	☐ Clermont
☐ Clinton	☐ Columbiana	☐ Coshocton	☐ Crawford
☐ Cuyahoga	☐ Darke	☐ Defiance	☐ Delaware
☐ Erie	☐ Fairfield	☐ Fayette	☐ Franklin
☐ Fulton	☐ Gallia	☐ Geauga	☐ Greene
☐ Guernsey	☐ Hamilton	☐ Hancock	☐ Hardin
☐ Harrison	☐ Henry	☐ Highland	☐ Holmes
☐ Huron	☐ Jackson	☐ Jefferson	☐ Knox
☐ Lake	☐ Lawrence	☐ Licking	☐ Logan
☐ Lorain	☐ Lucas	☐ Madison	☐ Mahoning
☐ Marion	☐ Medina	☐ Meigs	☐ Mercer
☐ Miami	☐ Monroe	☐ Montgomery	☐ Morgan
☐ Morrow	☐ Muskingum	☐ Noble	☐ Ottawa
☐ Paulding	☐ Perry	☐ Pickaway	☐ Pike
☐ Portage	☐ Preble	☐ Putnam	☐ Richland
☐ Ross	☐ Sandusky	☐ Scioto	☐ Seneca
☐ Shelby	☐ Stark	☐ Summit	☐ Trumbull
☐ Tuscarawas	☐ Union	☐ Union	☐ Van Wert
☐ Vinton	☐ Warren	☐ Washington	☐ Wayne
☐ Williams	☐ Wood	☐ Wyandot	☐ **All Counties**

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LANGUAGES

Languages spoken by the provider/staff (other than English):

Language 1: _____ ☐ Spoken ☐ Written ☐ Both

Language 2: _____ ☐ Spoken ☐ Written ☐ Both

Do you use a language interpreter? ☐ Yes ☐ No

Do you use an American Sign Language interpreter? ☐ Yes ☐ No

LICENSURE / CERTIFICATIONS:

Please provide applicable licenses and/or certifications for the services you are rendering per location as applicable.

ACCREDITATION:

Please provide documentation supporting the completion of accreditations you are affiliated with.

INSURANCE:

Please attach all applicable insurance forms per location. (Example: general, professional, workers' compensation, etc.)

QUESTIONNAIRE:

*Please answer all questions and provide explanation for any answers of Yes.
If you don't check an answer or provide explanations, application processing may be delayed.

1. Has the provider license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed?
   *☐ Yes ☐ No

2. Has the provider been denied participation, suspended from or denied renewal from Medicare or Medicaid?
   *☐ Yes ☐ No

3. Has the provider ever had its professional liability coverage cancelled but not renewed?
   *☐ Yes ☐ No

4. Has the provider been denied accreditation by its selected accrediting body (e.g., JCAHO), or had its accreditation status reduced, suspended, revoked or in any way revised by the accrediting body?
   *☐ Yes ☐ No

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PROVIDER ATTESTATION / CONSENT AND RELEASE FORM

Any alteration or failure to sign and date this form can delay the processing of this application.

By signing below, I attest that I am the duly authorized representative of the Provider, that all information on the application pertains to the above-named Provider, and that such information is current, complete and correct.

Your signature is required to complete this application. Stamped signatures are NOT acceptable.

PROVIDER NAME

NAME (Print or Type)

TITLE

SIGNATURE

DATE