Dear Provider:

Thank you for accepting a recent referral from HOMELINK.

HOMELINK® is a National Ancillary Provider Network that maintains national accreditation with the "Accreditation Commission for Health Care, Inc." (ACHC). Achieving accreditation in addition to developing programs and systems that meet Medicare standards have enabled HOMELINK to become the largest ancillary network of its kind in the United States.

As a National Ancillary Provider Network HOMELINK has contracts with multiple insurance companies and other payor sources to provide in-network services for their members/clients. These insurance companies and other payor sources require HOMELINK to coordinate orders with credentialed providers.

Please note we need the attached information completed in order to work with you. If credentialing is not returned your company will be placed in CLOSED status and you will not be eligible for future referrals.

Questions? Contact our credentialing team at 866-575-8482 or HomelinkCredentialing@vgm.com.

Sincerely,

Dave Kazynski - HOMELINK President  
Teri Smith - Credentialing Officer

*The following document is not a contract*

Notice of Confidentiality: The document accompanying this electronic transmission contains confidential information belonging to the sender, which is legally and/or medically privileged. The information is intended only for the use of the individual or entity named above. If you are the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking of the contents of the information is strictly prohibited. If you have received this electronic transmission in error, please immediately notify us by telephone to arrange a return of the document to us.
HOMELINK® Nursing Provider Credentialing Application/Home Nursing Network Of America

Accredited?

Please circle the accreditation entity that applies to you.

- [ ] JCAHO
- [ ] HQAA
- [ ] URAC
- [ ] CHAP
- [ ] ACHC
- [ ] Medicare Certified
- [ ] BOC
- [ ] Compliance Team

Other Accreditation: ____________________________

Are you Medicare Certified  □ Yes  □ No

Please fax or mail your completed application within 10 business days of receipt to

Fax
855-863-7189
Credentialing Team

Mail
HOMELINK Credentialing
PO Box 1860
Waterloo, IA 50704

Credentialing Information can also be emailed to homelinkcredentialing@vgm.com
I. Demographic Information

Legal Company Name: ____________________________________________________________

DBA: __________________________________________________________________________

Director of Nursing Operations: __________________________________________________

Directors Phone: _____________________ Directors Fax: _____________________________

Directors Email: __________________________________________________________________

Billing Contact: __________________________________________________________________

Additional Contacts: __________________________________________________________________

Physical/Standard Address: __________________________________________________________________

City: __________________________ State: _______ Zip Code: ______________________

Phone: ___________________ Alt Phone: ___________________ Fax: ___________________

Central Intake Number: __________________________________________________________

Remit Address: __________________________________________________________________

City: __________________________ State: _______ Zip Code: ______________________

Phone: ___________________ Alt Phone: ___________________ Fax: ___________________

Billing Email Address: __________________________________________________________

Website Address: _____________________________________________________________

National Provider Identifier (NPI): ________________________________________________

**Attach a list of current locations and hours of operation, including after hours coverage.
**Additional Locations may be attached - please include hours of operation and NPI for each.

**Weekdays** | **Hours of Operation** | **Weekend** | **Hours of Operation**
--- | --- | --- | ---
Monday | | Saturday | 
Tuesday | | Sunday | 
Wednesday | | Holiday Hours of Operation | 
Thursday | | 
Friday | | 

24 hour on-call/after hours policy: Yes No

Federal Tax ID: ____________________ □ Corporate-Wide □ By Location

**Attach 2 copies of W-9**

Medicare #: ______________ Medicaid #: ______________

Business License # ______________ State Sales Tax #: __________________

**Attach copy of Medicare Certification letter and Sales Tax Certificate.**

Is your company minority owned? □ Yes □ No

Is your company owned by a woman? □ Yes □ No
II. General Information

Accreditation Status - mark the box that applies

☐ JCAHO  ☐ HQAA  ☐ URAC  ☐ CHAP  ☐ ACHC  ☐ ABC  ☐ BOC  ☐ None

Other Accreditation: ____________________________________________

**Attach a current copy of each accreditation certificate including expiration dates.

Are you a skilled licensed agency?  ☐ Yes  ☐ No

Are you required to have a state license/certification to provide services?  ☐ Yes  ☐ No

**Attach a current copy of each license with expiration dates.

Have you or your organization now or ever been on the state Medicaid Exclusion list or the OIG/SAM Exclusion lists? This information will be verified.  ☐ Yes  ☐ No

Do you complete employee background checks?  ☐ Yes  ☐ No

Are you surety bonded?  ☐ Yes  ☐ No

(if yes, include a copy with dollar amount)

Are you hands on with patients?  ☐ Yes  ☐ No

**Attach a copy of your Human Resources Hiring Policy & Procedure.

Do you currently possess any Foreign Assets/Companies/Offices?  ☐ Yes  ☐ No

**If yes, attach a copy of your W-8.

*Our company’s policy is not to engage in any services or financial activity with any individual or organization that has or has been suspected to have direct or indirect ties with terrorism.*

III. Insurance Information

General Liability Insurance?  ☐ Yes  ☐ No

Professional Liability Insurance?  ☐ Yes  ☐ No

**Attach a copy of your General and Professional Liability Proof of Insurance including amount of coverage.

Please send us an updated copy of your Proof of Insurance when it is renewed each year.

Has your General Liability or Professional Liability Insurance or coverage been denied, suspended, cancelled, lapsed, or not renewed within the last five years?  ☐ Yes  ☐ No

**If Yes, attach a copy of any General and Professional Liability Insurance adverse actions for the past five

Have you been convicted of a crime or are you under indictment for an alleged crime within the last five years?  ☐ Yes  ☐ No

**If Yes, attach a summary of any convictions and/or alleged crimes for the past five years, if applicable.

Do you have a history of sanctions or disciplinary actions within the last five years with any of the following?

- State License/Certification/Registration  ☐ Yes  ☐ No
- Medicare, Medicaid, or any other government health program  ☐ Yes  ☐ No
- HMO, PPO, PHO, IPA or any prepaid health plan or managed care participation  ☐ Yes  ☐ No

**Attach a summary of any adverse sanctions or disciplinary actions (Signed by owner)
IV. Quality Program and Patient Satisfaction

**Attach a copy of your Patient Satisfaction Survey**
**Attach a copy of your Quality Program**
**Attach a copy of State required Workers’ Compensation Certification/Training, if applicable.**

Do you subcontract any of your services? □ Yes □ No

**If Yes, please provide a list of agencies or individuals that you subcontract with along with a list of services these agencies or individuals are subcontracted for.**

If yes, who credentials these subcontractors? __________________________________________

Do you have a process in place to verify professional licensures are current? □ Yes □ No

**If Yes, please attach a copy of your policy**

(Manufacturers/Distributors Only): Do you comply with Product Information and Patient Information Standards? □ Yes □ No

V. HIPAA/Privacy Statement Form

Are you compliant with the current HIPAA policies and procedures? □ Yes □ No

**Attach a copy of your HIPAA/Privacy Statement.**

VI. Products & Services

Check all that apply:

<table>
<thead>
<tr>
<th>Home Health</th>
<th>Pharmacy</th>
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<tbody>
<tr>
<td>□ RN</td>
<td>□ Pain Management</td>
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<tr>
<td>□ Supplies</td>
<td>□ Enteral Therapy</td>
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<td>□ DME Services</td>
<td>□ TPN</td>
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<td>□ Pediatric</td>
<td>□ Sub-Q Injection</td>
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<td>□ Bilirubin Draw</td>
<td>□ PICC Line Insertion</td>
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<td>□ Home Health Aide</td>
<td>□ Antibiotic Therapy</td>
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<td>□ MSW</td>
<td>□ Hydration</td>
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<td>□ Homemaker Services</td>
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<td>□ LPN/LVN</td>
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<td>□ High-Tech Nursing</td>
<td>□ Immunotherapy</td>
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<td>□ Occupational Therapy</td>
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<tr>
<td>□ Dietician</td>
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</tbody>
</table>

Other Services: ____________________________________________________________

__________________________________________________________________________

□ Instruction provided on all above services
VII. Provider Confidentiality Statement

As a credentialed entity for HOMELINK®, Provider understands that their employees will routinely be handling and in receipt of sensitive patient information and/or financial data. Provider agrees to hold said information about patients and their needs in confidence and not disclose any information without contacting HOMELINK to review privacy and security policies and procedures (HIPAA) surrounding the release of any patient information (PHI). Provider understands that the medical records, medical information, personal information and financial data are the property of HOMELINK and that the information contained within is property of the patient and HOMELINK.

By signing this agreement, Provider agrees to conform with the release of information policies and the confidentiality of the information about the patients with whom both parties are engaged in providing services. Provider understands that both Federal and State laws apply to some parts of the release of information and any violation of HOMELINK's policies will be a violation of these laws.

Provider accepts complete responsibility for the actions of their employees and understands that violation of the privacy policies, initiates immediate termination of this agreement between HOMELINK and Provider and/or legal action.

VIII. Signature to complete credentialing

By signing below, I attest that the information on this application is correct and complete.

I agree to notify HOMELINK in a timely manner not to exceed 30 - 60 days of any change in the information contained in this application.

Name of Company: ____________________________________________ (Print)

By: __________________________________________________________ (Print)

Signature: ____________________________________________________

Title: __________________________________ Date: __________

The information requested will be used in HOMELINK's credentialing process. All information will be treated as confidential information. Thank you for completing this application.
HOMELINK® Nursing
Provider Credentialing Checklist

To facilitate prompt processing, please return only the forms and documents requested below. It is not necessary to
send booklets or binders as extraneous material delays processing. If you need assistance completing this application,
please contact the HOMELINK Credentialing Team at HomelinkCredentialing@vgm.com or call (866) 575-8482.
Please send your completed application to:

Mail
HOMELINK Credentialing
PO Box 1860
Waterloo, IA 50704

Fax
855-863-7189
Credentialing Team

☐ Completed HOMELINK Credentialing Application signed and dated.
☐ A list of current or any additional locations.
☐ A copy of your Medicare Certification letter and a copy of your Sales Tax Certificate.
☐ A copy of your state license, accreditations and personnel licensures of employees or contracted professionals
   with expiration dates.
☐ A copy of your General and Professional Liability Proof of Insurance including amount of coverage and expiration
dates.
☐ A copy of any General or Professional Liability Insurance adverse actions for the past five years.
☐ A copy of your most recent customer satisfaction survey with results and existing quality program.
☐ A copy of your current HIPAA Compliance Policy/Privacy Statement form.
☐ A copy of State required Workers' Compensation Certification/Training, (if applicable).
☐ 2 copies of your W-9 signed and if applicable, W-8 signed.
☐ A copy of your Human Resource Hiring Policy and Procedures (if applicable).
☐ A summary of any convictions and/or alleged crimes for the past five years (if applicable).
☐ A summary of any adverse sanctions or disciplinary actions signed by owner (if applicable).

Thank you for your prompt attention!