



HOMELINK Translation Agreement

PO Box 1860 · Waterloo, IA 50704
Main Phone 800-482-1993 · Credentialing Phone 866-575-8482 · Fax 855-863-7189

To: Provider

Fax: Fax

Attn: Dear Provider

Date: 08/31/2017

From: HOMELINK Credentialing Team

Pages: Page 1 of 7

Re: HOMELINK Translation Agreement

Dear Provider:

HOMELINK® is a National Provider Network that currently has contracts with multiple insurance companies and other payer sources to provide in-network services to their clients.

HOMELINK contracts with a wide variety of insurance companies to arrange for the medically needed products and services. Providing superior quality service to these patients is a cornerstone of our business.

The enclosed HOMELINK Translation Agreement contains the terms and process requirements to become part of our Network.

Please review each section prior to signing this agreement and contact our Credentialing/Certification Team by phone at **866-575-8482** or Email: HomelinkCredentialing@vgm.com if you have any questions. We also have a website page to obtain a copy of the certification application at www.HomelinkCredentialing.com.

Thank you for your prompt attention to this matter; your cooperation is greatly appreciated. **Please respond with your completed information within 15 business days of receipt.** Your completed agreement requirements can be faxed to 855-863-7189 or mailed to:

HOMELINK ATTN:
CREDENTIALING/CERTIFICATION TEAM
PO BOX 1860
WATERLOO, IA 50704

Sincerely,

Dave Kazynski - HOMELINK President

Teri Smith - Credentialing/Certification 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® Network Translation Provider Agreement

This agreement is entered into by and between VGM Group Inc. dba HOMELINK (hereinafter called “HOMELINK”) and (hereinafter called “Provider”):

THAT WHEREAS, HOMELINK is engaged in the business of delivery of healthcare services at the request of various Insurers, Health Maintenance Organizations, Employers and other Third Party Payers; and

WHEREAS the Provider, being duly registered and appropriately licensed as required in the State(s) in which it provides services, agrees to provide translation services to patients referred to it and as authorized by HOMELINK upon the following terms and conditions:

I. Engagement of Services

The Provider shall provide services to patients in the areas that it serves as referred and authorized by HOMELINK. Provider, at its sole discretion, has the option to accept or reject any referral from HOMELINK, but upon acceptance agrees that services will include the provision of translation services and same shall be provided only as ordered and as authorized by HOMELINK pursuant to this agreement.

II. Insurance

Provider agrees to defend and hold HOMELINK harmless from any and all liability arising from any acts or omissions of the Provider including claims and suits in which it is claimed that a party indemnified hereunder is also or partially at fault. Provider will provide required general insurance verification within thirty (30) days of the date of contract execution, but, in any event, prior to rendering any services. Provider will have HOMELINK listed as an additional insured for both Auto & General Liability policies.

III. Non-Discrimination

The validity of this Agreement and any of its terms and provisions is bound by non-discrimination in hiring practices outlined in regulations and relevant orders of the Secretary of Labor.

IV. Relationship Between Parties

None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship between the parties other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. None of the parties, or any of their employees shall be construed to be the agent, employer or representative of the other. A failure of HOMELINK to perform under this agreement shall not relieve Provider of its obligations to patients.

V. Entire Agreement

This instrument contains the entire Agreement of the parties hereto and supersedes all prior oral or written agreements or understanding between them with respect to the matters provided for herein. This Agreement may not be amended, modified or assigned except by written agreement duly executed by each party to this Agreement.



VI. Termination

This Agreement shall continue until terminated upon ninety (90) days written notice by any party to each of the others at the address set forth in the Notice paragraph, sent certified or registered mail, return receipt requested. In the event any party fails to comply with any provision of the Agreement, the party in violation must be given written notice of their failure to comply and ten (10) business days from receipt of notice within which to rectify the non-compliance. If the non-compliance is not rectified within the allotted ten (10) days, notice may be given

VII. Notice

*Any notice regarding this Agreement shall be in writing and sent certified or registered mail to Provider at **Provider**, Address, City, State Zip and to **HOMELINK**, Attn: Credentialing/Certification Team, PO Box 1860, Waterloo, Iowa 50704.*

VIII. Attestation To Correctness and Completeness

I agree to notify Homelink immediately in writing should events occur during the course of participation that would change any information on this application.

I understand that my continued participation with Homelink is contingent upon my acceptance to the Network and my continuing to positively maintain appropriate certifications.

I attest that all information, including, supporting documentation, submitted by me in connection with this application is true and complete to the best of my knowledge and belief. I agree to update this application while it is being processed, should there be any change in the information provided that could affect the application or its outcome.

IX. Confidentiality and Non-Disclosure Statement

This Agreement and the terms and conditions herein shall be treated by the parties as strictly confidential. Accordingly, the parties agree not to directly or indirectly disclose this Agreement or the terms and conditions herein, including but not limited to, all schedules and financial terms to any third party. The parties agree that the breach or prospective breach of this provision will cause irreparable harm for which money damages may not be adequate. The parties therefore agree that in addition to any other remedies, the non-breaching party shall be entitled to injunctive or other equitable relief to restrain the breach hereof. This provision shall not apply to disclosures required by law, provided such disclosure is limited to the extent required by law. This paragraph will survive termination of this Agreement.

Name of Company: _____ (Print)

By: _____ (Print)

Signature: _____ Date: _____

Title: _____ Phone: _____

The information requested will be used in HOMELINK's credentialing/certification process. All information will be treated as confidential information. Thank you for completing this credentialing application.



HOMELINK® Translation Provider Agreement Application

I. Demographic Information

Legal Company Name: _____

DBA: _____

Physical/Standard Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Alt Phone: _____ Fax: _____

Central Intake Number: _____

Web Referral Email Address: _____

Website Address: _____

Remit Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Alt Phone: _____ Fax: _____

Billing Contact: _____

Billing Email Address: _____

National Provider Identifier (NPI) If applicable: _____

***Additional Locations may be attached - please include hours of operation and NPI for each.*

II. Hours of Operation

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: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Federal Tax ID: _____ Corporate-Wide By Location

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

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.

Is your company minority owned? Yes No

Is your company owned by a woman? Yes No

III. General Information

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

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

Do you complete employee background checks? Yes No

IV. 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 and listing HOMELINK as an additional insured on the policy.**

****If you have separate Professional Liability & General Liability policies, it is recommended that you have a minimum of \$1 million in coverage with \$2 million aggregate (\$1m/\$2m) and the minimum occurrence limit of \$1 million for each. If you have a combined Professional Liability & General Liability policy, we recommend \$1m/\$2m limits.**

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

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

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

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

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

V. Legal Action

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.**

Have you or your organization:

Been convicted of a criminal offense as described in sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act? Yes No

Had any civil monetary penalties or assessments imposed under section 1128A of the Social Security Act?

Yes No

Had a direct or indirect ownership interest (or any combination thereof) of 5% or more in the organization?

Yes No

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

****If marked "yes" to any of the above please attach a summary of any adverse sanctions or disciplinary actions (Signed by owner)**

Does your organization have a formal program or process for the maintenance of a drug free working environment? Yes No

If no, please provide explanation:_____

VI. Quality Program and Patient Satisfaction

*****Attach a copy of your Patient Satisfaction Survey, if applicable***

*****Attach a copy of your Quality Program, if applicable***

*****Attach a copy of State required Worker's Compensation Certification/Training, if applicable.***

Do you subcontract any of your services? Yes No

If yes, who validates credentials for these subcontractors? _____

Do you require your translators/interpreters to be certified? Yes No

*****If Yes, please attach a copy of current certificates***

Please list all languages spoken fluently by translators/interpreters providing services _____

VII. HIPAA/Privacy Statement Form

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

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



HOMELINK® Credentialing Checklist

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

HOMELINK ATTN:
CREDENTIALING TEAM
PO BOX 1860
WATERLOO, IA 50704

- Completed HOMELINK Credentialing Application
- A list of locations, hours of operation (including after hours coverage) and NPI for each location (if applicable)
- Servicing Counties:** Please attach a list of all servicing counties by state. Only a listing of specific counties will be accepted. Do not submit maps and/or regional designations (e.g., southeast Iowa, etc.)
- 2 copies of your W-9
- W-8 signed, if applicable
- A copy of your business certificates/licensures, and personnel licensures of employees or contracted professionals with expiration dates
- A copy of your Human Resource Hiring Policy and Procedures.
- A copy of your General and Professional Liability Proof of Insurance including amount of coverage and listing HOMELINK as an additional insured on the policy.
- A copy of any General or Professional Liability Insurance adverse actions for the past five years.
- A summary of any convictions and/or alleged crimes for the past five years
- A summary of any adverse sanctions or disciplinary actions (signed by owner)
- A copy of your most recent customer satisfaction survey with results and existing quality program
- A copy of State required Worker's Compensation Certification/Training
- A copy of your current HIPAA Compliance Policy/Privacy Statement form.

Thank you for your prompt attention to this important request.