HOMELINK Credentialing

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	**Pages:**	Page 1 of 7
Re:	HOMELINK Provider Credentialing		

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.

These companies require HOMELINK to credential providers that provider goods and/or services to their members/clients.

Please review each section prior to signing this application 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

I. Demographic Information

☐ Home Health Agency ☐ Home Infusion ☐ Non Skilled Agency ☐ Other

Legal Company Name: _____

DBA: _____

Director of Nursing/Operations: _____

Directors Phone: _____ Directors Fax: _____

Total Number of Nurses: _____ Staffing Ratio: %RN: _____ % LPN: _____

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): _____

***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, CMS Disclosure of Ownership form and Copy of 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 ☐ NCQA ☐ URAC ☐ CHAP ☐ ACHC ☐ ABC ☐ BOC

Other Accreditation: _____

***Attach a current copy of your letter of acceptance and the accreditation certificate including expiration dates.**

If you are not accredited by one of the above bodies, please confirm that you provide ongoing educational opportunities and training to your employees. ☐ Yes ☐ No

***Attach the most current copy of your CMS or State Agency survey/site visit results.**

Frequency of training: Monthly Quarterly Bi-Annually Annually Other:_____

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 submit performance data as required by CMS? ☐ Yes ☐ No ☐ N/A

Do you do monthly OIG/SAM/Medicaid exclusion checks on all subcontracted providers and on your employees? (You may be asked to provide verification of this at any time.) ☐ Yes ☐ No

Do you complete employee background checks? ☐ Yes ☐ No

Are you surety bonded? ☐ Yes ☐ No

(if yes, include a copy with dollar amount)

(if no, 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.**

Are you a skilled licensed agency? ☐ Yes ☐ No

Are you certified by the Drug Enforcement (DEA) agency? ☐ Yes ☐ No

***Attach a current copy of your Drug Enforcement Agency (DEA) Certification**

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 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.**

IV. Disclosure Info.

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

Been excluded from participation in Medicare or any of the State health care programs, such as Medicaid? ☐ Yes ☐ No

Had a direct or indirect ownership interest (or any combination thereof) of 5% or more in the organization? ☐ Yes ☐ No

Has any person in your organization with a ≥ 5% indirect or direct ownership or control interest in the organization (or any combination thereof), or who is an agent or managing employee of the organization, been convicted of a criminal offense related to that person's involvement in any Medicare or Medicaid program? ☐ Yes ☐ No

If you or your organization is an Iowa Medicaid Provider, have you completed the online Ownership and Control Disclosure form as part of the Iowa Medicaid Universal Provider Enrollment Application process? ☐ 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
- 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

****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:_____

Other Attestations

Provider attests to compliance with the standards of Title 45, Section 156.705 (Maintenance of Records for Federally-Facilitated Exchanges) and Section 156.715 (Compliance Reviews of QHP Issuers in Federally-Facilitated Exchanges) in the Code of Federal Regulations? ☐ Yes ☐ No ☐ N/A

Provider attests to compliance with the Section 1557 of the Affordable Care Act of 2010, in regards to ensuring that individuals with disabilities and/or limited English proficiency have access to its applicable materials and services? ☐ Yes ☐ No

V. 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 Worker's 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

Provider agrees that any employed or subcontracted Physical Therapy Assistant (PTA's) and Certified Occupational Therapist Assistant (COTA's) will hold a current, unrestricted license or certification in the appropriate state of jurisdiction prior to rendering services. ☐ Yes ☐ No

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

VI. HIPAA/Privacy Statement Form

Are you compliant with the current HIPAA policies and procedures? ☐ Yes ☐ No
Attach a copy of your HIPAA/Privacy Statement.

VII. Products & Services

Check all that apply: ☐ ***Instruction provided on all below marked services***

Home Health Services

- ☐ High-Tech RN
- ☐ RN
- ☐ LPN/LVN
- ☐ Pediatric Nurse
- ☐ Enterostomal Nurse
- ☐ PICC Line Certified Nurse
- ☐ Psychiatric Nurse*
- ☐ MSW (Medical Social Worker)
- ☐ Psychiatric Social Worker
- ☐ Hospice
- ☐ HIV
- ☐ Certified Wound Care
- ☐ Respiratory Therapy
- ☐ Home Health Aide

Home Health Services

- ☐ Certified Nurse Assistance
- ☐ Homemaker/Chore Services
- ☐ Attendant/Care Services
- ☐ Companion Care
- ☐ Personal Care Services
- ☐ Respite Care, Unskilled
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Dietician
- ☐ Lab Drawing** (e.g., biliruben)
- ☐ Phlebotomy Service
- ☐ DME Services
- ☐ Supplies

Pharmacy Services

- ☐ Pain Management
- ☐ Enteral Therapy
- ☐ TPN
- ☐ Sub-Q Injection
- ☐ PICC Line Insertion
- ☐ Antibiotic Therapy
- ☐ Hydration
- ☐ Anti-Coagulant
- ☐ Growth Hormone
- ☐ Chemotherapy
- ☐ Dobutamine
- ☐ Immunotherapy
- ☐ Catheter Care Supplies
- ☐ Midline Insertion

Hearing Health Services

- ☐ Hearing Aids
- ☐ Hearing Supplies/Batteries

Hearing Health Services

- ☐ Custom Ear Molds
- ☐ Hearing Eval/Test

*Psychiatric Nurse: If the agency provides this services, you must submit the applicable CMS Approval Letter to be verified.
**Lab Drawing: If the agency provides lab services, you must submit a copy of the current Clinical Laboratory Improvement Amendment (CLIA) Certificate to be verified.

VIII. 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 health 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.

IX. 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: _____ **Date:** _____

Title: _____ **Phone:** _____

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

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**.

Your completed application can be faxed to 855-863-7189 or mailed to:

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 Medicare Certification Letter
- ☐ A copy of your CMS Disclosure of Ownership Form
- ☐ A copy of your Sales Tax Certificate
- ☐ 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 (if applicable)
- ☐ A copy of your current HIPAA Compliance Policy/Privacy Statement form.
- ☐ A copy of your letter of acceptance and the accreditation certificate including expiration dates (if applicable)
- ☐ A copy of your current CMS or State Agency survey/site results, including deficiencies and corrective action plans (if you have a Medicare PTAN and are NOT accredited)
- ☐ A copy of your Drug Enforcement Agency (DEA) Certification (if applicable)

Thank you for your prompt attention to this important request.