Dear Provider,

Thank you for your interest in joining Integrated Home Care Services. Our mission is to provide compassionate care to patients in need of our services and connecting them with qualified resources to improve the delivery of care in the home setting.

Integrated Home Care Services is pleased to contract with network providers who share our commitment in offering compassionate, high-quality care to patients in the comfort of their homes.

Attached, you will find Integrated Home Care Services credentialing application for your completion. In order to expedite the process, please ensure that all sections of the application are complete and copies of the items on the checklist are provided. If a section is not applicable, please indicate N/A.

Credentialing Application may be returned to:

- **Mail:** Integrated Home Care Services, ATTN: Credentialing/Provider Relations Dept, 3700 Commerce Parkway, Miramar, FL 33025
- **Email:** ProviderNetwork.Credentialing@ihcscorp.com
- Fax: 954-624-8744

We appreciate your time and effort in completing this credentialing application as it's an important step in becoming part of our network. In order to qualify as a participating ancillary provider for Integrated Home Care Services, Inc. and it's affiliates, a provider must meet the requirements which include, but are not limited to the attached requests.

For any questions, please contact the Credentialing/Provider Relations Department at (844)215-4264 Extension 7534.

Thank you,

Credentialing Department

PROVIDER'S RIGHTS DURING CREDENTIALING

- The right to review information submitted to support their credentialing application.
- The right to correct erroneous information.
- The right to verify the status of Credentialing/Re-Credentialing application upon request, within 60 days of the Committee meeting.
- The right to be notified about these rights.
- The right to appeal decision made by the Credentials Committee by written request.
- The right to contact the Credentialing Department to receive further information
- To initiate these rights you may contact the Lazara Barreto, Manager of the Credentialing/Provider Relations Department, either via telephone at 844-215-4264 Ext 7409 or email at Lbarreto@ihcscorp.com .

PROVIDER'S ONGOING CREDENTIALING OBLIGATIONS

- Providers are obligated to notify **Integrated Home Care Services, Inc**. of any changes regarding the following: Change of Name, Ownership, NPI number, Tax ID number, Address, Telephone number, Fax number, Billing Address, State License, Occupational or Certifications, Accreditation, Liability and Worker's Compensation insurance.
    - All requested changes must be made on a company letterhead.
    - Note: For Name or Ownership changes additional documents may be requested by **Integrated Home Care Services, Inc**.
- Providers requesting termination of their contract must complete the Provider Termination Form.
    - Requests for the Provider Termination Form may be sent via email to the Credentialing Department at ProviderNetwork.Credenitlaing@ihcscorp.com.

Credentialing Required Documents Check List

	Credentialing Application for each location included under this contract
	Signed and dated attestation on page two and three of credentialing application
	Copy of current State license, certification, or registration. Oxygen permits as applicable.
	Occupational Business License per location included under this contract
	Current DEA or CDS Certificate
	Attach a copy of the letter or documentation from Centers for Medicare and Medicaid Services (CMS) and AHCA (as applicable) which verifies your Medicare and/or Medicaid effective date and provider number.
	Copy of provider valid National Provider Identifier (NPI) and taxonomy number letter.
	Copy of Accreditation and last survey report.
	Copy of one of the following: most recent State Survey, Federal Survey, or Inspection report, if not accredited
	Current Professional Liability Insurance & General Liability Insurance certificate for each of your locations, with limits of no less than $1,000,000 per occurrence and 3,000,000 annual aggregate at a minimum
	Worker' Compensation – With state law required amounts
	Liability Claims History (Minimum of five years) (Please send details for any OPEN Claims) If there aren't any please send a statement from insurance carrier that there's no claims history for the past five years.
	Articles of Incorporation
	Copy of patients Handbook
	Copy of W-9 for tax identification number (IRS requirement). The provider name and address used for payment must be the same as what is used for IRS purposes.
	Table of Organization / Corporate Organization Chart
	Maintenance of an active, documented quality management program including, at a minimum, the following items with copies of such documentation made available to Integrated Home Care Services, Inc. upon submission of credentialing application. Table of Contents for the following: Policy & Procedure Manual (If Applicable) Pediatric Manual (If Applicable) Quality Improvement Plan Utilization review Plan Personnel Policy and procedures On-Call Emergency Procedures Client Satisfaction Measurement Tool Yearly Review Emergency Preparedness / Disaster Recovery Plan
	FL Disclosure of Ownership Form ATTACHED
	FDR / Affiliate Compliance ATTACHED

	Casper report based on the last 12 months of your Oasis submission (required for Florida Medicare and Medicaid Certified Home Health Agencies Only)
	Provide a policy and procedure which validates and ensures current licensure and certification of professional staff e.g. RN, LPN, MSW, PT, OT, ST, RT, etc., that it's monitored and complies with State, Medicare and Medicaid regulations (as applicable).
	Provide a staff roster of RN, LPN, MSW, PT, ST, OT, and RT staff e.g. Full names, Specialty, State License, and State License Expiration Date). Only applicable to HH providers and IV providers as applicable.
	DME providers must provide us with a $50,000 surety bond.
	For Home Health Only: Please provide current Stars Rating with proof of such:

PROVIDER CREDENTIALING APPLICATION

TYPE OF ORGANIZATION

☐ Home Health Agency ☐ Nurse Registry ☐ Homemaker & Companion
☐ Durable Medical Equipment, Medical Supplies, Respiratory Equipment
☐ Home Infusion

Provider Legal Name:

Provider d.b.a. Name (if applicable):

Physical Business Address:

City, State, Zip Code: County/Parish:

Billing Address, if different from physical address:

City, State, Zip Code: County/Parish:

Hours of Operations:

Please indicate your staff's multilingual and multicultural capabilities (e.g. languages spoken) other than English:

Spanish / Creole / Portuguese/ Other: _____

Email Address:		Credentialing Email Address:	
Office Phone Number:		Office Fax Number:	
Credentialing Phone Number:		Credentialing Fax Number:	
Name of Administrator:		Name of Director of Nursing:	
Federal Tax I.D. Number:		N.P.I. Number:	

To better assist with staffing, please list the counties that your company covers and the Zip Codes within those counties/parishes for the above location (provide additional pages as needed). Zip codes are only required if your company does not service an entire county. This requirement will ensure appropriate referral activities to your company:

Age Range of Patients Treated:

Provider Services:	***Yes***	***No***	**Provider Services:**	***Yes***	***No***	**Provider Services:**	***Yes***	***No***
Pediatrics	☐	☐	Wound Care	☐	☐	Home Health Aide Hourly Visit	☐	☐
Private Duty Nursing	☐	☐	Wound Vac	☐	☐	Live-In	☐	☐
Pediatric Occupational Therapy	☐	☐	RN Evaluation	☐	☐	Respiratory Therapy Visit	☐	☐
Pediatric Physical Therapy	☐	☐	RN Visit	☐	☐	Intrastromal Skilled Visit	☐	☐
Pediatric Speech Therapy	☐	☐	LPN Visit	☐	☐	Blood and Blood Product Administration	☐	☐
Pediatric Respiratory Therapy	☐	☐	RN Hourly Shifts	☐	☐	Durable Medical Equipment	☐	☐
Adult Occupational Therapy	☐	☐	LPN Hourly Shifts	☐	☐	Home Infusion	☐	☐
Adult Physical Therapy	☐	☐	Hi-Tech RN Visit	☐	☐	Medical Supplies	☐	☐
Adult Speech Therapy	☐	☐	Midline Insertion	☐	☐	Respiratory Equipment	☐	☐
Adult Respiratory Therapy	☐	☐	Medical Social Worker Visit	☐	☐	Other:_____	☐	☐
PICC Line Insertion	☐	☐	Obstetrical Skilled Visit	☐	☐			
High Tech Nursing for IV	☐	☐	Home Health Aide Visit	☐	☐			

LICENSURE
State License / Business License / Registration Number: _____ Expiration Date: / / _
Have there been any restrictions, actions or sanctions on your licensure, certification, or registration in the past five (5) years?
Yes (If answered yes, provide a summary) No
***** If the answer is to the above questions is yes, please provide details on a separate sheet*****
DEA or CDS certificate DEA Number: _____ DEA Expiration Date: _____
(as applicable) CDS Number:_____ CDS Expiration Date: _____
Are you certified/ participating as a provider in the Medicare program? Yes/ No Medicare Provider Number: _____
Are you certified/ participating as a provider in the Medicaid program? Yes/ No Medicaid Provider Number: _____
Do you have a Medicaid Waiver? Yes/ No Medicaid Waiver Number: _____
***** Please submit copies of each letter or document for above, per office/location with exception of Tennessee providers.***
ACCREDITATION:
Accrediting Organization: Accreditation Number:_____
Effective Date: / / Expiration Date: / /
Other Accrediting Organization: Accreditation Number:
Effective Date: / / Expiration Date: / /
Has your organization lost its accreditation, been denied accreditation, or otherwise been sanctioned by the accrediting body within the last five (5) years?
☐ Yes (If answered yes, provide a summary)
☐ No
***** If the answer is to the above questions is yes, please provide details on a separate sheet*****
INSURANCE COVERAGE
Professional Liability Carrier:_____ Pol Eff. Date: _____ Exp. Date: _____
Policy Number: _____ Occurrence Amount: _____ Aggregate Amount:_____
General Liability Carrier: :_____Pol Effective Date: _____Exp..Date: _____
Policy Number: **:**_____ Occurrence Amount: _____ Aggregate Amount:_____
Worker's Compensation Carrier: _____Pol Eff. Date: _____ Exp.Date: _____
Policy Number: **:**_____ Occurrence Amount:_____ Aggregate Amount: _____
** Please submit a copy of each insurance policy declaration page (Face sheet) indicating current status and coverage amounts.
QUESTIONNAIRE
***** If the answer to any of the following questions is yes, please provide details on a separate sheet*****
Have criminal proceedings ever been initiated against your Company or its authorized representative(s)?
☐ Yes
☐ No
In the last five years, have there been any liability claims history or law suits, or are there currently any pending or potential suits against your Company, or have any judgments been made or settlements paid on its behalf?
☐ Yes
☐ No

Must be in compliance with all Federal and State licensure, regulatory and accreditation requirements. Has there been any disclosure of complaints or adverse action reports files with a local, state or national professional society or licensing board?
☐Yes
☐ No
Has there been any disclosure of refusal, restriction, or cancellation of professional liability insurance?
☐Yes
☐ No
Initial Credentialing Purposes:
Owners, Director, Officers of the company can't have any felony convictions or fraud convictions. May not be on any Medicare or Medicaid Pre-Payment Review. List any sanctions or notifications from Medicare or Medicaid regarding overpayments within the last 5 years If overpayments exist, please provide supporting documentation that the overpayment was not due to fraud, waste or abuse. Has your Company ever been the subject of an investigation, suspended, sanctioned, loss of license, has had limitations of privileges or disciplinary actions, and/or otherwise restricted from participating in any private, state or federal health insurance program (for example Medicare or Medicaid)?
☐Yes
☐ No
Please be advise authorizations will not be issued without a face to face assessment with the patient's physician.
Re-credentialing Purposes:
Since your last credentialing cycle with **Integrated Home Care Services, Inc.** 'or' in the last three years since you've been in Network with **Integrated Home Care Services, Inc.** has your Company ever been the subject of an investigation, suspended, sanctioned, loss of license, has had limitations of privileges or disciplinary actions, and/or otherwise restricted from participating in any private, state or federal health insurance program (for example Medicare or Medicaid)?
☐Yes
☐ No
May not be on any Medicare or Medicaid Pre-Payment Review. List any sanctions or notifications from Medicare or Medicaid regarding overpayments within the last 5 years If over payments exist, please provide supporting documentation that the overpayment was not due to fraud, waste or abuse.

Additional Informations:
Do you allow the release of your Company's Liability Claims History and Liability Insurance Certificate to **Integrated Home Care Services, Inc.?**
☐Yes
☐No
Do you or Company's staff, per diem and/or contractors presently or have a history of any physical, mental health or other conditions including illegal substance abuse, and/or chemical, and/or alcohol abuse dependency that may affect your/their ability to perform your professional duties appropriately?
☐Yes
☐No
DME companies must have a licensed Respiratory Therapist on staff and all CPAP, BiPAP, Ventilator, Apnea Monitor, Phototherapy and Suction equipment must be delivered by a Respiratory Therapist.
Authorizations will not be issued without a face to face assessment with the patient's physician.
Provider will not market or solicit a Physician's Office, Case Managers, Discharge Planners or any other referral source to obtain business.
All referrals/prescriptions must be sent to IHCS from the referral source and NOT from Provider.
Provider must be able to provide every item on the Medicare / Medicaid Fee Schedule directly. Provider may not sub-contract for any services authorized by IHCS.
Provider may not be related or have any family members related to any referring physician or other referral source.
In the event that Provider violates any of these requirements, IHCS has the right to immediately terminate Provider from the Network

All providers must have an internal system for measuring quality. As a provider, you must have procedures for evaluating patient satisfaction. I release from liability that **Integrated Home Care Services, Inc.** and all representative of **Integrated Home Care Services, Inc.** for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations that provide information to **Integrated Home Care Services, Inc.** in good faith without malice or negligence concerning my professional competence, character and ethics. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension or curtailment or participation status, membership from **Integrated Home Care Services, Inc.**

I attest and certify that I have completed the above application truthfully and that information given in or attached to this application are true, correct, and complete to the best of my knowledge. I authorize and hereby give my consent to the Company to collect any information necessary to verify the information provided in this credentialing application. I have acknowledged that I have received a copy of my rights as a Provider during credentialing.

I understand that, as a condition to signing this attestation, any misrepresentations or misstatements in, or omission of any of these answers, whether intentional or not shall constitute grounds for rejection of my request for participation with Integrated Home Care Services, Inc.…

_____ _____

Print Name Signature

_____ _____

Title Date

I hereby attest and certify to the following:

☐ **COMPLIANCE WITH FRAUD, WASTE & ABUSE TRAINING**

My agency/business practices have met the, Fraud, Waste and Abuse (**FWA**) certification requirements through enrollment into the Medicare program or accreditation as a (circle one) DME/HHA/IV provider and is deemed to have met the training and education requirements for fraud, waste and abuse per 42 C.F.R. S423.504(b)(4)(vi)(C).

☐ **ATTESTATION OF COMPLIANCE HIPAA TRAINING**

My agency/business conducts HIPPA training within 30 days of hire, **or prior to exposure to PHI**, whichever is sooner. Thereafter, employees receive additional HIPAA training by way of an annual Code of Conduct training that includes a discussion regarding the importance of protecting patient information and compliance with HIPAA, periodic webinars focused on compliance issues, newsletter articles, and emails from the legal and/or compliance department and/or management staff.

☐ **ATTESTATION OF COMPLIANCE STANDARDS OF CONDUCT TRAINING**

My agency/business attests to the completion of annual training of all staff to our Standards of Conduct and have read Integrated Home Care Services Standards of Conduct located in the Provider Training Manual. Every staff member has completed training on the company's Standards of Conduct and has signed an acknowledgement of the training and their responsibilities. Documentation of the training will be made available upon request. When applicable,all employees or contractors that will enter a patient's property or residence have completed the annual training on "Abuse, Neglect and Exploitation".

☐ **VERIFICATION OF THE ELIGIBILITY FOR EMPLOYMENT ATTESTATION**

My agency/business has verified employment eligibility for all my employees using the E-Verify database and/or by approved documents per Form I-9 they are all eligible to work in the United States. "E-Verify is an Internet-based system that allows businesses to determine the eligibility of their employees to work in the United States." www.uscis.gov"U.S. law requires companies to employ only individuals who may legally work in the United States – either U.S. citizens, or foreign citizens who have the necessary authorization

☐ **LEVEL 2 BACKGROUND SCREENING**

My agency/business is compliant with the Agency for Health Care Administration (AHCA) and contractual requirements to ensure all direct care givers have completed and cleared the AHCA required Level 2 background screening.

_____

Name of the Agency/Contractor

_____ _____ _____

Name of the person attesting **Title** **Signature** **Date of Attestation**