FIDELIS CARE®

DOULA – INDIVIDUAL & AGENCY CREDENTIALING APPLICATION FORM

Check the applicable box:

- ❑ **Individual**
  or
- ❑ **Agency/Group**

INDIVIDUAL DOULA APPLICATION CHECKLIST

In order to expedite processing, please complete every item on this application. Please DO NOT write "see CV" or "refer to CV" in place of completing the information requested. Please enclose copies of the documentation listed below, and sign and date the consent and release form. Please review and complete the Individual Questionnaire (*including the criminal history questions) at the end of the application. Thank you for your assistance!

"X" if enclosed

- ■ State Medicaid ID # ***(Applicable to individual only)***;
- ■ Current Liability Insurance Certificate;
- ■ Doula Training Completion Documents;
- ■ Work History/CV/Resume;
- ■ Signed and dated Consent and Release form; and
- ■ W-9 Form (*IRS W9 form link*);
- ■ ODF (Ownership Disclosure Form).

AGENCY/GROUP APPLICATION CHECKLIST

In order to expedite processing, please complete every item on this application. Please enclose copies of the documentation listed below. The application must be signed and dated by an authorized representative of the organization. Please review and complete the AGENCY/GROUP QUESTIONNAIRE (*including the criminal history questions) at the end of the ap plication. Thank you for your assistance!

"X" if enclosed

- ■ State Medicaid ID #***(Applicable to agency/group only)***;
- ■ Current Liability Insurance Certificate;
- ■ Listing of all locations included under the contract;
- ■ Accreditation Certificate, as applicable;
- ■ W9 Form*(IRS W9 form link)*;
- ■ ODF (Ownership Disclosure Form).

Additional Guidance - For individual applicants, *you must provide either a SSN or a EIN, a 7-digit Medicaid Provider #, and a NPI # (individual).* ***For group applicants,*** *you must provide a EIN, a 7-digit Medicaid Provider #, and a NPI # (individual).* ***Thank you for your assistance!***

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Individual Doula
Last Name_____ **First Name** _____ **Middle Initial** ___ **Degree** ____

or

Agency/Group
Company/Organization Name:_____

_____

_____

Name of Organization/Facility and or Provider/Group/Practice Name:

_____

Primary(Office/Residential)Address *(residential addresses **will not be listed in any** provider directories)* City State Zip
(For additional locations, please complete next page.)

_____

County Office Phone # Office Fax # Office Email (*For receiving email from Member)*

Treats Homeless? Yes___ No___ Electronic Health Records? Yes___ No___

_____

Office Manager or Contact Name Telephone and Extension *(If applicable)* Email address (*For receiving email from Plan)*

_____

Office Hours: Mon Tues Wed Thu Fri Sat Sun

_____

Name to whom checks should be made payable (*If different than Organization/Practice/Group name*)

_____

Billing Address *(Location where payments will be sent, **P.O Box accepted)*** City State Zip

_____

Billing Office Telephone Number Billing Office Fax Number Billing Email address (*For receiving email from Plan)*

_____

Correspondence Address (*Used for credentialing purposes)* City State Zip

_____

Office Phone # Office Fax # Contact Name Email address (*For receiving email from Plan)*

Patient Age Ranges
☐ 12 yrs - 99+ yrs ☐ 18 yrs - 99+ yrs
Other _____

Language(s) spoken in addition to English_____

_____

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Individual Doula & Agency/Group General Information:

Sex: Male_____ Female _____ Date of Birth _____

For EEOC Compliance Requirements Only*: Please indicate the following:*

☐ ***African American*** ☐ ***Arabic*** ☐ ***Hispanic American*** ☐ ***Other/NA***
☐ ***Asian American*** ☐ ***Caucasian*** ☐ ***Native American*** ☐ _____

INDIVIDUAL & AGENCY/GROUP DOULA REGULATORY ** Please provide copy of documents.

Tax ID # ** **(include copy of W-9)**:	Social Security #: (Applicable to individual only)
State Medicaid ID#: (Applicable to individual only)	
Any additional licenses #:	State Medicaid Agency/Group ID#:(Applicable to agency/group only)
National Provider Identification # Type 1 – Individual Doula:	National Provider Identification # Type 2 – Group:

INDIVIDUAL & AGENCY/GROUP SPECIALTY/TAXONOMY

Name of Specialty	*Taxonomy Code*

INDIVIDUAL DOULA EDUCATION – Please complete separate sheet if necessary.

Name of School/College	*Type of Training*	*Dates Attended*

INDIVIDUAL & AGENCY/GROUP DOULA PROFESSIONAL LIABILITY DATA – Provide full address.

Name & Address of Insurance Carrier	*Policy # Effective Start/End Dates*	*Policy Limits of Coverage*	*Retroactive Date of Coverage*

AGENCY/GROUP CERTIFICATION OR ACCREDITATION STATUS (Organizational Providers only)

Agency Name	*Status*	*Date*	*Expiration Date*

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INDIVDUAL QUESTIONNAIRE (*including the criminal history) **-** If the answer to any of the questions is yes, plea se provide details on a separate sheet**. **Only Applicable to Individual Doulas Contracting Directly.**

Please answer the following questions by checking the appropriate box:	**YES**	**NO**
Do you have any physical or mental health problems or limitations in ability that may affect your ability to practice and provide health care with reasonable skill and safety?		
Do you have any history of chemical dependency/substance abuse?		
Have you been the subject of an investigation, or have proceedings ever been initiated to have your State Medicaid ID# (Applicable to individual only) to practice limited, suspended, revoked, denied, sanctioned or subject to probationary conditions, or have you voluntarily or involuntarily relinquished your State Medicaid ID# (Applicable to individual only)in this or any other state?		
Have you been the subject of an investigation, or have you ***ever*** been suspended, sanctioned or otherwise restricted from participating in any private, state, or federal health insurance program, for example Medicaid?		
Are you aware of any information that may prevent you from participating in Medicaid?		
Have you ***ever*** been named a defendant in a criminal proceeding?		
Has your medical staff membership, employment, or medical staff status at any health care institution, ***ever*** been rejected, limited, suspended, revoked, not renewed or subject to probationary conditions, or have you been the subject of an investigation, or, relinquished medical staff membership or clinical privileges while under investigation or disciplinary action, or are any such actions pending?		
In the last five years, have you been a defendant in a malpractice/professional liability suit, or are there currently any pending or potential suits against you, or, have any judgments been made or settlements paid on your behalf?		
Have you ***ever*** been denied professional liability insurance coverage or had your professional liability insurance coverage cancelled by your carrier for reasons other than the carriers termination of operation in your state?		
Have you ***failed*** to meet the State Medicaid ID (or Certified Doula status if applicable) requiremen ts for continuing medical education?		

AFFIRMATION OF ACCURACY AND COMPLETENESS

I understand I have the responsibility for producing adequate information for proper evaluation of my qualifications and for addressing any concerns about such qualifications. I understand that a condition of this application is that any misrepresentation or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and it shall not be processed any further. In the event credentialing information received from other sources substantially varies from that provided by me, I will be notified by the Company, and I understand I will be given the opportunity to correct such information. In the event that my application is rejected for this reason, I may not be entitled to any hearing, appeal or other due process rights as may otherwise be provided in the Policies and Procedures of the Company. I affirm that information provided in or attached to this application is current, correct and complete.

DOULA RELEASE AND HOLD HARMLESS

By applying for participation, I accept the following conditions. These conditions shall remain in effect for the duration of any term of participation I may be granted:

I acknowledge that the Company may at its sole discretion share or disclose the information provided in the credentialing and re-credentialing process to affiliates and subsidiaries or other related entities of WellCare Health Plans of New Jersey, Inc.

(1) I extend immunity to, and release from liability, the Company, its authorized representatives and any third parties, as defined below, for any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken or received by the Company or its authorized representatives, in good faith, relating, but not limited to matters or inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; or any other matter that might directly or indirectly have an effect on my competence, on patient care or on the orderly operation of this health care organization.

(2) I authorize the Company and its authorized representatives to consult with any third party who may have information bearing on my professional qualifications (credentials). This authorization includes the right to inspect or obtain clinical privileges,

documents, recommendations, reports, statements or disclosures relating to such questions. I also expressly authorize said third parties to release this information to the Company and its authorized representatives upon request.

(3) The term "Company and its authorized representatives" means any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application:

a. members of the Board and its appointed representatives;
b. the Chief Executive Officer or his/her designee;
c. all appointees to medical staff committees;
d. other Company employees;
e. consultants to the Company;
the Company's attorney and members of his/her firm, associates or designee;
any delegated or subdelegated agency with which the Company contracts for credentialing purposes.

(4) The term "third parties" means the following:

a. government agencies;
b. malpractice insurance carriers;
c. peer references;
d. hospital affiliations;
e. any delegated or sub-delegated agency with which the Company contracts for credentialing purposes.

_____ _____

SIGNATURE OF INDIVIDUAL DOULA APPLICANT ATTESTATION DATE

_____

PRINTED NAME

AGENCY/GROUP QUESTIONNAIRE (*including the criminal history) - If the answer to any of the questions is yes, please provide details on a separate sheet.

***Please answer the following questions by checking the appropriate box*:**	**YES**	**NO**
1. Have criminal proceedings ever been initiated against your Company or its authorized representative(s)		
2. Has your Company ever been the subject of an investigation or ever been suspended, sanctioned or otherwise restricted from participating in any private, state or federal health insurance program (for example Medicaid)?		
3. Does your Company or its authorized representative(s) have any physical or mental health problems or limitations in ability that may affect your ability to practice and provide health care with reasonable skill and safety?		
4. Does your Company or its authorized representative(s) have any history of chemical dependency/substance abuse?		
5. Has your Company or its authorized representative(s) been the subject of an investigation, or have proceedings ever been initiated to have your State Medicaid Agency/Group ID# (Applicable to agency/group only) to practice limited, suspended, revoked, denied, sanctioned or subject to probationary conditions, or have you voluntarily or involuntarily relinquished your State Medicaid Agency/Group ID# (Applicable to agency/group only) in this or any other state?		
6. Has your Company or its authorized representative(s) been the subject of an investigation, or have you ever been suspended, sanctioned or otherwise restricted from participating in any private, state, or federal health insurance program, for example Medicaid?		
7. Is your Company or its authorized representative(s) aware of any information that may prevent you from participating in Medicaid?		
8. Has your Company or its authorized representative(s) ever been named a defendant in a criminal proceeding?		
9 . Has your Company or its authorized representative(s) medical staff membership, employment, or medical staff status at any health care institution, ever been rejected, limited, suspended, revoked, not renewed or subject to probationary conditions, or have you been the subject of an investigation, or, relinquished medical staff membership or clinical privileges while under investigation or disciplinary action, or are any such actions pending?		
10. In the last five years, has your Company or its authorized representative(s) been a defendant in a malpractice/professional liability suit, or are there currently any pending or potential suits against you, or, have any judgments been made or settlements paid on your behalf?		

11. Has your Company or its authorized representative(s) ever been denied professional liability insurance coverage or had your professional liability insurance coverage cancelled by your carrier for reasons other than the carriers termination of operation in your state?		
12. Has your Company or its authorized representative(s) failed to meet the State requirements?		

AFFIRMATION OF ACCURACY AND COMPLETENESS

I affirm that information provided in or attached to this application is current, correct and complete. I understand that a condition of this application is that any misrepresentation or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and it shall not be processed any further.

AGENCY/GROUP RELEASE AND HOLD HARMLESS

By applying for provider participation, the following conditions are accepted as legally binding. These conditions shall remain in effect for the duration of any term of provider participation:
To the extent permitted by law, applicant shall release and hold harmless from liability, the Company, its authorized representatives and any third parties, as defined below, for any actions, recommendations, reports, statements, communications, or disclosures, that are made, taken or received in good faith by the Company or its authorized representatives relating to the following:
a. applications for participation;
b. periodic reappraisals undertaken for renewal thereof.
Authorization is given to the Company and its authorized representatives to consult with any third party who may have information bearing on services as a provider.

SIGNATURE OF AGENCY/GROUP AUTHORIZED REPRESENTATIVE _____ ATTESTATION DATE _____

PRINTED NAME _____

DISCLOSURE STATEMENT
OWNERSHIP AND CONTROL INTEREST, RELATED BUSINESS TRANSACTIONS AND PERSONS CONVICTED OF A CRIME
(NJ MEDICAID/FAMILYCARE)

With respect to the New Jersey Medicaid/FamilyCare Program, Provider agrees to provide a complete, accurate form to Payor at the time of initial contracting, upon any change to the information provided in the form, and upon request in accordance with federal and state law. Additionally, Provider acknowledges and understands that as to other providers with whom it subcontracts and who will be in Payor's network, it shall provide a complete, accurate form to Payor at the time of initial contracting, upon any change to the information provided in the form, and upon request in accordance with federal and state law. *For definitions, procedures and requirements, refer to the last page of this form and 42 CFR 455.100-106 (copy available upon request).*

Attach Separate Sheets As Needed

I. Identifying Information of Disclosing Entity (Provider or Subcontractor)

Name of the Disclosing Entity and D/B/A:				
Street Address:	City:	County:	State:	Zip Code:
Telephone No:		Medicaid Provider No		

II. Ownership and Control Interest

A. Provide the information requested below for each person (individual or corporation) with an Ownership or Control Interest in the Disclosing Entity or in any Subcontractor in which the Disclosing Entity has a direct or Indirect Ownership Interest of 5 percent or more. If none, indicate "N/A."

1.

Name:	Relationship:
	Percent of Ownership:
Primary Address:	Date of Birth: *(For Individuals)*
	SSN: *(For Individuals)*
PO Box Address: *(For Corporation)*	
IRS ID/Other Tax ID: *(For Corporations)*	
All business location addresses: (*For Corporations*)	
Relationship to other persons with Ownership or Control Interest. List all.	

2.

Name:	Relationship:
	Percent of Ownership:
Primary Address:	Date of Birth: *(For Individuals)*
	SSN: *(For Individuals)*
PO Box Address: *(For Corporation*)	
IRS ID/Other Tax ID: *(For Corporations)*	
All business location addresses: (*For Corporations*)	
Relationship to other persons with Ownership or Control Interest. List all.	

3.

Name:	Relationship:
	Percent of Ownership:
Primary Address:	Date of Birth: *(For Individuals)*
	SSN: *(For Individuals)*
PO Box Address: *(For Corporation*)	
IRS ID/Other Tax ID: *(For Corporations)*	
All business location addresses: (*For Corporations*)	
Relationship to other persons with Ownership or Control Interest. List all.	

B. Please list below the information requested for any Medicaid provider, fiscal agent or managed care entity in which a person with an Ownership or Control Interest in the Disclosing Entity also has an Ownership or Control Interest. This requirement applies to the extent that the Disclosing Entity can obtain this information by requesting it in writing from the person. The Disclosing Entity must (i) keep copies of all these requests and the responses to them; (ii) make them available to the Secretary of DHHS, the Medicaid agency and Health Plan upon request; and (iii) advise DMAHS and Health Plan when there is no response to a request. If none, indicate "N/A."

Name	Address	Relationship

III. Disclosure by Disclosing Entity: Information Related to Managing Employees. Please list the information requested below for any Managing Employee of the Disclosing Entity.

1.

Name:	
Address:	
Date of Birth:	SSN:

2.

Name:	
Address:	
Date of Birth:	SSN:

3.

Name:	
Address:	
Date of Birth:	SSN:

IV. Disclosure by Disclosing Entity: Information Related to Business Transactions.

Information that must be disclosed: (If none, indicate "N/A.")

(1) The ownership of any Subcontractor with whom the Disclosing Entity has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between the Disclosing Entity and any Wholly Owned Supplier, or between the Disclosing Entity and any Subcontractor, during the 5-year period ending on the date of the request.

Name	Address	Ownership

(3) Information on types of transactions with a "party in interest" as defined in Section 1318(b) of the Public Health Service Act (Section 1903(m)(4)(A) of the Social Security Act).

Name of party in interest	Description of Transaction	Accrued $ Value	Justification

V. Disclosure of Information on Persons Convicted of Crimes.

Is there any person with an Ownership or Control Interest in the Disclosing Entity, or who is a director, officer or managing employee of the Disclosing Entity, who has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, CHIP or the Title XX services program since the inception of those programs?

Yes ___ No ___ **If yes, list names and addresses of individuals or corporations.**

Name	Address	DOB and SSN, or TIN

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this Disclosure Statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the state agency or the secretary, as appropriate.

Name of Authorized Representative (Typed), Title

Signature **Date**

REMARKS: