********** FOR INSTRUCTIONAL USE ONLY **********

READ BEFORE COMPLETING YOUR MEDICAID FORM

All Medicaid Providers must complete, sign and return the documents below.
Please submit documents to:

The Ohio Department of Developmental Disabilities
Office of Provider Certification
30 E. Broad Street
13th Floor
Columbus, Ohio 43215

You may also fax these documents to 614-728-7836 or email documents to:
Provider.Certification@dodd.ohio.gov.

Please remember, all documents must be signed to be considered for review of your application to provide HCBS Waiver Services.

********** FOR INSTRUCTIONAL USE ONLY **********

Submit completed signed application/agreement with the required attachments to:
Provider Network Management Section
Provider Enrollment Unit
Columbus, OH 43216-1461
Call the Interactive Voice Response (IVR) System at 1-800-686-1516

Ohio Department of Job and Family Services

OHIO HEALTH PLANS PROVIDER ENROLLMENT APPLICATION/TIME LIMITED AGREEMENT FOR ORGANIZATIONS

Complete all applicable items if you plan to bill Medicaid as a sole proprietor of a business, or if you are a publicly or privately held business with more than one owner. (This does not apply to individual practitioners or practitioner groups.)

Organizational Provider Types: - Required

Mark the **ONE** appropriate type

☐ Ambulance (82)	☐ Home Health Agency (JC/CHAPS) (1 6)	☐ PACE (08)
☐ Ambulatory Surgery Center (46)	☐ Hospice (44)	☐ Pharmacy (70)
☐ Ambulette (83)	☐ Independent Diagnostic Testing Facility (IDTF) (79)	☐ Portable X-ray Laboratory 81)
☐ Assisted Living Waiver Provider (74)	☐ Independent Laboratory (80)	☐ Primary Care Clinic (50)
☐ Durable Medical Equipment (76)	☐ Medicaid School Program (28)	☐ Professional Dental School Clinic (56)
☐ End-Stage Renal Disease Dialysis Clinic (59)	☐ Mental Health Clinic (51)	☐ Professional Optometry School Clinic (55)
☐ Family Planning Clinic (54)	☐ Mental Hospital (02)	☐ Public Health Department Clinic (52)
☐ Federally Qualified Health Center (1 2)	☐ Optician (75)	☐ Rural Health Clinic (05)
☐ General Hospital (01)	☐ Outpatient Health Facility (04)	☐ Targeted Case Management (85)
☐ Hearing and Speech Clinic (58)	☐ Outpatient Rehabilitation Clinic (53)	☐ Waiver Service Provider (45)
☐ Home Health Agency (Medicare Cert.) (60)	☐ ODADAS Certified/Licensed Treatment Program	☐ ODMH Certified Comm Mental Hlth Agency

Provider Identification: - Required

(Print or type entries)

Organization Name

Abbreviated Organization Name *(If your name exceeds 30 spaces, indicate preferred abbreviation.)*

Employer Identification Number

You must attach a signed W-9 form

Address Information: - Required

Physical Location of Business *(Applicants: If more than one location, list Primary. Required field)*

Building Name / or / Department / or / In care of

Business Address (Number, Street, Avenue, Route, etc: P.O. and Drop Boxes are not acceptable)

Suite Number

City

County

State

Zip Code *(Zip + 4, if possible)*

Telephone Number

"Pay to" Address

(Name & Address to which Payment and/or Remittance Advice is to be mailed)

Building Name / or / Department / or / In care of

Address

Suite Number

City

State

Zip Code *(Zip + 4, if possible)*

Mailing/Correspondence Address

(Name & address to which all other material is to be mailed)

Building Name / or / Department / or / In care of

Address

Suite Number

City

State

Zip Code *(Zip + 4, if possible)*

National Provider Identifier:

If you have received your National Provider Identifier (NPI) number, please report it here:

NPI Number

If you had a previous NPI number, please report it here:

NPI Number

*** You must attach a copy of the notice from the NPI Enumerator to verify the National Provider Identifier Number.*

Medicare Identification Information: - Required if applicable

PIN Number*

PIN Number*

**You must attach of CLIA Certificate*

PIN Number*

**You must attach copy of Department of Health and Human Services Approval Letter.*

Clinical Laboratory Improvement Act Information - REQUIRED FOR ALL HOSPITALS AND ALL LABORATORIES

CLIA number*

**You must attach a copy of CLIA Certificate*

CLIA number*

**You must attach a copy of CLIA Certificate*

CLIA number*

Optional Categories of Service:

Check your Provider Type, and any other Categories of Service you are licensed and/or authorized to provide.

Provider Type	Optional Category of Service
☐ Ambulance (82)	☐ Ambulette Services (38)
☐ End-Stage Renal Disease Dialysis Clinic (59)	☐ Prescribed Drugs (30) ☐ Supplies & Med Equip (32)
☐ Family Planning Clinic (54)	☐ Supplies & Med Equip (32)
☐ General Hospital (01)	☐ Ambulance Services (37) ☐ Ambulette Services (38)
☐ Mental Health Clinic(51)	☐ Supplies & Medical Equip(32)

Provider Type	Optional Category of Service
☐ Outpatient Rehabilitation Clinic (53)	☐ Supplies & Med Equip (32)
☐ Primary Care Clinic (50)	☐ Dental Services (45) ☐ Optometric Services (47) ☐ Advanced Practice Nurse (21) ☐ Supplies and Medical Equip (32) ☐ Physician Services (43) ☐ EPSDT Services (40)
☐ Professional Optometry School Clinic (55)	☐ Supplies & Med Equip (32)
☐ Public Health Department Clinic (52)	☐ Dental Services (45) ☐ Optometric Services (47) ☐ Supplies & Medical Equip (32)

Federally Qualified Health Centers, Rural Health Facilities, Outpatient Health Facilities

Providers may be enrolled as only one type of alternative payment clinic. An "alternative payment clinic" shall be defined as an FQHC, rural health clinic (RHC), or outpatient health facility (OHF). Check the appropriate box:

☐ Section 330 of Public Health Service Act grants – recipient or under a contract with the recipient
(include documentation from CMS that identifies the specific service site(s) included in the 330 public health services project)

☐ Health and Human Services Certification as a Federally Qualified Health Center
(include documentation from US secretary of health and human services confirmation letter that the service site(s) is/are considered an FQHC look-alike with respect to Medicaid coverage)

Medicaid School Program

Medicaid School Program

A Medicaid School Program Provider must document effort to coordinate with an eligible child's medical home. The documentation must indicate effort made to obtain a release of information that would allow notation of the eligible child's primary healthcare provider's contact information and/or Medicaid managed care plan in the child's special education record. The release must allow the Medicaid School Program Provider to share health informational records with a child's primary healthcare provider and/or Medicaid managed care plan. Documentation must also include the efforts made to establish protocol for a bilateral exchange of information with the primary healthcare provider or managed care plan consistent with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, as applicable. These efforts should facilitate the coordination and non-duplication of screening, diagnostic, and treatment services for the eligible child.

Ohio Department of Education Internal Retrieval Number (IRN):

Internal Retrieval Number (IRN)*

Type of School District *(check one only):*

- ☐ City School
- ☐ Community School
- ☐ State School for the Deaf
- ☐ State School for the Blind
- ☐ Exempted Village
- ☐ Local School

Clinics *Check the applicable Clinic Provider Type, and attach a copy of the required documentation as indicated for your Provider Type*

Ambulatory Health Care Clinics - Required

Provider Type	Required documentation (to be submitted with application)
☐ 59 - End-Stage Renal Dialysis Clinic	☐ Medicare Certification as a Dialysis Clinic ☐ Licensure by the Ohio Department of Health as a dialysis provider
☐ 54 - Family Planning Clinic	☐ Affiliation with the Planned Parenthood Federation of America (PPFA) ☐ Grant award for the provision of family planning services under Title X of the Public Health Services Act ☐ Grant award through the Ohio Department of Health for family planning services under the Child and Family Health Services program ☐ Grant award through the Ohio Department of Health's Women's Health Services, in accordance with rule 3701-68-01 of the Administrative Code
☐ 58 - Hearing and speech Clinic	☐ Specialize in either speech language/audiology services or diagnostic imaging services
☐ 51 - Mental Health Clinic	☐ Ohio Department of Health Recognition as an Alcoholism Outpatient and After-care Services Program. ☐ Ohio Department of Mental Health Certification as an Outpatient Mental Health Facility.
☐ 53 - Outpatient Rehabilitation Clinic	☐ Medicare Certification as an Outpatient Rehabilitation Clinic OR ☐ Medicare Certification a Comprehensive Outpatient Rehabilitation Clinic
☐ 50 - Primary Care Clinic	☐ Joint Commission Accreditation ☐ Accreditation Association for Ambulatory Health Care (AAAHC) ☐ Healthcare Facilities Accreditation Program of the American Osteopathic Association ☐ Community Health Accreditation Program (CHAP) ☐ Receipt of state or federal grant funds for the provision of health services
☐ 56 - Professional Dental Clinic	☐ Accreditation by the Council on Dental Education (CODA) of the American Dental Association (ADA)
☐ 55 - Professional Optometry School Clinic	☐ Accreditation by the Council on Optometry Education (ACOE) of the American Optometric Association
☐ 52 - Public Health Department Clinic	☐ Legal Status as a County Health Department, City Health Department, or Combined Health District

Hospitals - Required

Hospital License Registry Number*	License Registry *(mm/dd/yyyy)*	Current License Registry Expiration Date* *(mm/dd/yyyy)*

**You must attach copy of License*

Hospital Beds - You must attach a copy of the letter from Department of Health with Your Bed Certification.

TOTAL HOSPITAL BEDS _____

Please check all that apply and attach supporting documentation for each block checked

- ☐ Children's Hospital
- ☐ Hospital has a Distinct Part Psychiatric Unit
- ☐ Major Teaching Hospital (Submit intern to bed ratio from fiscal intermediary)
- ☐ Rural Referral Center
- ☐ For hospitals in Ohio, please specify Nursery Level (Submit documentation form Ohio Dept. of Health)
  - ☐ Level 1
  - ☐ Level 2
  - ☐ Level 3
- ☐ Rehabilitation Hospital
- ☐ Long Term Acute Care Hospital
- ☐ Cancer Hospital
- ☐ HMO owned Hospital
- ☐ Specialty Hospital

If you provide Pharmacy and/or Ambulance/Ambulette services you must also complete the Pharmacy and Transportation sections of this application

National Provider Identifier: Secondary NPIs

Psychiatric Unit NPI	Rehabilitation Unit NPI

Hospital Cost Report Contact- Required

Name/Title		
Address		Suite Number
City	State	Zip Code *(Zip + 4, if possible)*
Phone Number	Fax Number	e-Mail Address

Hospital Cost Report Contact- Required

Name/Title		
Address		Suite Number
City	State	Zip Code *(Zip + 4, if possible)*
Phone Number	Fax Number	e-Mail Address

Upper Payment Limit (UPL) Program Contact

(If contact is not different from "Hospital Cost Report Contact", leave blank.)

Name/Title		
Address		Suite Number
City	State	Zip Code *(Zip + 4, if possible)*
Phone Number	Fax Number	e-Mail Address

Pharmacies - Required

State Pharmacy Board License Number*	DEA Registration Number*
*You must attach a copy of license.	*You must attach a copy of Controlled Substance Registration Certificate.

Name of Licensed, Registered Pharmacist (In full and actual charge of the Pharmacy) *(print or type.)*

Pharmacist's License Number*	Pharmacist's Signature	Date of Signature *(mm/dd/yyyy)*

*You must attach a copy of license.

Medical Suppliers - Required

State Vendor's License Number* **or** Orthotics / Prosthetics License Number* **or** State Tax Exemption Certificate Number*

*You must attach a copy of license. *You must attach a copy of license. *You must attach a copy of license.

Do you have a Respiratory Board license? ☐ **Yes** ☐ **No** **(This is required to bill for respiratory services)**

State Respiratory Board License Number*	Date license was issued *(mm/dd/yyyy)*	Date license expires *(mm/dd/yyyy)*
*You must attach a copy of license.	*You must attach a copy of license.	

Are you dispensing hearing aids? ? ☐ **Yes** ☐ **No** **If yes, please enter the appropriate License Number below.**

Hearing Aid Dispenser License Number* **or** Audiologist License Number*

*You must attach a copy of license. *You must attach a copy of license.

Independent Diagnostic Testing Facilities - Required

Physician's Certification: I certify that (check one):

☐ **I own or partially own the facility and employ the operating personnel.**

☐ **I am a part-time employee or an employee under contract whose responsibilities include checking the procedural and quality applicable federal, state, and local licensure and registration requirements, and assuring that safe operating procedures and quality control procedures are used.**

Physician's Name (print)	Physician's Signature	Date of Signature *(mm/dd/yyyy)*

Eligible Medicaid providers of Independent Diagnostic Testing Facility services must meet the following criteria:

1. Possess a current unrevoked or unsuspended Medicare Provider Number as an Independent Diagnostic Testing Facility.
2. Be in conformity with all applicable federal, state, and local laws and regulations.
3. Provide nonradiological services under the general supervision of a physician who is certified or meets the requirements and/or training in the performance and interpretation of diagnostic testing procedures.
4. Provide radiological services under the following conditions:
   a) The services are performed under the general supervision of a licensed doctor of medicine or licensed doctor of osteopathy who is qualified by advanced training and experience in the use of x-rays as defined below:
      i) The physician is certified in radiology by the American Board of Radiology or by the American Osteopathy Board of Radiology or possesses qualifications which are equivalent to those required for such certification;
      ii) The physician is certified or meets the requirements for certification in a specialty in which the physician has become qualified by experience and/or training in the use of x-rays for diagnostic purposes.
   b) All operators of the x-ray equipment must meet the following requirements:
      i) Successful completion of a program of formal training in x-ray technology of not less than 24 months duration in a school approved by the Council on Education of the American Medical Association, or have earned a bachelor of science degree or associate degree in radiology technology from an accredited college or university.
      ii) For those whose training was completed prior to July 1, 1966, but on or after July 1, 1960, successful completion of 24 full months of training under the direct supervision of a physician who meets the definition of a qualified physician.
5. Radiology procedures are conducted in compliance with radiology safety standards which assure that the equipment and the operating procedures used minimize the radiation exposure and hazards for patients, personnel, and other persons in the immediate environment. X-ray equipment and shielding are inspected by qualified individuals at intervals not greater than every 24 months.

Ambulance/Ambulette Transportation Services

Are you publicly owned and operated? ☐ Yes ☐ No
If no, enter your State Medical Transportation Board Service Number* here

** You must attach a copy of the State Medical Transportation Board Certificate of Licensure*

Medicare Certification Number *(Ambulance Provider Applicants only)**

** You must attach a copy of the Medicare Certification*

Ambulance/Ambulette Personnel *(This page may be copied as needed to list all drivers.)*

Ambulance providers: All drivers must have EMT certification (include a copy of EMT card for each driver with the application)
A copy of each driver's driving record from the Bureau of Motor Vehicles to be submitted with the application.

Ambulette providers:
Each driver and each attendant must have a current card as proof of successful completion of the "American Red Cross" (or equivalent certifying organization) basic course in first aid and a CPR certification
Each card must be signed and a copy of each driver's card, front and back, must be included with the application

OR EMT certification for each driver/attendant (include a copy of each driver's/attendant's EMT card with the application)

List the driver/attendant information below. Be sure to include the appropriate certification cards with the application for each driver/attendant. Please print or type all responses.

Driver/Attendant's Name	EMT Card Number Required for Ambulance Drivers	American Red Cross Basic/Community First aid and CPR	EMT Expiration Date or Completed Date of American Red Cross Basic/Community First Aid Training/CPR *(mm/dd/yyyy)*
		First Aid	EMT expiration date or First Aid completion date
Driver Attendant		CPR	CPR completion date
		First Aid	EMT expiration date or First Aid completion date
Driver Attendant		CPR	CPR completion date
		First Aid	EMT expiration date or First Aid completion date
Driver Attendant		CPR	CPR completion date
		First Aid	EMT expiration date or First Aid completion date
Driver Attendant		CPR	CPR completion date
		First Aid	EMT expiration date or First Aid completion date
Driver Attendant		CPR	CPR completion date
		First Aid	EMT expiration date or First Aid completion date
Driver Attendant		CPR	CPR completion date

Requirements for Ambulette Vehicle Providers
Documents to be included with the application

You must include, with your application, copies of documents for each item listed on this page. In addition, all ambulette vehicle providers must have documented proof on file of compliance with the following requirements, to be available upon request from the Department of Job and Family Services.

Check each block to certify compliance and include required documentation

☐	Currently, the ambulette service is operating vehicles. The provider maintains a valid current vehicle license registration with the Ohio Bureau of Motor Vehicles for each vehicle. Include a copy of the vehicle registration for each vehicle.
☐	Each vehicle displays the company logo, insignia, or name on both sides and rear of the vehicle. Include photos of each vehicle for verification.
☐	The provider maintains liability insurance coverage in the amount of not less than five hundred thousand dollars per occurrence and not less than five hundred thousand dollars in the aggregate, for any cause for which the provider would be liable. Include proof of insurance.
☐	The provider maintains bodily injury and property damage insurance with solvent and responsible insurers licensed to do business in this state for any loss or damage resulting from any occurrence arising out of or caused by the operation or use of any ambulette vehicle. The insurance plan shall insure each vehicle for the sum of not less than one hundred thousand dollars for bodily injury to or death of more than one person in any one accident and for the sum of fifty thousand dollars for damage to property arising from any one accident. Include proof of insurance.
☐	Each driver and attendant must submit himself or herself for criminal background checks in accordance with section 109.572 of the Revised Code. Any applicant or employee who has been indicted, convicted, or pleaded guilty to violation cited in divisions (A)(1)(a), (A)(2)(a), (A)(4)(a), and/or (A)(5)(a) of section 109.572 of the revised code shall not provide services to Medicaid patients unless the exceptions set forth in paragraphs (A) and (B) of rule 3701-13-06 of the Administrative Code apply. Include a copy of the BCI criminal background check results.
☐	Each driver and each attendant has current cards issued as proof of successful completion of the “American Red Cross” (or equivalent) basic or community course in first aid and CPR. Each card must be signed on the back by the driver or attendant who completed the course. Include a copy of each card for each driver and attendant with the application.
☐	Each driver must have a copy of his or her driving record provided from the Bureau of Motor Vehicles. The date of the driving record submitted at the time of the application must be no more than fourteen days prior to the date of application for employment. Persons with six or more points on their driving record in accordance with section 4507.02 of the Revised Code cannot be an ambulette driver. Include a copy of each driver’s driving record with the application.
☐	The qualifications of each driver and each attendant must comply with local, state, and federal laws and regulations, including a valid driver’s license and be eighteen years or older. Include a copy of a valid driver’s license for each driver.

Requirements for Ambulette Vehicle Providers

All ambulette providers must certify that they operate vehicles that meet the following standards and have documentation to verify compliance that is available upon request.

Check each block to certify compliance

☐	Each vehicle is specifically designed to transport one or more patients sitting in wheelchairs and has fasteners to secure the wheelchair to the floor or side of the vehicle to prevent wheelchair movement. In addition, the vehicle is equipped with restraints to secure the patient in the wheelchair.
☐	Each vehicle has a minimum ceiling to floor height of fifty-six inches.
☐	Each vehicle is equipped with a communication system capable of two-way communication.
☐	The provider must conduct daily inspection and testing of the hydraulic lift or access ramp.
☐	Each vehicle is equipped with, at a minimum, a fire extinguisher and an emergency first-aid kit.
☐	Each vehicle has provisions for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and driver in the event of an accident.
☐	The provider must complete vehicle inspection documentation in the form of a checklist to include at a minimum wheelchair restraints, wheelchair lifts, lights, windshield wipers/washers, emergency equipment, mirrors, and brakes.
☐	The provider maintains on file evidence that at least an annual vehicle inspection was completed by the Ohio State Highway Patrol Safety Inspection Unit, or a certified mechanic and each vehicle has been determined to be in good working condition.
☐	Each ambulette driver and each attendant has an identification card available to the patient identifying his or her complete name and company affiliation.
☐	The provider maintains on file a signed statement from a licensed physician for each driver and attendant declaring that they do not have physical, including vision and hearing, or mental limitation likely to interfere with safe driving, passenger assistance, or emergency activity and does not have a communicable disease that could jeopardize the health or welfare of patients being transported.
☐	Each ambulette driver has undergone testing for alcohol and controlled substances in accordance with 49 CFR 382.
☐	Each ambulette and each attendant has completed a passenger assistance training course to include at a minimum the basic characteristics of major disabling conditions affecting ambulation, basic considerations for functional factors, management of wheelchairs, assistance and transfer techniques, environmental considerations, and emergency procedures.

Disclosure and Ownership/Control Interest Statement

Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations in spaces provided. List any additional names and addresses on the proper section of the sheet provided.

1. A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organization, agency, or practice that have been indicted or convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

☐ YES ☐ NO

Name	When? Give date *(mm/dd/yyyy)*	SSN/EIN
Name	When? Give date *(mm/dd/yyyy)*	SSN/EIN

1. B. Are there any directors, officers, agents, or managing employees of the institution, agency, organization, or practice who have ever been indicted or convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

☐ YES ☐ NO

Name	When? Give date *(mm/dd/yyyy)*	SSN/EIN
Name	When? Give date *(mm/dd/yyyy)*	SSN/EIN

2. A. List names, addresses, and SSNs for individuals, and the names, addresses, and Employer Identification Numbers (EIN) for organizations having direct or indirect ownership or a controlling interest in the entity or practice. Place an "X" in the box labeled Related for all names listed who are related to each other.

Name	Related	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN

2. B. Type of Entity or Practice: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Unincorporated Associations ☐ Other *(specify)* _____

2. C. If the disclosing entity or practice is a corporation, list names, addresses, and SSNs of the Directors and the name, address, and EIN of the parent corporation, if applicable.

Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN

2. D. Have you ever been issued an Ohio Medicaid 7-digit Provider Number?

☐ YES ☐ NO If, YES, you must list them in the boxes below.

7-digit Provider Number	7-digit Provider Number	7-digit Provider Number	7-digit Provider Number

2.E. Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership, or Members of the Board of Directors.) If yes, list names, addresses of individuals, and provider numbers. If under Title XIX, list vendor number.
☐ YES ☐ NO

Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number
Name	Address	Provider (Title XIX Vendor) Number

3.A. Has there been a change in ownership or control within the last year? If yes, when? *(mm/dd/yyyy)*
☐ YES ☐ NO *ATTACH EXPLANATION*

B. Do you anticipate any change in ownership or control within the year? If yes, when? *(mm/dd/yyyy)*
☐ YES ☐ NO *ATTACH EXPLANATION*

4. Is this entity operated by a management company, or leased in whole or part by another organization? If yes, give date of change in operations. *(mm/dd/yyyy)*
☐ YES ☐ NO

5. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?
☐ YES ☐ NO

6. Is this entity chain affiliated? (If yes, list name, address of Corporation, and EIN number.)
☐ YES ☐ NO

Name	Address	EIN

7. Are there any Directors, Officers, Agents, or Managing Employees of the Institution, Agency, Organization, or Practice who have ever been indicted or convicted of a violation of State or Federal Law?
☐ YES ☐ NO

Name	Type of offense	When give date? *(mm/dd/yyyy)*	SSN/EIN

Hospitals, only:
8. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?
☐ YES ☐ NO If yes, give year of change. Current Beds Prior Beds

Disclosure statement: Additional Names, Addresses, and Numbers by section.

Section: **1.A.**

Who was it? Give name	When? Give date *(mm/dd/yyyy)*	SSN/EIN
Who was it? Give name	When? Give date *(mm/dd/yyyy)*	SSN/EIN
Who was it? Give name	When? Give date *(mm/dd/yyyy)*	SSN/EIN

Section: **1.B.**

Who was it? Give name	When? Give date *(mm/dd/yyyy)*	SSN/EIN
Who was it? Give name	When? Give date *(mm/dd/yyyy)*	SSN/EIN
Who was it? Give name	When? Give date *(mm/dd/yyyy)*	SSN/EIN

Section: **2.A.**

Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN
Name	Related ☐	Address	SSN/EIN

Section: **2.C.**

Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN
Name	Address	SSN/EIN

All providers must read the statements below, print name, initial, and date

In accordance with Executive Order 2007-01 S, Vendor or Grantee, by signature on this document, certifies: (1) it has reviewed and understands Executive Order 2007-01 S, (2) has reviewed and understands the Ohio ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Vendor or Grantee understands that failure to comply with Executive Order 2007-01 S is, in itself, grounds for termination of this contract or grand and may result in the loss of other contracts or grants with the State of Ohio.

A copy of Executive Order 2007-01 S can be found at: http://www.dot.state.oh.us/cic/governor.asp

Authorized Representative Name and Title *(please print)*	
Authorized Representative Initials	Date

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this 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.

Authorized Representative Name and Title *(please print)*	
Authorized Representative Initials	Date

For all Ambulatory Health Care Clinics Only

All Ambulatory Health Care Clinics must provide documentation indicating the facility:

* Is Free Standing - no administrative, organizational, financial, or other connection with a hospital or long term care facility;
* Furnishes outpatient (non-institutional) health care by or under the direction of a physician or dentist;
* Has a fixed location or specifically designed mobile unit;
* Does not provide overnight accommodations;
* Is not eligible as a Medicaid provider as a professional association of physicians, dentists, optometrists, opticians, podiatrists, or limited practitioners such as physical therapists, psychologists, or chiropractors enrolled as a Medicare provider.

Ohio Medicaid Provider Agreement

This provider agreement is a contract between the Ohio Department of Job and Family Services (the Department) and the undersigned provider of medical assistance services in which the Provider agrees to comply with the terms of this provider agreement, sate statutes, Ohio Administrative Code rules, and Federal statutes and rules, and agrees and certifies to

1. Render medical assistance services as medically necessary for the patient and only in the amount required by the patient without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap, submit claims only for services actually performed, and bill the Department for no more than the usual and customary fee charged other patients for the same service.

2. Ascertain and recoup any third-party resource(s) available to the recipient prior to billing the Department. The Department will then pay any unpaid balance up to the lesser of the provider's billed charge or the maximum allowable reimbursement as set forth in Chapter 5101:3 of the Administrative Code.

3. Accept the allowable reimbursement for all covered services as payment-in-full and, except as required in paragraph 2 above, will not seek reimbursement for that service from the patient, any member of the family, or any other person.

4. Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer.

5. Furnish to the Department, the secretary of the Department of Health and Human Services, or the Ohio Medicaid fraud control unit or their designees any information maintained under paragraph 4 above for audit or review
purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of Medicaid or Disability Assistance Medical payments and may result in termination from the Medicaid and Disability Assistance Medical programs.

6. Inform the Department within thirty days of any changes in licensure, certification, or registration status; ownership; specialty; additions, deletions, or replacements in group membership and hospital-based physicians; and address;

7. Disclose ownership and control information, and disclose the identity of any person (as specified in 42 CFR, Parts 455, Subpart B and 1002, Subpart A, as amended, and as specified in rule 5101:3-1-17.3 of the Administrative Code) who has been convicted of a criminal offense related to Medicare, Medicaid, Disability Assistance Medical or Title XX services.

8. Neither the individual practitioner, nor the company, nor any owner, director, officer, employee of the company, or any independent contractor retained by the company or any of the aforementioned persons, currently is subject to sanction under Medicare, Medicaid, Disability Assistance Medical or Title XX or otherwise is prohibited from providing services to Medicare, Medicaid, Disability Assistance Medical or Title X beneficiaries.

9. To follow the regulations and policies set forth in the appropriate edition of the Medicaid Handbook.

10. Provide to ODJFS, through the court of jurisdiction, notice of any action brought by the provider in accordance with the Title 11 of the United States Code (Bankruptcy). Notice shall be mailed to: "Office of Legal Services, Ohio Department of Job and Family Services, 30 East Broad Street - 31st Floor, Columbus, Ohio 43215".

11. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d). This provider agreement may be canceled by either party upon 30 days written notice prior to termination date. I further certify that I am the individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive officer, or general partner of the business organization that is applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.

I accept the terms and conditions

Agreement Date _____ Certain provider agreements may be made retroactive (up to 12 months) to encompass dates on which the provider furnished covered services to a Medicaid consumer and the service has not been billed to Medicaid.
Provision Check (Yes No) circle one A failure to select YES shall be taken by ODJFS to mean that you waive your rights to a retroactive period of months prior to the date ODJFS approves your application. This agreement is limited to 5 years from the effective date.
Signature_____

For help completing the application, please call the Provider Enrollment Customer Service Line. You can reach the Provider Enrollment Unit through the Interactive Voice Response Unit.

The telephone number is:

800-686-1516

Our business hours are 8:00 a.m. to 4:30 p.m. Monday through Friday.

For State Use Only

Date Received (**1**)	Date Received (**2**)	Date Received (**3**)	Date Received (**4**)
Date Returned (**1**)	Date Returned (**2**)	Date Returned (**3**)	Date Returned (**4**)

Date Processed	Effective Date	Provider Number
Operator's Number	[redacted]	Ticket Number

Ohio Department of Job and Family Services

OHIO HEALTH PLANS PROVIDER ENROLLMENT APPLICATION/TIME LIMITED AGREEMENT FOR ORGANIZATIONS

DISCLOSURE EXPLANATION ATTACHMENT

3.A Has there been a change in ownership or control within the last year?
If yes, when? (mm/dd/yyyy)
Explanation:

3.B Do you anticipate any change in ownership or control within the year?
If yes, when? (mm/dd/yyyy)
Explanation: