Disclosing Entity Provider Application

* Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Tax ID Credentialing Packet Instructions and Attachments

In order for the application to be considered complete:

1. All information must be legible. Please print or type all information.
2. This application is broken up into four sections. Please note you may only receive applicable sections:
   a) **TAX ID *Credentialing Packet*** (**Green** Header Pages)
   b) **NPI *Credentialing Packet*** (**Orange** Header Pages)
   c) **Behavioral Health Addendum** (**Yellow** Header Pages)
   d) **LTSS** Addendum (**Purple** Header Pages)
3. A separate application must be completed for each Legal Entity/TIN.
4. The Application must be signed and dated – see ***Tax ID Credentialing Packet – Page 4.***
5. If necessary, use a separate sheet of paper to provide additional information.
6. The original application with attachments should be attached to the Provider Agreement.
7. Fill-in the Tax ID# at the bottom of every page for reference purposes.

Attach the following documents to the completed application:

☐ State Operational License

☐ Other applicable State/Federal Licensures (e.g., CLIA/Lab Permit, DEA, Pharmacy or Department of Health)

☐ Accreditation/Certification (by a nationally recognized accrediting body, e.g., TJC/JCAHO/CARF/COA/or AOA) Accreditation letter with dates of accreditation

  ☐ If not accredited by a nationally recognized accrediting body, attach the Site Evaluation Results from a governmental agency

☐ Certificate of Compliance

☐ W-9

☐ Ownership and Disclosure Form (DOO)

☐ Other applicable State/Federal Licensures (See the last page of **NPI *Credentialing Packet*** for a list of state-required documents)

☐ Copy of Declaration Sheet and/or Certificate of Insurance

- HCBS Providers who are not providing medical or behavioral health service: General Liability Insurance Policies
- All other provider types: BOTH current Professional Malpractice and Comprehensive General Liability Insurance policies

☐ **Initial Credentialing / Assessment**

☐ **Re-Credentialing / Re-Assessment**

☐ **Addition of new site / location to current contract**

Tax ID Credentialing Packet
Complete Tax ID Credentialing Packet – for each individual TIN

Legal Entity Information (Name on Income Tax Return)

Tax ID Holder Name:		
Federal Tax ID Number:	PA PROMISe ID: (9 digits)	☐ Profit ☐ Non-Profit
Legal/Tax Address *(where you want the 1099 sent):*		
Website:		

Credentialing Contact Information

If questions about this application, contact:	Phone Number:
Email:	Fax Number:

Insurance Information (General Liability)

Carrier:	Amount of Coverage:	Coverage Dates:

Billing Information

Pay To Name *(Issue check to):* Note: May be different than name on the 1099.		
Pay To Address *(Send remittance to):*	City, State, Zip:	Phone Number:
Billing Contact Name:	Billing Contact Email:	Fax Number:

Tax ID Credentialing Packet	
Sanctions Questions – *Please indicate If the answer differs for Provider Type(s) listed in Tax ID Credentialing Packet – Page 2*	
Have there been or are there any currently pending malpractice claims, suites, settlements or proceedings involving your Organization within the past five years?	☐ **Yes*** ☐ **No**
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	☐ **Yes*** ☐ **No**
Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?	☐ **Yes*** ☐ **No**
Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?	☐ **Yes*** ☐ **No**
Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended or revoked for any reason?	☐ **Yes*** ☐ **No**
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?	☐ **Yes*** ☐ **No**
Has the corporation, an officer or board member ever been convicted of a felony?	☐ **Yes*** ☐ **No**

**If you answered "Yes" to any question above, please explain on a separate sheet of paper.*

PROVIDER RESPONSIBILITY STATEMENT

Provider hereby understands that as a prospective/current **Pennsylvania Health & Wellness** provider, the Provider is solely responsible for ensuring that any licensed practitioners under our employment or working in association with our clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within Provider's practice. Further, Provider agrees that each such individual must be fully presented to **Pennsylvania Health & Wellness** Credentials Committee for their review and approval, and, absent such affirmative approval, **Pennsylvania Health & Wellness** members assigned to our care may not be treated or assisted by such individuals under our employment or associated to Provider's practice without prior approval from **Pennsylvania Health & Wellness**. Further, from time to time, such licensed practitioners may change, as Provider's practice associates. In all such cases, Provider accept responsibility for notifying **Pennsylvania Health & Wellness** in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy **Pennsylvania Health & Wellness** credentials/re-credentials requirements for all such individuals associated with Provider's practice.

By applying for participation to the Plan, Provider hereby fully understands that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need-to-know basis. Notwithstanding the foregoing, Provider agrees to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that Provider, as the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photocopy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photocopy shall have the same force and effect as the signed original.

Name of Facility: _____ Date: _____
Print or Type Name of Facility

_____
Signature of Provider or Authorizing Representative Title

NOTE: A stamp signature or typed font is not acceptable

NPI Credentialing Packet Instructions and Attachments

In order for the application to be considered complete:

1. All information must be legible. Please print or type all information.
2. If necessary, use a separate sheet of paper to provide additional information.
3. Fill-in the Tax ID# at the bottom of every page for reference purposes.
4. For each different NPI fill out the Credentialing Packet below for each service location, the entire packet must be filled out.

NPI Credentialing Packet		
This application applies to the following Provider Types: *(Choose all that apply)*		
☐ Hospital NPI:	☐ Hospital (Critical Access) NPI:	☐ Hospital (General Acute Care) NPI:
☐ Hospital (Rehabilitation) NPI:	☐ Hospital (Psychiatric) NPI:	☐ Hospital (Swing Bed) NPI:
☐ Hospital (Substance Abuse) NPI:	☐ Orthotics and Prosthetics NPI:	☐ SPU NPI:
☐ Ambulance NPI:	☐ Clinic – Indian Health (IHC) NPI:	☐ Outpatient Clinic NPI:
☐ Diagnostic Imaging Center NPI:	☐ Dialysis NPI:	☐ Outpatient Infusion / Chemotherapy NPI:
☐ Cardiac Catheterization Services NPI:	☐ Clinic – Rural Health Center (RHC) NPI:	☐ Clinic – Federally Qualified Health Center (FQHC) NPI:
☐ Durable Medical Equipment NPI:	☐ Skilled Nursing Facility NPI:	☐ Sleep Diagnostic NPI:
☐ Cardiac Surgery Program NPI:	☐ Surgical Services (OP or ASC NPI:	☐ Hospice NPI:
☐ Laboratory NPI:	☐ Family Planning Clinics NPI:	☐ Home Health Agency NPI:
☐ Critical Care Services – Intensive Care Units (ICU) NPI:	☐ Transplant ☐Heart/Lung ☐Kidney ☐Heart ☐Liver ☐Lung ☐Pancreas NPI:	☐ Rehabilitation Facility (Outside of Hospitals) NPI:
☐ Mammography NPI:	☐ Physical Therapy NPI:	☐ Occupational Therapy NPI:
☐ Speech Therapy NPI:	☐ Urgent Care (Free Standing) NPI:	☐ Urgent Care (Attached to Hospital) NPI:
☐ Behavioral Health Agency/Child Placing Agency NPI:	☐ Chemical Dependency/Substance Abuse NPI:	☐ Community Mental Health Center (CMHC) NPI:
☐ Autism Facility NPI:	☐ Intensive Family Intervention NPI:	☐ Inpatient Psychiatric Services NPI:
☐ Residential Treatment Center NPI:	☐ Other: NPI:	☐ Other: NPI:

NPI Credentialing Packet

Service Location ____ of ____ **Complete this section for each Group NPI**

Group or Facility Name (*to be displayed in the Directory*)		
Tax ID Number:	Provider Type:	Group National Provider ID (NPI) #:
Primary Specialty:		Taxonomy:
State License Number:	PA PROMISe ID # (with 4-digit location):	Medicare Number:
Location Street Address: ☐ Same as Legal Entity	City, State, Zip:	County:
Location Phone Number:	Location Fax Number:	Email:
Billing Information: ☐ Same as indicated in Tax ID section (*If different, complete below*)		
Pay To Name (Issue check to): *Note: May be different than name on the 1099*.		
Pay To Address (Send remittance to):		
Billing Contact Name:	City, State, Zip:	Phone Number:
Billing Contact Email:		Fax Number:

Region(s) Served:
☐ Southeast ☐ Lehigh/Capital ☐ Southwest ☐ Northeast ☐ Northwest ☐ Statewide

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

☐ 24 Hours ☐ 8 – 5

ADA Compliant? *(Check all that apply)*

☐ **PROGRAMMATIC ACCESS (PA)**: Programmatic access includes but is not limited to methods of communicating with member for the provision of individual medical information and general health information; appointment scheduling procedures and time slots; and system-wide coordination and flexibility to enable access.

☐ **EXTERIOR BUILDING (EB)**: There is an accessible ramp to the building. Curb ramps and other ramps to the building are wide enough for a wheelchair/scooter. Handrails are provided on both sides of the ramp. Doors are wide enough to allow entrance for a wheelchair/scooter and the doors have handles that are easily opened.

☐ **PARKING (P)**: Parking spaces, including van-accessible space(s), are accessible. Pathways have curb ramps between the parking lot, office and at drop-off locations.

☐ **INTERIOR BUILDING (IB)**: Doors are wide enough for a wheelchair/scooter and have handles that are easily opened. There are interior ramps available, and the ramps have handrails. If an elevator is present, it must be available for use by the public and members. The elevator has easy-to-hear sounds and Braille buttons within reach. The elevator is large enough for a wheelchair/scooter to turn around. The restroom is accessible, has doors wide enough to accommodate a wheelchair/scooter and are easy to open. Offices have height adjustable exam table(s), and adequate, clear floor space inside the area where the equipment is for side transfers by wheelchair or scooter users. When needed there is availability of lift equipment. If a chair lift is present, it can be utilized without help.

Are you located on a Public Transportation route? ☐ Yes ☐ No	Service Location Accepting New Patients? ☐ Yes ☐ No	Has the Provider Office completed Cultural Training? ☐ Yes ☐ No
Crisis Intervention / Emergency Services Offered? ☐ Yes* ☐ No	*If Yes, explain:	

Please list any languages *(including American Sign Language)* offered by the Provider or Skilled Medical Interpreter:

Do you provide services to any of the following special needs population? *(Check all that apply)*:

☐ Deaf/Hearing Impaired ☐ Physical Disability ☐ Blind/Vision Impaired ☐ Developmental Disability

☐ Other (Please specify: _____)

Gender or Age restrictions

Gender: Female Only ☐ Male Only ☐ Both ☐ **Age Limits:** Lowest Age ___ Highest Age ___

Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name	*Level Status*	*Applied Date*	*Expiration Date*
Accreditation Commission for Health Care (ACHC)			
American Association of Ambulatory Health Centers (AAAHC)			
American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)			
American College of Radiology (ACR)			
American Osteopathic Hospital Association (AOHA)			
Board of Orthotist / Prosthetist Certification (BOCUSA)			
Clinical Laboratory Improvement Act (CLIA)			
Commission on Accreditation for Rehab Facilities (CARF)			
Community Health Accreditation Program (CHAP)			
Council on Accreditation (COA)			
DEA Certificate			
Healthcare Quality Association on Accreditation (HQAA)			
The Joint Commission (TJC (aka JCAHO))			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)			
National Association of Boards of Pharmacy (NABP)			
National Committee for Quality Assurance (NCQA)			
Pharmacy			
State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)			
Others (please list):			

For Inpatient Facilities please complete the box(s) below:

Facility Type	*CMS Certified (Y/N/Pending)*	*Current Survey Date*	*Bed Count*
Acute Inpatient			
ICU/CCU			
Skilled Nursing			
Inpatient Psychiatric			

Facility Behavioral Health Addendum Instructions and Attachments

In order for the application to be considered complete:

1. All information must be legible. Please print or type all information.
2. If necessary, use a separate sheet of paper to provide additional information.
3. Fill-in the Tax ID# at the bottom of every page for reference purposes.
4. This Behavioral Health Addendum must be completed in its entirety for any Behavioral Health agreement. Please complete this page for ***EACH*** service location

Behavioral Health Addendum	*Service Location ____ of ____*
Date Completed:	Name:
Service Location Address:	
Do you provide services to the following populations? *(Check all that apply)* ☐ Serious Mental Illness (SMI) ☐ Serious Emotional Disturbance (SED) ☐ Severe Persistent Mentally Ill (SPMI)	
Please Select the types of services you offer. *(Check all that apply)*	
☐ Inpatient Mental Health – Adult	☐ Psychological Testing
☐ Inpatient Mental Health – Child & Adolescent	☐ Neuropsychological Testing
☐ Inpatient Substance Abuse – Adult	☐ Partial Hospitalization Program (PHP) – Mental Health (Adult)
☐ Inpatient Substance Abuse – Child & Adolescent	☐ Partial Hospitalization Program (PHP) – Mental Health (Child & Adolescent)
☐ Inpatient – Eating Disorder	☐ Partial Hospitalization Program (PHP) – Substance Abuse (Adult)
☐ Inpatient Detox - Adult	☐ Partial Hospitalization Program (PHP) – Substance Abuse (Child & Adolescent)
☐ Inpatient Detox – Child & Adolescent	☐ Residential Treatment – Chemical Dependency (Adult)
☐ Intensive Outpatient Program – Substance Abuse (Adult)	☐ Residential Treatment – Chemical Dependency (Child & Adolescent)
☐ Intensive Outpatient Program – Substance Abuse (Child & Adolescent)	☐ Residential Treatment – Mental Health (PRTF) - Adult
☐ Intensive Outpatient Program (IOP) – Mental Health (Adult)	☐ Residential Treatment – Mental Health (PRTF) – Child & Adolescent
☐ Intensive Outpatient Program (IOP) – Mental Health (Child & Adolescent)	☐ Community Based Services
☐ OP Treatment Services – Substance Abuse (Adult)	☐ Targeted Case Management
☐ OP Treatment Services – Substance Abuse (Child & Adolescent)	☐Specific Medication Treatment ☐ Suboxone ☐ Vivitrol ☐ Methadone
☐ OP Treatment Services – Mental Health (Adult)	☐ Opioid Centers of Excellence
☐ OP Treatment Services – Mental Health (Child & Adolescent)	☐ Electroconvulsive Therapy (ECT) – Outpatient
☐ Crisis Stabilization	☐ Electroconvulsive Therapy (ECT) – Inpatient
☐ Acute Care Hospitals with Adolescent Inpatient Substance Use Beds	☐ Acute Care Hospitals with Child Inpatient Substance Use Beds
☐ Acute Care Hospitals with Adult Inpatient Substance Use Beds	☐ Other (please specify):

LTSS Addendum Instructions and Attachments

In order for the application to be considered complete:

1. All information must be legible. Please print or type all information.
2. If necessary, use a separate sheet of paper to provide additional information.
3. Fill-in the Tax ID# at the bottom of every page for reference purposes.
4. **Complete a new LTSS addendum (Pages 1 & 2) for each service location**
5. This LTSS Addendum must be completed in its entirety for any LTSS agreement.

LTSS Addendum	*Service Location ____ of ____*
Name:	
Address:	
Location Phone Number:	
Promise ID:	
State License Number:	
Tax ID:	

Provider Type

☐ Durable Medical Equipment (DME)	☐ Skilled Nursing Facility (SNF)	☐ HCBS Facility (59)
☐ Home Health	☐ Hospice	☐ County Nursing Home

Select the counties where your agency is authorized by OLTL to provide services for this location

☐ All counties in Pennsylvania	☐ Cambria	☐ Delaware	☐ Lackawanna	☐ Montour	☐ Susquehanna
☐ Adams	☐ Cameron	☐ Elk	☐ Lancaster	☐ Northampton	☐ Tioga
☐ Allegheny	☐ Carbon	☐ Erie	☐ Lawrence	☐ Northumberland	☐ Union
☐ Armstrong	☐ Centre	☐ Fayette	☐ Lebanon	☐ Perry	☐ Venango
☐ Beaver	☐ Chester	☐ Forest	☐ Lehigh	☐ Philadelphia	☐ Warren
☐ Bedford	☐ Clarion	☐ Franklin	☐ Luzerne	☐ Pike	☐ Washington
☐ Berks	☐ Clearfield	☐ Fulton	☐ Lycoming	☐ Potter	☐ Wayne
☐ Blair	☐ Clinton	☐ Greene	☐ McKean	☐ Schuylkill	☐ Westmoreland
☐ Bradford	☐ Columbia	☐ Huntingdon	☐ Mercer	☐ Snyder	☐ Wyoming
☐ Bucks	☐ Crawford	☐ Indiana	☐ Mifflin	☐ Somerset	☐ York
☐ Butler	☐ Cumberland	☐ Jefferson	☐ Monroe	☐ Sullivan	
	☐ Dauphin	☐ Juniata	☐ Montgomery		

LTSS Addendum

Service Location ____ of ____

Services Provided (*Check all that apply)*

- ☐ Adult Day Care (410)
- ☐ Respite (512)
- ☐ Adult Daily Living Enhanced (411)
- ☐ Service Coordination (219)
- ☐ Assisted Living Facility
- ☐ Structured Day Habilitation (528)
- ☐ Assistive Technology (544)
- ☐ Telecare (29)
- ☐ Therapeutic and Counseling Services – BH (209)
- ☐Therapeutic and Counseling Services – Cognitive Rehab (207)
- ☐ Community Integration (525)
- ☐ Therapeutic and Counseling Services –Non-medical (231)
- ☐ Community Transition Services (551)
- ☐ Therapeutic and Counseling Services – Nutritional (230)
- ☐ DME - Durable Medical Equipment and Supplies (250)
- ☐ Transitional Service/Support Coordination - (219)
- ☐ Vehicle Modification (255)
- ☐ Residential Habilitation (510)
- ☐ Pest Eradication (501)
- ☐ Exceptional Durable Medical Equipment and Supplies
- ☐ ISO-Fiscal/Employer Agent – Financial Mgmt Services (541)
- ☐ Architectural Modification – Home Adaptations (440)
- ☐ Non-Medical Transportation (267)
- ☐ Home-Delivered Meals (460)
- ☐ Participant-Directed Community Supports
- ☐ Home Health Aide
- ☐ Participant-Directed Goods and Services
- ☐ Home Health Agency – Nursing/Therapies (50)
- ☐ Home Health Nursing L.P.N. (161)
- ☐ Personal Emergency Response System (PERS) (25)
- ☐ PERS– Monthly Maintenance (28)
- ☐ Home Health Nursing R.N. (160)
- ☐ Personal Care-Individual-(PAS) – Agency (360)
- ☐ Home Health Services Occupational Therapy (171)
- ☐ Personal Assistance Services (362)
- ☐ Home Health Services Speech and Language Therapy (173)
- ☐ Hospice
- ☐ Other (Please Specify):

Employment Services Provided (*Check all that apply)*

All staff are required to have one of the following credentials/certificates in order to perform the Employment Services below.
Please select the applicable credentials/certificates below each type of Employment Service

- ☐ Employment-Benefits Counseling (502)
  - ☐ WIP-C
  - ☐ CPWIC
  - ☐ CWIC
- ☐ Career Assessment (503)
  - ☐ CESP
  - ☐ ACRE
- ☐ Employment-Job Coaching (504)
  - ☐ CESP
  - ☐ ACRE
- ☐ Employment Skills Development (505)
  - ☐ CESP
  - ☐ ACRE
- ☐ Job Finding (530)
  - ☐ CESP
  - ☐ ACRE

1. Has the facility had a post-licensing onsite visit by a government agency such as the Department of Health or CMS within the past 36 months?

☐ Yes. Date of most recent standard survey (MM/DD/YYYY)_____ (Submit copy with application)

☐ No. Successful completion of a health plan onsite visit will be required to complete credentialing

2. Were any deficiencies cited during the last full survey? ☐ Yes ☐ No ☐ N/A - no recent survey
If yes, have all deficiencies been corrected?

☐ Yes. Provide evidence of state acceptance of your CAP (Submit copy with application)

☐ No. Provide an explanation and your plan to correct all deficiencies (Submit with application)

If no deficiencies were cited during the last full survey, please submit verification of no deficiencies

LTSS Addendum

Attestation Statement

*INSTRUCTIONS: Please complete either **Section A or Section B** for consideration to participate in the PA Health & Wellness provider network. For any "Yes" response to one or more of the questions in Section B, complete the Attestation Question Explanation Section.*

This attestation pertains to all employed and contracted provider(s) authorized to provide or supervise care provided by _____ (the "Agency").

I, _____, the undersigned representative of Agency, on its behalf, understand and agree that as part of the credentialing process for participation in the Health Plan provider network,

Section A

…attest that the Agency has conducted the following on each caregiver prior to allowing each to provide care to a Health Plan member:

- ☐ Criminal Background Check and;
- ☐ State Child Abuse Registry (if applicable) and;
- ☐ Other State Mandated Clearance Checks

Section B

…assure through a background check and other reasonable means the following with respect to each caregiver providing care and each attendant supervising care on behalf of the Agency:

☐ YES ☐ NO 1. Have applicable license(s) held by caregiver(s) and/or attendant(s) been revoked, refused, restricted or voluntarily surrendered?

☐ YES ☐ NO 2. Have caregiver(s) and/or attendant(s) been convicted of, or pled guilty to, a felony?

☐ YES ☐ NO 3. Has any caregiver or attendant been terminated, suspended, barred, sanctioned or voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program?

☐ YES ☐ NO 4. Is/Are caregiver(s) and/or attendant(s) unable to perform the essential functions of his or her job with reasonable accommodation?

_____ _____

Signature Print

_____ _____

Title Date

Report any "Yes" response to one or more of the questions on the Attestation Statement. Record the question number in the first column, then your explanation in the second column. If you need additional space to explain a "Yes" response, write explanation on additional sheet of paper and attach.

Question #	Explanation

State Requirements for Full Time Equivalent Counts

Service Location ____ of ____ *Please use a separate form for each location*

Service Address:
Service Location Promise ID:
Tax ID:

Full Time Equivalent (FTE) data is required by the State of Pennsylvania for the Specialties listed below. Please indicate the number of FTE staff available and the counties served by the FTE staff in the chart.

- Staff member working 35-40 hours is equal to 1 FTE
- Staff member working less than 35 hours is equal to 0.5 FTE

PA Counties

1 Adams	13 Carbon	24 Elk	35 Lackawanna	46 Montgomery	57 Sullivan
2 Allegheny	14 Centre	25 Erie	36 Lancaster	47 Montour	58 Susquehanna
3 Armstrong	15 Chester	26 Fayette	37 Lawrence	48 Northampton	59 Tioga
4 Beaver	16 Clarion	27 Forest	38 Lebanon	49 Northumberland	60 Union
5 Bedford	17 Clearfield	28 Franklin	39 Lehigh	50 Perry	61 Venango
6 Berks	18 Clinton	29 Fulton	40 Luzerne	51 Philadelphia	62 Warren
7 Blair	19 Columbia	30 Greene	41 Lycoming	52 Pike	63 Washington
8 Bradford	20 Crawford	31 Huntingdon	42 McKean	53 Potter	64 Wayne
9 Bucks	21 Cumberland	32 Indiana	43 Mercer	54 Schuylkill	65 Westmoreland
10 Butler	22 Dauphin	33 Jefferson	44 Mifflin	55 Snyder	66 Wyoming
11 Cambria	23 Delaware	34 Juniata	45 Monroe	56 Somerset	67 York
12 Cameron					

Primary Specialty Code	Primary Specialty Name	Staff Count per County	County Served	Staff Count per County	County Served	Staff Count per County	County Served	Staff Count per County	County Served
362	PERSONAL ASSISTANCE SERVICE								
209	BEHAVIOR THERAPY								
207	COGNITIVE THERAPIST								
525	COMMUNITY INTEGRATION								
551	COMMUNITY TRANSITION SERVICES								
502	EMPLOYMENT - BENEFITS COUNSELING								
503	CAREER ASSESSMENT								
504	EMPLOYMENT - JOB COACHING								
505	EMPLOYMENT - SKILLS DEVELOPMENT								
510	HOME AND COMMUNITY HABILITATION								
530	JOB FINDING								
50	HOME HEALTH AGENCY								
161	LICENSED PRACTICAL NURSE								
267	NON-EMERGENCY TRANSPORTATION								
231	NON-MEDICAL COUNSELING								
171	OCCUPATIONAL THERAPIST								
360	PERSONAL CARE - INDIVIDUAL								
170	PHYSICAL THERAPIST								
160	REGISTERED NURSE								
230	REGISTERED NUTRITIONIST								
512	RESPITE CARE - HOME BASED								
173	SPEECH/HEARING THERAPIST								
361	PERSONAL CARE - AGENCY								
456	CRR-ADULT								