

13 ADDRESS INFORMATION * = MANDATORY FIELD

FOR COUNTY CODES, SEE APPENDIX B (page 8). PLEASE USE STANDARD POST OFFICE ABBREVIATIONS FOR STATE & LOCATIONS.

FOR EXAMPLE:

S for South	Blvd for Boulevard	Rd for Road
W for West	Ln for Lane	Rt for Route
Apt for Apartment	Pl for Place	RR for Rural route
Ave for Avenue	Plz for Plaza	St for Street
NY for New York State	PA for Pennsylvania	FL for Florida

a. CORRESPONDENCE ADDRESS:

ATTENTION LINE (Title or Department Name only - example "Accounts Manager" or "Business Office")

* STREET ADDRESS LINE 1 (For correspondence address, this cannot be a P.O. Box unless accompanied by a street address)

STREET ADDRESS LINE 2

* CITY COUNTY CODE See Appendix B

* STATE ZIP CODE + 4 AREA CODE PHONE NUMBER EXTENSION

e-mail address

b. PAY-TO ADDRESS: (Complete even if EFT is chosen)

ATTENTION LINE (Title or Department Name only - example "Accounts Manager" or "Business Office")

* STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

* CITY COUNTY CODE See Appendix B

* STATE ZIP CODE + 4 AREA CODE PHONE NUMBER EXTENSION

c. SERVICE ADDRESS INFORMATION: *If pre-filled, do not alter*

ATTENTION LINE (NO MAIL IS SENT TO THIS ADDRESS)

* STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

* CITY COUNTY CODE See Appendix B

* STATE ZIP CODE + 4 AREA CODE PHONE NUMBER EXTENSION

d. CORPORATE ADDRESS INFORMATION: Annual tax documents will be sent to this address.

NOTE: The address supplied here will be ignored if Medicaid already recognizes an address for the FEIN listed in Question # 2.

* ENTER THE NAME EXACTLY AS IT APPEARS ON THE FEIN DOCUMENTATION

ATTENTION LINE (Title or Department Name only - example "CFO" or "Accounting Office")

* STREET ADDRESS LINE 1

STREET ADDRESS LINE 2

* CITY COUNTY CODE See Appendix B

* STATE ZIP CODE + 4 AREA CODE PHONE NUMBER EXTENSION

e-mail address

Questions 14 thru 19 pertain to the disclosure of ownership and control of the entity covered by this enrollment application. The accurate completion of this entire section is required by 42 CFR Part 455.104. Failure to provide the information requested will cause the application to be returned.

OWNERSHIP / CONTROL Disclosure List

This form may be copied Page _____ of _____	Complete if Name listed is an individual	Complete if Name listed is a corporation	Check all that apply										Relationship Information Type of relationship (parent, child, sibling, spouse) # of persons related to	
Name	Title	Home Address	Social Security Number & Date of Birth (required for all -- see Privacy statement)	Federal Employer Tax ID number, & National Provider Identifier (NPI), if applicable NOTE: Corporations must also complete question 18 regarding all corporate addresses	O w n e r	A d m i n i s t r a t o r	B o a r d m e m b e r	O f f i c e r	L a b o r	S u p p l i e r	S t o c k h o l d e r	M a n a g i n g	5% or more	
1			SS#: _____ DOB: _____	FEIN# _____ NPI: _____										# _____ # _____ # _____
2			SS#: _____ DOB: _____	FEIN# _____ NPI: _____										# _____ # _____ # _____
3			SS#: _____ DOB: _____	FEIN# _____ NPI: _____										# _____ # _____ # _____
4			SS#: _____ DOB: _____	FEIN# _____ NPI: _____										# _____ # _____ # _____
5			SS#: _____ DOB: _____	FEIN# _____ NPI: _____										# _____ # _____ # _____
6			SS#: _____ DOB: _____	FEIN# _____ NPI: _____										# _____ # _____ # _____
7			SS#: _____ DOB: _____	FEIN# _____ NPI: _____										# _____ # _____ # _____
8			SS#: _____ DOB: _____	FEIN# _____ NPI: _____										# _____ # _____ # _____

* Include Compliance Officer
For Definitions of ownership, indirect ownership, managing employee, refer to
NYCRR Title 18 Section 504.1

- 15 Respond to these questions on behalf of yourself and any individuals or organizations having a direct or indirect ownership or control interest of 5% or more (including stockholders) and any directors, administrators, officers, agents or managing employees of the above named agency, institution or organization.

Has any one listed in # 14 ever been terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned under any of the programs established by Title XVIII (Medicare), XIX (Medicaid) or XX (Social Services) in any State?

Yes No

Has anyone listed in # 14 ever been convicted of stealing, welfare fraud or public assistance fraud as a result of your involvement in any of the programs established by Titles XVIII (Medicare), XIX (Medicaid) or XX (Social Services) in any State?

Yes No

Has anyone listed in # 14 had their license or registration revoked, suspended, surrendered or, in any way, restricted by probation or agreement by a licensing authority in any State?

Yes No

For anyone listed in # 14, are there currently pending any proceedings that could result in any of the above stated sanctions?

Yes No

If you answered "yes" to any of the above questions, an additional disclosure questionnaire will be sent when the enrollment is received for review.

When completed and returned, it will be forwarded to the Office of the Medicaid Inspector General for review.

Has there been a change of ownership or control within the last year?

Yes No If "yes", give date: _____

(NOTE: This enrollment is not automatically transferrable when there is a change in ownership. Contact the Department of Health for "CHOW" instruction.

Do you anticipate a change of ownership within the year?

Yes No If "yes", when: _____

Is this facility operated by a management company, or leased in whole or part by another organization?

Yes No If "yes" give date of Change of Operations: _____

Has there been a change in your lab director or supervising pharmacist within the last year?

Yes No Not Applicable _____

Do you currently have any unpaid balances owed to the Medicaid Program?

Yes No

If yes, then please indicate the amount: \$ _____

Has payment been arranged? Yes No If "Yes", please attach verification of the arrangement.
(If you have not arranged payment, this enrollment will be referred to the Office of the Medicaid Inspector General for review.)

16 Are any of the owner(s) or corporations listed in # 14 also owner(s) or stockholders of other Medicare/Medicaid facilities?

Yes No

If "yes", list names and NPIs or Medicaid ID #s. (Please indicate if Medicare and/or Medicaid). Attach additional sheets if necessary.

OWNER'S NAME

FACILITY NAME

NPI or Medicaid ID #

17 Are any of the owner(s) or corporations listed in # 14 also owner(s) or stockholders with an interest of 5% or more in a subcontractor providing service to the applicant?

Yes No

If "yes", list names and Tax ID numbers. Attach additional sheets if necessary.

OWNER'S NAME

SUBCONTRACTOR NAME (Individual or Corporation) & ADDRESS

FEIN / SS#

18 Are any of the owner(s) or stockholders listed in # 14 related to an owner or stockholder of a subcontractor providing service to the applicant?
(Parent, Child, Sibling, Spouse)

Yes No

If "yes", list names and relationships. Attach additional sheets if necessary.

OWNER'S NAME

SUBCONTRACTOR NAME & FEIN or SS#

NAME & RELATIONSHIP

19 For each corporation listed in question 14 -- Corporation Name: _____

List the primary business address: _____

List all other addresses associated with this corporation including P.O. Box information.

(Attach additional pages, if needed) _____

20 SIGNATURE AND AFFIRMATION

By signing this enrollment application with the New York State Medicaid Program, the prospective provider agrees to the following:

- ◆ As a Medicaid provider you agree to comply with the rules, regulations and official directives of the Department, including, but not limited to Part 504 of 18 NYCRR which can be found at the Department of Health's website, www.health.state.ny.us.
- ◆ In addition, pursuant to 42 CFR § 455.105, by enrolling in the Medicaid program, you agree to disclose the following regarding business transactions within the next 35 days upon request of the Department or the Secretary of Health and Human Services.
 - (1) Information about the ownership of any subcontractor with whom the provider 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 provider and any wholly owned supplier, or between the provider and any subcontractor during the 5-year period ending on the date of the request.
- ◆ As a Medicaid provider you agree to abide by all applicable Federal & State laws as well as the rules and regulations of other New York State Agencies particular to the type of program covered by this enrollment application
- ◆ As a Medicaid provider you agree to notify this Department immediately of any changes to the information supplied in this enrollment agreement, including impending ownership changes.
- ◆ For those providers for whom the Mandatory Compliance Law applies (see www.OMIG.state.ny.us) , the Provider has certified via the Office of the Medicaid Inspector General's web site referenced above that the provider and its affiliates have adopted, implemented and maintain an effective compliance program that meets the requirements of Social Services Law §363-d & 18 NYCRR Part 521. A copy of the certification confirmation must be included with this enrollment.
- ◆ Unannounced site visits by Medicaid, CMS or their agents/designated contractors may be a condition of initial and continued enrollment. In addition, the provider and/or owners (defined as at least a 5 percent interest) may be required to consent to criminal background checks including fingerprinting.

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 SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (print or type)

Title

If prospective Provider is a legal entity other than a person, the person signing this enrollment document on behalf of the Provider warrants that he/she has legal authority to bind Provider.

Signature

Date

Preparer's Name & Title (print or type)

Contact Telephone Number

PERSONAL PRIVACY LAW NOTIFICATION TO MEDICAID PROVIDERS

The State's Personal Privacy Protection Law, which took effect September 1, 1984, requires us to inform every person from whom we request personal information why we are requesting the information and how we will use it. The information you have been asked for will enable us to make proper payments to you as a Medicaid provider according to the provisions of applicable State and Federal law and regulations. Collection of this information is authorized by Section 367-b of the Social Services Law.

This information will be used as one element of various audits before payment is made for the goods or services furnished and/or for any post payment audits considered by the State or Federal authorities to be necessary.

The information will also be used to satisfy the reporting requirements imposed upon us by State and Federal regulations (e.g. by IRS for payment information reporting purposes).

Your failure to provide us with the information requested may prevent us from establishing the necessary records to enroll you as a Medicaid provider.

The information will be maintained by the Department of Health, Division of Provider Relations & Utilization Management, Suite 6E, 150 Broadway, Albany, New York 12204-2736.

FOR STATE USE ONLY

1 LICENSE / CERT #	<input type="text"/>	AGENCY CODE	<input type="text"/>		
Begin Date	<input type="text"/> <small>M M D D Y Y Y Y</small>	End Date	<input type="text"/> <small>M M D D Y Y Y Y</small>		
2 LICENSE / CERT #	<input type="text"/>	AGENCY CODE	<input type="text"/>		
Begin Date	<input type="text"/> <small>M M D D Y Y Y Y</small>	End Date	<input type="text"/> <small>M M D D Y Y Y Y</small>		
3 LICENSE / CERT #	<input type="text"/>	AGENCY CODE	<input type="text"/>		
Begin Date	<input type="text"/> <small>M M D D Y Y Y Y</small>	End Date	<input type="text"/> <small>M M D D Y Y Y Y</small>		
4 LICENSE / CERT #	<input type="text"/>	AGENCY CODE	<input type="text"/>		
Begin Date	<input type="text"/> <small>M M D D Y Y Y Y</small>	End Date	<input type="text"/> <small>M M D D Y Y Y Y</small>		
CATEGORY OF SERVICE:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
SPECIALTY CODES:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
STATE TRACKING #:	<input type="text"/>				
ENTITY ID #:	<input type="text"/>				
CROSS REFERENCE NUMBER:	<input type="text"/>				
CHOW EFFECTIVE DATE:	<input type="text"/>				
MAIL SUPPRESSANT:	<input type="checkbox"/>	Program:			

NOTE: RETURN ALL PAGES OF THIS ENROLLMENT PACKAGE, INCLUDING THIS PAGE

APPENDIX A
CONTROL OF FACILITY CODES

ALL COUNTIES

- 01 Federal Facility
- 02 State Teaching Facility
- 03 State Non-Teaching Facility
- 04 County Teaching Facility
- 60 – Federally Qualified
- 61 – Provisionally Federally Qualified
- 62 – Prepaid Health Plans (PHP)
- 63 – State Defined Plans
- 64 – Physician Case Management Plan

ALL COUNTIES EXCLUDING NEW YORK CITY

- 05 County Non-Teaching Facility
- 06 State Non-Teaching Facility - NYSMH
- 50 Municipal Teaching Facility
- 51 Municipal Non-Teaching Facility
- 52 Private, Non-Profit, Charitable or Religious Teaching Facility
- 53 Private, Non-Profit, Charitable or Religious Non-Teaching Facility
- 54 Private, Non-Profit, Teaching Facility, Other Than Charitable or Religious
- 55 Private, Non-Profit, Non-Teaching Facility, Other Than Charitable or Religious
- 56 Proprietary Teaching Facility
- 57 Proprietary Non-Teaching Facility
- 58 Other

NEW YORK CITY ONLY (CIB - city inter-burrough HHC - Health Hospital Corporation)

- 10 Municipal Teaching Facility - HHC
- 11 Municipal Non-Teaching Facility - HHC
- 12 Other - HHC
- 20 Private, Non-Profit, Charitable or Religious Teaching Facility - CIB
- 21 Private, Non-Profit, Charitable or Religious Non-Teaching Facility CIB
- 22 Private, Non-Profit, Teaching Facility, Other Than Charitable or Religious - CIB
- 23 Private, Non-Profit, Non-Teaching Facility, Other Than Charitable or Religious - CIB
- 24 Other - CIB
- 29 CIB - Inpatient & Nursing Home, DSS, Other
- 30 Municipal Teaching Facility - DOH
- 31 Municipal Non-Teaching Facility - DOH
- 32 Other - DOH
- 40 Municipal Non-Teaching Facility - DSS
- 41 Private, Non-Profit, Charitable or Religious Teaching Facility - DSS
- 42 Private, Non-Profit, Charitable or Religious Non-Teaching Facility DSS
- 43 Private, Non-Profit, Teaching Facility, Other Than Charitable or Religious - DSS
- 44 Private, Non-Profit, Non-Teaching Facility Other Than Charitable or Religious - DSS
- 45 Proprietary Teaching Facility - DSS
- 46 Proprietary Non-Teaching Facility - DSS
- 47 Other - DSS

APPENDIX B
COUNTY CODES

- | | | | |
|----------------|---------------|-----------------|-----------------------------|
| 01 Albany | 17 Fulton | 33 Orange | 49 Tioga |
| 02 Allegany | 18 Genesee | 34 Orleans | 50 Tompkins |
| 03 Broome | 19 Greene | 35 Oswego | 51 Ulster |
| 04 Cattaraugus | 20 Hamilton | 36 Otsego | 52 Warren |
| 05 Cayuga | 21 Herkimer | 37 Putnam | 53 Washington |
| 06 Chautauqua | 22 Jefferson | 38 Rensselaer | 54 Wayne |
| 07 Chemung | 23 Lewis | 39 Rockland | 55 Westchester |
| 08 Chenango | 24 Livingston | 40 St. Lawrence | 56 Wyoming |
| 09 Clinton | 25 Madison | 41 Saratoga | 57 Yates |
| 10 Columbia | 26 Monroe | 42 Schenectady | 58 Bronx |
| 11 Cortland | 27 Montgomery | 43 Schoharie | 59 Kings (Brooklyn) |
| 12 Delaware | 28 Nassau | 44 Schuyler | 60 New York (Manhattan) |
| 13 Dutchess | 29 Niagara | 45 Seneca | 61 Queens |
| 14 Erie | 30 Oneida | 46 Steuben | 62 Richmond (Staten Island) |
| 15 Essex | 31 Onondaga | 47 Suffolk | 99 Other |
| 16 Franklin | 32 Ontario | 48 Sullivan | |