

# **INSTRUCTIONS FOR COMPLETING A NEW YORK STATE ENROLLMENT FORM FOR NURSING HOME TRANSITION & DIVERSION (NHTD) WAIVER PROGRAM COS 0263**

## *Review Criteria Set 4611*

### **GENERAL INSTRUCTIONS:**

- If the services you are enrolling with this application require a National Provider Identifier, then the NPI **MUST** be obtained **prior** to submission of this enrollment.
- Complete all items specified
- Document copies included with your enrollment **MUST** cover the application date and be continuous through the current date.
- Completion of all signature fields is required and must be original. Initials or rubber stamped signatures will not be accepted.
- Type or legibly print in black or blue ink. Do not use red ink, nor white-out. All attachments must be scanned so they must be legible and on standard 8 1/2 x 11 paper in good condition.
- Keep a copy of all documents submitted.

### **INSTRUCTIONS SPECIFIC TO THE ABOVE TYPE OF SERVICE:**

1. **Application Date** - If pre-filled, do not alter. If blank, please enter the begin date of your (NHTD) certification.
2. **Federal Employer ID #** - Enter the FEIN number assigned to this entity and attach a copy of the federal notification. (NYS does not accept W-9s.)
3. **Provider Name** - If pre-filled, do not alter. This name should reflect the name on the (NHTD) certification.
4. **Doing Business As** - Complete if this entity does business under an assumed name.
5. **NPI - N/A**
6. **License numbers - N/A**
7. **Other NPIs** - Please list any other NPI that the entity has already enrolled with New York State Medicaid.
8. **Fiscal year end date** - Enter the end date of the entity's fiscal year in Month/Day format.
9. **Ownership Code** - Enter the appropriate code from the list provided which defines the proprietary nature of the facility.
10. **Control of Facility Code** - N/A
11. **DEA number** - N/A
12. **Medicare Participation** - N/A
13. **# of Medicare & Medicaid beds** - N/A
14. **Type of Review** - N/A
15. **Associated Names** - Nursing Home Transition & Diversion Waiver Programs must complete Owner Name if corp or LLC.
16. **Address information:** Special note for completing addresses on the enrollment form: At this time, any information necessary for proper mail delivery to your Correspondence Address or Pay-to Address should be included in address lines 1 & 2 and NOT input in the Attention line field.
  - a. **Correspondence Address** - This address cannot be a P.O. Box unless it is accompanied by an actual street address. This is where all correspondence not related to payments will be sent.
  - b. **Pay to Address** - This address is where any checks or remittance statements will be sent.
  - c. **Service Address** - If pre-filled, do not alter. This address is the licensed or certified site. It cannot be a P.O. Box.
  - d. **Corporate Address** - Utilize this address field if the entity on the FEIN documentation is a parent corporation or agency. Legal correspondence will be sent to this address such as a 1099, etc.
17. **Disclosure of Ownership and Control** - Complete all fields in this section.
18. **Affirmations & Signature** - This section must be completed. Signatures must be original.



15 ASSOCIATED NAMES: Only complete items that apply to your enrollment type - See Instruction Sheet (LAST NAME, COMMA, SPACE, FIRST NAME)

FACILITY ADMINISTRATOR: [grid] ENTER THE NAME OF THE PERSON WHO HAS THIS FUNCTION IN THIS FACILITY

REVIEW COMMITTEE MEMBER: [grid] ENTER THE NAME OF THE PERSON DESIGNATED AS A MEMBER OF THE PROFESSIONAL (UTILIZATION) REVIEW COMMITTEE IN THIS FACILITY

OWNER NAME: [grid] ENTER THE NAME OF THE CORPORATION WHICH OWNS THIS FACILITY, IF APPLICABLE

NURSING HOME OWNER: [grid] ENTER THE NAME OF THE PERSON WHO HAS THIS FUNCTION IF THIS IS A NURSING HOME FACILITY

LAB DIRECTOR: [grid] ENTER THE NAME OF THE PERSON WHO HAS THIS FUNCTION IF THERE IS A LABORATORY IN THIS FACILITY

SUPERVISING PHARMACIST: [grid] ENTER THE NAME OF THE PERSON WHO HAS THIS FUNCTION IF THERE IS A PHARMACY LOCATED IN THIS FACILITY

16 ADDRESS INFORMATION \* = MANDATORY FIELD

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

FOR EXAMPLE:

S for South	Bldg 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 (Invoices & Mail):

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

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

[grid] STREET ADDRESS LINE 2

\* [grid] CITY [grid] COUNTY CODE See Appendix B

\* [grid] STATE \* [grid] ZIP CODE - [grid] + 4 \* ([grid]) [grid] - [grid] [grid] EXTENSION

e-mail address [grid]

b. PAY-TO ADDRESS (Checks & Remittances):

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

\* [grid] STREET ADDRESS LINE 1

[grid] STREET ADDRESS LINE 2

\* [grid] CITY [grid] COUNTY CODE See Appendix B

\* [grid] STATE \* [grid] ZIP CODE - [grid] + 4 \* ([grid]) [grid] - [grid] [grid] EXTENSION

c. SERVICE ADDRESS INFORMATION:

[grid] ATTENTION LINE (NO MAIL IS SENT TO THIS ADDRESS)

\* [grid] STREET ADDRESS LINE 1

[grid] STREET ADDRESS LINE 2

\* [grid] CITY [grid] COUNTY CODE See Appendix B

\* [grid] STATE \* [grid] ZIP CODE - [grid] + 4 \* ([grid]) [grid] - [grid] [grid] EXTENSION

**d. CORPORATE ADDRESS INFORMATION: Supply this information if this NPI is associated with a corporate entity which sponsors other Medicaid services enrolled under other NPI(s) .**

**NOTE:** Annual tax documents will be sent to this address. If you previously enrolled an NPI with this FEIN, the address on file for the FEIN will be duplicated here. If this is the first NPI you are reporting for this FEIN and this field is left blank, the address you supplied as the Pay-To address will be duplicated here.

\* \_\_\_\_\_  
 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 \_\_\_\_\_

**17 DISCLOSURE OF OWNERSHIP AND CONTROL**

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, and any directors, officers, agents or managing employees of the above named agency, institution or organization.

Have you 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

Have you 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 your license or registration ever been revoked, suspended, surrendered or, in any way, restricted by probation or agreement by a licensing authority in any State?  
 Yes  No

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, you may be required to complete an additional disclosure questionnaire.*

List names and addresses for individuals or the EIN (Employer Identification Number) for organizations having direct or indirect ownership or a controlling interest of 5% or more in the above named agency, institution or organization. If non-profit or government related, attach list of board of directors, commissioners or other persons in authority. If more than one individual is reported and any of these persons are related to each other, attach a separate sheet listing these individuals and their relationship to each other. Corporations and LLCs - attach a list of the Board of Directors.

NAME	ADDRESS	EIN

Type of Entity

Sole Proprietorship     Unincorporated Association     Partnership

Corporation     Governmental     LLC     Other (specify)

Are any of the above owner(s) also owner(s) of other Medicare/Medicaid facilities? If "yes", list names and NPIs.  
(Please indicate if Medicare and/or Medicaid). Attach additional sheets if necessary.

Yes  No

OWNER'S NAME	FACILITY NAME	NPI

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 \_\_\_\_\_

**18 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](http://www.health.state.ny.us)
- ◆ In addition, pursuant to 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 regarding 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 notify this Department immediately of any changes to the information supplied in this enrollment agreement, including impending ownership changes.

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





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

# eMedNY PROVIDER ENROLLMENT FORM

## ADDITIONAL SERVICE ADDRESSES

OPTIONAL PAGE  
MAY BE PHOTOCOPIED

### SERVICE ADDRESS INFORMATION:

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

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