Credentialing Application

To initiate your request for participation as a provider for Independent Living Systems, the following information must be submitted to the Provider Services Department. Please Print clearly or Type to ensure that we can process your request efficiently. Should your response(s) warrant the submission of additional detail (explanation/documentation) please attach to the application, referencing to which section/question it applies. Missing information will delay the Credentialing process.

Please submit your application and documentation by mail or fax to:	
Credentialing Department Fax: 305-961-1336 credentialing@ilshealth.com	**Provider Relations Department** Fax: 888- 827-6170 floridaproviders@ilshealth.com
Mailing Address: **ATTN: CREDENTIALING / PROVIDER RELATIONS** Independent Living Systems, LLC 4601 NW 77th Avenue Doral, FL 33166	

Credentialing Application

All information must be completed in full, signed and dated by Applicant.
Indicate any areas that Do Not Apply with N/A.

All items below MUST be checked accordingly, in order for the Credentialing package to be accepted.

_____ Credentialing Application **ALL** sections: **Complete and Legible**.

_____ Professional Historical Data Questionnaire: **All questions must be answered, signed & dated.**

_____ Explanation(s) for any "Yes" answer of questionnaire.

_____ If any "Pending" or open Malpractice Cases: Copy of **Complaint Notice of Intent with Affidavit.**

_____ General Provisions of application: **Signed and Dated**.

_____ State Professional License: **Current Copy.**

_____ Accreditation certificate: **Current Copy**

Table of Contents

Independent Living Systems – Credentialing Application

4601 NW 77th Avenue, Doral, Florida 33166

I. SECTION I: FACILITY DEMOGRAPHIC INFORMAT

❒ Initial Credentialing ❒ Re-Credentialing

***Please complete the below section** *(Please Print in **Black Ink**)*

Legal Business Name (*as reported to the IRS*):	***Provider Type:*** ❒ Assisted Living Facility (ALF) ❒ Home Health Agency (HHA) ❒ Homemaker & Companion Services ❒ Adult Family Care Home ❒ Home Medical Equipment ❒ Diagnostic Center	❒Adult Day Care ❒Nursing Facility ❒Hospice ❒Nurse Registry ❒Transportation ❒Other: _____
Doing Business As (DBA) Name (*if applicable*):		

Contact Person:	Contact Job Title:	Contact Phone #:	Contact Email:
NPI #:	Medicare #:	Medicaid #:	Federal Tax ID :
Race/Ethnic Group: (*Optional*): ❒ Black ❒ American Indian ❒Asian ❒ White ❒Hispanic ❒Other:		Electronic Medical Records ❒ Yes ❒ No	
Provider Type (Facility/Ancillary):			

Foreign Language: (*Identify any foreign language(s) or sign language spoken fluently when working with patients*)

❒ Arabic (AR)	❒ Spanish (SP)	❒ Japanese (JA)	❒ Hindi (HI)	❒ Other:
❒ German (GE)	❒ Vietnamese (VI)	❒ Portuguese (PO)	❒ Korean (KO)	
❒ Italian (IT)	❒ Chinese (CH)	❒Farsi (FA)	❒ Russian (RU)	
❒ Laotian (LA)	❒ Hebrew (HE)	❒ Sign Language (SL)	❒ Tagalog (TA)	

Address Information
(*Please list all locations and group affiliations. If needed, use 'Attachment A' enclosed.)*

Total Number of Locations: _____

Primary Facility Location				**Second Facility Location** *(if applicable)*			
Legal Business Name				Legal Business Name			
Street Address			Suite#	Street Address			Suite#
City	State	Zip Code	County	City	State	Zip Code	County
Phone	Fax	TTY Number		Phone	Fax	TTY Number	
NPI # (If different than above):				NPI # (if different from above)			
Federal Tax ID *(if different from above):*				Federal Tax ID *(if different from above):*			
Email:				Email:			
Translation Services Available ❒ Yes ❒ No				Translation Services Available ❒ Yes ❒ No			
Normal Business Hours	Schedule: *(Check all that apply to this location)* ❒S ❒M ❒T ❒W ❒T H ❒F ❒ S			Normal Business Hours	Schedule: *(Check all that apply to this location)* ❒S ❒M ❒T ❒W ❒T H ❒F ❒ S		
Electronic Medical Records ❒ Yes ❒ No				Electronic Medical Records ❒ Yes ❒ No			
Mailing Address *(if different from above)*				**Claims Payment Address** *(as applicable)*			
Legal Business Name				Legal Business Name			
Street Address	Suite #			Street Address	Suite #		
City	State	Zip		City	State	Zip	
Phone	Fax			Phone	Fax		
Email:				Email:			

SECTION II: FACILITY INFORMATION CONT'D

Select to identify if this location is recognized as one of these Essential Community Providers (ECP)	
☐ Federally Qualified Health Center (FQHC)	☐ Hospital
☐ Indian Provider	☐ Family Planning Provider
☐ Ryan White Provider	☐ Other ECP (Identify)
Select all applicable attributes to identify Provider or staff working with patients or members at this location with any special experience, skills and training including expertise in treating Persons and Individuals in these categories:	
☐ Physical disabilities	☐ Chronic Illness
☐ Co-occurring disorders	☐ Homeless
☐ HIV/AIDS	☐ Deaf or hard-of-hearing
☐ Blind or Visually Impaired	☐ Serious Mental Illness
☐ Other Specialties (Identify)	
Select from the section below to identify attributes of culturally appropriate services available to patients or members at this location or by this provider.	
Does your facility offer meals? If yes, please select from the categories below.	
☐ Latin Meals	Identify other Ethnic Meals:

SECTION III: LICENSING/CERTIFICATION/ACCREDITATION

Facility License Information: *(identify all licenses used to operate your office(s). Please return copies of each)*

Provider License Type	State of License	License No. *(attach copy of license)*	Expiration Date

Facility Accreditation: *(Please indicate if this location has been reviewed by any of the Accrediting authorities listed below and provide a copy of the most recent accreditation report.)*

☐ American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)	☐ Accreditation Association for Ambulatory Health Care (AAAHC)
☐ Accreditation Commission for HealthCare (ACHC)	☐ American Osteopathic Association (AOA)
☐ American Association of Diabetes Educators (AADE)	☐ Commission on Accreditation of Rehabilitation Facilities (CARF)
☐ Continuing Care Accreditation Commission (CCAC)	☐ Community Health Accreditation Program (CHAP)
☐ Clinical Laboratory Association Improvement Amendments (CLIA)	☐ Council on Accreditation for Children and Family Services (COA)
☐ Commission on Office Laboratory Accreditation (COLA)	☐ Det Norske Veritas National Integrated Accreditation for Healthcare Organization (DNV)
☐ Healthcare Facilities Accreditation Program (HFAP)	☐ Indian Health Service (HIS)
☐ The Joint Commission (TJC)	☐Not Applicable

SECTION IV: LIABILIY INSURANCE INFORMATION

☐ ***Professional Liability Insurance - Please attach a copy of your current Professional Liability Insurance Certificate or declaration page showing the dates and the amounts of coverage.*** ☐ ***Not Applicable (N/A)***		
Current Insurance Carrier		
Policy #	Amounts of Coverage $ Occurrence / $ Aggregate	
Effective Date	Expiration Date	Years with Carrier
Name of Contact with Carrier	Phone	Email

Malpractice Claims Information

☐ N/A ☐Malpractice Actions/Sanctions

Please complete this form if you reported any malpractice actions or sanctions on your application. All questions must be answered completely. If additional sheets are required, please photocopy this page as many times as needed prior to completing. A separate sheet must be used for each malpractice action. In the event that a Malpractice Claim is not applicable please mark N/A, print name, sign and date at the bottom of this page.

Name of Patient and/or case #: _____
Allegation: _____
Date of incident: _____ Date reported: _____
Location of incident: _____ Insurance Carrier: _____
Additional defendants: _____
Claim Status: Open ❒ Attach copy of **Complaint Notice of Intent with Affidavit**.

Closed ❒ Date Closed: _____

If closed, indicate method of closing:
Dismissed ❒ Settled ❒ Judgment ❒

Amount of settlement or judgment: _____

Describe your care and treatment of the patient. Explain the **condition and diagnosis at time of incident, dates and description of treatment rendered and condition of patient subsequent to treatment.** If additional space is necessary, use the reverse side or attach additional sheets. Your narrative must provide adequate clinical details to allow proper evaluation by a committee of physicians.

Narrative:

_____

_____

_____

_____ _____
Name (*Please Print or type*) **Signature & Date**

SECTION V: OWENERSHIP DISCLOSURE FORM

PROVIDER ENTITY STATUS (Check if Applicable)	**MINORITY & OWNERSHIP CHARACTERISTICS** (Check if Applicable)
❒ Sole Proprietorship ❒ Professional Association ❒ Partnership or Limited Liability Company ❒ Corporation-For Profit ❒ Corporation-Not for Profit	❒ African American ❒ Hispanic American ❒ Asian American ❒ Native American ❒ American Women ❒ Other Minority (Please Specify) _____

List names and addresses of all principals and indicate percent ownership, if applicable ("Principal" means any shareholder, officer, partner, joint venture or anyone else having an ownership in or managerial control over the PROVIDER. Attach additional sheets if necessary.)

Officer, Director or Partner Name	**Title**	**Address**	**Ownership Percentage**

SECTION VI: EVACUATION PLAN FOR RESIDENTIAL FACILITIES

If you are a "Residential Facility" such as an ALF, AFCH, CLF, SLF, or SNF, please list those facilities that you have a mutual aid agreement with in order for Care Coordinators to have access to this information in the event of a disaster.

Potential Evacuation Facility	Telephone	Address of Potential Evacuation Facility	Contact Person

SECTION VII: PROFESSIONAL HISTORICAL DATA QUESTIONNAIRE

IF YOU ANSWER *"YES"* TO ANY OF THE QUESTIONS BELOW, PLEASE COMPLETE THE FORM ON THE FOLLOWING PAGE OR PROVIDE A LETTER OF EXPLANATION WITH CLINICAL DETAILS, SETTLEMENT AMOUNTS AND DATES WITH THIS APPLICATION

Mandatory Questionnaire

IMPORTANT: If any of the following questions is answered "Yes", please attach an explanation for each answer. If any questions do not apply to you, please answer "No".
Failure to check an answer or provide your explanations for "Yes" responses may result in delay of application processing.

Licensure Information	Y or N
1. Have you been censured, reprimanded, or had disciplinary action taken by an ethical standards committee, licensing board, or other board of inquiry?	❒Y ❒N
2. Have you voluntarily surrendered your professional license, had your professional license revoked, suspended, or limited, or worked under a probationary license or consent agreement?	❒Y ❒N
3. Have you been the subject of any investigation by any private, federal, or state health program or is any such action pending?	❒Y ❒N
4. Have your Federal DEA and/or State Controlled Dangerous Substance (CDS) Certificate(s) been voluntarily or involuntarily limited, suspended, revoked, relinquished, or not renewed or are proceedings currently pending?	❒Y ❒N

Hospital and Other Affiliations	Y or N
1. Have you been denied hospital privileges?	❒Y ❒N
2. Has your request for any specific clinical privileges been denied or granted with stated limitations (aside from ordinary or initial requirements of proctorship), or has such a denial or limitation been recommended by a medical staff or peer review committee to a governing board?	❒Y ❒N
3. Have you had any previous or pending challenges to, or voluntarily or involuntarily relinquished any medical staff membership; clinical privilege(s), as the result of or to prevent any investigation or disciplinary action?	❒Y ❒N

Criminal History	Y or N
1. Have you been convicted of or pleaded guilty to a crime, or are you presently under investigation or have you ever been indicted for a crime?	❒Y ❒N
2. Have you entered into a consent agreement, entered a plea of guilty, or been found guilty of, fraud or abuse involving payment of health care claims by any health care payer or been sanctioned by any third party payer or health care claims or professional review organization, governmental entity, or agency, or is any such action pending?	❒Y ❒N

Insurance Information	Y or N
1. Has your professional liability insurance coverage been terminated, or modified by action of any insurance company?	❒Y ❒N
2. Have you been denied professional liability coverage or rated in a higher-than-average risk class for your specialty?	❒Y ❒N
3. Have any professional or general liability suits, actions, or claims alleging malpractice been filed, or are there any pending against you?	❒Y ❒N
4. Have any judgments been made against you in professional liability cases or claims, or have you entered into any settlements?	❒Y ❒N
5. To your knowledge, has information pertaining to you been reported to the National Practitioner Data Bank?	❒Y ❒N

Health Status	Y or N
1. Are you currently using any illegal drugs?	❒Y ❒N
2. Have you been under the influence of alcohol during working hours, or have you used drugs illegally?	❒Y ❒N
3. Are you unable, with or without reasonable accommodation, to practice to the fullest extent of your license, qualification, and privileges without in any way posing a risk of harm to your patients?	❒Y ❒N
4. Do you suffer from any medical or mental health conditions which impair your ability to practice, with or without reasonable accommodations?	❒Y ❒N
5. Have you received any mental health treatment for a diagnosis identified in DSM-IV which was ordered by an ethical standards committee, licensing board, or other board of inquiry?	❒Y ❒N
6. Have you voluntarily participated in a rehabilitation program or other treatment for substance abuse?	❒Y ❒N

Name *(print or type)*

Signature & Date

SECTION VIII: LIST ALL CLINICAL STAFF MEMBERS RENDERING SERVICES

Providers may have additional staff rendering services to patients such as PA, ARNP, RN, LPN, etc. Therefore, we are requesting the following information **OR you may submit a Roster:**

Staff Name	Type of License	State of License	License Number	Years of Experience

SECTION XI: GENERAL PROVISIONS OF APPLICATION

I, the undersigned, hereby acknowledge that the information submitted on this application is true and complete to the best of my knowledge and belief. I fully understand that any significant misstatements or omissions on this Application, constitutes cause for denial of privileges.

I understand and agree that I, as a Potential Provider*, have the responsibility of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and resolving any doubts about such qualifications.

I further understand that an investigative report may be made as to my professional abilities, character, and general reputation. I authorize all past employers, schools, Provider Recovery Network, hospitals, persons, financial institutions and organizations having relevant information to provide it to *INDEPENDENT LIVING SYSTEMS* and its affiliates for its use in making a decision on this application. I hereby release from liability all individuals and organizations who provide information to *INDEPENDENT LIVING SYSTEMS* and its affiliates or its staff, in good faith and without malice concerning my professional competence, ethics, character credentials and other qualifications for provider status, and I hereby consent to the release of such information.

I understand and agree that the information submitted by me on this form, and the information provided to INDEPENDENT LIVING SYSTEMS its affiliates, its officers, directors, employees and representatives may be used:

I. To evaluate my credentials for provider status; and
II. To re-evaluate my credentials at any time during my provider's relationship with *INDEPENDENT LIVING SYSTEMS* and its affiliates.

I hereby acknowledge that this Attestation, Consent and Release form will be valid for a period of three (3) years from the date it is signed by me, and that a photocopy or fax will serve as an original.

_____ _____

Signature of Applicant **Date**

_____

Print Name

* (Potential Provider is defined as any and all parties who wish to be considered for *Independent Living Systems* and its affiliates, as a Primary Care physician, or as a Specialty Care provider.)

ATTACHMENT A: ADDITIONAL SERVICE LOCATIONS

Location No. ____________

Business Name:		Phone #:	Fax #:
Street Address:		Suite #:	City:
State:	Zip:	County:	
NPI #:		Federal Tax ID #:	
Normal Business Hours:		Schedule: (Check all that apply to this location) ❒S ❒M ❒T ❒W ❒TH ❒F ❒S	

Location No. ____________

Business Name:		Phone #:	Fax #:
Street Address:		Suite #:	City:
State:	Zip:	County:	
NPI #:		Federal Tax ID #:	
Normal Business Hours:		Schedule: (Check all that apply to this location) ❒S ❒M ❒T ❒W ❒TH ❒F ❒S	

Location No. ____________

Business Name:		Phone #:	Fax #:
Street Address:		Suite #:	City:
State:	Zip:	County:	
NPI #:		Federal Tax ID #:	
Normal Business Hours:		Schedule: (Check all that apply to this location) ❒S ❒M ❒T ❒W ❒TH ❒F ❒S	

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.