MINNESOTA UNIFORM FACILITY CREDENTIALING APPLICATION

☐ Initial Credentialing ☐ Re-credentialing

APPLICATION INSTRUCTIONS

- ALL fields must be completed unless otherwise directed
- Please do not use abbreviations when completing the application
- Submit completed application along with **all** required documentation
- Please E-mail or Fax Completed Application to

APPLICATION NOTES

- For the purposes of this application, "facility" is defined as a hospital; home health agency; skilled nursing facility; ambulatory surgery center; and inpatient, residential, and ambulatory behavior health facility
- As required by the facility contract and accrediting agencies, one unique application is required for each facility type and location as listed on page three
- Failure to complete this application in its entirety, including submission of required documentation may delay or suspend network participation
- The Minnesota Uniform Facility Credentialing Application may be used by other organizations

ATTACHMENTS

THE PROCESSING OF YOUR APPLICATION WILL BE DELAYED IF ALL REQUIRED INFORMATION IS NOT SUBMITTED

☐	Copy of all current State and/or local licenses required to operate as a health care facility. If your State / provider type does not require a State / local license [Explanation Needed]
☐	Current copy of your onsite governmental agency site survey including facility's corrective action plan if deficiencies were cited, OR cover letter/e-mail from licensing agency stating facility is in substantial compliance with licensing standards
☐	Current copy of facility Commercial Liability Insurance Certificate
☐	Current copy of facility Professional Liability Insurance Certificate covering all facility employees
☐	Copy of current accreditation letter or certificate is required please note all CMS accrediting organizations are accepted
☐	Signed copy Medicare certification documents from CMS

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1. FACILITY IDENTIFICATION

CORPORATE IDENTIFICATION INFORMATION

LEGAL BUSINESS NAME *(as reflected on W-9)*	**FEDERAL TIN/TAX ID** *(application cannot be processed without valid 9 digit TIN)*
BUSINESS ADDRESS *(if different than facility address)*	**TYPE-2 NPI** *(application cannot be processed without valid 10-digit NPI)*
ORGANIZATION CLASSIFIED AS: ☐ Corporation ☐ Partnership ☐ Not-For-Profit Corp ☐ Sole Proprietorship ☐ Other (Specify)	**Is facility owned in whole or in part or managed by a hospital or health care system/facility?** ☐ Yes, owned in whole or in part by ☐ Yes, managed by ☐ No, not affiliated with a hospital or health care system/Facility

FACILITY INFORMATION

FACILITY DOING BUSINESS AS NAME *(as reflected on W-9)*

STREET ADDRESS:		**CITY:**	**STATE:**	**ZIP CODE:**
COUNTY:	**PHONE:**	**FAX:**	**WEBSITE:**	

OFFICE ADMINISTRATOR *(Name, Title, Email, Phone, Fax)*

APPLICATION CONTACT PERSON *(Name, Title, Email, Phone, Fax)*

MAILING/CORRESPONDENCE ADDRESS

☐ Check here if all correspondence can be directed to the facility location directly above. Otherwise, complete the section below.

FACILTY NAME

FACILITY ADDRESS

FACILITY COUNTY AND PHONE NUMBER

OFFICE ADMINISTRATOR *(Name, Title, Email, Phone, Fax)*

APPLICATION CONTACT PERSON *(Name, Title, Email, Phone, Fax)*

2. MEDICAL DIRECTOR OR EQUIVALENT

A specific physician Medical Director or equivalent must clearly be identified and must be licensed in good standing.

Name: MD ☐ DO ☐ Other ☐ Specialty:

License Number: NPI Number:

Phone Number: Email Address:

3. FACILITY TYPE

One box must be checked based on licensure status. If your provider type is not listed below, do NOT complete this application

	MEDICAL
☐	Ambulatory Surgery Center _ Free Standing
☐	Home Health Care Agency – Providing skilled nursing services
☐	Hospital – All Types including Psychiatric (# of Medicare certified beds:)
☐	Skilled Nursing Facility / Nursing Home (# of Medicare certified beds:)
☐	Birthing Center
	BEHAVIORAL HEALTH
☐	Adult Licensed Residential Crisis
☐	Children's Residential Facility – Mental Health Treatment
☐	Children's Residential Facility – Substance Abuse Treatment
☐	Eating Disorders Residential Facility
☐	Mental Health Residential Treatment, IRTS, or Residential Crisis
☐	Partial Psych/Partial Hospitalization – Free standing only
☐	Substance Abuse Treatment – Outpatient and / or Residential / Inpatient
☐	Outpatient Treatment Program

FOR HOSPITALS ONLY

Does your Facility provide any of the following services?

Critical Access Hospital	☐ Yes	☐ No	Cardiac Surgery Program	☐ Yes	☐ No
Outpatient Dialysis	☐ Yes	☐ No	Physical Therapy	☐ Yes	☐ No
Critical Care Services - Intensive Care Unit (ICU)	☐ Yes	☐ No	Occupational Therapy	☐ Yes	☐ No
Diagnostic Radiology	☐ Yes	☐ No	Outpatient Infusion / Chemotherapy	☐ Yes	☐ No
Mammography	☐ Yes	☐ No	Speech Therapy	☐ Yes	☐ No
Genetic Counseling and Testing	☐ Yes	☐ No	Laboratory Services	☐ Yes	☐ No
Cardiac Catheterization Services	☐ Yes	☐ No			

4. FACILITY LICENSURE

Attach a copy of each Facility license for the facility listed on page three

Licensing Agency	License Number	Effective date	Expiration Date

5. MEDICARE STATUS

Is this facility/program/agency Medicare certified? ☐ YES ☐ NO

If Yes: Medicare number: Date of initial Certification:

☐ Check here if facility is not eligible for Medicare certification.

6. ACCREDITATION

The Facility being credentialed must be listed in the accreditation and a copy of each accreditation is required

☐	**AAAASF - American Association for Accreditation of Ambulatory Surgery Facilities**
☐	**AAAHC - Accreditation Association for Ambulatory Health Care**
☐	**ACHC - Accreditation Commission for Health Care**
☐	**CARF - Commission on Accreditation of Rehabilitation Facilities**
☐	**CCAC - Continuing Care Accreditation Commission**
☐	**COA - Council on Accreditation**
☐	**DNV / NIAHO - Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations**
☐	**HFAP - Healthcare Facilities Accreditation Program**
☐	**TJC - The Joint Commission (Formerly known as JCAHO)**
☐	**Other**

1. Date of last full site survey by accrediting body:

2. Site survey is scheduled:

3. Effective date of accreditation: through

Facility is not currently accredited. *Complete Non Accredited Facility Section below.*

7. NON ACCREDITED FACILITY

Complete this section if facility is not accredited.

Medical Facility: Has your State completed an onsite licensing review or has CMS certification survey within the past 36 months?

☐ **YES - Date of most recent onsite survey:**

Attach copy of the most recent onsite licensing/certification survey along with your Corrective Action Plan (CAP), if deficiencies were cited; OR attach a letter or email from the licensing/certification agency stating that the facility is in substantial compliance with the most recent survey standards.

☐ **NO -** ***Successful completion of a health plan onsite visit will be required to complete re/ credentialing.*** **You will be contacted by health plan to schedule the visit.**

If your State has not had a Services Site survey within the past 36 months, please note when your next site survey is scheduled:

Behavioral Health Facility: Has your State completed an onsite licensing site review within the past 36 months?

☐ **YES- Date of most recent onsite survey:**

Attach copy of the most recent onsite licensing/certification survey along with your Corrective Action Plan (CAP), if deficiencies were cited; OR attach a letter or email from the licensing/certification agency stating that the facility is in substantial compliance with the most recent survey standards.

☐ **NO –** ***Successful completion of a health plan onsite visit will be required to complete re/credentialing.*** **You will be contacted by health plan to schedule the visit.**

If you have not had a State site survey within the past 36 months, please note when your next site survey is scheduled:

8. HEALTH PLAN SITE VISIT:

Does your branch or satellite location(s) follow the same policies and procedures as your main facility?

☐ Yes - Fill out the attached Policy and Procedure Attestation on the page 7.

☐ No - When the health plan contacts you to schedule the health plan site visit, it will be determined if site visits are required for the branch/satellite locations.

POLICY ATTESTATION

Please list any other facilities under the same name and/or tax id number as name of facility, specialty and location listed on this application.

If your facility follows the same policies and procedures as your main facility, the **Health Plan** may limit a site visit.

Attestation:

I, the undersigned authorized agent, hereby attest and certify that (name of facility, specialty and location) shares the same policies and procedures as: (list all facilities, specialty and locations)

Facility Name	Specialty	Location	TIN	NPI

_____ _____/_____/_____

Signature of Authorized Representative Date Signed

_____ _____

Printed Name Title

9. CREDENTIALING PROGRAM

Indicate how credentialing is ensured for all health care professionals employed or contracted at the facility:

☐ Credentialing procedures are performed internally

☐ Credentialing procedures are outsourced/delegated to:

Name : Phone Number:

10. INSURANCE COVERAGE

1. This facility is covered by **Commercial General** liability insurance in the minimum amount of

$ per occurrence and $ aggregate? (Excess liability/Umbrella coverage can count toward the

$ aggregate amount.)

☐ YES - Attach copy of insurance certificate. We prefer the Acord® Certificate of Liability Coverage

☐ Facility is covered by Government insurance. – Attach documentation detailing coverage.

2. Is this facility covered by **Professional** liability insurance in the minimum amount of $1 million per

occurrence and $3 million aggregate? Policy must state it covers all facility employees.
(Excess liability/Umbrella coverage can count toward the $3 million aggregate amount.)

☐ YES - Attach copy of insurance certificate. We prefer the Acord® Certificate of Liability Coverage form.

☐ Facility is covered by Government insurance - Attach documentation detailing coverage.

NOTE: Hospitals may be required to have additional insurance cover amounts

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FACILITY CREDENTIALING APPLICATION LANGUAGES

●Check all languages spoken by facility/agency/program staff fluently enough to treat patients/clients who speak only that language.

●Indicate if Sign Language and/or an Interpreter Service is available at your facility

☐	AFRIKAANS	☐	HILIGAYNON	☐	OROMO
☐	AKAN	☐	HINDI	☐	PAKASTANI
☐	ARABIC	☐	HINDU	☐	PERSIAN
☐	ARABIC NORTH LEVAN	☐	HMONG	☐	POLISH
☐	ARMENIAN	☐	IBO OF NEGERIA	☐	PORTUGUESE
☐	ASSAMESE	☐	ICELANDIC	☐	ROMANIAN
☐	BENGA	☐	INDONESIAN	☐	RUSSIAN
☐	BENGALI	☐	IOLCANO	☐	SERBIAN
☐	BOSNIAN	☐	ITALIAN	☐	SINDHI
☐	BULGARIAN	☐	KANNADA	☐	SINHALA
☐	BURMESE	☐	KAREN	☐	SLAVIC
☐	CAMBODIAN	☐	KASHMIRI	☐	SLOVENIAN
☐	CANTONESE	☐	KISII	☐	SOMALI
☐	CHILEAN	☐	KISWAHILI	☐	SPANISH
☐	CHINESE	☐	KONKANI	☐	SWAHILI
☐	CHINESE MANDARIN	☐	KOREAN	☐	SWEDISH
☐	CROATIAN	☐	KUNIAN	☐	TAGALOG
☐	CZECH	☐	KURDISH	☐	TAIWANESE
☐	DANISH	☐	LATIAN	☐	TAMIL
☐	DUTCH	☐	LAOTIAN	☐	TELUGU
☐	EGYPTIAN	☐	LATVIAN	☐	THAI
☐	ESAN	☐	LIINGALA	☐	TIGRIGNA
☐	EATONIAN	☐	LITHUANIAN	☐	TSWANA
☐	FARSI	☐	LUGANDA	☐	TURKISH
☐	FILIPINO	☐	LUO	☐	TURKMEN
☐	FINNISH	☐	MALAY	☐	UKRANIAN
☐	FLEMISH	☐	MALATALAM	☐	URDU
☐	FRENCH	☐	MANDARI	☐	VIETNAMESE
☐	GERMAN	☐	MANDINKA	☐	WELSH
☐	GREEK	☐	MARATHI	☐	WOLOF
☐	GUJARATI	☐	NEPALI	☐	YIDDISH
☐	HAITIAN CREOLE FRENCH	☐	NORWEGIAN	☐	YORUBA

OTHER:

☐	AMERICAN SIGN LANGUAGE	☐	INTERPRETER SERVICE UTILIZED BY FACILITY

11. NON -MEDICARE CERTIFIED HOME CARE AGENCY SECTION

Complete this section ONLY if the facility is a Home Care Agency that is not Medicare (CMS) certified. Answer ALL questions.

1. Indicate the age range of clients accepted. to

2. Number of agency employees in each category:

- Registered Nurses (RN):
- Licensed Practical Nurses (LPN):
- Home Health Aide:
- Other

3. Give reason(s) this home care agency has not pursued/been granted Medicare certification.

12. PROVIDER INTEGRITY ATTESTATION OR ELECTRONIC SIGNATURE

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire Application are true, accurate and complete to the best of my knowledge. I fully understand that any falsification of information or omissions from this Application may be grounds for denial of this Application as a participating provider.

I further understand, as an authorized agent of the applicant, that I and the organization have the burden of producing adequate information for the proper evaluation of the organization's competence, character, and ethics in resolving doubts about such qualifications.

I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

Signature of Authorized Representative **Printed Name of Authorized Representative**

Date Signed **Authorized Representative's Title**