

Contact Information	
If questions about this application, contact:	Phone Number:
Email:	Fax Number:
Mailing Address:	City, State, Zip:

Credentialing Contact Information <input type="checkbox"/> Same as Contact Information	
If questions about this application, contact:	Phone Number:
Email:	Fax Number:
Mailing Address	City, State, Zip:

Insurance Information – complete or attach insurance certificate	
Professional Carrier:	Amount of Coverage: Per Occurrence: Per Aggregate:
Policy Number:	Coverage Dates:

Facility Information		
Service Location Address:		
Physical Street Address:	City, State, Zip:	County:

Accreditation/Certification Type			
<i>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.</i>			
Agency Name	✓	Effective 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):			

Sanctions	
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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended or revoked for any reason?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Has the corporation, an officer or board member ever been convicted of a felony?

Yes

No

If you answered yes to any of the above, please explain below, or in a separate document.

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 photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

Name of Facility: _____ **Date:** _____
Print or type name

Signature of Authorizing Representative Title

A stamp signature is not acceptable

Attestation of Compliance with Criminal History Background Checks (CHRI) and the Federal Regulatory Requirements for Home and Community Based Services (HCBS) final rule regarding HCBS settings, as applicable.

Dear Provider,

The State of New Jersey, Division of Medical Assistance and Health Services (DMAHS) requires that providers submit proof to WellCare Health Plans of New Jersey of compliant with **N.J.S.A. 45:1-30 et seq. requiring a criminal history background check for every person who possesses a license or certificate as a health care professional as well as a fingerprint based background check for all Providers and their employees who provide face-to-face services to Members, when required by statute or regulation and compliance with 42 Code of Federal Register (CFR) Section 441.301 (c) (4) (5) and 42 CFR Section 441.710 (a) (1) (2) for Home and Community Based Services (HCBS) final rule regarding HCBS settings.**

As a contracted provider with WellCare Health Plans of New Jersey, we request that you submit evidence of policies and procedures that demonstrate compliance with requirements for pre-employment criminal history check and/or background investigation on all staff, as well as the Home and Community Based Services (HCBS) final rule regarding HCBS settings.

Please submit evidence of compliance, along with this attestation as part of the credentialing, re-credentialing process. The health plan reserves the right to request evidence of compliance upon request.

Submit this attestation form to facilitycred@centene.com within 5 days of receipt of this letter.

Thank you for your prompt response.

WellCare of New Jersey

550 Broad Street, 12th Floor | Newark, New Jersey 07102

Consuelo.Taveras@wellcare.com | www.wellcarenewjersey.com | WC_NJPR@wellcare.com

Attestation of Compliance with Criminal History Background Checks (CHRI) and the Federal Regulatory Requirements for Home and Community Based Services (HCBS) final rule regarding HCBS settings, as applicable.

Agency Name: _____

TAX ID #: _____

NPI#: _____

Agency Location: _____

Additional Locations: _____

Best email address: _____

Criminal History Background Checks (CHRI)

I attest that, Agency Name: _____ is compliant with the State requirements to have a pre-employment criminal history check and/or background investigation on all staff Members providing direct care to MLTSS members.

Name of Authorized Representative: _____

Signature Authorized Representative: _____

Date: _____

Frequency of background checks: _____

Data Source used: _____

Providers with multiple locations, may add additional pages if required. Please include Tax ID number and NPI number for each location this attestation to applies to.

Community Based Services (HCBS) Final Rule Regarding HCBS Settings

I attest that, Agency Name: _____ is compliant with State and Federal requirements related to Home and community-based settings (HCBS).

The facility has all required qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan under Federal Reference [42 CFR § 441.301\(c\)\(4\)](#)

Name of Authorized Representative: _____

Signature Authorized Representative: _____

Date: _____

NJ Statewide HCBS Verification Tool

Date of State's Review: _____

State Agency: _____

State Agency Representative: _____

Outcome/Status/Comments: _____