



*Simply, the right choice.*  
 COMMUNITY HEALTH PLAN

**HOME CARE SERVICES  
 CREDENTIALING APPLICATION**

- Home Health
- Home Infusion
- Hospice

**SECTION I - PRACTICE INFORMATION**

Name of Business: \_\_\_\_\_

Administrator: \_\_\_\_\_

Address: \_\_\_\_\_

Street City  
 \_\_\_\_\_  
 County State Zip Code

Office Telephone: ( ) \_\_\_\_\_ Fax# ( ) \_\_\_\_\_

Office Manager's Name: \_\_\_\_\_

Tax ID#: \_\_\_\_\_ (Attach copy of W9)

Medicare Provider #: \_\_\_\_\_ Medicaid Provider #: \_\_\_\_\_

National Provider ID# \_\_\_\_\_

Office Hours:

HOURS	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
<b>A.M.</b>						
<b>P.M.</b>						

Locations of all offices not listed above:

\_\_\_\_\_  
 Street City County Zip Telephone  
 \_\_\_\_\_  
 Street City County Zip Telephone

**HOME CARE SERVICES  
CREDENTIALING APPLICATION  
PAGE 2**

Number of years of practice at current location: \_\_\_\_\_

List all languages spoken at office: \_\_\_\_\_

Do you have 24 hour call service?  YES  NO

Is someone available for home services 24 hours/day if necessary?

**SECTION II**

*Any responses, which cannot be included in the space provided, may be included on supplementary attachments.*

**Service**

Please mark the home care services which you provide:

Home Care Services

- |   |   |
|---|---|
| <input type="checkbox"/> RN Visit               | <input type="checkbox"/> High Tech RN Visit       |
| <input type="checkbox"/> RN Hourly/Staffing     | <input type="checkbox"/> Maternal/Child RN        |
| <input type="checkbox"/> LPN Visit              | <input type="checkbox"/> LPN Hourly Staffing      |
| <input type="checkbox"/> NA (HHA) Visit         | <input type="checkbox"/> NA (HHA) Hourly/Staffing |
| <input type="checkbox"/> Physical Therapist     | <input type="checkbox"/> Respiratory Therapist    |
| <input type="checkbox"/> Enterostomal Therapist | <input type="checkbox"/> Social Worker            |
| <input type="checkbox"/> Speech Therapist       | <input type="checkbox"/> Occupational Therapist   |
| <input type="checkbox"/> Homemaker              | <input type="checkbox"/> Other _____              |

1. What services, if any, are you not able to provide or subcontract out?
2. What is your policy and practice for handling referrals that you do not have the staff to accommodate?
3. What clinical protocols do you have in place (Critical Pathways, Guidelines, etc.)?
4. What additional services do you offer (i.e., intake coordination at the hospital or other settings)?
5. Do you have centralized intake? What are the credentials of the person providing intake services for your company?
6. Are you willing to co-develop new pathways with partners such as Community Health Plan?
7. Are you willing to adopt clinical pathways written by Community Health Plan physicians for Community Health Plan members?

**HOME CARE SERVICES  
CREDENTIALING APPLICATION  
PAGE 3**

**Quality**

1. Do you measure or monitor your quality of service? How is it measured?
  
2. What are your quality indicators?
  
3. What is your complication rate?
  
4. What is your unexpected readmission rate (within 14 days)? How is it measured?
  
5. Are you accredited by a National Accredited Organization?  
Name: \_\_\_\_\_  
Date: \_\_\_\_\_
  
7. What is your patient satisfaction level? How is it measured? How frequently is it measured?
  
8. How do you measure/monitor the effectiveness of your patient education programs? How frequently is it measured?

**SECTION III**

*If your answer is YES to any of the following questions, please furnish details on a separate sheet.*

1. Has a judgement or settlement ever been made against your company in a professional liability case or are there any currently pending?  
 YES    NO   If yes, please give details on the attached form.
  
2. Have you ever voluntarily surrendered or had your state license refused, restricted, suspended or revoked?  
 YES    NO
  
3. Has your company been suspended, sanctioned, fined or restricted from participation as a Medicare or Medicaid provider?

**HOME CARE SERVICES  
CREDENTIALING APPLICATION  
PAGE 4**

YES  NO If yes, please explain on a separate sheet.

Completed by: \_\_\_\_\_  
Please Print

\_\_\_\_\_  
Signature Title Date

**Please attach copies of the following documents (if applicable):**

1. State license(s).
2. Proof of Professional Liability Coverage
3. Medicare Certificate
4. Accreditation Certificate (if applicable)
5. W9 Form
6. Quality Improvement Plan

**HOME CARE SERVICES  
CREDENTIALING APPLICATION  
PAGE 5**

**COMMUNITY HEALTH PLAN  
STATEMENT OF APPLICATION  
(Please read carefully before signing)**

All information submitted by me on behalf of the organization noted below in this Application, and all documentation submitted by me in support of this Application, is true to the best of my knowledge and belief. I fully understand that any misleading statement or material omission in this Application may constitute cause for denial of eligibility.

By applying for membership in Community Health Plan, I hereby authorize Community Health Plan and its representatives to seek relevant information, whether written or oral, from health maintenance organizations, health plans (including employer-sponsored), institutions, state licensing and other regulatory boards, and professional organizations with which our organization has been associated, and with others, including past and present malpractice carriers (Health Care and Related Entities), who may have information bearing on the professional competence, character, and ethical qualifications. I hereby further consent to the inspection by Community Health Plan and its representatives of all documents that may be material to an evaluation of the organization's qualifications and competence as well as moral and ethical qualifications for eligibility. I hereby further authorize all Health Care and Related Entities to release to Community Health Plan and its authorized representatives any information, whether written or oral, with respect to the organization's, status with such Health Care and Related Entities pursuant to a written request from Community Health Plan, or its authorized representative, that such information be provided.

I hereby release from liability all representatives of Community Health Plan for their acts performed in good faith and without malice in connection with evaluating the Application.

I understand and agree that our organization, as an applicant for membership in Community Health Plan, have the burden of producing adequate information for proper evaluation of our professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications. As such, I will before and after approval of my Application, notify Community Health Plan in writing of any changes, errors or omissions with respect to the information I have provided in this Application.

I authorize any State Licensing Board to release any and all information regarding the organization's licensure, including any and all information regarding past or present, proved or alleged violations, complaints, letters of concern issued, reprimands and any past or present disciplinary actions relating to the organization's license.

A photocopy of this Certification, Authorization and Release shall be as effective as the original when so presented.

Organization: \_\_\_\_\_

Name and Title: \_\_\_\_\_  
(Please print or type)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_