

**INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISE™  
PROVIDER ENROLLMENT BASE APPLICATION  
EXTENDED CARE FACILITY OR  
INTERMEDIATE CARE FACILITY/INTELLECTUAL DISABILITIES**

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**Applications must be typed or completed in black ink, or they will not be accepted.  
Applications will be scanned - please do NOT staple.**

1. Enter the complete name of the facility.
- 2a-b Check the appropriate boxes for the action(s) you request and complete the entire application.
- 2c. If you are reactivating a provider number, indicate the PROMISE™ **9 digit** provider number you wish to have reactivated and complete the application as an initial enrollment.
3. **Enter your National Provider Identifier (NPI) Number and taxonomy(s). Include a legible copy of the NPPES Confirmation letter that shows the NPI Number and Taxonomy(s) assigned to the healthcare provider applying for enrollment. Refer to:**  
<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/nationalprovideridentifiernpiinformation>
4. Enter the requested effective date for your action request.
5. Enter your Tax Identification Number (FEIN/TIN).  
**A copy of the TIN label or document generated by the Federal IRS containing the name and IRS number of the entity applying for enrollment must accompany this application. A W-9 form will not be accepted.**
6. Enter your legal name as it is filed with the IRS and as it appears on IRS-generated documents.
7. Enter your provider type number and description (e.g., provider type 03, Extended Care Facility)
8. Enter your specialty name and code number. **See the requirements for your provider type.**
- 9a. Indicate whether or not you participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs).
- 9b. Enter the names of any Pennsylvania Medicaid Managed Care Organizations with which you participate.
- 10a. Indicate whether the provider operates under a fictitious business/doing-business as (d/b/a) name.
- 10b. If applicable, enter the statement/permit number and the name. **Attach a legible copy of the recorded/ stamped fictitious business name statement/permit.**
- 11a. Enter your IRS (Legal Entity) address. **This address is where your 1099 tax documents will be sent.**
- 11b-f. Enter the contact information for the IRS address.
12. Check the appropriate box for the business type of the facility applying for enrollment. Check only one box.  
**\*Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.**
- 13a. Enter a valid service location address.  
**\*The address must be a physical location, not a post office box.  
\*The zip code must contain 9 digits and the phone number must be for the service location.  
\*Refer to block #20 of the application to list an additional address (es) for Pay-to, Mail-to, and/or Home Office locations if different from the Service Location address entered in Block 13a.**

NOTE\* you can sign up for the **Electronic Funds Transfer Direct Deposit Option** by following the link below:  
<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/electronicfundstransferdirectdepositinformation/index.htm>

- 13b-c. Answer question. If yes, enter your E-mail Address. If no, follow directions to access the bulletin information yourself. If you require paper bulletins or RA's please call 1-800-537-8862 option 1 to see if you meet the requirements.
- 13d-g. Enter contact information.
- 13h. Indicate whether you or your staff is able to communicate with patients in any language other than English.
- 13i. If applicable, list the additional languages in which you or your staff can communicate.
- 13j. Enter the appropriate Provider Eligibility Program (PEP). **\*Refer to the PEP Description.**
14. Enter your license number, issuing state, number of licensed beds, issue date, and expiration date.  
**\*A copy of your license must be included with the application.**
15. Enter your CMS Certification number
16. Indicate whether you retain any managing employees or agents.  
**\*IF "yes" complete Attachment I (pg 16 of this document)**
17. Check date the facility will submit their annual MA cost report and enter projected resident days.
- 18a-e. The representative of the facility applying for enrollment must complete ALL confidential information questions, A through E.  
**\*If you answer "Yes" to any of the questions, you must provide a detailed explanation (on a separate piece of paper) and attach it to your application. (Refer to the Confidential Information sheet).**
- 18f. Include responses 18f, 1 to 14, if you answered YES to any of the questions in 18A-E.
19. Sign the application and print your name, title, and date (**The signature should be that of someone able to represent the facility applying for enrollment**). Use BLACK ink.
20. This page, beginning with block #20, may be used to add a mail-to, pay-to, and/or home office address to the **previously defined** service location address listed in 15a. **This sheet cannot be used to add a service location.**
- 20a. Enter the corresponding mail-to, pay-to, and/or home office address for the service location.
- 20b. Indicate whether you are adding a mail-to, pay-to, and/or home office address.
- 20c. Enter the e-mail address of the contact person for this address.
- 20d-g. Enter the contact information for this address.
- **Facilities must complete a new base application to add additional provider types to their file.**
  - **A representative of the facility applying for enrollment must complete the Provider Agreement included with the application.**

When completed, review the "Did You Remember..." Checklist included with the application.

**Return your application and other documentation to the following address:**

DPW/Office of Long-Term Living  
Bureau of Quality and Provider Management  
Attention: Provider Enrollment  
PO Box 8025  
Harrisburg, PA 17105-8025

## **Provider Eligibility Program (PEP) Descriptions**

A Provider Eligibility Program (PEP) code identifies a program for which a provider may apply. A provider must be approved in that program to be reimbursed for services to consumers of that program. Providers should use the following PEP codes when enrolling in PROMIS<sup>e</sup>™ and should use the descriptions in this document to determine which PEP code to use when enrolling in PROMIS<sup>e</sup>™.

### **Fee-for-Service (FFS)**

**Contact Number: (717) 772-2570 or (800) 932-0939**

Email: [ra-hcbsevenprov@pa.gov](mailto:ra-hcbsevenprov@pa.gov)

A comprehensive set of Medical Assistance services which include reimbursement for direct inpatient skilled nursing services to consumers through components of the Medical Assistance Program. If you are trying to provide services under the FFS program, you should select the FFS PEP.

### **Aging Waiver**

**Contact Number: (717) 772-2570 or (800) 932-0939**

Email: [ra-hcbsevenprov@pa.gov](mailto:ra-hcbsevenprov@pa.gov)

Website: <http://www.dpw.state.pa.us/fordisabilityservices/alternativestonursinghomes/agingwaiver/index.htm>

Providers should enroll in the Aging Waiver if they would like to provide temporary respite services within the facility to Nursing Facility Clinically Eligible (NCFE) individuals age 60 or over. If you are trying to provide respite services under the Aging Waiver, you should select the AGING PEP.

The Aging Waiver also provides additional home and community-based services. Information and listing of services provided by this PEP can be found by following the link above. For service descriptions and qualifications required of providers follow the “View the Current Aging Waiver” link under the “Learn more” section of the webpage.

**NOTE:** If the facility wishes to provide any of the additional services under this PEP, you must complete the entire application and enroll as a Home and Community-Based Services (HCBS) provider. All providers in this PEP must be approved by the Office of Long-Term Living (OLTL).

## **Specialty Codes for Provider Type 03**

Please choose from the following:

- |     |                         |     |   |
|-----|-------------------------|-----|---|
| 030 | Nursing Facility        | 038 | State Mental Retardation Center         |
| 031 | County Nursing Facility | 039 | ICF/ORC                                 |
| 032 | ICF/ID 8 Beds or Less   | 040 | Special Rehabilitation Nursing Facility |
| 033 | ICF/ID 9 Beds or More   | 042 | DMVA Nursing Facilities                 |
| 037 | State LTC Unit          | 382 | Hospital Based Nursing Facility         |
| 036 | Respite                 |     |   |

# PROMISE™ PROVIDER ENROLLMENT BASE APPLICATION

1. Enter Name of Facility:

\_\_\_\_\_

2. Action Request: Check Boxes that Apply:

a.  Initial Enrollment

b.  Revalidation

c.  Check here if previously enrolled in Medical Assistance (MA).

Enter Provider Number (if known): \_\_\_\_\_ (9 digits)

(Complete the application as an initial enrollment.)

3. National Provider Identifier Number: \_\_\_\_\_ (10 digits)

Taxonomy(s): \_\_\_\_\_ (10 digits) \_\_\_\_\_ (10 digits)

Taxonomy(s): \_\_\_\_\_ (10 digits) \_\_\_\_\_ (10 digits)

4. Requested Effective Date:  
yyyy / mm / dd – (2004/07/31)

\_\_ \_\_ \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

5. Federal Tax ID Number: \_\_\_\_\_ (9 Digits)

**\*A copy of a document generated by the Federal IRS with your name and IRS number must accompany this application**

6. Legal Name Shown on Attached Document: \_\_\_\_\_

7. Provider Type Number and Description:

Number: \_\_\_\_\_ (2 digits)

Description: \_\_\_\_\_

8. Specialty(s) and Code(s), if applicable:

Code Number: \_\_\_\_\_ (3 digits)

Specialty: \_\_\_\_\_

9a. Do you intend to participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs)?

Yes  No

9b. If yes, list the MCO(s):

\_\_\_\_\_  
\_\_\_\_\_

**FOR INTERNAL USE ONLY:**

MPI Legal Entity Number: \_\_\_\_\_ SL Code: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

10a. Does the provider operate under a Fictitious business/doing business as (d/b/a) name?

Yes  No

10b. If yes, list the Statement/Permit number and the name:

Number: \_\_\_\_\_

Name: \_\_\_\_\_

\*A legible copy of the recorded/stamped fictitious business name statement/permit is required for your application to be processed.

11a. IRS Address: **Note: This is the address where your 1099 tax document will be sent.**

Street: \_\_\_\_\_ Room/Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_ (9 digits)

11b. Contact Name/Title:

Name: \_\_\_\_\_

Title: \_\_\_\_\_

11c. Contact E-Mail Address:

\_\_\_\_\_

11d. Contact Phone:

( )

11e. Contact Toll-Free Phone:

( )

11f. Contact Fax Number:

( )

12. Business Type: (Check 1 Box Only)

Business Corporation, For Profit

Not for Profit

Partnership

Government Owned

Estate/Trust

Sole Proprietorship

13a. Service Location Address: (A POST OFFICE BOX IS NOT A VALID SERVICE LOCATION. THE ADDRESS MUST BE A PHYSICAL LOCATION.)

Street: \_\_\_\_\_ Room/Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_ (9 digits) County: \_\_\_\_\_

Business Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

Fax Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

Is this location handicap accessible?  Yes  No

If no, do you have an exemption from the U.S. Department of Justice excusing compliance with Title III of the Americans with Disabilities ACT?  Yes (Attach a copy of the exemption to your application)  No

Has the provider named in Block 1 been screened for this location within the last 12 months by:

Medicare?  Yes  No

Another state's Medicaid program?  Yes (Complete below)  No

\_\_\_\_\_  
Screening State

\_\_\_\_\_  
Screening Contact Phone Number

\_\_\_\_\_  
Screening contact email address

Check all applicable boxes. This service location is also a:  Pay-to  Mail-to  Home Office

If Pay-to, Mail-to, and/or Home Office are different from above address, refer to Block #20.

If you wish to utilize the **Electronic Funds Transfer Direct Deposit Option** please follow link for further information:

<http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/electronicfundstransferdirectdepositinformation/index.htm>

13b. Would you like to receive E-Mail notification of new bulletins? Yes  No

If YES, E-Mail address is **required** to receive notification of MA bulletins:

\_\_\_\_\_

By answering **NO** you are agreeing to be responsible to check for new MA bulletins on your own by visiting the following website: <http://www.dpw.state.pa.us/publications/bulletinsearch/index.htm> **OR** by signing up to receive notification of new MA Bulletins through the Listserv option on the DPW website: <http://www.dpw.state.pa.us/provider/index.htm> (select 'eBulletins' Listserv option to join).

**If you wish to continue receiving paper bulletins call 1.800.537.8862 Option 1 to see if you meet the requirements.**

13d. Contact Name: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_(\_\_\_\_\_)\_\_\_\_\_

13e. Contact Toll-Free Phone:  
(\_\_\_\_)\_\_\_\_\_

13f. Contact Fax Number:  
(\_\_\_\_)\_\_\_\_\_

13g. Contact E-Mail address:  
\_\_\_\_\_

13h. In addition to English, do you or your staff communicate with patients in another language?  
Yes  No

13i. If "Yes",  
List language(s): \_\_\_\_\_  
\_\_\_\_\_

13k. Provider Eligibility Program (PEP). Refer to PEP descriptions included in the instructions. **You must choose at least one (1) PEP:**

a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

14. a. License Number: \_\_\_\_\_ b. Issuing State: \_\_\_\_\_ c. Number of Licensed Beds: \_\_\_\_\_  
d. Issue Date: \_\_\_\_\_ e. Expiration Date: \_\_\_\_\_

**\*A copy of your current license is required for your application to be processed.**

15. CMS Certification number: \_\_\_\_\_

16. Does the provider retain any managing employees or agents?  Yes  No

**IF "YES" please complete Attachment I (Pg. 16)**

17a. For Cost Reporting Purposes:

Fiscal Year Ending Date:  June 30  December 31

Projected Resident Days for the next 12 months: \_\_\_\_\_

**18. CONFIDENTIAL INFORMATION**

Have you, any agent, or managing employee ever:

A. Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?

Yes

No

B. Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?

Yes

No

C. Had a controlled drug license withdrawn?

Yes

No

D. Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation?

Yes

No

E. In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?

Yes

No

F. If you answered "Yes" to any of the questions listed above, you **MUST** provide a detailed explanation (on a separate piece of paper) and submit three (3) statements from professional associates or peer review bodies giving factual evidence of why they believe the violation(s) will not be repeated and attach it to your application. Include the following information as applicable to the situation:

- |  |   |
|--|---|
| 1. Name and title of individual                          | 8. Disposition/State  |
| 2. Name of federal or state health care program          | 9. Date license was surrendered                             |
| 3. Name of licensing/certifying agency taking the action | 10. Name of court   |
| 4. Date of action  | 11. Date of conviction                                      |
| 5. Type of action taken                                  | 12. Offense(s) convicted of                                 |
| 6. Length of action                                      | 13. Sentence(s)   |
| 7. Basis for action                                      | 14. Categorization of offense<br>(e.g. felony, misdemeanor) |

19. This form requires the original signature of the individual representing the facility applying for enrollment.

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
**Original Signature**

\_\_\_\_\_  
Date

**Mail-To/Pay-To/Home Office Information For The Service Location Entered In 17a**

NOTE: Do not use this sheet to add service locations.

<b>20 a. Address:</b> Street	Suite/Box	City	State	Zip (9-digits)
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b. This address is a:  
 Mail-to    Pay-to  
 Home Office

c. E-Mail address:

d. Contact Name/Title:  
Name: \_\_\_\_\_ Title: \_\_\_\_\_

e. Business Phone:  
(     )

f. Toll-Free Phone  
(     )

g. Fax Number:  
(     )

<b>a. Address:</b> Street	Suite/Box	City	State	Zip (9-digits)
---------------------------	-----------	------	-------	----------------

b. This address is a:  
 Mail-to    Pay-to  
 Home Office

c. E-Mail address:

d. Contact Name/Title:  
Name: \_\_\_\_\_ Title: \_\_\_\_\_

e. Business Phone:  
(     )

f. Toll-Free Phone  
(     )

g. Fax Number:  
(     )

<b>a. Address:</b> Street	Suite/Box	City	State	Zip (9-digits)
---------------------------	-----------	------	-------	----------------

b. This address is a:  
 Mail-to    Pay-to  
 Home Office

c. E-Mail address:

d. Contact Name/Title:  
Name: \_\_\_\_\_ Title: \_\_\_\_\_

e. Business Phone:  
(     )

f. Toll-Free Phone  
(     )

g. Fax Number:  
(     )

**COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE  
OFFICE OF LONG TERM LIVING**

**NURSING FACILITY PROVIDER AGREEMENT**

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas \_\_\_\_\_  
(FACILITY NAME)

(hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.
2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.  
  
(b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding Payments the Facility has claimed.  
  
(c) To provide such information as may otherwise be required by state or federal law.
3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on \_\_\_\_\_ and will continue until notified that its enrollment is terminated or otherwise affected by lawful actions undertaken by state or federal officials.
4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.
5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

**PROVIDER:**

\_\_\_\_\_  
(FACILITY NAME)

\_\_\_\_\_  
(SIGNATURE OF CEO/CFO/ADMINISTRATOR)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(NAME - PLEASE TYPE OR PRINT)

\_\_\_\_\_  
(PROMISE #)

**COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE  
OFFICE OF LONG TERM LIVING**

**INTERMEDIATE CARE FACILITY/INTELLECTUAL DISABILITIES PROVIDER AGREEMENT**

Whereas providers are required by law to agree to certain conditions as a prerequisite to enrollment as providers in the Medical Assistance Program; and

Whereas \_\_\_\_\_,  
(FACILITY NAME)

(hereafter, the Facility), wishes to enroll as a provider in the Medical Assistance Program;

NOW, THEREFORE, AS REQUIRED BY LAW, THE FACILITY HEREBY AGREES:

1. That the submission by, or on behalf of, the Facility of any claim, either by hard copy or electronic means, shall be certification that the services or items for which payment is claimed actually were provided to the person identified as a medical assistance resident by the person or entity identified as the Facility on the dates indicated.
2. (a) To keep records necessary to fully disclose the extent of services provided to medical assistance residents.  
  
(b) To provide information, as requested, to the Department of Public Welfare, the U.S. Department of Health and Human Services, and the Medicaid Fraud Control Unit, or their agents, and to provide any additional information needed regarding Payments the Facility has claimed.  
  
(c) To provide such information as may otherwise be required by state or federal law.
3. That the Facility's enrollment, when approved by the Department of Public Welfare, is effective on \_\_\_\_\_ and will continue until \_\_\_\_\_.

If the Facility is cited by the Department of Health as having deficiencies, then the Facility's enrollment is subject to automatic cancellation at the close of \_\_\_\_\_, unless all required corrections have been satisfactorily completed or the Facility has made substantial progress in correcting such deficiencies and an acceptable plan of correction has been received by the Department of Health, Division of Long Term Care.

4. That the Facility's enrollment may be terminated by the Facility upon thirty (30) days prior written notice to the Department of Public Welfare; and will terminate automatically, without further notice on \_\_\_\_\_, unless a new provider agreement for a further period shall be expressly approved in writing by the Department of Public Welfare; and, may be terminated by the Department of Public Welfare immediately for failure to comply with terms of this agreement or, as otherwise may be provided by law now and hereafter.
5. That the Facility's participation in the Medical Assistance Program is subject to the laws and regulations effective as to the period of participation, including all of those that may be effective after the date of the agreement and that the Facility has the responsibility to know the law with respect to participation in the Medical Assistance Program.

**PROVIDER:**

\_\_\_\_\_  
(FACILITY NAME)

\_\_\_\_\_  
(SIGNATURE OF CEO/CFO/ADMINISTRATOR)

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(NAME - PLEASE TYPE OR PRINT)

\_\_\_\_\_  
(PROMISE #)

Pennsylvania Provider Reimbursement and Operations Management Information System electronic (PROMISe™) Medicaid Management Information System (MMIS) is a HIPAA compliant database. All information entered is maintained according to Federal HIPAA and privacy regulations. For your reference, please visit the link below for Medical Assistance Bulletin (MAB) 99-11-05.

<http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx?BulletinId=4718>

## Provider Disclosure Statement Definitions

The definitions below are designed to clarify certain questions on the following forms. If you cannot report all of the necessary information in a designated section of the form because of space limitations, please attach additional sheets.

**Agent** means any person who has been delegated the authority to obligate or act on behalf of a provider.

**Disclosing entity** means a Medicaid provider (other than an individual practitioner), or a fiscal agent.

Any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act means:

- a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
- b. Any Medicare intermediary or carrier; and
- c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

**Fiscal agent** means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

**Group of practitioners** means two or more health care practitioners who practice their profession at a common location (whether or not the share common facilities, common supporting staff, or common equipment).

**Indirect ownership interest** means an ownership interest in an entity that has a direct or indirect ownership interest in the disclosing entity.

**Individual practitioner** means a person licensed or certified under State Law to practice his or her profession.

**Managing employee** means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day to day operation of an institution, organization, or agency.

**Ownership interest** means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

**Person with an ownership or control interest** means a person or corporation that –

- a. Has an ownership interest totaling 5 percent or more in a disclosing entity;
- b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
- c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
- d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- e. An officer or director of a disclosing entity that is organized as a corporation; or
- f. Is a partner in the disclosing entity that is organized as a partnership.

**Significant business transaction** means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of a provider's total operating expenses.

**Subcontractor means** –

- a. An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

**Supplier means** an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer or hospital beds, or a pharmaceutical firm).

**Wholly owned supplier** means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

**\*If you are a non-profit organization please skip this section and complete Attachment II.**  
**\*\*This is the contact name and phone number we will use if we have any questions about this document.**

Contact Name: \_\_\_\_\_ Provider Name: \_\_\_\_\_

Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

## **OWNERSHIP OR CONTROL INTEREST**

**Note: Ownership and Controlling Interest information is required in accordance with Federal Regulations 42 CFR, Part 455 published July 17, 1979, and expanded through additional subparts on February 02, 2011 through the Provider Enrollment and Screening provisions of the Affordable Care Act.**

**Please enter the full name and address of partners, stockholders, corporate owners, or officers that have at least 5% direct or indirect ownership interest.**

**Complete below for INDIVIDUALS:**

\_\_\_\_\_  
Name (First) (Middle) (Last) Social Security Number

\_\_\_\_\_  
Street Address Date of Birth

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Name (First) (Middle) (Last) Social Security Number

\_\_\_\_\_  
Street Address Date of Birth

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Name (First) (Middle) (Last) Social Security Number

\_\_\_\_\_  
Street Address Date of Birth

\_\_\_\_\_  
City State Zip Code

**\*\*ATTACH ADDITIONAL SHEETS IF NECESSARY\*\***

**Ownership or Control Interest (Cont'd)**

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**Complete below for CORPORATE ENTITIES:**

**\*\*The address for each corporate entity MUST include: primary business address, every business location, and P.O. Box address – Use space provided below or attach a separate sheet of paper if needed.**

---

Name of Corporation FEIN/Tax ID number

---

Street Address PO Box

---

City State Zip Code

---

Name of Corporation FEIN/Tax ID number

---

Street Address PO Box

---

City State Zip Code

---

Name of Corporation FEIN/Tax ID number

---

Street Address PO Box

---

City State Zip Code

---

Name of Corporation FEIN/Tax ID number

---

Street Address PO Box

---

City State Zip Code

**\*\*ATTACH ADDITIONAL SHEETS IF NECESSARY\*\***

**Ownership or Control Interest (Cont'd)**

**Please enter the full name and address of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more.**

\_\_\_\_\_  
Name (First) (Middle) (Last) Social Security Number

\_\_\_\_\_  
Street Address Date of Birth

\_\_\_\_\_  
City State Zip Code

**\*\*Has this individual been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program?  Yes \*  No**

**If "YES" please attach details.**

\_\_\_\_\_  
Name (First) (Middle) (Last) Social Security Number

\_\_\_\_\_  
Street Address Date of Birth

\_\_\_\_\_  
City State Zip Code

**\*\*Has this individual been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program?  Yes \*  No**

**If "YES" please attach details.**

**\*\*ATTACH ADDITIONAL SHEETS IF NECESSARY\*\***

**Are any of the aforementioned persons related to each other as a spouse, parent, child or sibling? If so, please list the names of the individuals and how they are related.**

Names: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_

Names: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_

**Ownership or Control Interest (Cont'd)**

---

**DO YOU OR ANY OF THE AFOREMENTIONED INDIVIDUALS HAVE A CONTROLLING INTEREST IN, OR OWN OTHER PROVIDERS OF SERVICES?**

If "YES", list the name and address of each provider.     Yes                     No

---

Provider Name

---

Street Address

---

City

State

Zip Code

---

Name of individual with ownership or control interest:

---

Name    (First)

(Middle)

(Last)

Social Security Number

---

Street Address

Date of Birth

---

City

State

Zip Code

---

**Has the provider had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period?**

Yes                     No

**If "YES", give the information below for each wholly owned supplier or subcontractor.**

---

Name    (First)

(Middle)

(Last)

Social Security Number

---

Street Address

Date of Birth

---

City

State

Zip Code

---

Name    (First)

(Middle)

(Last)

Social Security Number

---

Street Address

Date of Birth

---

City

State

Zip Code

**ATTACHMENT I**

**Managing Employee or Agent Disclosure Form**

---

**A.** Please Provide the name, address, social security number, and date of birth of any person who is an agent or managing employee of the provider.

Is the following individual a: **Managing employee**  or **Agent**

---

Name (First) (Middle) (Last) Social Security Number

---

Street Address Date of Birth

---

City State Zip Code

Is the following individual a: **Managing employee**  or **Agent**

---

Name (First) (Middle) (Last) Social Security Number

---

Street Address Date of Birth

---

City State Zip Code

**B.** Please provide the name, and description of offense of any person who is an agent or managing employee and has been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program.

---

Name (First) (Middle) (Last)

Description of Offense:

---

---

Name (First) (Middle) (Last)

Description of Offense:

---

**ATTACHMENT II**

**Non-Profit Disclosure**

**Please add anyone who has a Controlling interest or is a Board Member.**

**President:**

---

Name (First) (Middle) (Last) Social Security Number

---

Street Address Date of Birth

---

City State Zip Code

---

**Vice President:**

---

Name (First) (Middle) (Last) Social Security Number

---

Street Address Date of Birth

---

City State Zip Code

---

**Secretary:**

---

Name (First) (Middle) (Last) Social Security Number

---

Street Address Date of Birth

---

City State Zip Code

---

**Treasurer:**

---

Name (First) (Middle) (Last) Social Security Number

---

Street Address Date of Birth

---

City State Zip Code

**ATTACHMENT II cont.**

**Other:**

---

Name (First) (Middle) (Last) Social Security Number

---

Street Address Date of Birth

---

City State Zip Code

---

Name (First) (Middle) (Last) Social Security Number

---

Street Address Date of Birth

---

City State Zip Code

---

Name (First) (Middle) (Last) Social Security Number

---

Street Address Date of Birth

---

City State Zip Code

---

Name (First) (Middle) (Last) Social Security Number

---

Street Address Date of Birth

---

City State Zip Code

---

Name (First) (Middle) (Last) Social Security Number

---

Street Address Date of Birth

---

City State Zip Code

**\*\*ATTACH ADDITIONAL SHEETS IF NECESSARY\*\***

The following checklist contains the most common reasons Pennsylvania Medicaid Program enrollment applications are returned. Please complete this checklist and **submit it with your application**. Incomplete applications will be returned.

**Please remember applications will be scanned - do not staple.**

**Did you remember to....**

- USE BLACK INK or TYPEWRITE. Application must be typed or printed in black ink.
- Complete all spaces** as required on the application with either your correct information or N/A.
- Complete the **Provider Disclosure/Ownership or Control Interest form** included with the application
- Ensure that you have entered the **correct number of digits** where specified.
- Indicate provider type and provider specialty(s), as applicable.
- Include **documentation generated by the Federal IRS** showing the name and number associated with the FEIN. Remember, a **W-9 is not permissible**.
- Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.
- Include a copy of your Department of Health license.
- Include a legible copy of the **NPPES Confirmation letter** that shows the NPI Number and Taxonomy(s) assigned to the entity applying for enrollment.
- Enter at least one (1) Provider Eligibility Program (PEP).
- Only the representative of the facility applying for enrollment can sign and date the Confidential Information Sheet and two (2) Provider Agreements. Signature stamp is not accepted.**

**Then return your application and other documentation to the address listed below:**

**DPW/OLTL  
Bureau of Quality and Provider Management  
Attention: Provider Enrollment  
PO Box 8025  
Harrisburg, PA 17105-8025**