

**INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISe™  
PROVIDER ENROLLMENT BASE APPLICATION  
OFFICE OF LONG-TERM LIVING WAIVER PROVIDER**

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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.**

**Note: Out-of-State providers must submit proof of participation in your State's Medicaid Program.**

1. Enter the complete name of the individual or facility.
- 2a. Check the appropriate boxes for the action(s) you request and complete the entire application.
- 2b. If this is a revalidation, please complete the entire application. If you have additional service locations for revalidation, please complete Page 14.
- 2c. If you are reactivating a provider number, indicate the PROMISe™ **13 digit** provider number you wish to have reactivated and complete the application as an initial enrollment.
- 2d. If you are adding a provider to an existing group, enter the PROMISe™ 13 digit group provider number. The 4-digit service location code must correspond with a valid active street address. **We will not assign fees to a service location listed as a P.O. Box.**  
• **Fee assignments may only be made between "like provider types". Call the Enrollment Hotline for verification at 1-800-537-8862.**
- 3.. **Enter your National Provider Identifier (NPI) Number and taxonomy(s). If you have more than 4 taxonomy codes, please attach an additional sheet noting the additional codes. 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.dhs.state.pa.us/provider/doingbusinesswithdhs/nationalprovideridentifiernpiinformation>
4. Enter the requested effective date for your action request.
5. Not applicable.
6. Not applicable.
7. Not applicable.
8. Enter your Social Security Number. **A copy of your Social Security card, W-2, or document generated by the Federal IRS containing your Social Security Number must accompany your application. If completing #8, do not complete #9. Refer to the checklist for additional requirements.**
9. Enter your Tax Identification Number (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. If completing #9, do not complete #8.**
10. Enter your legal name as it is filed with the IRS. The name must match your IRS-generated documents.

- 11a. Indicate whether or not you participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs).
- 11b. Enter the names of any Pennsylvania Medicaid Managed Care Organizations with which you participate.
- 12a. Indicate whether the provider operates under a fictitious business/doing-business as (d/b/a) name.
- 12b. If applicable, enter the statement/permit number and the name. **Attach a legible copy of the recorded/stamped fictitious business name statement/permit.**
13. Enter your date of birth if enrolling as an individual only.
14. Enter your gender if enrolling as an individual only.
15. Enter the title/degree you currently hold if enrolling as an individual only.
- 16a. Enter your IRS address. The address must match your IRS-generated documents and is where your 1099 tax documents will be sent.
- 16b-f. Enter the contact information for the IRS address.
17. Check the appropriate box for the business type of the individual or facility applying for enrollment. Check one (1) box only. Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.
- 18a-d. Enter your license number (if applicable), issuing state, issue date, and expiration date.  
**\*A copy of your license must be included with the application.**
19. Enter your CMS number, if applicable.
- 20a. 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 Page 13 of the application to list an additional address(es) for Mail-to and/or Pay-to locations if different from the Service Location address entered in Block 20a.**  
**Please indicate if the physical address is handicap accessible.**  
**Please indicate if the physical address has been screened by one of the listed entities.**
- NOTE: you can sign up for the [Electronic Funds Transfer Direct Deposit Option](http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/electronicfundstransferdirectdepositinformation) by following the link below:**  
**<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/electronicfundstransferdirectdepositinformation>**
- 20b. 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.
- 20c. Enter contact information for the service location.
- 20d. Indicate whether you or your staff is able to communicate with patients in any language other than English.
- 20e. If applicable, list the additional languages in which you or your staff can communicate.
- 20f. Enter the appropriate Provider Eligibility Program(s) (PEP(s)). **Refer to the PEP Descriptions on Pages XXX.**

21.a-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).**

21f. If you answered YES to any of the questions in 23A-E, include responses to 21f, 1 to 14.

22. Sign the application and print your name, title, and date. **(The signature should be that of the individual applying for enrollment or someone able to represent the facility applying for enrollment). Use black ink.**

23-24. This page, beginning with block #24, may be used to add a Mail-To and/or Pay-To address to the **previously defined** service location address listed in 20a. **This sheet cannot be used to add a service location.**

23a. Enter the corresponding Mail-To address for the service location.

23b-d. Enter the contact information for the Mail-To address.

24a. Enter the corresponding Pay-To address for the service location.

24b-c. Enter the contact information for the Pay-To address.

- Facilities must complete a new base application to add additional service locations to their file.
- The individual applying for enrollment or a representative of the facility applying for enrollment must complete the Provider Agreement for Outpatient Providers included with the application.

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

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

**OLTL / BQPM  
Attention: Provider Enrollment  
PO Box 8025  
Harrisburg, PA 17105-8025**

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HUMAN SERVICES

**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 beneficiaries of that program. Providers should use the following PEP codes when enrolling in Medical Assistance (MA). Providers should use the descriptions in this document to determine which PEP code to use when enrolling in MA.

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

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

**ACT 150 Program**

This program provides services to eligible persons with physical disabilities in order to prevent institutionalization and allows them to remain as independent as possible. The ACT 150 Program is operated only with State funds.

**Eligibility:**

Recipients either do not meet the level of care for a federally supported waiver or do not meet the financial limitations for the Attendant Care Waiver.

**Services:**

- Personal Assistance Services
- Personal Emergency Response System
- Service Coordination

**Aging Waiver (Formerly PDA Waiver/Bridge Program)**

This program provides services to eligible persons over the age of 60 in order to prevent institutionalization and allows them to remain as independent as possible.

**Eligibility:**

Recipients must be 60 years of age or older, meet the level of care needs for a Skilled Nursing Facility, and meet the financial requirements as determined by the County Assistance Office (CAO).

**Services:**

- Accessibility Adaptation
- Adult Daily Living
- Community Transition Services
- Home Delivered Meals
- Home Health
- Non-Medical Transportation

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

### **Aging Waiver (continued)**

- Personal Assistance Services
- Personal Emergency Response System
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies
- Telecare Services
- Therapeutic and Counseling Services
- Transition Service Coordination

### **Attendant Care Waiver**

This program provides services to eligible persons with physical disabilities in order to prevent institutionalization and allows them to remain as independent as possible.

#### Eligibility:

Recipients must be between the ages 18–59, physically disabled, mentally alert, and eligible for nursing facility services.

#### Services:

- Community Transition Services
- Personal Assistance Services
- Personal Emergency Response System
- Service Coordination
- Transition Service Coordination

### **Community Care Waiver (COMMCARE)**

This program was designed to prevent institutionalization of individuals with traumatic brain injury (TBI) and to allow them to remain as independent as possible.

#### Eligibility:

Pennsylvania residents age 21 and older who experience a medically determinable diagnosis of traumatic brain injury and require a Special Rehabilitative Facility (SRF) level of care. Traumatic brain injury is defined as a sudden insult to the brain or its coverings, not of a degenerative, congenital or post-operative nature, which is expected to last indefinitely.

#### Services:

- Accessibility Adaptations
- Adult Daily Living
- Community Integration

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

### Community Care Waiver (Continued)

- Community Transition Services
- Home Health
- Non-Medical Transportation
- Personal Assistance Services
- Personal Emergency Response System
- Prevocational Services
- Residential Habilitation
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies
- Structured Day
- Supported Employment
- Therapeutic and Counseling Services
- Transition Service Coordination

### Independence Waiver

This program provides services to eligible persons with physical disabilities in order to prevent institutionalization and allows them to remain as independent as possible.

#### Eligibility:

Recipients must be 18 years of age and older, suffer from severe physical disability which is likely to continue indefinitely and results in substantial functional limitations in three or more major life activities. Recipients must be eligible for nursing facility services, the primary diagnosis cannot be a mental health diagnosis or mental retardation, and the recipients cannot be ventilator dependent.

#### Services:

- Accessibility Adaptation
- Adult Daily Living
- Community Integration
- Community Transition Services
- Home Health
- Non-Medical Transportation
- Personal Assistance Services
- Personal Emergency Response System
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies

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

### **Independence Waiver (Continued)**

- Supported Employment
- Therapeutic and Counseling Services
- Transition Service Coordination

### **Omnibus Budget Reconciliation Act Waiver (OBRA Waiver)**

Also known as the Community Services Program for Persons with Disabilities, provides services to persons with developmental disabilities so that they can live in the community and remain as independent as possible (this includes relocating or diverting individuals from a nursing home to a community setting).

#### Eligibility:

Recipients must be developmentally disabled, the disability manifests itself before age 22, and the disability is likely to continue indefinitely which results in substantial functional limitations in three or more major life activities. The recipient can be a nursing facility resident determined to be inappropriately placed. The primary diagnosis cannot be a mental health diagnosis or mental retardation and community residents who meet ICF/ORC level of care (high need for habilitation services) may be eligible.

#### Services:

- Accessibility Adaptation
- Adult Daily Living
- Community Integration
- Community Transition Services
- Home Health
- Non-Medical Transportation
- Personal Assistance Services
- Personal Emergency Response System
- Prevocational Services
- Residential Habilitation
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies
- Structured Day
- Supported Employment
- Therapeutic and Counseling Services
- Transition Service Coordination

# PROMISe™ PROVIDER ENROLLMENT BASE APPLICATION

1. Enter Name of  
Provider: \_\_\_\_\_  
or  
Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

2. Action Request: Check Boxes that Apply:

- a.  Initial Enrollment:  Individual  Facility  
b.  Revalidation:  Individual  Facility  
c.  Check here if previously enrolled in Medical Assistance (MA).

Enter Provider Number (if known): \_\_\_\_\_ (13 digits)  
(Complete the application as an initial enrollment.)

- d.  Fee Assignment – Add this provider to existing provider group. Specify group provider number:  
\_\_\_\_\_ (Must be a 13 digit number to be processed).

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. Provider Type and Description:  
Number: 5 9 (2 digits)  
Description: OLTL PROGRAMS

6. Primary Specialty and Code  
Primary Specialty: N/A  
Code Number: N/A (3 digits)

7. Specialty(s) and Code(s)  
Specialty(s): N/A  
Code Number(s): N/A / N/A (3 digits)

8. Social Security Number \*:  
(If #9 is completed, DO NOT complete this item)  
\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

9. Federal Tax ID Number \*\*:  
(If #8 is completed, DO NOT complete this item)  
\_\_\_\_\_ (9 digits)

**\*A copy of your social security card OR a document generated by the IRS with your name and SSN must accompany this application.**  
**\*\*A copy of a document generated by the Federal IRS with your name, address and FEIN number must accompany this application.**

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

11a. Do you intend to participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs)? <input type="checkbox"/> Yes <input type="checkbox"/> No	11b. If yes, list the MCO(s): _____ _____
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12a. Does the provider operate under a fictitious business/doing business as (d/b/a) name? <input type="checkbox"/> Yes <input type="checkbox"/> No	12b. 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.
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13. Date of Birth: yyyy/mm/dd (ex: 2004/07/31) ____ / ____ / ____	14. Gender: Male    Female <input type="checkbox"/> <input type="checkbox"/>	15. Title/Degree as it appears on license:
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16a. IRS Address: **Note: This is the address where your 1099 tax document will be sent.**

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

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

County: \_\_\_\_\_

16b. Contact Name/Title: Name: _____ Title: _____	16c. Contact E-Mail Address: _____
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16d. Phone Number: (____) _____	16e. Contact Toll-Free Phone: (____) _____	16f. Fax Number: (____) _____
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17. Business Type: (Check 1 Box Only)

<input type="checkbox"/> Business Corporation, For Profit	<input type="checkbox"/> Not For Profit	<input type="checkbox"/> Sole Proprietorship
<input type="checkbox"/> Estate/Trust	<input type="checkbox"/> Partnership	
<input type="checkbox"/> Government Owned	<input type="checkbox"/> Public Service Corporation	

18. a. License Number: \_\_\_\_\_ b. Issuing State: \_\_\_\_\_

c. Issue Date: \_\_\_\_\_ d. Expiration Date: \_\_\_\_\_

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

19. CMS Certification number: \_\_\_\_\_, if applicable

09/08/2015 9

20a. 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: \_\_\_\_\_

County: \_\_\_\_\_

Business Phone: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

(1) Does the facility have exterior or interior steps leading to the main entrance doorway?

Yes  No  Exterior  Interior

(2) If the answer to (1) is YES, does the facility have a permanent or portable wheelchair ramp?

Yes  No  Permanent  Portable

(3) If the answer to (1) is YES, is there an alternate entrance that has no exterior or interior steps or has a wheelchair ramp?

Yes  No  No exterior steps  No interior steps  
 Permanent ramp  Portable ramp

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

CMS/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:  Mail-to  Pay-to

If Pay-to and/or Mail-to are different from above address, refer to Blocks #20 and #21.

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

<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/electronicfundstransferdirectdepositinformation>

20b. Would you like to receive E-Mail notification of new bulletins?  Yes  No

E-Mail address is **required if answered YES** to receive notification of MA bulletins:

\_\_\_\_\_

\*By answering **NO** you are agreeing to be responsible to check for new MABs on your own by visiting the following website: <http://www.dhs.state.pa.us/publications/bulletinsearch> OR by signing up to receive notifications of new MABs through the [MA Electronic Bulletins Listserv](#)

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

Once enrolled, you can retrieve RAs from PROMISE™ online. If you require paper RAs, please call 1.800.537.8862 Option 1 to see if you meet the requirements.

20c. Contact's Name: \_\_\_\_\_

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

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

20d. In addition to English, do you or your staff communicate with patients in another language?

Yes  No

20e. If "Yes", list language(s):

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20f. Provider Eligibility Program (PEP). Refer to PEP descriptions included in the instructions.

**You must choose at least one (1) PEP:**

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

**THIS SPACE INTENTIONALLY LEFT BLANK.**

21. 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
2. Name of federal or state health care program
3. Name of licensing/certifying agency taking the action
4. Date of action
5. Type of action taken
6. Length of action
7. Basis for action
8. Disposition/State
9. Date license was surrendered
10. Name of court
11. Date of conviction
12. Offense(s) convicted of
13. Sentence(s)
14. Categorization of offense (e.g. felony, misdemeanor)

- 22. This form requires the original signature of the individual applying for enrollment.

Printed Name

Title

Original Signature

Date

**Mail-To and/or Pay-To Information for the Service Location Entered in Block 20a**

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

**23a. "MAIL TO" Address:**

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ -- \_\_\_\_\_

**b. Contact Name/Title:**

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

E-Mail address: \_\_\_\_\_

c. Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

d. Fax Number: ( \_\_\_\_\_ ) \_\_\_\_\_

**24a. "PAY TO" Address:**

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ -- \_\_\_\_\_

**b. Contact Name/Title:**

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

E-Mail address: \_\_\_\_\_

c. Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

d. Fax Number: ( \_\_\_\_\_ ) \_\_\_\_\_

**THIS SPACE INTENTIONALLY LEFT BLANK.**

**COMMONWEALTH OF PENNSYLVANIA**  
**DEPARTMENT OF HUMAN SERVICES**  
**OFFICE OF MEDICAL ASSISTANCE PROGRAMS**

**Provider Agreement for Outpatient Providers**

This Agreement, made by and between the Department of Human Services (hereinafter the "Department") and

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(hereinafter the "Provider") sets forth the terms and conditions governing participation in the Medical Assistance Program. The parties to this Agreement, intending to be legally bound, agree as follows:

1. The Provider agrees to comply with all applicable State and Federal statutes and regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance Program.
2. The Provider agrees to keep any records necessary to disclose the extent of services the Provider furnishes to recipients.
3. The Provider agrees upon request, furnish to the Department, the United States Department of Health and Human Services, the Medicaid Fraud Control Unit, any other authorized governmental agencies and the designee of any of the foregoing, any information maintained under the paragraph above and any information regarding payments claimed by the Provider for furnishing services under the Pennsylvania Medical Assistance Program.
4. To the extent applicable, the Provider agrees to comply with the advance directive requirements for hospitals, nursing facilities, Providers of home health care and personal care services and hospices as specified in 42 C.F.R. § 489, subpart I.
5. The Provider agrees to comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B (relating to Disclosure of Information by Providers and Fiscal Agents), or any amendments thereto.
6. The Provider agrees that it will submit within 35 days of the date of request by the Department or the United States Department of Health and Human Services Secretary full and complete information about the following:
  - A. the ownership of any subcontractor with whom the Provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
  - B. any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request.
7. The Provider agrees that it will allow the Centers for Medicare and Medicaid Services, its agents and its contractor and the Department to conduct unannounced on-site inspections of any and all of its locations, including locations where services are provided.
8. The Provider agrees that it will consent to criminal background checks, including fingerprinting, of individuals with an ownership interest in the Provider, and will provide to the Department any information needed for the Department to conduct a background check of the Provider and its owners.

9. The Provider agrees that upon written request from the Department it will disclose the identity of any person who has an ownership or control interest in the Provider or is an agent or managing employee of the Provider that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI (CHIP).
10. The Provider agrees that if there is any change in the ownership or control of the Provider, it will submit updated disclosure information to the Department within 35 days of the change in ownership or control of the Provider.
11. This agreement shall continue in effect unless and until it is terminated by either the Provider or the Department. Either the Provider or the Department may terminate this agreement, without cause, upon thirty days prior written notice to the other. The Provider's participation in the Pennsylvania Medical Assistance Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State law and regulations.

The Provider represents and warrants that the person signing this agreement is a duly authorized representative of the Provider and has the authority to enter into a legal, valid, and binding obligation on behalf of the Provider.

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**(Provider – Original Signature)**

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**(Date)**

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**(Name – Please Type or Print)**

Pennsylvania Provider Reimbursement and Operations Management Information System electronic (PROMISe™) Medicaid Management Information System (MMIS) is a HIPAA compliant database.

## Provider Disclosure Statement Definitions

The definitions below are designed to clarify certain questions on the following Ownership and Control Disclosure Forms. The full text of the regulations governing the disclosure of information by providers and fiscal agents can be found in [42 CFR Part 455 Subpart B](#).

**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 group of practitioners), or a fiscal agent.

**Other Disclosing entity** means 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. This includes:

- 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 they share common facilities, common supporting staff, or common equipment).

**Indirect ownership interest** means an ownership interest in an entity that has an ownership interest in the disclosing entity.

Note: The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example:

If you own 10 percent of the stock in Corporation A, which owns 80 percent of the stock of the disclosing entity, you would have an 8 percent indirect ownership interest in the disclosing entity.

If you own 20 percent of the stock in Corporation A, which owns 50 percent of the stock in Corporation B which owns 80 percent of the stock of the disclosing entity, you would have an 8 percent indirect ownership interest in the disclosing entity.

**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** 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.

Note: The percentage of ownership of a mortgage, deed of trust, note, or other obligation is determined by multiplying the percentage of interest owned in the obligation by the percentage of the disclosing entity's assets used to secure the obligation. For example:

If you own 10 percent of a note secured by 60 percent of the disclosing entity's assets, you would have a 6 percent interest in the disclosing entity's assets.

- e. Is 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 of 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.





**Section II: (cont.)**

b. Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity?

**Yes (Provide details below)**                       **No**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
\*Attach separate sheet, if necessary\*

3. Does the individual listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

**Yes (Provide details below)**                       **No**

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

Address: \_\_\_\_\_ Suite/Apt: \_\_\_\_\_

\_\_\_\_\_  
(City)    (State)    (Zip Code)    (+4)

\*Attach separate sheet, if necessary\*

4. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?

**Yes (Provide details below)**                       **No**

5. Description of Offense: \_\_\_\_\_

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

\*Attach separate sheet, if necessary\*

**\*\*COPY SECTION II A TO ADD ADDITIONAL INDIVIDUALS\*\***

## Section II: (cont.)

### CORPORATE ENTITIES WITH AN OWNERSHIP OR CONTROL INTEREST IN THE DISCLOSING ENTITY

- B.** Please enter the full name, tax identification number, and primary business address of corporate entities that have at least 5% direct or indirect ownership interest in the disclosing entity.

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

Federal Tax ID: \_\_\_\_\_

Address: \_\_\_\_\_ Suite/Apt: \_\_\_\_\_

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip Code)

\_\_\_\_\_  
(+4)

1. Please enter the percentage and ownership type that the corporate entity listed above has in the disclosing entity.

**Direct:** \_\_\_\_\_%  
(Percent of Ownership)

**Indirect:** \_\_\_\_\_%  
(Percent of Ownership)

\_\_\_\_\_  
(Name of Entity Owned)

2. Please enter any additional business locations and PO Boxes for the corporate entity listed above.

Address: \_\_\_\_\_ Suite/Apt: \_\_\_\_\_

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip Code)

\_\_\_\_\_  
(+4)

\*Attach separate sheet, if necessary\*

3. Does the corporate entity listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

**Yes (Provide details below)**     **No**

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

Address: \_\_\_\_\_ Suite/Apt: \_\_\_\_\_

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip Code)

\_\_\_\_\_  
(+4)

\*Attach separate sheet, if necessary\*

**\*\*COPY SECTION II B TO ADD ADDITIONAL CORPORATE ENTITIES\*\***

## Section II: (cont.)

### OWNERSHIP OR CONTROL INTEREST IN SUBCONTRACTORS

- C. Please enter the full name, date of birth, and address of each person with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

Name: \_\_\_\_\_  
(First Name) (Middle Name) (Last Name)

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Suite/Apt: \_\_\_\_\_  
\_\_\_\_\_  
(City) (State) (Zip Code) (+4)

1. a. Name of Subcontractor: \_\_\_\_\_

Federal Tax ID of Subcontractor: \_\_\_\_\_

- b. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

**Direct:** \_\_\_\_\_%  **Indirect:** \_\_\_\_\_% \_\_\_\_\_  
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

- c. Please enter the percentage and ownership type that the individual listed above has in the subcontractor.

**Direct:** \_\_\_\_\_%  **Indirect:** \_\_\_\_\_% \_\_\_\_\_  
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

- d. Is the individual listed above the spouse, parent, child, or sibling of any other individuals with at least 5% direct or indirect ownership or control interest in the disclosing entity?

**Yes (Provide details below)**  **No**

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

- e. Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity?

**Yes (Provide details below)**  **No**

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

- f. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?

**Yes (Provide details below)**  **No**

**Section II: (cont.)**

g. Description of Offense: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*Attach separate sheet, if necessary\*

**\*\*COPY SECTION II C TO ADD ADDITIONAL INDIVIDUALS\*\***

**D.** Please enter the full name, tax identification number, and primary business address of any corporate entity with an ownership or control interest in any subcontractor which the disclosing entity has a direct or indirect ownership interest of 5% or more.

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

Federal Tax ID: \_\_\_\_\_

Address: \_\_\_\_\_ Suite/Apt: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip Code) (+4)

1. a. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

**Direct:** \_\_\_\_\_%  **Indirect:** \_\_\_\_\_% \_\_\_\_\_  
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

b. Please enter the percentage and ownership type that the corporate entity listed above has in the subcontractor.

**Direct:** \_\_\_\_\_%  **Indirect:** \_\_\_\_\_% \_\_\_\_\_  
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

**\*\*COPY SECTION II D TO ADD ADDITIONAL CORPORATE ENTITIES\*\***

**Section II: (cont.)**

E. Please enter the full name, tax identification number, and primary business address of all subcontractors in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

1. a. Name of Subcontractor: \_\_\_\_\_

Federal Tax ID of Subcontractor: \_\_\_\_\_

b. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

**Direct:** \_\_\_\_\_ %       **Indirect:** \_\_\_\_\_ %      \_\_\_\_\_  
(Percent of Ownership)      (Percent of Ownership)      (Name of Entity Owned)

**\*\*COPY SECTION II E TO ADD ADDITIONAL SUBCONTRACTORS OF THE DISCLOSING ENTITY\*\***

**OWNERSHIP OR CONTROL INTEREST IN OTHER ENTITIES**

F. Does the disclosing entity have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

**Yes (Provide details below)**       **No**

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

Address: \_\_\_\_\_ Suite/Apt: \_\_\_\_\_

\_\_\_\_\_  
(City)                                      (State)                                      (Zip Code)                                      (+4)

**\*\*COPY SECTION II F TO ADD ADDITIONAL ENTITIES\*\***

**SIGNIFICANT BUSINESS TRANSACTIONS**

G. Has the disclosing entity had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period?

**Yes (Provide details below)**       **No**

Name of Supplier/Subcontractor: \_\_\_\_\_

Social Security Number or Federal Tax ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Individuals only)

Address: \_\_\_\_\_ Suite/Apt: \_\_\_\_\_

\_\_\_\_\_  
(City)                                      (State)                                      (Zip Code)                                      (+4)

**\*\*COPY SECTION II G TO ADD ADDITIONAL SIGNIFICANT BUSINESS TRANSACTIONS\*\***

**Section III: Non-Profit Organization Disclosure (Not Organized as a Corporation)**

**\*If the disclosing entity is a non-profit organized as a corporation, please complete Section II\***

**A.** Please enter the full name, address, social security number, and date of birth of any person who is a director (board member) or officer of the disclosing entity.

Name: \_\_\_\_\_  
(First Name) (Middle Name) (Last Name)

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Suite/Apt: \_\_\_\_\_  
\_\_\_\_\_  
(City) (State) (Zip Code) (+4)

1. What position is held by the individual listed above?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> <b>President</b>      | <input type="checkbox"/> <b>Chairman</b>      | <input type="checkbox"/> <b>Member</b> |
| <input type="checkbox"/> <b>Vice President</b> | <input type="checkbox"/> <b>Vice Chairman</b> |  |
| <input type="checkbox"/> <b>Secretary</b>      | <input type="checkbox"/> <b>Director</b>      |  |
| <input type="checkbox"/> <b>Treasurer</b>      | <input type="checkbox"/> <b>Officer</b>       |  |

2. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XX (CHIP), or a state health care program?

3.  **Yes (Provide details below)**     **No**

Description of Offense: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*Attach separate sheet, if necessary\*

**\*\*COPY SECTION III TO ADD ADDITIONAL INDIVIDUALS\*\***

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.
- Ensure that you have entered the **correct number of digits** where specified.
- If you have more than 4 taxonomy codes, please attach a separate sheet listing the additional codes.
- Complete the **Ownership and Control Interest Disclosure form** included with the application.
- Include a copy of your **Social Security card, W-2 or any document generated by the Federal IRS** showing your name and SS number. If the Social Security card states "Valid for work only with INS authorization", please submit the paperwork generated by the INS or Department of Homeland Security that shows proof of authorization to work in the United States.
- Include **documentation generated by the Federal IRS** showing the name 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.
- If applicable, **include a copy** of your:
  - Professional license
  - Department of Health license.
  - Any other certification, license, or permit that applies.
- 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).
- Show proof of home state Medicaid participation (out of state providers only).
- Only the **person applying for enrollment or a representative of the facility applying for enrollment** can sign and date the **Confidential Information Sheet, the Provider Agreement for Outpatient Providers, the OLTL-HCBS Waiver Agreement and Rider A**. Signature stamps not accepted.
- Include the **Home and Community Based Waiver Services Provider Enrollment Information Form**.

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

**OLTL / BQPM  
ATTN: Waiver Provider Enrollment  
PO Box 8025  
Harrisburg, PA 17105-8025**