Credentialing Application

Date: _____

Dear Provider / Facility Administrator:

It is the policy of Sunshine Health Plan to credential all new Long Term Care (LTC) facility providers. Attached please find your credentialing packet necessary for completion. Please refer to the attached **checklist (Pg 2)** and fill out all required forms in their entirety including signature and date. You may submit all completed and required documents to your Contract Negotiator via email or fax**:**

Name: _____ Email: _____ Fax: _____

It is the sole responsibility of the applicant to provide all necessary information and documentation in a timely manner as agreed on the Credentialing Criteria Section of the signed Provider Agreement in order to conduct a thorough examination of all credentials.

During the credentialing process, Sunshine Health obtains information from various outside sources to evaluate your application. You have the right to review any primary source information that Sunshine Health collected during this process such as the Licensing, Sanctions and Exclusions. However, this does not include references or recommendations or other information that is peer review protected.

You also have the right to request the status of your application at any time during the credentialing process. Requests for primary source verification documentation must be submitted in writing directly to Sunshine Health, Attn: Credentialing Department at P.O. Box 459089, Ft Lauderdale, FL 33345-9089.

If you have any questions or require further information, please contact me at _____

We look forward to completing your credentialing process timely.

Sincerely,

_____
Name / Title

cc: credentialing File

LTC CREDENTIALING REQUIRED DOCUMENTS CHECKLIST

Documents (All Fields Completed)	Included Y/N	Page #	Comments
Application			
➢ Active NPI & Taxonomy		3	Match to licensed specialty
➢ Active Medicaid / Medicare Number		3	Medicare – as applicable
➢ **Service(s) Attestation Form**		4	
➢ All questions answered		5	
Provider Application Attestation Form		6	
Direct Service Provider – Affidavit Form		7	
Disclosure of Ownership (DOO)		8-10	
➢ Grid & Level II Background Copies		10	
Participation Direction Option (PDO) Form		11	Must be signed an included
Workers Compensation Exemption Form		12	As Applicable
➢ AHCA Exemption Letter			As Applicable
Homeowner/Property Waiver Form		13	
Behavioral Management Attestation Form		14	As applicable - Home Health
Attestation of Compliance – Background Screening		15-18	Administrator or Owner
➢ Name / Facility Name & Address		15	
➢ Purpose / Date of prior screening		17	Must be within last 5 years
➢ Name / Signature / Title / Date		18	Name on Pg. 15 must sign
➢ Level II Background Results Copy			Name on Pg. 15 – w/in 5 yrs.
W-9		19	
NPI/Taxonomy/Medicaid Information	Y	20	
Provider CHOW Process Information	Y	21	
AHCA Alert regarding Registered Medicaid Numbers	Y	22	
Additional Documents Required – (shows specific facility name and address)			
General or Professional Insurance		Must show facility name & Address	
Homeowner/Property Insurance		Adult Family Care Home Only	
Workers Compensation Insurance		Must show facility name & Address	
Business Tax or Occupational License			
Facility or Business License			
Board Certification (PT, OT, ST, RT, MT)		As Applicable	
Transportation / Home Delivered Meals			
➢ Driver's License & Insurance		As Applicable	
➢ OAA / CCE / Other Agreement		As Applicable	
Emergency Preparedness Plan (EPP) – As applicable			
➢ Local Emergency Certification / CEMP Letter			
➢ Any Supporting Documents		If Pending	
Service Medical License ****State Requirement**: **One** copy **only** for **each** service specialty required either staff or contracted personnel**			
RN, LPN, CNA, Home Health Aide, PT, OT, ST, RT, SW, other		As Applicable	
List of Affiliated Providers		As Applicable	

**** All documents must match to specific licensed name, specialty and address ****

Credentialing Application

Please submit the completed and signed application with requested documentation to Sunshine Health.

Provider Information

Legal Name (as it appears on W-9): _____

Dba Name (as it appears on License): _____

Tax ID:_____ NPI:_____ Medicaid ID:_____ Medicare ID:_____

Facility/Provider Type: _____ License #:_____

Contact Name: _____ Title: _____

Website Url: _____ Email: _____

Primary Address: _____ City/ST/Zip: _____

Region: ____ County: _____ Phone: _____ Fax: _____

Cell: _____ Hours/Bed Count: _____ Language(s): _____

Billing Address: _____

Servicing Counties	
☐**Region 1**	☐Escambia ☐Okaloosa ☐Santa Rosa ☐Walton
☐**Region 2**	☐Bay ☐Calhoun ☐Franklin ☐Gadsden ☐Gulf ☐Holmes ☐Jackson ☐Jefferson ☐Leon ☐Liberty ☐Madison ☐Taylor ☐Wakulla ☐Washington
☐**Region 3**	☐Alachua ☐Bradford ☐Citrus ☐Columbia ☐Dixie ☐Gilchrist ☐Hamilton ☐Hernando ☐Lafayette ☐Lake ☐Levy ☐Marion ☐Putnam ☐Sumter ☐Suwannee ☐Union
☐**Region 4**	☐Baker ☐Clay ☐Duval ☐Flagler ☐Nassau ☐St. Johns ☐Volusia
☐**Region 5**	☐Pasco ☐Pinellas
☐**Region 6**	☐Hardee ☐Highlands ☐Hillsborough ☐Manatee ☐Polk
☐**Region 7**	☐Brevard ☐Orange ☐Osceola ☐Seminole
☐**Region 8**	☐Charlotte ☐Collier ☐Desoto ☐Glades ☐Hendry ☐Lee ☐Sarasota
☐**Region 9**	☐Indian River ☐Martin ☐Okeechobee ☐Palm Beach ☐St. Lucie
☐**Region 10**	☐Broward
☐**Region 11**	☐Miami-Dade ☐Monroe
☐**Statewide**	

SERVICE(S) ATTESTATION FORM

Services		
What population do you provide services for? ☐Adult ☐Pediatric Ages _____ Please list any exclusions or limitations: _____		
☐Adult Companion	☐Home Accessibility Adaptation	☐Nutritional Assess & Risk Reduction
☐Adult Day Care	☐Home Delivered Meals	☐Personal Care
☐Assisted Living Facility Services	☐Homemaker	☐Personal Emergency Response Sys
☐Assistive Care Services	☐Hospice	☐Pest Control
☐Behavior Management	☐Medication Administration	☐Respite Care – In ALF
☐Caregiver Training	☐Medication Management	☐Respite Care – In Home
☐Durable Medical Equipment	☐Nursing Facility Care (SNF)	☐Transportation *(must be licensed)*
☐Private Duty Nursing - LPN *(**0-21 yrs**: 2 – 24 hours per day)*	☐Private Duty Nursing - RN *(**0-21 yrs**: 2 – 24 hours per day)*	☐Attendant Nursing Care *(**LTC only**: 2 – 24 hours per day)*
☐Intermittent Nursing- LPN *(1 – 2 hour visits per day)*	☐Intermittent Nursing- RN *(1 – 2 hour visits per day)*	☐Respiratory Therapy
☐Occupational Therapy	☐Physical Therapy	☐Speech Therapy
☐Medical Social Worker		

Provider attests that they are licensed for and currently able to provide the indicated services to Sunshine Health Plan Members for all contracted Products as applicable. If there are any changes to services provided (additions or removals) prior to re-credentialing, Provider will submit an updated service(s) attestation to Sunshine Health.

_____

(Facility / Provider Name)

_____ _____

(Signature) *(Date)*

_____ _____

(Print Name) *(Position/Title)*

sunshine health
Long Term Care

Credentialing Application

Indicate the effective date of accreditation or certification, for any applicable organizations listed below.

Agency Name	Acronym	Effective Date	Expiration Date
Accreditation Commission for Health Care, Inc.	ACHC		
Commission on Accreditation for Rehab Facilities	CARF		
Clinical Laboratory Improvement Act	CLIA		
Community Health Accreditation Program	CHAP		
Healthcare Quality Association on Accreditation	HQAA		
National Committee for Quality Assurance	NCQA		
Joint Commission on Accreditation of Healthcare Orgs.	TJC		
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc.	URAC		
Other:			

****ALL questions must be answered in adherence to Florida Statutes****

Credentialing Attestation	Check One
Have you been involved in any professional liability claims within the last 5 years?	☐Yes ☐No ☐N/A
Have you, the corporation, any officer or board member ever been convicted of or plead *nolo contendre* to any felony?	☐Yes ☐No ☐N/A
Have any sanctions been imposed on you by Medicare or Medicaid, in any state?	☐Yes ☐No ☐N/A
Have you had any disciplinary action imposed or loss or limitation of privileges, in this or any state?	☐Yes ☐No ☐N/A
Has your license ever been restricted, suspended or revoked, in this or any state?	☐Yes ☐No ☐N/A
Have you ever been subjected to sanctions by a Professional Review Organization, a Third Party Payor, or a Regulatory Agency?	☐Yes ☐No ☐N/A
Do you have any ownership or management participation in this facility/organization?	☐Yes ☐No ☐N/A
I attest adherence to American Disabilities Act (ADA) accessibility requirements in accordance to F.S. 553 Part II.	☐Yes ☐No ☐N/A
I attest that the HCB Setting Requirements are in Compliance and adherence with the Assisted Care Communities Resident Bill of Rights in accordance to F.S. 429.28.	☐Yes ☐No ☐N/A
I attest that all background screening status have been verified through the AHCA Care Provider Background Clearinghouse in accordance to F.S. 435.12.	☐Yes ☐No ☐N/A
I attest that all direct service providers have completed and satisfied Level II background screening requirements with no disqualifying offenses in accordance to F.S. 430.042 and F.S. 435.04.	☐Yes ☐No ☐N/A
I attest that all personnel/FDRs have participated in the fraud, waste and abuse awareness compliance training (FWA) as required by the final rules in 42 CFR Parts 422.503 and 423.504 (Required for All Facility Types)	☐Yes ☐No ☐N/A
I attest that staff has received appropriate training in reporting Abuse, Neglect and Exploitation and will report knowledge or reasonable suspicion of these activities via the Florida abuse statewide toll free hotline (1-800-96-Abuse) in accordance with F.S. 415.	☐Yes ☐No ☐N/A
I agree to immediately notify Sunshine Health Plan of any changes to the above.	☐Yes ☐No ☐N/A

I certify that I have answered all the questions on the application truthfully, correctly and completely.

Provider Signature: _____ Date: _____

Provider Name (print): _____ Title: _____

PROVIDER APPLICATION ATTESTATION FORM

In order to evaluate this application for 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 Provider: _____ Date: _____

(Print or type name)

_____ _____

Signature of Provider or Authorizing Representative Title:

(*Electronic signature acceptable - stamp signature is not acceptable)*

DIRECT SERVICE PROVIDER (DSP)
LEVEL II BACKGROUND SCREENING AFFIDAVIT FORM

The below named provider attests that they meet the definition of "direct service provider" (provider, employee or volunteer) and has completed a Level II criminal history background screening on each "direct service provider" to determine whether any have disqualifying offenses as provided for in F.S. 430.0402 and F.S. 435.04. Any "direct service provider" who has a disqualifying offense is prohibited from providing services to enrollees. No additional Level II background screening is required of the provider if they are a Limited Enrolled or Fully Enrolled Medicaid provider. No additional Level II screening is required of an employee or volunteer of the provider who is qualified for licensure or employment by the Agency pursuant to its background screening standards under F.S. 408.09 and the individual is providing a service that is within the scope of his or her licensed practice or employment. (See F.S. 430.0402(3)).

I, _____, owner/authorized _____
(Print Name) representative of (Business Legal Name & DBA)

Provider attests that all information on this form is accurate and true.

_____ _____
Signature Company Name

_____ _____
Tax ID Number Address

_____ _____
NPI Number City, State, Zip

_____ _____
Signature Name *(print)* Date

DISCLOSURE OF OWNERSHIP AND CONTROL STATEMENT

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to Sunshine Health within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

Practice Information

Check one that most closely describes you: ☐Individual ☐Group Practice ☐Disclosing Entity
Name of Individual, Group Practice or Entity:
DBA Name:
Address:
Federal Tax Identification Number:

Section I

List the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

List the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater.

Name of individual or entity	DOB	Address	SSN (for individual) TIN (for entity)

Please refer to attached grid addendum for updated background requirements

Section II

Are any of the individuals listed above related to each other? ☐Yes ☐No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of Relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐Yes ☐No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (for individual) TIN (for entity)

DISCLOSURE OF OWNERSHIP AND CONTROL STATEMENT

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX Program?

☐Yes; If yes, please list those persons below. (42.CFR 455.106) ☐No (verify through OIG Website)

Name / Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transactions with any subcontractors totaling more than $25,000 or any significant business transactions with any subcontractors? ☐Yes ☐No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period (42 CFR 455.105). Attach a separate sheet if necessary.

Name Supplier / Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under practice information 1) as a Disclosing Entity? ☐Yes ☐No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including name, date of birth (DOB), address, Social Security Number (SSN), and percent of interest.

Name / Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additional, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

_____ Signature

_____ Title (or indicate if authorized agent)

_____ Name (please print)

_____ Date

AHCA LEVEL II BACKGROUND SCREENING REQUIREMENTS GRID ADDENDUM

****Please complete the grid below and provide the Level II background result copies for the following****

1. **Owner/Administrator/ Financial Officer** – This 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.
2. **Controlling Interest** - Person with an ownership or control interest means a person or corporation that—
   - Has an ownership interest totaling 5 percent or more in a disclosing entity;
   - Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
   - Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
   - 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;
   - Is an officer or director of a disclosing entity that is organized as a corporation; or
   - Is a partner in a disclosing entity that is organized as a partnership

Position Title	Name	% of Ownership	Social Security Number	Date of Birth	Background Results Attached (Yes or No)
Administrator					
Financial Officer / CFO					
Other Managerial Assigned					
Ownership/Controlling Interest					
Ownership/Controlling Interest					
Ownership/Controlling Interest					
Other:					

Facility/Service Type	Owner/Administrator Controlling Interest	Financial Officer
Adult Day Care Centers	Level 2	Level 2 (Excluding AFCH)
Adult Family Care Homes		
Assisted Living Facilities		Level 2
Health Care Service Pools		
Home Health Agencies		
Homemaker/Sitter/Companion		
Home Medical Equipment Providers		
Homes for Special Services		
Hospice		
Intermediate Care Facilities for the Developmentally Disabled		
Nurse Registries		
Nursing Homes		
Prescribed Pediatric Extended Care		
Transitional Living Facilities		

The following is a summary of Chapter 2018-24, Laws of Florida, (SB 622) that apply to employees and contractors of health care providers licensed through the Agency for Health Care Administration and other employees subject to Chapter 435. The changes to section 408.809 and Chapter 435, Florida Statutes, (F.S.) take effect July 1, 2018:

- The bill amends s. 408.809, F.S., to require background screening for any person who is a controlling interest, contractors with a licensee or provider who work for 20 hours or more per week and have access to client funds, personal property, or living areas. The contractor's employer or the licensee may retain evidence of contractor screening.
- The bill amends s. 395.1055, F.S., to require Level 2 background screening for personnel of distinct part nursing units of hospitals who provide personal care or services directly to clients or have access to client funds, personal property, or living areas.

PARTICIPANT DIRECTION OPTION (PDO) QUALIFICATIONS FORM

Provider Name: _____

I hereby attest that individuals of the enrollee's choosing that provide PDO services meet the minimum provider qualifications in Table 2 below and are age eighteen (18) years and older. The PDO providers have signed and dated a Participant/Direct Service Worker Agreement with a satisfactory Level II background screening in adherence to all requirements in Florida Statutes 408.809, 430.042 and 435.04.

Table 2

PDO Provider Qualifications

LTC Program Benefit	Qualified Service Provider Types	Minimum Provider Qualifications
Adult Companion	Individual	None *
Attendant Nursing Care	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Chapter 464, F. S.*
Homemaker	Individual	None *
Intermittent/ Skilled Nursing	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Chapter 464, F. S.*
Personal Care	Individual	None*

Signature: _____

Printed Name: _____

Date: _____

** If this form is not, and will never be, applicable to your facility please indicate below and sign:

☐ **I attest this form is NOT APPLICABLE to my facility type**

Signature: _____

Printed Name: _____

Date: _____

WORKERS' COMPENSATION EXEMPTION FORM

The below named provider is requesting that proof of Workers' Compensation insurance be waived as a credentialing requirement in order to participate in Sunshine Health Plan's Long Term Care Program. Provider affirms that they are exempt to the requirement to have Workers' Compensation Insurance set by the State of Florida as they are not in the construction industry and have fewer than four (4) employees. Provider agrees and fully understands that their request and/or future approval of this exemption from Sunshine Health Plan does not relieve them of any requirements under Chapter 440 Florida Statutes. Provider also agrees to provide Sunshine Health Plan with any records needed to verify this information with the Department of Financial Services. Provider also understands that Sunshine Health Plan will not be held responsible for any injuries that the Provider's employees incur while working for the Provider.

I, _____, owner/authorized representative of _____
(Name) *(Business Legal Name and DBA)*

attest that as an employer (**non**-construction), with fewer than four employees, am exempt by Florida Law from the requirement to carry Workers' Compensation.

Provider attests that all information on this form is accurate and true.

_____	_____
Signature	Company Name
_____	_____
Printed Name	Address
_____	_____
Date	City, State, Zip

ADULT FAMILY CARE HOME (AFCH)
HOMEOWNERS/PROPERTY INSURANCE WAIVER FORM

The below named provider is requesting that proof of Homeowners/Property insurance be waived as a credentialing requirement in order to participate in Sunshine Health Plan's Long Term Care Program. Provider affirms that they meet the Fire & Safety standards set by the State of Florida under 633.206. Provider agrees and fully understands that their request and/or future approval of this waiver from Sunshine Health Plan does not relieve them of any requirements under Chapter 429.73 Florida Statutes. Provider also agrees to provide Sunshine Health Plan with any records needed to verify this information with the State Fire Marshal. Provider also understands that Sunshine Health Plan will not be held responsible for any injuries that Provider's employees incur while working for the Provider.

I, _____, owner/authorized representative of _____
(Name) *(Business Legal Name and DBA)*

attest that as an employer (**non**-construction), with fewer than four employees, am exempt by Florida Law from the requirement to carry Worker's Compensation.

Provider attests that all information on this form is accurate and true.

_____ Signature

_____ Company Name

_____ Printed Name

_____ Address

_____ Date

_____ City, State, Zip

BEHAVIORAL MANAGEMENT SERVICE ATTESTATION FORM
(HOME HEALTH ONLY)

Provider Name: _____

I hereby attest that the home health agency listed above, licensed under Chapter 400, Part III of the Florida Statutes, employs staff with at least a minimum of 2 years direct experience working with adult populations diagnosed with Alzheimer's disease, other dementias, or persistent behavioral problems.

Requires a RN Psych qualification and/or license copy

Signature: _____

Printed Name: _____

Date: _____

One Form Only – For Administrator or Owner

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form may be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**
- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name:
Address of Health Care Provider:

I hereby attest to meeting the requirements for employment and that I have not been arrested for or been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(f) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: _____

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: _____

*****A copy of the Exemption from Disqualification decision letter must be attached*****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening:_____

Screening conducted by: _____ Date of Prior Screening: _____

☐ Agency for Healthcare Administration
☐ Department of Health
☐ Agency for Persons with Disabilities
☐ Department of Elder Affairs
☐ Department of Financial Services
☐ Department of Children and Family Services

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

Employee/Contractor Signature	Title	Date

If background screening has been conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., the attestation of Compliance with Background Screening Requirements, AHCA Form 3100-008 may be submitted in lieu of Agency screening.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

___ - ___ - ____

or

Employer identification number

__ - _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Cat. No. 10231X Form **W-9** (Rev. 10-2018)

NPPES (NPI) & AHCA PROVIDER MASTER LIST (PML) INFORMATION

Dear Facility Administrator,

We will be processing your credentialing application for participation in our Provider Network. In order to process your application in a timely fashion, the following elements should be reviewed and updated as necessary: your NPPES/NPI record and also AHCA's Provider Master List (PML), so that your Medicaid information shows on the Florida Medicaid Web Portal for verification. Please note:

- **NPI/Medicaid Number must be unique to each specific licensed location/specialty**
- **NPI Type must be Type 2 – Organization**
- **License street address must be shown, either primary or secondary**
- **Taxonomy should match to licensed specialty and be included on the NPPES/NPI record**

Please call **NPPES** at **800-465-3203** or use the **NPPES** link: https://nppes.cms.hhs.gov/#/ to have your record updated as necessary. The credentialing process cannot proceed until your NPPES/NPI record has been updated.

Please review your Medicaid Information on AHCA's PML site link to ensure enrollment status is **LIMITED** or **FULLY ENROLLED**, also, that all fields are complete and accurate including NPI Crosswalk section to match your specific license address, specialty and licensed taxonomy if so, then your Medicaid information will show on the Florida Medicaid Web Portal by NPI.

- AHCA Provider Master List (PML)
- AHCA Florida Medicaid Web Portal

Please call **AHCA** at **800-377-8216** to have your information updated as necessary.

Upon completion, provide an email for file to your Contract Negotiator.

During the credentialing process, Sunshine Health obtains information from various outside sources to evaluate your application. You have the right to review any primary source information that Sunshine Health collected during this process such as the Licensing, Sanctions and Exclusions. However, this does not include references or recommendations or other information that is peer review protected.

You also have the right to request the status of your application at any time during the credentialing process. Requests for primary source verification documentation must be submitted in writing directly to Sunshine Health, Attn: Credentialing Department at P.O. Box 459089, Ft Lauderdale, FL 33345-9089.

If you need further clarification on outstanding item(s), please contact your Contract Negotiator

Thank you in advance for your assistance and prompt response in this matter.

cc: Credentialing File

INFORMATION ONLY

Provider Change of Ownership (CHOW) Notifications

In order to improve the quality of service delivered to our providers, Sunshine Health has implemented a new process to ensure we quickly capture any change of ownership (CHOW) requests. CHOW occurs when a provider needs to contract a new business entity and terminate an existing business entity with Sunshine Health.

Affected providers include but are not limited to: Adult Day Care Center, Skilled Nursing Facility, Assisted Living Facility, Home Health Agency, Nurse Registry, Homemaker and Companion, Hospice, Adult Family Care Home, Home Medical Equipment and Hospitals.

HOW IT WORKS

Sunshine Health will ensure a smooth transition, working with the provider as well as our internal LTC Service Area Managers, Contracting and Claims departments.

In order to expedite this process the following information is required to be submitted by the provider for *both* the old and new provider-

Provider Name		Provider county	
Provider contact name		Provider Tax ID number	
Provider phone number		Provider Billing NPI	
Provider email address		Provider Medicaid ID	
Provider mailing address		Enrollment end date of old provider	
Provider specialty		Enrollment start date of new provider	

QUESTIONS?

For questions on the CHOW process, please email: Sunshine_SCALTC@Centene.com

To Submit a CHOW request, please visit www.sunshinehealth.com

FLORIDA MEDICAID

A Division of the Agency for Health Care Administration

Florida Medicaid Health Care Alert

January 6, 2021

Provider Type(s): All

Effective 10-1-21: Claims will Deny if Referring, Ordering, Prescribing, and Attending Providers are Not Enrolled

Effective October 1, 2021, any fee-for-service (FFS) claim submitted with a National Provider Identifier (NPI) for a provider not enrolled with Florida Medicaid will deny, and the provider will not receive reimbursement for services. This includes claims that list a Referring, Ordering, Prescribing, or Attending (ROPA) provider. ROPA providers must be enrolled with Florida Medicaid in accordance with Title 42, Code of Federal Regulations, Section 455.410(b).

Starting October 1, 2021, claims will not pay for any practitioner, group practice, facility, or pharmacy providing services to Florida Medicaid recipients based on a ROPA provider's referral, order, prescription, or attending services, unless the ROPA provider identified by NPI on the FFS claim is actively enrolled with Florida Medicaid.

Florida Medicaid features a quick and easy, automated ROPA provider enrollment application on the Florida Medicaid Web Portal Enrollment Application Wizard page.

Please visit the Agency Initiatives page of the Web Portal for updated ROPA information, including the ROPA Providers Frequently Asked Questions and Quick Reference Guides on ROPA provider enrollment and claims billing.

Providers may call the Provider Services Contact Center at 1-800-289-7799, option 7, for billing assistance and option 4 for enrollment assistance.

QUESTIONS? FLMedicaidManagedCare@ahca.myflorida.com
COMPLAINTS OR ISSUES? ON LINE http://ahca.myflorida.com/Medicaid/complaints/| **CALL** 1-877-254-1055

The Agency for Health Care Administration is committed to its mission of providing "Better Health Care for All Floridians." The Agency administers Florida's Medicaid program, licenses and regulates more than 48,000 health care facilities and 47 health maintenance organizations, and publishes health care data and statistics at www.FloridaHealthFinder.gov. Additional information about Agency initiatives is available via Facebook (AHCAFlorida), Twitter (@AHCA_FL) and YouTube(/AHCAFlorida).