MINNESOTA UNIFORM FACILITY CREDENTIALING APPLICATION

The Minnesota Uniform Facility Credentialing Application may be used by other organizations

(●) Initial Credentialing ( ) Re-credentialing

APPLICATION INSTRUCTIONS

- ALL fields must be completed unless otherwise directed
- Please do not use abbreviations when completing the application
- Submit completed application along with **all** required documentation
- Submit completed applications to email: hhcredentialing@hennepin.us or fax: 612-677-6264

GENERAL RULES

- For this application, **Facility** is defined as a hospital, home health agency, skilled nursing facility, ambulatory surgery center, inpatient, residential, and ambulatory behavioral health facility
- One application is required for each facility type and location (as listed on page 3)
- Failure to complete this application in its entirety and submit all required documentation will result in processing delays and affect network participation

ATTACHMENTS

APPLICATION PROCESSING WILL BE DELAYED IF ALL REQUIRED INFORMATION IS NOT SUBMITTED

- Copy of the most recent onsite licensing review site survey including corrective action plans, “all clear” letters and/or confirmation that the facility is in substantial compliance with licensing standards, per the auditing agency.
- Current copy of facility Commercial Liability Insurance Certificate
- Current copy of facility Professional Liability Insurance Certificate, covering all facility employees
- Current copy of all accreditation letter(s) or certificate(s), including CMS accrediting organizations
- Medicare certification documents signed by CMS
- Current copy of all current State and local licenses required to operate as a health care facility.

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1. FACILITY IDENTIFICATION

CORPORATE IDENTIFICATION INFORMATION

LEGAL BUSINESS NAME *(as reflected on W-9)*	**FEDERAL FEIN/TAX ID** *(must include valid 9-digit ID)*
BUSINESS ADDRESS *(if different than facility address)*	**TYPE-2 NPI** *(application will not be processed without valid NPI)*
ORGANIZATION CLASSIFIED AS: ◉ Corporation ○ Partnership ○ Not-For-Profit Corp ○ Other (Specify) ○ Sole Proprietorship	**Is facility owned in whole or in part or managed by a hospital or health care system/facility?** ◉ Yes, owned in whole or in part by ○ Yes, managed by ○ No, not affiliated with a hospital or health care system/Facility

FACILITY INFORMATION

FACILITY DOING BUSINESS AS NAME *(as reflected on W-9)*

STREET ADDRESS:		**CITY:**	**STATE:**	**ZIP CODE:**
COUNTY:	**PHONE:**	**FAX:**	**WEBSITE:**	

OFFICE ADMINISTRATOR *(Name, Title, Email, Phone, Fax)*

APPLICATION CONTACT PERSON *(Name, Title, Email, Phone, Fax)*

MAILING/CORRESPONDENCE ADDRESS

☐ Check here if correspondence can be directed at the facility location directly above. If not, complete section below

FACILTY NAME

FACILITY ADDRESS

FACILITY COUNTY AND PHONE NUMBER

OFFICE ADMINISTRATOR *(Name, Title, Email, Phone, Fax)*

APPLICATION CONTACT PERSON *(Name, Title, Email, Phone, Fax)*

2. MEDICAL DIRECTOR OR EQUIVALENT

A physician Medical Director or equivalent must clearly be identified and licensed in good standing

Name: _____ **Type:** (*MD, DO, Other*) _____ **Specialty:** _____

License #: _____ **Type 1 NPI #**: _____

Phone: _____ **Email Address**: _____

3. FACILITY TYPE

1 box must be checked (based on licensure); do NOT complete this application if your provider type is not listed below

	MEDICAL FACILITY
☐	Ambulatory Surgery Center _ Free Standing
☐	Birthing Center
☐	Home Health Care Agency – Providing skilled nursing services
☐	Hospital – All Types including Psychiatric (# of Medicare certified beds: _____)
☐	Skilled Nursing Facility / Nursing Home (# of Medicare certified beds: _____)
	BEHAVIORAL HEALTH
☐	Adult Licensed Residential Crisis
☐	Children's Residential Facility – Mental Health Treatment
☐	Children's Residential Facility – Substance Abuse Treatment
☐	Eating Disorders Residential Facility
☐	Mental Health Residential Treatment, IRTS, or Residential Crisis
☐	Partial Psych/Partial Hospitalization – Free standing only
☐	Substance Abuse Treatment – Outpatient/ Residential / Inpatient
☐	Outpatient Treatment Program

FOR HOSPITALS ONLY
Does your Facility provide any of the following services?

SERVICE	YES	NO	SERVICE	YES	NO
Cardiac Catheterization Services	☐	☐	Mammography	☐	☐
Cardiac Surgery Program	☐	☐	Occupational Therapy	☐	☐
Critical Access Hospital	☐	☐	Outpatient Dialysis	☐	☐
Critical Care Services - ICU	☐	☐	Outpatient Infusion / Chemotherapy	☐	☐
Diagnostic Radiology	☐	☐	Physical Therapy	☐	☐
Genetic Counseling and Testing	☐	☐	Speech Therapy	☐	☐
Laboratory Services	☐	☐			

4. FACILITY LICENSURE

Attach a copy of each license for the facility types selected on page 3

Licensing Agency	License #	Effective date	Expiration Date

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5. MEDICARE STATUS

Is your facility eligible for Medicare certification? (Yes/No) _____

Is this facility/program/agency Medicare certified? (Yes/No) _____

If yes, provide Medicare #: _____ Date of initial certification: _____

6. ACCREDITATION

The facility being credentialed must be listed in the accreditation; a copy of each applicable accreditation is required

If the Facility is not currently accredited, complete section 7. Non-accredited facility

ACCREDITED (Indicate Yes)	**ACCREDITATION AGENCY**
	AAAASF - American Association for Accreditation of Ambulatory Surgery Facilities
	AAAHC - Accreditation Association for Ambulatory Health Care
	ACHC - Accreditation Commission for Health Care
	CARF - Commission on Accreditation of Rehabilitation Facilities
	CCAC - Continuing Care Accreditation Commission
	COA - Council on Accreditation
	DNV / NIAHO - Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations
	HFAP - Healthcare Facilities Accreditation Program
	TJC - The Joint Commission (Formerly known as JCAHO)
	Other

Effective date of accreditation: _____ through _____

Date of most recent full site survey by an accrediting body: _____

Date of next site survey, if known: _____

7. NON-ACCREDITED FACILITY

If your facility is not accredited, complete this section

MEDICAL FACILITY

1. Has your State completed an onsite licensing review or has CMS completed a certification survey within the past 36 months?

☐ YES

Date of most recent site survey: _____

Attach a current copy of your most recent onsite licensing/certification survey including all corrective action plans, "all clear" letters and/or confirmation from the licensing agency stating the facility is in substantial compliance with licensing standards

☐ NO

The health plan will determine which satellite/branch locations require a site visit and contact you for scheduling

2. If your State has not completed an onsite licensing review within the past 36 months, enter the date of next site survey, if known: _____

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BEHAVIORAL FACILITY

1. Has your State completed an onsite licensing review or has CMS completed a certification survey within the past 36 months?

   ☐ YES

Date of most recent site survey: _____

Attach a current copy of your most recent onsite licensing/certification survey including all corrective action plans, "all clear" letters and/or confirmation from the licensing agency stating the facility is in substantial compliance with licensing standards

☐ NO

The health plan will determine which satellite/branch locations require a site visit and contact you for scheduling

2. If your State has not completed an onsite licensing review within the past 36 months, enter the date of next site survey, if known: _____

8. NON -MEDICARE CERTIFIED HOME CARE AGENCY SECTION

Complete this section, in its entirety, ONLY if the facility is a Home Care Agency that is not Medicare (CMS) certified

1. Indicate the age range of clients accepted: _____ to _____

2. Number of agency employees in each category:

   Registered Nurses (RN): _____ Licensed Practical Nurses (LPN): _____

   Home Health Aide: _____ Other (Specify): _____

3. Explanation as to why this home care agency has not pursued/been granted Medicare certification:

_____

_____

_____

9. HEALTH PLAN SITE VISIT

- A site visit is not required if the provider/facility is in a rural area, as defined by the U.S. Census Bureau and the state or CMS has not conducted a site review.
- If a provider has branch/satellite locations that follow the same policies and procedures as the main facility, site visits may be limited to the main facility.

Does the satellite location(s) follow the same policies and procedures as your main facility?

☐ YES

Complete the Policy Attestation in Section 12 of this application

☐ NO

The health plan will determine which locations require a site visit and will contact you for scheduling

10. CREDENTIALING PROGRAM

Indicate how credentialing is ensured for all health care professionals employed or contracted at the facility

☐ Credentialing procedures are performed internally

☐ Credentialing procedures are outsourced/delegated

Name: _____ **Phone:**

11. INSURANCE COVERAGE

- Attach copies of the insurance certificates. We prefer the Acord® Certificate of Liability coverage
- If the facility is covered under Government insurance, attach documentation detailing coverage
- Excess liability/Umbrella coverage can count toward the aggregate amount

1. This facility is covered by **Commercial General** liability insurance in the minimum amount of

   $ _____ per occurrence and $ _____ aggregate $ _____ umbrella amount

2. This facility is covered by **Professional** liability insurance in the minimum amount of $1 million per occurrence / $3 million aggregate
3. $ _____ per occurrence and $ _____ aggregate $ _____ umbrella amount

NOTE: Hospitals may be required to have additional insurance cover amounts

12. POLICY ATTESTATION

List all the facilities under the same Legal Business Name, Tax ID and specialty of the facility listed on this application

Facility Name	Specialty	Location	Tax ID	NPI

I, the undersigned authorized agent, hereby attest and certify that the facilities listed above share the same policies and procedures as the location listed on page 2 of this application.

_____ _____/_____/_____

Signature of Authorized Representative Date Signed

_____ _____

Printed Name Title

13. PROVIDER INTEGRITY ATTESTATION

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire Application are true, accurate and complete to the best of my knowledge. I fully understand that any falsification of information or omissions from this Application may be grounds for denial of this Application as a participating provider.

I further understand, as an authorized agent of the applicant, that I and the organization have the burden of producing adequate information for the proper evaluation of the organization's competence, character, and ethics in resolving doubts about such qualifications.

I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

_____ _____/_____/_____

Signature of Authorized Representative Date Signed

_____ _____

Printed Name Title