As part of the Carelon Post Acute Solutions, we have designed a comprehensive set of standards to ensure patients have confidence they will receive the best service available. Please REVIEW all requirements listed within this document prior to applying/reapplying to the network.

- Please contact if you have questions at **Contracting@carelon.com** or **Credentialing@carelon.com**

Procedure: **General Requirements**

- Completion of an application with current signed and dated attestation.
- Offer on-call support services 24 hours / 7 days a week.
- Copy of a current W-9 and/or W-8 (if applicable) if not supplied during contracting.
- Disclosure of Ownership and Control Interest Statement
- Must have appropriate license(s) and certification(s) mandated by governmental regulatory agencies, including, but not limited to, state license (if applicable).
- Facility shall maintain comprehensive general liability insurance at minimum levels required by Payer, but in no event less than $1,000,000 per claim and $3,000,000 in the annual aggregate and submit a copy of current general liability face sheet indicating the applicant as the insured with policy period and coverage amounts.
    - Facility's insurance shall cover the acts and omissions of its agents and employees and will ensure that participating providers have adequate coverage.
    - The Network Management Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.
- Practitioner shall maintain professional liability insurance at minimum levels required by Payer, but in no event less than $1,000,000 per claim and $3,000,000 in the annual aggregate and submit a copy of current professional liability face sheet indicating the applicant as the insured, with policy period and coverage amounts.
    - The Network Management Committee, in states where the maximum amount of coverage obtainable is less than the limits above, may make exceptions.
- Provide a malpractice claims history and/or litigation documentation for the preceding five years – if applicable. When a judgment / settlement includes a confidentiality agreement or is pending, the applicant must provide a brief statement detailing the facts of the claim, the allegation and the response of the

applicant. The applicant must submit a corrective action plan that details areas of deficiency, action steps implemented and relevant prevention initiatives.

- Medicare certification letter
- Must maintain a good standing with Medicare and Federal programs.
  - Facilities or Practitioners cannot be excluded from participating in federal government contracts or funded health care programs.

The following required criteria are specific to Home Health Agencies (HHA):

- Hold current accreditation with one of the following CMS recognized accrediting organizations or supply a current (within the last 3 years) Site Survey with supporting documentation if deficiencies were identified.
  - Accreditation Commission for Health Care, Inc (ACHC)
  - The Joint Commission (TJC)
  - Community Health Accreditation Program (CHAP)
- If your agency lacks accreditation, it's required you supply a current (within the last 3 years) Site Survey with supporting documentation if deficiencies were identified.
- Maintain a star rating at a minimum of 1.5 or higher to demonstrate your Facility strives to achieve quality results consistent or better than the surrounding market.
  - Exceptions to this requirement can be made if access to care isn't met.
- CLIA certification

The following required criteria are specific to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS):

- Hold current accreditation with one of the following CMS recognized accrediting organizations listed below:
  - Accreditation Commission for Health Care, Inc (ACHC)
  - American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)
  - Board of Certification/Accreditation International
  - Commission on Accreditation of Rehabilitation Facilities (CARF)
  - Community Health Accreditation Program (CHAP)
  - HealthCare Quality Association on Accreditation (HQAA)
  - National Association of Boards of Pharmacy (NABP)
  - The Compliance Team, Inc.
  - The Joint Commission (TJC)

The following required criteria are specific to Practitioner's:

- Current board certification in the specialty practicing, if applicable to specialty.
    - If Non-MD or DO, highest level of Education or Training will be verified.
- If applicable, must possess a current Drug Enforcement Administration (DEA) Certification and/or State Controlled Substance (CDS) certificate.
- Practitioner must attest to the following:
    - Not been convicted of a felony. *Practitioner only*
    - No history of loss of license.
    - Reports loss of privileges or disciplinary actions.
    - Practitioner is in good health. *Practitioner only*
    - Practitioner shall report any physical or mental problems that may affect his/her ability to practice.
    - No history of abusing drugs or alcohol. *Practitioner only*
    - If not met, an explanation must be obtained, and Facility or Practitioner's file is presented to the committee for review.
- Foreign medical school graduates must submit an Educational Commission for Foreign Medical Graduates (ECFMG) Certificate.
- Practitioner disclosure of all work history gaps in the past 5 years that are greater than 6 months.
- Practitioner has not and shall not have been disciplined, suspended or terminated for cause, from a PPO, HMO, hospital privileges or other managed care organization.

The following criteria apply to all facilities serving the network unless superseded by applicable state laws or regulations and are NOT required criteria, but shall be collected from the facility as available:

Facility Setting:

- Be handicapped accessible to all patients, including, but not limited to, its entrance, parking and bathroom facilities. Regulatory "grandfathering" provisions will be accepted.
- Have a waiting room able to accommodate at least five patients and a sufficient number of changing rooms to allow for patient privacy.
- Posted office hours.
- The Provider shall maintain appropriate medical records and shall, subject to applicable law, provide such records to Carelon Post Acute Solutions as deemed necessary by Carelon Post Acute Solutions, in its sole discretion, for the purpose of utilization management and/or quality assessment.

Closed Markets:

- Business needs of the organization could be evaluated to determine a markets capacity to support further contracting efforts. If a contract request is received in a market that is closed, the facility or Practitioner initiating the contract request will be notified of the closure. All contract materials submitted will be kept on file for 6 months. Evaluations of market need is periodically performed to ensure compliance with CMS, state and federal requirements.

PROVIDER NAME: **Tax ID:**

CREDENTIALING REQUIREMENTS FOR HOME HEALTH AGENCIES (HHA)	
PLEASE CHECK AND SUBMIT COPIES OF THE FOLLOWING	
☐ Completed Signed Application	Complete the entire application including all fields. If not applicable, please indicate N/A.
☐ W-9	Please include a copy of the W-9 ONLY *if not submitted with your Contract Packet*
☐ HHA State License	Copy of HHA's current, valid state license (as applicable for servicing state) if applicable
☐ HHA Accreditation Certificate	HHA's accreditation report or letter from an approved accrediting body below: (1) The Joint Commission on Accreditation of Healthcare Organizations (2) The Community Health Accreditation Program (3) The Accreditation Commission for Health Care *As applicable for HHA. If not Accredited, see "CMS and/or State Agency Survey" below.
☐ CMS and/or State Agency Survey	If not accredited, must submit the most recent HCFA/CMS site review report and/or state review. Any correction plan(s) must be present. Report must be most recent and may not be greater than 3 years at the time of verification.
☐ Medicare Certification	Copy of HHA's most recent/current Medicare Certification Letter. HHA must have an active Medicare Provider Number.
☐ General Liability Insurance Coverage	A general liability malpractice insurance face sheet must include current coverage dates, provider name, and limits of coverage. The minimum coverage varies by State.
☐ CLIA Certificate	A copy of the current Clinical Laboratory Improvement Amendment (CLIA) Certificate OR Waiver, if applicable.
☐ Disclosure of Ownership (DOO) Executed Form	All HHAs applying for Credentialing will be asked to submit an up-to-date DOO Form for all ownership entities (individual & organizations) with +5% ownership in the HHA, all general partnership interests, officers/directors, and/or all managing HHA employees (ex: general manager, business manager, administrator, director, or others).
☐ Attestation	Please read and sign the Attestation Form.

Please return to Carelon Post Acute Solutions via email or fax.

- Email: credentialing@carelon.com or fax 615-724-7468
- At any time during the application process, each applicant will have the right to review information related to the credentialing process, correct erroneous information, and receive updates regarding the status of their credentialing application. All such requests made to Carelon Post Acute Solutions will be responded to within 48 hours. This shall not include access to references, review recommendations and/or protected peer review information.

HOME HEALTH AGENCY CREDENTIALING APPLICATION

PLEASE NOTE: IF YOU HAVE MULTIPLE FACILITIES AND LICENSES, BUT ONE TAX ID #, COMPLETE ONLY ONE APPLICATION. IF EACH LICENSED ENTITY IS UNDER A DIFFERENT TAX ID #, PLEASE COMPLETE ONE APPLICATION FOR EACH ENTITY.

Legal Agency Name:

Doing Business As (DBA) Name*:
**If different from Legal Agency Name*

Primary Agency Address:

City: **State:** **Zip Code + 4:**

Agency General Contact Information:

Phone: **Fax:**

Website *(if applicable)*: **Email:**

Agency Identification Numbers: *If multiple locations with the same tax identification number apply, complete Attachment A.*

Federal Tax I.D. #: **National Provider Identifier #:**

State License # *(if applicable)*: **State License Expiration Date:**

Medicare Provider: ____ **NO** _____ **YES** **CMS Certification #:** _____

CLIA Certificate/Waiver #*:* **CLIA Expiration Date:**

INSURANCE INFORMATION

General Liability Carrier:	Coverage Amounts:	Expiration Date:
ACCREDITED ORGANIZATION	EXPIRATION DATE	
TJC: ___ CHAP: ____ ACHC:____		

Please indicate if your staff has multilingual and /or multicultural capabilities (Language) Spanish: ☐ Sign:☐ Other: ☐

Multiple Facilities: ☐ **NO** ☐ **YES**

Number # of Branches: _____

- **If YES and under the same Tax ID #, complete Attachment A**
- **If YES and under separate Tax ID, copy and complete one credentialing application for each location.**

Credentialing Point of Contact Name:

Email: **Phone:**

Note: This person should not be from a third party. Information sent to this email relates directly to the agency's ability to confirm CMS Directory information.

Verification Point of Contact Name: **Email:**

SCOPE OF SERVICES – HOME HEALTH	**Mark with a X**			**Mark with a X**	
Services	**Yes**	**No**	**Services**	**Yes**	**No**
Attendant/Care Services			Pediatric Nurse		
Certified Nurse Assistance			Personal Care Services		
Companion Care			Physical Therapy		
Enterostomal Nurse			PICC Line Certified Nurse		
Hi-Tech RN			Psychiatric Nurse		
Home Health Aide			Psychiatric Social Worker		
Homemaker/Chore Services			Respiratory Therapy		
Lab Drawing			Respite Care, Unskilled		
LPN			RN		
Medical Social Worker			Speech Therapy		
Occupational Therapy			Wound Care		

These questions apply to all locations listed under the same Tax ID.
Please include details for each location included in a "YES" response.

Mark with an X

COMPLIANCE QUESTIONNAIRE	YES	NO
Have you had any Medicare / Medicaid sanctions within the past 10 years?		
Has your organization or any member of your staff ever been expelled, excluded, or suspended from any federal program or from service reimbursement under Medicare or Medicaid?		
Has your organization's had liability restrictions?		
Has any insurance carrier at present or during the last 5 years made an out-of-court settlement or paid a judgment on a professional liability claim on your organization's behalf?		
Have there ever been any actions against your organization's license, accreditation, certifications or permits or the license of any member of your staff, including restrictions, limitations, denial, suspension, revocation, or cancellation?		
Has your organization or any member of your staff ever been convicted of or pleaded nolo contendere to a felony or other criminal offense, including, without limitation, a criminal offense related to Medicare, Medicaid, or any other federal program?		
If Provider has indicated "Yes" for any of the above questions, please provide explanation		

ATTESTION FORM _____

(Please Print Provider/Organization's Name with Tax ID#)

1. I hereby attest that the applying facility has given me the authority and responsibility to execute contractual agreements and to provide credentialing and re-credentialing information on the facility's behalf. I understand that a credentialing process is the process established by medical institutions, insurance companies, and other health care providers to identify the capacity, quality, professionalism, and ethical conduct, among other important criteria, of its contracting providers; and that I must possess significant knowledge about the facility that I represent regarding the issues questioned in this application to accurately and responsibly complete and sign this application.

2. I hereby attest that all information provided in or attached to this application is complete and correct to the best of my knowledge. I fully understand that any misstatements in or omissions from this application or its attachments, whether intentional or not, constitute cause for participation denial or termination.

3. I understand and agree that the applying facility has the burden of producing adequate information for proper evaluation of the facility and for resolving any doubts about such qualifications.

4. I agree to provide updated information for credentialing matters as such information becomes available.

5. I hereby give authorization to Carelon Post Acute Solutions to request, collect and evaluate information regarding this facility's competence, conduct, ethics, malpractice history, and any other matter bearing on the facility's qualifications to perform the services being contracted. This includes, but is not limited to, information from health care providers, certification and licensing entities, monitoring agencies, attorneys, State and Federal agencies, organizations with databases of information regarding companies providing patient care services and any entity with information related to information provided in or attached to this application. I furthermore authorize for the release of this information to Carelon Post Acute Solutions whether such information is private, public, privileged, or confidential. I hereby release from any liability all entities and individuals providing this information in good faith.

6. I hereby release Carelon Post Acute Solutions any other organization contracted or affiliated to Carelon Post Acute Solutions, and any individual acting on behalf of any of these entities from any liability arising from any action taken related to this facility's participation in Carelon Post Acute Solutions , whether such action is directly related to the applying facility, its owners, or leaders.

7. I hereby release from liability and hold harmless all individuals and organizations and their respective directors, employees or agents for acts made in good faith and without malice in connection with the evaluation of my facility's competence and qualifications.

8. I understand and agree that Carelon Post Acute Solutions may be required to provide information about the entity that I represent and/or about the relationship between Carelon Post Acute Solutions and the entity that I represent to State and Federal entities, to databanks, monitoring agencies, and other contracting organizations. I hereby authorize for the release of such information and release from any liability all entities and individuals providing this information in good faith.

9. I understand that records kept by Carelon Post Acute Solutions relating to the applying facility may be subject to review by State and Federal entities, monitoring and accrediting organizations, and other organizations contracted or applying to contract Carelon Post Acute Solutions I hereby authorize for such reviews and release from any liability all entities and individuals participating in such reviews.

10. I understand that as a condition for participation, Carelon Post Acute Solutions may review this facility's records and conduct an inspection of the site. I hereby consent to these reviews and agree to fully cooperate for such reviews to be done timely and accurately.

11. I further acknowledge and agree that communications and/or documents which are required in writing to comply with applicable laws and regulations shall be considered to be in compliance with any such laws and regulations, if transmitted, acknowledged, and/or executed through the use of mail (email), electronic data interface, (EDI), internet or other electronic transmission.

12. I hereby acknowledge that this Consent and Release Form will be valid for a period of one hundred eighty (180) days from the date I sign it, and that a photocopy or fax will serve as an original.

Provider Name: _____

Applicant's Signature: _____

Print Name: _____

Title: _____

Date: _____

ATTACHMENT A

ADDITIONAL LOCATIONS UNDER SAME TAX ID

Only complete for agencies operating at different service locations/names under the SAME tax id

Complete one page for each location

Legal Agency Name:
Doing Business As (DBA) Name*: **If different from Legal Agency Name*
Primary Agency Address: **City:** **State:** **Zip Code + 4:**
Agency General Contact Information: **Phone:** **Website** *(if applicable)*: **Email:**
Agency Identification Numbers: *If multiple locations with the same tax identification number apply, complete Attachment A.* **Federal Tax I.D. #:** **National Provider Identifier #:** **State License #** *(if applicable)*: **State License Expiration Date:**
Medicare Provider: ____ **NO** _____ **YES** **CMS Certification #:** _____ **CLIA Certificate/Waiver #**: **CLIA Expiration Date:**

Please complete one per location

ATTACHMENT A
ADDITIONAL LOCATIONS UNDER SAME TAX ID

SCOPE OF SERVICES – HOME HEALTH					
Services	**Yes**	**No**	**Services**	**Yes**	**No**
Attendant/Care Services			Pediatric Nurse		
Certified Nurse Assistance			Personal Care Services		
Companion Care			Physical Therapy		
Enterostomal Nurse			PICC Line Certified Nurse		
Hi-Tech RN			Psychiatric Nurse*		
Home Health Aide			Psychiatric Social Worker		
Homemaker/Chore Services			Respiratory Therapy		
Lab Drawing**			Respite Care, Unskilled		
LPN			RN		
Medical Social Worker			Speech Therapy		
Occupational Therapy			Wound Care		

Counties Form

State _____

If you service ALL COUNTIES in the state, check here: ☐

County Name	Partial County

Instructions for Completing the Disclosure of Ownership and Control Interest Statement

Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles V, XVIII, XIX and XX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the appropriate State agency to enter into an agreement or contract with any such institution in termination of existing agreements.

GENERAL INSTRUCTIONS

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section referencing the item number to be continued. If additional space is needed, use an attached sheet.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. NO instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

ITEM I – Identifying Information

(a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, and name of trade or corporation.

ITEM II – Self–explanatory.

ITEM III – Owners, Partners, Officers, Directors, and Principals List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity. 501 (c) (3) nonprofit and state-owned entities must list the officers or directors that have a control interest in the entity and managing employees in Section III(a). Since there will be no entries for any person with an ownership interest (Section III[b]), the percentage of ownership will always be less than 100 percent.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if "A" owns 25 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, "A's" interest equates to a 20 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices; the ability or authority, expressed or reserved to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved to control the sale of any or all of the assets to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

ITEMS IV through VII – Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For items IV through VII, if the **Yes** box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

ITEM IV – Ownership

(a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

ITEM V – Management

If the answer is **Yes**, list name or the management firm a nd employer identification number (EIN) or the leasing organization. A management company is defined as a ny organization t hat operates and names a business on behalf of the owner of that business with the owner retaining ultimate legal responsibility for operation of the facility.

ITEM VI – Staffing

If the answer is **Yes**, identify which has changed (Administrator, Medical Director or Director of Nursing) and the date the change was made. Be sure to include name of the new administrator, Director of Nursing or Medical Director, as appropriate.

ITEM VII – Affiliation

A chain affiliate is any freestanding health-care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more freestanding health-care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital–based home health agencies are not considered to be chain affiliates.

ITEM VIII – Capacity

If the answer is **Yes**, list the actual number of beds in the facility now and the previous number.

ITEM IX - Disclosure of Relationship

Please disclose any of familial relationships between principals and/ or the provider (i.e., Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling).

I.	Identifying information		
(a)	**Legal Name:** *(according to the IRS)*	**DBA:**	**Telephone number:**
	Physical/Corporate Address: Number Street Suite City State ZIP		

II.	Answer the following questions by checking Yes or No. *If any of the questions are answered Yes, list names and addresses of individuals or corporations under Remarks on the Disclosure of Ownership and Control Interest Statement form. Identify each item number to be continued.*	
(a)	**Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations, in any of the programs established by Titles XVIII, XIX, or XX?**	☐ Yes ☐ No
(b)	**Does this provider have any current employees in the position of manager, accountant, auditor, or in a similar capacity and who were previously employed by this provider's fiscal intermediary or carrier within the last 12 months?** *(Medicare providers only)*	☐ Yes ☐ No

III.	Owners, Partners, Officers, Directors, and Principals		
(a)	**Identify individuals who are sole proprietors or owners, partners, officers, directors, and principals of the applicant and list the percentage of ownership, if applicable. Total ownership should equal 100 percent unless otherwise noted in the instructions (see previous page). If ownership does not total 100 percent, the provider must submit a letter explaining the discrepancy. As it relates to owners, include all individuals with 5 percent or more ownership in the company, whether this ownership is direct or indirect.** ***(Add additional pages if necessary.)***		
	1.	**Name:**	**Percentage Owned:**
	2.	**Name:**	**Percentage Owned:**
	3.	**Name:**	**Percentage Owned:**
	4.	**Name:**	**Percentage Owned:**

(b)	**Identify the entities with ownership of a controlling interest in the applicant (whether such ownership of the controlling interest is direct or indirect). Provide the entity's name and federal tax identification number.** *See Instructions for Completing the Disclosure of Ownership and Control Interest Statement. List any additional names and addresses under Remarks on the Disclosure of Ownership and Control Interest Statement. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.*		
	Name:	**Address:**	**Federal Tax ID:**

(c)	**Do you currently have a creditor with a security interest in a debt that is owed by you?** **Is the creditor(s) security interest protected by at least 5 percent of your property?**		☐ Yes ☐ No ☐ Yes ☐ No
	List each creditor with a security interest in a debt that is owed by you if the creditor's security interest is protected by at least 5 percent of your property.		
	Last Name/Company Name:	**First Name:**	**Percent of Security Interest:**
(d)	**Type of Entity:** *Select only one - must match entity on W9*		
	☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Limited liability company. (*Enter the tax classification [C=C corporation, S=S corporation, P=partnership]*) _____ ☐ Trust/estate ☐ Other *(specify)* _____		
(e)	**If the disclosing entity is a corporation, list names, addresses of the directors and EINs for corporations in remarks.** *Attach additional pages if needed.*		
	Remarks:		

IV.	**Ownership**		
(a)	**Has there been a change in ownership or control within the last year?**		☐ Yes ☐ No
	If **Yes**, *give date:*		
(b)	**Do you anticipate any change of ownership or control within the year?**		☐ Yes ☐ No
	If **Yes**, *give date:*		
(c)	**Do you anticipate filing for bankruptcy within the year?** *(see provider agreement for additional information)*		☐ Yes ☐ No
	If **Yes**, *give date:*		
(d)	**Are any of the new owners related to any of the former owners?**		☐ Yes ☐ No
(e)	**Did any former owners transfer their ownership interest to any new owners in anticipation of or following the assessment of a civil monetary penalty?** *If yes, please list the name of the former owners below.*		☐ Yes ☐ No
	Last Name:	**First Name:**	Middle Initial:

V.	**Management**	
	Does the provider identified in Section I. above comprise or include a facility that is operated by a management company, or a facility that is leased in whole or in part by another organization?	☐ Yes ☐ No
	If **Yes**, *give date of change in operations:*	

VI.	Staffing	
(a)	**Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?**	☐ Yes ☐ No

VII.	Affiliation		
(a)	**Is the provider identified in Section I. above chain affiliated?**		☐ Yes ☐ No
	If **Yes**, *provide the name, address, and Federal Tax ID number of the chain's corporate/home office:*		
	Name	Address	Federal Tax ID

VIII.	Capacity			
(a)	**Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last two years?** *(For Hospitals only)*			☐ Yes ☐ No
	If **Yes**, *give:*	**Year of change:**	**Current Beds:**	**Prior Beds:**

IX.	Disclosure of Relationship		
(a)	**Please disclose any of the following familial relationships between principals and/or the provider (Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling):**		
	Provider/Principal 1:	**Has a Relationship as:**	**To Provider/Principal Name 2:**