Hospital/Facility Ancillary Roster Addendum

Instructions: In order for the addendum to be considered complete:

1. All information must be legible. Please print or type all information.
2. Roster must be completed in its entirety.
3. The Sanctions Questions below must be answered and Attestation signed and dated.
4. If necessary, use a separate sheet of paper to provide additional information.
5. One addendum form must be completed for each Tax ID number being submitted on Roster.
6. Fill-in the applicable Tax ID# at the bottom of every page for reference purposes.
7. If your entity provides any HCBS services, you will need to complete an Iowa Total Care HCBS Waiver Provider Application instead of the Hospital/Facility Application.

Attach the following to the completed addendum when applicable:

- ☐ **State Operational License**
- ☐ **Any Other applicable State/Federal Licensures** (e.g., CLIA, DEA, Pharmacy or Department of Health)
- ☐ **Accreditation Certificate(s)** or **Accreditation letter with dates of accreditation** (by a nationally recognized accrediting body, e.g., TJC/JCAHO/CARF/COA/ or AOA)
- ☐ **Site Evaluation Results:** If not accredited by a nationally recognized accrediting body, attach the Site Evaluation Results from a governmental agency.
- ☐ **W-9** signed and dated. Signed and dated **Disclosure of Ownership** if not enrolled with Iowa Medicaid.
- ☐ **Professional/Facility Liability Insurance**. Attach a copy of the Certificate of Insurance (COI) detail with amounts and coverages listed. Minimum requirement: $1M per occurrence /$3M per aggregate.

LEGAL INFORMATION:

Entity Legal Name:	**Tax ID Number:**

Sanctions Questions *If yes, to any question below, please explain on a separate sheet of paper.*	
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	☐ **Yes** ☐ **No**
Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?	☐ **Yes** ☐ **No**
Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?	☐ **Yes** ☐ **No**
Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended or revoked for any reason?	☐ **Yes** ☐ **No**
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?	☐ **Yes** ☐ **No**
Has the corporation, an officer or board member ever been convicted of a felony?	☐ **Yes** ☐ **No**

PROVIDER RESPONSIBILITY STATEMENT

I hereby understand that as a prospective/current Iowa Total Care Health Plan provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to Iowa Total Care Health Plan Credentials Committee for their review and approval, and, absent such affirmative approval, Iowa Total Care Health Plan members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from Iowa Total Care Health Plan. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Iowa Total Care Health Plan in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Iowa Total Care Health Plan credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued 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 Entity:_____ **Date:** _____

Print or type name

Signature of Authorized Representative: _____ **Title:**_____

A stamp signature is not acceptable

Please email completed documents to networkmanagement@iowatotalcare.com