DEPARTMENT OF SOCIAL SERVICES

MISSOURI MEDICAID AUDIT AND COMPLIANCE

ADULT DAY CARE PROVIDER ENROLLMENT APPLICATION

THIS FORM IS *MANDATORY* FOR ALL PROVIDERS. Read and answer all questions carefully.
Failure to provide this information is grounds for denial of the application and/or termination of provider participation.
A SEPARATE form MUST be completed for each provider identifier. EACH form MUST be signed and have all questions answered on both sides. Attach an additional sheet, when necessary, to provide complete information for any question.
Enrollment inquires may be directed to Provider Enrollment via e-mail at mmac.ihscontracts@dss.mo.gov.

PROVIDER'S LEGAL NAME

CONTACT PERSON'S NAME (Indicate the person to contact if there are questions regarding this enrollment application)

CONTACT PERSON'S PHONE NUMBER:	CONTACT PERSON'S EMAIL ADDRESS:

ALL APPLICANTS MUST SUBMIT A LIST SHOWING: Each individual's full name (first, last, middle initial and Jr., Sr., etc.), date of birth, and social security number of any person who has 5% or greater direct/indirect ownership, controlling interest, partnership interest, any contractor or subcontractor, managing employees, officers and directors, or the name and Federal Employer Identification Number of the organization(s) having direct or indirect ownership or a controlling interest.

1. Is this application being made as a result of one or more of the following changes ? ☐ YES ☐ NO
   If yes, check all that apply and complete the required section below. If no, please continue to Question 2.
   ☐ Ownership Change ☐ Merger ☐ Asset Change ☐ New Clinic/Same Location
   ☐ Corporate Structure ☐ Replacement Facility ☐ Other
   If other, explain the change(s):

FORMER OWNER'S NAME(S), PROVIDER NUMBERS AND CLINIC/FACILITY NAME(S)

NEW OWNER'S NAME(S) AND ADDRESS, CLINIC/FACILITY NAME(S)

EFFECTIVE DATE OF CHANGE

A new MO HealthNet provider record is not created for changes, the preceding record is updated. Receiving new identifiers from other agencies/sources does not constitute creating a new MO HealthNet provider record. Payments go to the provider currently indicated on the Provider Enrollment Master File at the time the claim is processed. The provider is responsible for resubmitting any denials and/or crossover claims for any Medicare/MO HealthNet services that do not crossover electronically, before and after the change is made to the Provider Enrollment Master File. If a new provider record is created in error due to provider information being withheld at the time of application, the new record will be made inactive, the preceding record will be updated and the provider may be subject to sanctions.

2. **Has the application fee been paid?** ☐YES ☐NO **Your application will not be processed until this fee has been paid.** For details go to: http://mmac.mo.gov/providers/provider-enrollment/new-providers/application-fee/

NUMBERS 3 THRU 15 – IF YOU ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS, AN EXPLANATION, DATE, STATE, CITY AND COUNTY MUST BE COMPLETED. INCLUDE ATTACHMENTS IF NECESSARY.

3. Has the applying provider ever been personally terminated, denied enrollment, suspended, restricted by agreement or otherwise sanctioned by Medicare, Medicaid, MO HealthNet or ANY federal programs in ANY state?
   ☐ YES ☐ NO Incidents where notice of program deficiency resulted in voluntary withdrawal must be included.

4. Has the applying provider ever had an ownership, indirect ownership, controlling interest, or been administrator of a facility or agency that has been terminated, denied enrollment, suspended, restricted by agreement or otherwise sanctioned by Medicare, Medicaid, MO HealthNet or ANY federal programs in ANY state? ☐YES ☐NO
   Incidents where notice of program deficiency resulted in voluntary withdrawal must be included.

5. Has the applying provider's license ever been revoked, suspended, surrendered or in any way restricted by probation or agreement by ANY licensing authority in ANY state? ☐ YES ☐ NO

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6. Is there any proceeding currently pending to revoke, suspend, censure or restrict by probation or agreement the applying provider's license in Missouri or in ANY state? ☐ YES ☐ NO

7. Does a person having direct or indirect ownership or a controlling interest have any outstanding criminal fines, restitution orders, or overpayments pertaining to health care in Missouri or ANY other state? ☐ YES ☐ NO

8. Has the applying provider ever been convicted of a crime? (excluding minor traffic citations) ☐ YES ☐ NO
If yes, list the conviction:
Where did it happen:
Date of conviction:

9. Are there any criminal proceedings pending for the applying provider, anyone having direct or indirect ownership, controlling interest or any individual involved with the applying provider's practice, clinic, group, corporation or any other association? ☐ YES ☐ NO
If yes, list pending charges:
Where did they happen:
Date of charges:

10. Is the applying provider related, including but not limited to, spouse, parent, child, sibling, etc. to any owner, officer, agent, managing employee, director or shareholder that has been convicted of a crime pertaining to health care services? ☐ YES ☐NO
If yes, list the conviction:
Where did it happen:
Date of conviction:

11. Does the applying provider now hold a certificate to dispense controlled substances from the Federal Drug Enforcement Agency (DEA), the Missouri Department of Health and Senior Services, Bureau of Narcotics and Dangerous Drugs (BNDD) or any other state? ☐ YES ☐ NO
If yes, list all states, include requested numbers AND complete question 12.
DEA# BNDD #

12. Have any of the DEA or BNDD certificates ever been suspended, revoked, surrendered or in any way restricted by probation or agreement? ☐ YES ☐ NO
If yes, explain and include date, state, city and county (include attachments):

13. Does the applying provider have any pending enrollment applications with any state or federal program, other than this application? ☐ YES ☐ NO If yes, list the state and program name:

14. Does the applying provider have any pending complaint investigations being reviewed by any professional boards?
☐ YES ☐ NO If yes, explain:

15. Does the applying provider or anyone having ownership, controlling interest, or any individual involved with the applying provider's practice, clinic, group, corporation or any other association, have any outstanding overpayments?
☐ YES ☐ NO If yes, explain:

16. Has the applying provider rendered services to a MO HealthNet participant in reference to this location?
☐ YES ☐ NO If yes, complete the information below and submit a copy of the license or required documentation covering these dates of services IN ADDITION TO your current licensure and required documentation.

	Participant's Full Name	Participant ID	Participant SSN	Date of Service

To the best of my knowledge, the information supplied on this application is accurate, complete and is hereby released to the Department of Social Services. I also understand that pursuant to 13 CSR 70-3.020(7), I must advise the Department in writing, of any changes affecting the provider's enrollment records.

➡ SIGNATURE OF APPLICANT:

TYPE OF PRINT NAME OF PERSON SIGNING	TITLE OF PERSON SIGNING	DATE SIGNED

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COMPLETE ALL FORMS AND RETURN TO

Missouri Medicaid Audit and Compliance

Provider Enrollment Unit

205 Jefferson Street,

2nd Floor, P.O. Box 6500

Jefferson City, MO 65102

mmac.ihscontracts@dss.mo.gov

FAX: 573-751-5065