

Provider Application ^{9.25} Long Term Care

This Long-Term Care Provider Application is for all iCare lines of business Family Care Partnership and Family Care, operating under the brand name Includa. In June 2023, Includa entered into an Asset Purchase Agreement with Independent Care Health Plan (“iCare”), a Humana Inc. subsidiary, pursuant to which iCare acquired substantially all Includa’s Family Care assets. iCare is working toward system integration; however, current iCare and Family Care branded Includa are operationally independent.

All providers must be enrolled with Wisconsin Medicaid prior to submitting an application to iCare. For more information on this requirement and to start your enrollment, if the link does not work, copy and paste into your internet explorer, https://www.forwardhealth.wi.gov/WIPortal/cms/public/ltc/provider_enrollment.htm

**INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED UNTIL ALL
INFORMATION REQUIRED HAS BEEN RECEIVED**

REQUIRED DOCUMENTS – all types of LTC providers	Applicable/Attached		
	Yes	No	N/A
Completed Long Term Care Application			
Completed W-9 Form			
Face Sheet of Current Business Liability Insurance			
LICENSED or CERTIFIED RESIDENTIAL & ADULT DAY CAR (these documents are required in addition to the above)	Yes	No	N/A
Copy of License or Certification for each location			
Copy of Program Statement for each location			
All Facility-based Programs	Yes	No	N/A
Documents of HCBS compliance			

- Providers Seeking **1-2 bed Adult Family Home certification and/or contracting** must complete the 1-2 bed AFH application **NOT** this application. See websites for the 1-2 bed AFH application.
- Submit application form and other documents requested by one of the following methods:**

Email: iCareApps@icarehealthplan.org

Mail: Independent Care Health Plan (iCare)
1555 North RiverCenter Drive, Suite 206
Milwaukee, WI 53212

Fax: 1-414-272-5618

Instructions: All fields **must** be completed, unless identified as “if applicable”

SECTION I – COMPANY / AGENCY INFORMATION

Legal Business Name (as it appears on your W-9 Form):	
Doing Business as Name (DBA) , if applicable:	
Address (as it appears on W-9 Form):	
City, State, Zip:	Website , if applicable:
General Phone Number:	General Fax Number:
Tax Identification Number (TIN) , EIN/SSN:	National Provider Identifier (NPI) , if applicable:
Medicaid ID# , if applicable:	Medicare ID# , if applicable:

SECTION II – CONTACT INFORMATION

Contract Contact Information		
Name:		Title:
Address:		City, State, Zip:
Phone:	Email:	Fax:
Billing Contact Information		
Name:		Title:
Address:		City, State, Zip:
Phone:	Email:	Fax:
Credentialing Contact Information		
Name:		Title:
Address:		City, State, Zip:
Phone:	Email:	Fax:
Payment/Remittance Information		
Name:		Title:
Address:		City, State, Zip:
Phone:	Email:	Fax:

SECTION III: MUST be completed for EACH LOCATION

This form is used to provide information for additional locations when submitting a contract to iCare or for adding new services or a new location to an existing contract. Complete a separate form for each location.

Legal Business Name (as it appears on your W-9 form):	
*Submission Reason: (select one)	Add Location to existing contract Add Services(s) to existing contracted location(s)
Additional information for a new Provider Application	

*Adding a new Location or Service to existing contract will require submission of an **updated W-9 and current Insurance**

Location Name (and dba, if applicable)		Address, City, State, Zip:
Location Contact/Title:	Location Email Address:	Location Phone Number:
Location Fax Number:	Location TIN:	NPI (if applicable):
Quality Contact Name:	Quality Contact Email Address:	Quality Contact Phone Number:
Referrals Contact Name:	Referral Contact Email Address:	Referral Contact Phone Number:

Services

Wheelchair Accessible (applicable to facility-based services) Yes No
 Interpreter Services Available: Languages other than English Sign Language TDD/TTY _____
 Cultural Competency training completed (for new staff and annual refresher): Yes No

Specialized Services Offered: Bariatric – less than 500 lbs Bariatric – over 500 lbs Correctional Clients Diabetic Expertise (sliding scale) Locked Egress Doors Mag Locked Facility Memory Care Traumatic Brain Injury Vent Care Wound Care Residential Services Only: Owner Occupied Corporate Accept Pets	Telehealth Services: Telehealth Only -check if no in-person services are available Video Telehealth Telephonic Telehealth
	Populations Served: Adults with physical disabilities Adults with intellectual/developmental disabilities Adults with Advanced Age
	Languages Spoken (other than English): Spanish Hmong Chinese Somali Lao Russian Burmese Other(s): _____

Hours						
Location Hours: 24/7 Yes No If location is not 24/7, please list hours below						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<p>iCare encourages all Minority-Owned (MBE), Service-Disabled Veteran-Owned (DVB) and Woman-Owned (WBE) businesses to register with WISDP Supplier Diversity Program.</p> <p>Indicate if you are registered with the WISDP Supplier Diversity Program:</p> <p>Minority Owned Business</p> <p>Service-Disabled Veteran-Owned</p> <p>Woman-Owned Business</p>						
Licensure, Certifications or Accreditation, if applicable						
	Name of Agency	Number	Effective Date	Expiration Date		
Wisconsin DQA Certified/Licensed	DQA					
Accrediting Organization						
Other Memberships/Certifications						
WI Coalition for Collaborative Excellence in Assisted Living	WCCEAL					
WI Supplier Diversity Program						
Has this location or facility ever been revoked or denied any of the above?					Yes	No
If Yes, explain:						

SECTION IV: LOCATION SERVICES, CHECK ALL THAT APPLY

For contract consideration, service providers must meet service definitions and standards as listed in the Scopes of Service (SOS) available at: https://www.icarehealthplan.org/Provider-Documents/Provider-Scope-of-Service.htm	
Adult Day Care (licensed) Assistive Technology (dog) Communication Assistance Community Supported Living (CSL) Competitive Integrated Employment (CIE) Exploration Consultative Clinical & Therapeutic Services for Caregivers (CCTS) Consumer Directed Supports (self-directed supports) Broker Consumer Education and Training Counseling & Therapeutic Resources (licensed, non-Medical certified therapies) Environmental Accessibility Adaptions (home modifications) Financial Management Services Habilitation Services: Daily Living Skills Training Habilitation Services: Day Habilitation Services Health & Wellness Home Delivered Meals Housing Counseling Personal Care Agency (Wisconsin Medicaid certified)	Personal Emergency Response Service (PERS) Prevocational Services Relocation Services Remote Monitoring Residential Services: Adult Family Home (3-4 Bed) Residential Services: Community Based Residential Facility (CBRF) Residential Services: Residential Care Apartment Complex (RCAC) Respite Care (in non-Institutional & Institutional settings) Respite Care (in substitute Living Facility) Skilled Nursing Services (RN/LPN) Supported Employment – Small Group Supported Employment – Individual Supported Home Care (chore services) Supportive Home Care (general including non-medical personal care) Training for Unpaid Caregivers Vehicle Modifications Vocational Futures Planning & Support Other (please specify):

SECTION IV: SERVICE AREA – Select the county(ies) you serve

Adams	Douglas	Juneau	Oneida	Sheboygan
Ashland	Dunn	Kenosha	Outagamie	St. Croix
Barron	Eau Claire	Kewaunee	Ozaukee	Taylor
Bayfield	Florence	La Crosse	Pepin	Trempealeau
Brown	Fond du Lac	Lafayette	Pierce	Vernon
Buffalo	Forest	Langlade	Polk	Vilas
Burnett	Fond du Lac	Lincoln	Portage	Walworth
Calumet	Forest	Manitowoc	Price	Washburn
Chippewa	Grant	Marathon	Racine	Washington
Clark	Green	Marinette	Richland	Waukesha
Columbia	Green Lake	Marquette	Rock	Waupaca
Crawford	Iowa	Menominee	Rusk	Waushara
Dane	Iron	Milwaukee	Sauk	Winnebago
Dodge	Jackson	Monroe	Sawyer	Wood
Door	Jefferson	Oconto	Shawano	

SECTION V: EXCLUSION CERTIFICATION

I hereby certify the online exclusion list for Health and Human Services, Office of Inspector General (OIG) is checked for all new hires and at least quarterly for existing employees to ensure that no excluded employees work in any capacity related to any state or federal health care program. I understand that Managed Care Organizations are precluded from contracting with providers who have been excluded from participation in any state or federal health care program. I also hereby certify that I will remove any employee found on one of the above referenced list from any work related to any state or federal health care program.

Signature of Authorized Representative

Printed Name of Authorized Representative

Authorized Representative's Title

Date Signed

SECTION VI: ATTESTATION QUESTIONS

Please answer the following questions “Yes” or “No.” If your answer to any of the following questions is “Yes,” please provide details and reasons, as specific to each question, on a separate sheet or letterhead. Please sign and date each additional sheet submitted. Provider attests that as it relates to the facilities and services selected:

Has this provider, under any current or former business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to (a) the delivery of an item or service under Medicare or State health care program, or (b) the abuse or neglect of a patient in connection with delivery of a health care item or service?	Yes	No
Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to fraud, theft, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?	Yes	No
Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	Yes	No
Has this provider, under any current or former name or business identity, ever had licensure to provide health care by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.	Yes	No
Has this provider, under any current or former name or business identity, ever had accreditation revoked or suspended?	Yes	No

Agency attests that as it relates to the facilities and services selected:

Has this provider, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in participation in any Federal Executive procurement or non-procurement program?	Yes	No
Is this provider, under any current or former name or business identity, currently suspended from Medicare payment under any Medicare billing number?	Yes	No
Has verified qualifications of each staff member, including academic preparation and relevant experience.	Yes	No
Maintains a training plan for each staff member and has a mechanism for ensuring that all necessary training has been completed <i>prior</i> to performing work.	Yes	No
Completes Caregiver Background Checks on all employees <i>prior</i> to the employee providing direct services to Member, and every four (4) years thereafter or any time that entity has a reason to believe that a new check should be obtained.	Yes	No
Has a mechanism to track the completion of Caregiver Background Checks to ensure compliance with the requirements in the iCare contract.	Yes	No

Maintains the Caregiver Background Check results on its premises for at least the duration of the Long-Term Care contract with iCare.	Yes	No
Change in Program: Prior approval by the certifying and licensing agencies is required for all program changes.	Yes	No
Prior approval by the licensing agency is required for all program changes. In addition, iCare requires proposed changes for approval 30 days prior to implementing the proposed program change.	Yes	No
Organization has trained or will train its employees and downstream related entities on cultural competency each calendar year. The content used is iCare's Cultural Competency Training or is materially similar.	Yes	No

The individual identified below acknowledges that they have reviewed the statements above and attests that the information herein be true and accurate:

Signature of Authorized Representative

Printed Name of Authorized Representative

Authorized Representative's Title

Date Signed

AUTHORIZATION FOR RELEASE OF INFORMATION AND ATTESTATION

The organization identified below (hereinafter “the Organization”) has applied to be a participating provider with Independent Care Health Plan (*iCare*). In order for *iCare* to evaluate the Organization’s qualifications, Organization authorizes *iCare* and its authorized representatives and agents to consult with any third party who may have information (including information that otherwise may be privileged or confidential) relating to the qualifications, competence and conduct of said Organization. Organization also authorizes any such third party (including the credentials verification organization) to release such information, related reports and documents to *iCare* and its authorized representatives and agents upon request and receipt of a copy of this Authorization for Release of Information.

The undersigned certifies that all information in the Organization’s application is warranted to be true, accurate and complete. Organization also agrees to immediately update *iCare* on any changes in the information submitted in the application and agrees to provide such additional information and execute such additional forms as may be requested by *iCare* in order to evaluate the Organization’s qualifications, competence and conduct.

As an applicant for credentialing or recredentialing with *iCare*, Organization has the right to review the information submitted in support of the credentialing application. Organization acknowledges that *iCare* will notify the Organization of any information obtained during the credentialing process that varies substantially from the information provided by Organization to *iCare* and that it will have the right to correct any and all erroneous information in the application.

By submitting an application for credentialing or recredentialing with *iCare*, Organization agrees to be bound by the terms of the credentialing program, as it may be amended by *iCare* from time to time. Organization understands that *iCare* will use this information solely in conjunction with the application for and status as a participating provider and that the information is not subject to re-disclosure except as permitted by Federal and State Law.

Organization hereby releases from liability *iCare* and its directors, officers, employees and authorized representatives, including the credentialing agent, its directors, employees, representatives, agents and third parties for any acts performed in good faith in providing or receiving information, reports or other documents relating to or in evaluating Organization’s professional qualifications, competence or conduct. This release from liability shall include, but not be limited to, actions related to the following:

- Organization’s application to be a participating provider with *iCare*.
- Periodic appraisals undertaken for recredentialing, utilization review or otherwise for quality management; and
- Proceedings for termination, suspension or restriction of the Organization’s status as a participating provider with *iCare* or any other disciplinary action.

This authorization is valid for 365 days and if the Organization becomes an *iCare* participating provider, for the time period that the Organization remains an *iCare* provider.

Signature of Authorized Representative

Printed Name of Authorized Representative

Authorized Representative’s Title

Date Signed

Print Name of Organization