iCare
INDEPENDENT CARE HEALTH PLAN

Life. Defined by you.
INCLUSA

A Humana Company

Provider Application 7.25
Long Term Care

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

All providers must be enrolled with Wisconsin Medicaid prior to submitting an application to *i*Care. For more information on this requirement and to start your enrollment use this link LTC Provider Enrollment

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			
Certificate of Liability Insurance, see requirements			
LICENSED or CERTIFIED RESIDENTIAL & ADULT DAY CARE (these documents 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**
Documentation 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: providerupdates@icarehealthplan.org

  Mail: Independent Care Health Plan (*i*Care)
  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. Additional pages found on the website.

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

*i*Care encourages all Minority-Owned (MBE), Service-Disabled Veteran-Owned (DVB) and Woman-Owned (WBE) businesses to register with WISDP Supplier Diversity Program.

Indicate if you are registered with the WISDP Supplier Diversity Program:

- ☐ Minority Owned Business
- ☐ Service-Disabled Veteran-Owned
- ☐ Woman-Owned Business

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: Contracting – Inclusa – Managed Care Organization – Family Care – Wisconsin – Commonunity

- ☐ 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 *prior* to performing work.	☐ Yes ☐ No
Completes Caregiver Background Checks on all employees *prior* 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 *i*Care contract.	☐ Yes ☐ No

Maintains the Caregiver Background Check results on its premises for at least the duration of the Long-Term Care contract with *i*Care.	☐ 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 *i*Care'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 (*i*Care). In order for *i*Care to evaluate the Organization's qualifications, Organization authorizes *i*Care 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 *i*Care 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 *i*Care 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 *i*Care in order to evaluate the Organization's qualifications, competence and conduct.

As an applicant for credentialing or recredentialing with *i*Care, Organization has the right to review the information submitted in support of the credentialing application. Organization acknowledges that *i*Care will notify the Organization of any information obtained during the credentialing process that varies substantially from the information provided by Organization to *i*Care 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 *i*Care, Organization agrees to be bound by the terms of the credentialing program, as it may be amended by *i*Care from time to time. Organization understands that *i*Care 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 *i*Care 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 *i*Care.
- 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 *i*Care participating provider, for the time period that the Organization remains an *i*Care provider.

_____	_____
Signature of Authorized Representative	Printed Name of Authorized Representative
_____	_____
Authorized Representative's Title	Date Signed

_____

Print Name of Organization