INSTRUCTIONS FOR COMPLETING A NEW YORK STATE ENROLLMENT FORM FOR CASE MANAGEMENT PROGRAM COS 0265

Review Criteria Set 4541

GENERAL INSTRUCTIONS:

- Complete all items specified
- Document copies included with your enrollment MUST cover the application date and be continuous through the current date.
- Completion of all signature fields is required and must be original. Initials or rubber stamped signatures will not be accepted.
- Type or legibly print in black or blue ink. Do not use red ink, nor white-out. All attachments will be scanned so they must be legible and on standard 8 ½ x 11 paper in good condition.
- Keep a copy of all documents submitted.

INSTRUCTIONS SPECIFIC TO THE ABOVE TYPE OF SERVICE:

1. Application Date - **I**f pre-filled, do not alter. If blank, please enter the begin date of your license, certification or authorization.
2. Federal Employer ID # - Enter the FEIN number assigned to this entity and attach a copy of the federal notification. (NYS does not accept W-9s.)
3. Provider Name - If pre-filled, do not alter. This name should reflect the name on the license, certification or authorization.
4. Doing Business As - Complete this field if this entity does business under an assumed name.
5. NPI – For all Case Management Programs EXCEPT OPWDD sponsored Case Management Programs, enter the NPI that was assigned by the National Plan & Provider Enumeration System (NPPES) for the services for which you are enrolling.
   You must include a copy of the NPI assignment confirmation with the submission of this application (an NPPES website printout is not sufficient for this purpose).
6. License numbers - **N/A**
7. Fiscal year end date - Enter the end date of the entity's fiscal year in Month/Day format.
8. Ownership Code - Enter the appropriate code from the list provided which defines the proprietary nature of the facility.
9. Control of Facility Code - **N/A**
10. DEA number - **N/A**
11. Medicare Participation - Check the appropriate box. If this entity participates in the Medicare program, attach a copy of the award letter or participation letter.
12. # of Medicare & Medicaid beds - **N/A**
13. Address information:
    a. Correspondence Address – This is where all correspondence not related to payments will be sent.
    b. Pay to Address – An address must be entered even if the facility has chosen Electronic Funds Transfer (EFT).
    c. Service Address - If pre-filled, do not alter. This address is the licensed or certified site. It cannot be a P.O. Box.
    d. Corporate Address – Utilize this address field if the entity on the FEIN documentation is a parent corporation or agency. Legal correspondence will be sent to this address such as a 1099, etc. The address supplied on this form will be ignored if NYS Medicaid already recognizes an address for the associated FEIN.

Questions 14 thru 19 pertain to the disclosure of ownership and control of the entity covered by this enrollment application. The accurate completion of this entire section is required by 42 CFR Part 455.104. Failure to provide the information requested will cause the application to be returned.

14. Ownership / Control Disclosure List – This is a comprehensive disclosure of any individual and/or organization which has direct or indirect control or ownership interest of 5% or more. This includes owners, stockholders, board of directors member, administrators, corporate officers (including compliance officer), agents or managing employees of the applying entity. For an individual, you must include the name, title, home address, date of birth and social security number. You must check any of the "role" boxes that apply. You must also disclose if the individuals are related to others on the disclosure list by indicating the number of the related individual and the relationship. For Corporate ownership, list the FEIN & NPI (if applicable). Corporate addresses must be disclosed in # 19.
This form may be copied. Number any additional pages.

15. Questions -- Answer all questions in this section. The first 4 questions pertain to all those disclosed in number 14. If any warrant a "yes" answer, you will be sent an additional questionnaire to complete when the enrollment is received for review.

16. Additional ownership - For those disclosed in number 14, indicate if any are owners or stockholders of other Medicare/Medicaid facilities. If so, list the owner name, the other facility name and NPI or Medicaid ID #. You may attach additional sheets as necessary.

17. Subcontractor Affiliations - For those disclosed in number 14, indicate if any are owners or stockholders of a subcontractor which provides service to the applicant. . If so, list the owner name, the subcontractor name & address and FEIN or SS# of the subcontractor. You may attach additional sheets as necessary.

18. Subcontractor Relationships - For those disclosed in number 14, indicate if any are related to an owner or shareholder of a subcontractor which provides service to the applicant. If so, list the owner name, subcontractor name & FEIN or SS# and the name of the related person and type of relationship.

19. Left Blank Intentionally

20. Affirmations & Signature – This section must be completed. Signatures must be original. **If the applicant is a legal entity other than a person, the person signing the application warrants that he/she has legal authority to bind the applicant.**

Additional Requirements:

OMIG Provider Compliance Certification – Confirmation notice for the OMIG Provider Compliance Program may be required. Visit www.omig.ny.gov to determine if the provider submitting this application must comply. If yes, a copy of the confirmation notice (printed from the website) must be included with this application.

42 CFR, Part 455.460 mandates that the New York State Medicaid Program collect an application fee. For more information, including the current fee amount, visit www.eMedNY.org/info/ProviderEnrollment./index.html.