Application for Fiscal Intermediary Authorization

GENERAL INSTRUCTIONS

Complete the Fiscal Intermediary Authorization application if you are:

1. Seeking INITIAL approval as an Authorized Fiscal Intermediary; or
2. Seeking to RENEW your Fiscal Intermediary Authorization; or
3. Reporting a change of ownership or operator, an acquisition or a change in control of an existing Authorized Fiscal Intermediary pursuant to New York State Social Services Law Section 365-f and Section 505.28 of Title 18 NYCRR; or
4. Seeking REINSTATMENT or REACTIVATION of your previous Fiscal Intermediary Authorization

Reference Material

The following reference materials may be of assistance when completing this application:

- Social Services Law, Section 365-f (4-a)
- Title 18 NYCRR, Section 505.28 - Consumer Directed Personal Assistance Program

The review process for applicants seeking approval requires staff review and recommendations concerning the application by the Office of Health Insurance Programs, Division of Long Term Care.

Instructions to Schedules and Attachments

In addition to these general instructions, instructions for the completion of specific portions of the application also are included within the application itself. Any responses to questions that require an attachment should be identified by number. Any non-duplicating numbering system may be used, but all instructions and questions which require attachments must have such attachment number noted in the appropriate section. Additional attachments may also be submitted if they are noted in the same manner.

Submission Requirements

There is no fee to file an application. Applications must be submitted electronically. Once signed and notarized, completed applications may be saved in Portable Document Format (PDF), and sent to: FIAuthorization@health.ny.gov

Acknowledgement/Completeness Review

The Division of Long Term Care will acknowledge receipt of the application via email. Each application will be assigned an application number which should be used in all correspondence referring to the application. The application number will be sent via email once it is generated. If the application is determined to be incomplete it will be returned for revision and resubmission.

As part of the review process, applicants should be aware that additional information may be requested. Any additional information requested must be submitted electronically and reference the corresponding application number.

Whom to Contact for Assistance

Any questions concerning the application process should be directed to the Division of Long Term Care by e-mail at: FIAuthorization@health.ny.gov

I. IDENTIFYING DATA

Instructions

- Enter the name and address of the Fiscal Intermediary entity as it is to appear on the Authorization.
- Enter the Fiscal Intermediary Employer Identification Number.
- Enter the name of the operator. Corporations applying for approval should enter the legal corporate name as it appears on the Certificate of Incorporation or Article of Incorporation. If the names and addresses of the operator are the same as for the Fiscal Intermediary entity, enter "same."
- Enter the name of the person who is assigned to provide additional information regarding the application.
- Check the box which indicates the type of ownership and class of operator for the Fiscal Intermediary named in Item 1.
- Existing Corporate applicants should attach a board resolution authorizing the application.
- For any attachments, indicate the attachment number in the place indicated.

THE INDIVIDUAL DELEGATED AUTHORITY BY THE APPLICANT TO SUBMIT THE APPLICATION MUST SIGN THIS SECTION.

Fiscal Intermediary Name:____

Address:____

City:_______________________________ State:_____ ZIP:___________

Telephone:________________________

If the Fiscal Intermediary already has a Medicaid Provider Identification Number, please provide it here:_____________________

Please identify which line(s) of business your Medicaid Provider Identification Number is associated with (CHHA, LHCSA, FI):______________________________

*If applicable, provide a list of all addresses at which the Fiscal Intermediary operates.
Attachment #:_____

Fiscal Intermediary Federal Employer Identification Number:____________________

Name of Operator if different from above:__________________

I. IDENTIFYING DATA (Continued)

Address:____

City:______________________ State:_____ ZIP:___________

Telephone:__________________________

Name of Person to Contact for Additional Information:______________________

Address:____

City:______________________ State:_____ ZIP:___________

Telephone:__________________________

Email:______________________________________

Type of Ownership:

- ☐ Individual
- ☐ Partnership
- ☐ For-Profit Corporation
- ☐ Not-for-Profit Corporation
- ☐ Limited Liability Company
- ☐ Other:____

Contractual Obligations:

Please identify below which entity/ies the Fiscal Intermediary will contract with:

- ☐ Local Department of Social Services
- ☐ A Health Maintenance Organization licensed under Article 44 of the Public Health Law
- ☐ An Accountable Care Organization licensed under Article 29-E of the Public Health Law
- ☐ All the above

Attach a brief description of the organizational structure of the Fiscal Intermediary, including a table of organization and relationship to any existing or proposed parent entity or controlling person. Attachment #:____

Provide a list of any contractual relationships you may have with other state agencies to provide services to such state agencies. Include all cooperative agreements with these agencies. Attachment #:____

I. IDENTIFYING DATA (Continued)

Board Resolution

Attach a certified copy of the resolution of the Board of Directors or Trustees, Board of Supervisors or other governing body having jurisdiction over the Fiscal Intermediary entity.

Attachment #:_____

Authorizing Signature

I, the undersigned, hereby certify under penalty of perjury that I am duly authorized to subscribe and submit this application and that the information contained herein and attached hereto, with the exception of those schedules pertaining to personal qualifying and disclosure information which must be individually certified, is accurate, true and complete in all material aspects.

Name:____

Signature:

Date:________________ **Title:**_______________________________________

II. PROJECT NARRATIVE

In the space provided below, check the box which best describes the purpose of this application and briefly describe.

- ☐ Initial Authorization
- ☐ Renewal
- ☐ Purchase or Merger
- ☐ Change of Stock Ownership
- ☐ Other Acquisition of Control
- ☐ Reinstatement or Reactivation

Description (If response is over 200 words, please provide a separate attachment, and number accordingly):

III. FISCAL INTERMEDIARY PROFILE

1. Fiscal Intermediary History and Overview

(a) Provide the history of the Fiscal Intermediary organization, along with an overview of the organization and all services it offers. Please include any relationships with outside agencies that may influence in any way the ability of the organization to provide Fiscal Intermediary services consistent with the manner described in this application.

Attachment #:____

(b) Provide copies of the Fiscal Intermediary's policies and procedures, including any contracts or other documents used in communications with Consumers.

Attachment #:_____

(c) Describe the Fiscal Intermediary's plans to solicit and consider input from Consumer's, staff, personal assistants and other interested parties which may be charged with roles including, but not limited to: quality assurance review, referral, program monitoring or development, or establishing and responding to community needs. Such input may be in the form of a board of directors, committee, survey or other mechanism, provided that the majority of input obtained as part of this process must be from individual Consumers and Consumer advocates of the Fiscal Intermediary.

Attachment # :_____

(d) Describe the organization's plan to address the needs of Consumers and their personal assistants in a timely manner, regardless of where they live, including but not limited to: input from Consumers, obtaining physicals and other health information from personal assistants, obtaining time records for payroll and timely processing of payroll.

Attachment #:_____

III. FISCAL INTERMEDIARY PROFILE (Continued)

2. Fiscal Intermediary Roles and Responsibilities

Social Services Law Section 365-f indicates the responsibilities of a Fiscal Intermediary and the services they shall perform on behalf of the Consumer. Further, the statute also sets forth the services a Fiscal Intermediary is not responsible for and may not engage in. Both are outlined below.

Fiscal Intermediary Services shall include the following:

- Wage and benefit processing for consumer directed personal assistants.
- Processing all income tax and other required wage withholdings.
- Complying with workers' compensation, disability and unemployment requirements.
- Maintaining personnel records for each consumer directed personal assistant, including time sheets and other documentation needed for wages and benefit processing, and a copy of the medical documentation required as outlined in 18 NYCRR Section 505.28 (i)(1)(iii).
- Ensure the health status of each consumer directed personal assistant is assessed prior to service delivery, as outlined in 18 NYCRR section 505.28(i)(1)(ii).
- Maintain records of service authorizations and/or reauthorizations.
- Monitor the Consumer's or, if applicable, the Designated Representative's continuing ability to fulfill the Consumer's responsibilities under the consumer directed program and promptly notify the authorizing entity of any circumstances that may affect the Consumer's, or the Designated Representative's ability to fulfill such responsibilities.
- Comply with regulations specifying the responsibilities of Fiscal Intermediary entities providing services as part of the consumer directed program.
- Enter into a Department approved Memorandum of Understanding with the Consumer that describes each party's responsibilities under the consumer directed program.

A Fiscal Intermediary shall exercise reasonable care in properly carrying out its responsibilities under the Consumer Directed Personal Assistance Program. A Fiscal Intermediary may not fulfill the responsibilities of the Consumer, or, if applicable, the Consumer's Designated Representative.

A Fiscal Intermediary shall not engage in:

- Managing the plan of care, including recruiting and hiring a sufficient number of consumer directed personal assistants;
- Training, supervising and scheduling consumer directed personal assistants;
- Terminating a consumer directed personal assistant's employment; or
- Assuring that each consumer directed personal assistant competently and safely performs the personal care services, home health aide services and/or skilled nursing tasks included in the Consumer's plan of care.

IV. ESTABLISHMENT INFORMATION Instructions

This must be completed by all applicants.

Select the structure below (from Sections A through G) which applies to this application, and check the appropriate box. Note the submissions required by the category checked, and identify all submitted attachments by number in the line reserved for attachment listings.

Review the information required in Section H (Related Organization Information) and, if appropriate, provide the required details as an attachment. Schedule 1 must be completed as indicated in Sections A through H. Note that these sections must be signed individually.

☐ A. SOLE PROPRIETOR

- The sole proprietor must submit Schedule 1.
- Copy of the existing or proposed certificate of doing business under an assumed name.
  Attachment #:_____
- Copy(s) of any agreement(s) relating to the proposed transfer of the business interest in the Agency's operation.
  Attachment #:_____

☐ B. PARTNERSHIP

- Each partner must submit Schedule 1. The partnership must submit the following:
- Complete list of partners.
  Attachment #:_____
- Copy of the existing or proposed certificate of doing business under an assumed name.
  Attachment #:_____
- Copy of the existing or proposed partnership agreement.
  Attachment #:_____
- Copy(s) of any agreement(s) relating to the proposed transfer of partnership interests.
  Attachment #:_____

☐ C. LIMITED LIABILITY COMPANY

- The Limited Liability Company must submit the following:
- Complete list of members indicating the percent of ownership of each member.
  Attachment #:_____
- Complete list of any managers.
  Attachment #:_____
- If the limited liability company will be managed by managers who are not members, a copy of the existing or proposed management agreement between the limited liability company and the manager.
  Attachment #:_____
- Copy of existing or proposed Articles of Organization.
  Attachment #:_____
- Copy of existing or proposed Operating Agreement.
  Attachment #:_____

IV. ESTABLISHMENT INFORMATION (Continued)

- Copy of an existing or proposed certificate of doing business under an assumed name. (If applicable)

  Attachment #:_____
- Copy(s) of any agreement(s) relating to the proposed transfer of membership interests. (If applicable).

  Attachment #:_____

☐ D. BUSINESS CORPORATION

- New or existing corporation proposing the operation of the Fiscal Intermediary.
- Each principal stockholder (holder of 10% or more of the issued and outstanding stock), officer and member of the Board of Directors must submit Schedule 1.
  The corporation must submit the following:
- Copy of the existing or proposed certificate of incorporation or copy of the executed or proposed certificate of amendment, merger, or consolidation or application for authority where appropriate.

  Attachment #:_____
- Copy of the existing or proposed certificate of doing business under an assumed name. (If applicable)

  Attachment #:_____
- Complete list of all board officers, directors and principal stockholders indicating position or title of each (i.e. board member, treasurer, etc.), contact information and the number of shares of stock to be owned by each.

  Attachment #:_____
- Copy of bylaws.

  Attachment #:_____

☐ E. BUSINESS CORPORATION (Transfer of Stock)

- Each individual that will become a principal stockholder and any officer or member of the Board of Directors of the acquired or acquiring entity must submit Schedule 1.
- Copy(s) of any agreement(s) relating to the proposed transfer of stock interests.

  Attachment #:_____

☐ F. Not-For-Profit CORPORATION

- Each officer or member of the Board must submit Schedule 1. The corporation must submit the following:
- Copy of the existing or proposed certificate of incorporation or copy of the executed or proposed certificate of amendment, merger or consolidation, or application for authority.

  Attachment #:_____
- Copy of the existing or proposed certificate of doing business under an assumed name. (If applicable)

  Attachment #:_____
- Complete list of officers and directors indicating position or title of each (i.e. board member, treasurer, etc.) and contact information.

  Attachment #:_____
- Copy(s) of any agreement(s) relating to the proposed transfer of the business interest in the agency operation.

  Attachment #:_____
- Copy(s) of any agreement(s) relating to the proposed transfer of the business interest in the agency operation.

  Attachment #:_____

IV. ESTABLISHMENT INFORMATION (Continued)

☐ G. GOVERNMENT SUBDIVISION

- The Government subdivision must submit the full name and address, and the license/certificate number, for all agencies or facilities that are operated by the applicant and certified or licensed for the provision of health care.

Attachment #:_____

☐ H. RELATED ORGANIZATION INFORMATION

1. List the full legal name and the address of the principal office and place of doing business of any existing or proposed parent corporation, controlling person or controlling organization which directly or indirectly, through one or more intermediaries, possesses or will possess the ability to direct or cause the direction of the actions, management or policies of the person, corporation, organization or agency or that is applying for approval as a Fiscal Intermediary.

   Attachment #:_____

2. With respect to each parent corporation, controlling person or other controlling organization identified in response to question (1) above:
   - (a) List the full name of each member of the Board of Directors, board officer, controlling person, principal stockholder, sponsor of such parent corporation or controlling person or organization. Each principal stockholder, board officer and member of the Board of Directors must submit Schedule 1.

     Attachment #:_____

   - (b) List the full legal name and the address of the principal office and place of doing business of any hospital, residential health care facility, diagnostic and/or treatment center, adult care facility, mental health facility, home health care or personal care program or agency, or other health care facility or program, regardless of location, owned or operated by such parent corporation or controlling person or organization, together with a photocopy of any operating license, permit or certificate issued for such facility or program, the full name of the issuing agency and dates of ownership.

     Attachment #:_____

   - (c) Describe in detail the relationship between the applicant and any parent corporation or subsidiary corporations, controlling person or organization and describe in detail the method or mechanism by which control over the Fiscal Intermediary is or will be effectuated (e.g. stock ownership, membership arrangement, common officers, directors or stockholders or other arrangement).

     Attachment #:_____

IV. ESTABLISHMENT INFORMATION (Continued)

3. With respect to any existing or proposed parent corporation or controlling person or organization identified in response to question (1) above:
   - (a) List the full legal name and the address of the principal office and place of doing business of any subsidiary corporation or organization that owns or operates any hospital, residential health care facility, diagnostic and/or treatment center, adult care facility, mental health facility, home health care or personal care program or agency or other health care facility or program, regardless of location, and the full legal name and the address of the principal office and place of doing business of any such health care facility or program, together with a photocopy of any operating license, permit or certificate issued for such facility or program, and the full name of the issuing agency and dates of ownership.

     Attachment #:_____

   - (b) List the full name of each of the members, directors, controlling persons, principal stockholders, board officers and sponsors of each subsidiary corporation or organization identified in response to (3) (a) above.

     Attachment #:_____

   - (c) Describe in detail the relationship between the applicant, parent corporation, controlling person or organization and each subsidiary corporation or organization identified in response to (3) (a) above and describe in detail the method or mechanism by which control over the subsidiary is or will be effectuated (e.g. stock ownership, membership arrangement, common officers, directors or stockholders or other arrangement).

     Attachment #:_____

Schedule 1

1. Personal Identifying Information

Name:____

Address:____

City:_________________________ State:_____ ZIP:___________

Telephone:_____________________ Email:_____________________________

Date of Birth (MM/DD/YYYY):__________ Place of Birth (County/State):_____________________

Current or Proposed Position with Proposed Fiscal Intermediary:_______________________
____

Business Name:____

Address:____

City:_________________________ State:_____ ZIP:___________

Telephone:_____________________ Email:_____________________________

2. Licenses Held

Type of Professional License & License Number:_____________________________

Institution Granting License:_____________________________

Effective Date:_____________ Expiration Date:_____________

Type of Professional License & License Number:_____________________________

Institution Granting License:_____________________________

Effective Date:_____________ Expiration Date:_____________

Type of Professional License & License Number:_____________________________

Institution Granting License:_____________________________

Effective Date:_____________ Expiration Date:_____________

Type of Professional License & License Number:_____________________________

Institution Granting License:_____________________________

Effective Date:_____________ Expiration Date:_____________

3. Employment History for the Past Five Years

☐ Currently Employed
☐ Retired   If retired, please specify date of retirement:___________

Start with MOST RECENT employment and include employment during the last five years. A resume or curriculum vitae (CV) may be substituted for this portion of the application but any additional information requested below and not contained in such resume or CV should be added. Please attach additional information, if necessary.

Name of Employer:____

Address:____

City:__________________________________ State:_____ ZIP:___________

Dates of Employment: (from)_____________ (to)______________

Position:____

Reason for Departure: ____

Responsibilities (If response is over 200 words, please provide a separate attachment, and number accordingly):

Name of Employer:____

Address:____

City:__________________________________ State:_____ ZIP:___________

Dates of Employment: (from)_____________ (to)______________

Position:____

Reason for Departure: ____

Responsibilities (If response is over 200 words, please provide a separate attachment, and number accordingly):

4. Offices Held or Ownership in Health Care

The purpose of this section is to obtain a listing of any affiliations as referenced below with which the owners, board officers, directors, controlling persons or partners of the proposed organization have been associated in the past 10 years. Affiliation, for the purposes of this section, includes serving as either a voting officer, director or principal stockholder of any health care, adult care, behavioral or mental health facility, program or agency requiring licensure or certification in New York State. Officerships and directorships in similar facilities or programs outside of New York State must also be disclosed. Include facilities for which applications were previously disapproved or withdrawn.

Provide documentation from the appropriate regulatory agency in the states (other than New York State) where you note affiliations, reflecting that the affiliated facilities, programs and agencies operated in substantial compliance with applicable codes, rules and regulations for the past ten years (or for the period of your affiliation, whichever is shorter).

A. Applicant's Offices/Ownership Interests
If not applicable, please check box: ☐

From:____________ To:__________ Name of Facility: ____________________________________

Address of Facility:____

Type of Facility:__________________________ Office Held/Nature of Interest:__________________

From:____________ To:__________ Name of Facility: ____________________________________

Address of Facility:____

Type of Facility:__________________________ Office Held/Nature of Interest:__________________

From:____________ To:__________ Name of Facility: ____________________________________

Address of Facility:____

Type of Facility:__________________________ Office Held/Nature of Interest:__________________

From:____________ To:__________ Name of Facility: ____________________________________

Address of Facility:____

Type of Facility:__________________________ Office Held/Nature of Interest:__________________

B. Relative's Ownership Interests
If not applicable, please check box: ☐

Name of Relative:______________________________ Relationship to applicant:________________

From:____________ To:__________ Name of Facility: ____________________________________

Address of Facility:____

Type of Facility:__________________________ Office Held/Nature of Interest:__________________

Name of Relative:______________________________ Relationship to applicant:________________

From:____________ To:__________ Name of Facility: ____________________________________

Address of Facility:____

Type of Facility:__________________________ Office Held/Nature of Interest:__________________

Name of Relative:______________________________ Relationship to applicant:________________

From:____________ To:__________ Name of Facility: ____________________________________

Address of Facility:____

Type of Facility:__________________________ Office Held/Nature of Interest:__________________

Name of Relative:______________________________ Relationship to applicant:________________

From:____________ To:__________ Name of Facility: ____________________________________

Address of Facility:____

Type of Facility:__________________________ Office Held/Nature of Interest:__________________

C. Enforcement Actions

During the period of your (or your relative's) affiliation, were any of the facilities subject to an enforcement or administrative action taken by the State regulatory agency due to the facility's violation of applicable laws and regulations?

☐ Yes ☐ No If Yes, please provide the following information:

Nature of Violation (If response is over 200 words, please provide a separate attachment, and number accordingly):

Agency or Body Enforcing Violation (Name & Address) (If response is over 200 words, please provide a separate attachment, and number accordingly):

Has the enforcement or administrative action been resolved?

☐ Yes ☐ No If No, please provide an explanation:

Explanation (If response is over 200 words, please provide a separate attachment, and number accordingly):

D. Affirmative Statement of Qualifications

For individuals who have not previously served as a director/officer nor have had managerial experience with a health facility/agency, please provide in the space below an affirmative statement explaining why you are qualified to operate the proposed Fiscal Intermediary. This statement should include, but not be limited to, any relevant community/volunteer background and experience.

Affirmative Statement (If response is over 200 words, please provide a separate attachment, and number accordingly):

5. Record of Legal Actions

1. Except for minor traffic violations, have you ever been convicted of, or had a sentence imposed for a crime?
   ☐Yes ☐ No
2. Are there any criminal actions pending against you?
   ☐Yes ☐ No
3. Have you ever been named as a defendant in any civil action, including but not limited to malpractice, fraud or breach of fiduciary responsibility?
   ☐Yes ☐ No
4. Are there now or have there ever been any civil or administrative actions pending against you involving Medicaid or Medicare issues?
   ☐Yes ☐No
5. Are there now or have there ever been any civil or administrative actions pending against you or any professional/business entity with which you are affiliated?
   ☐Yes ☐ No
6. Are there now or have there ever been any insurance arbitration awards against you or any professional/business entity with which you are affiliated?
   ☐Yes ☐ No
7. Have you ever been involved in a hearing before an official body in relation to the operation of a home or institution caring for people?
   ☐Yes ☐ No

If the answer to any of the above questions is "Yes," complete the section below. Attach additional sheets if necessary.

Attachment #:_______

Date of Action: ____________________ Type of Action: ____________________________

Location of Action: ____

Persons and/or Facilities Involved: ____

Give Any Further Details (If reponse is over 200 words, please provide a separate attachment, and number accordingly):

5. Record of Legal Actions (continued)

8. Have you ever changed your name (including a maiden name) or used an alias?
☐ Yes ☐ No

If Yes, Please Give Any Further Details (If response is over 200 words, please provide a separate attachment, and number accordingly):

9. During the last ten years, have you been refused a professional, occupational or vocational license by any public or governmental licensing agency or regulatory authority, or has such a license held by you during such period been suspended, revoked or otherwise subjected to administrative action?
☐ Yes ☐ No

10. Have you ever been involved in an action or proceeding brought by any public or governmental licensing agency or regulatory authority for violation of any securities, insurance, workers compensation, taxes, labor law or regulation or health law or regulation?
☐ Yes ☐ No

11. Have you ever been an officer, trustee, management employee or controlling stockholder of a company, including the applicant company, where you occupied any such position or served in any such capacity wherein the company:

- (a) became insolvent, declared or was forced to declare bankruptcy or was placed in receivership or conservatorship?
  ☐ Yes ☐ No
- (b) was enjoined from or ordered to cease and desist from violating any securities, insurance or health law or regulation?
  ☐ Yes ☐ No
- (c) was the subject of an investigation by either federal or state law enforcement agencies on issues related to Medicare or Medicaid fraud?
  ☐ Yes ☐ No
- (d) was required to enter into a Corporate Integrity Agreement as part of a settlement with the Office of Inspector General of the U.S. Department of Health and Human Services?
  ☐ Yes ☐ No
- (e) suffered the suspension or revocation of its certificate of authority or license to do business in any state?
  ☐ Yes ☐ No
- (f) was denied a certificate of authority or license to do business in any state?
  ☐ Yes ☐ No

If the answer to Questions 9, 10, or 11 is Yes, attach an explanation, including, where applicable, the date, type, and location of the action, and all relevant details.

Attachment #: ______________

12.Have you ever been in a position that required a fidelity bond?

☐ Yes ☐ No

If yes, were any claims made against that bond?

☐ Yes ☐ No

If Yes, Please Give Any Further Details (If response is over 200 words, please provide a separate attachment, and number accordingly):

13. Have you ever been denied a fidelity bond or had such fidelity canceled or revoked?

☐ Yes ☐ No

If Yes, Please Give Any Further Details (If response is over 200 words, please provide a separate attachment, and number accordingly):

This form must be signed and notarized to be valid.

Has the original of this document been signed and notarized?
☐Yes ☐No

Print or Type Name:____

Title:____

Applicant Signature:	Date:

Acknowledgement to Be Completed by a Notary Public

State of:___________________________ County of: ___________________________________

On the __________ day of _____________________ in the year ____________ before me, the undersigned, personally appeared ___________________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Notary Public Stamp

____

NOTARY PUBLIC (Please sign and affix stamp)