Assessment for Facility and Non-Credentialed Providers

Facilities and non-credentialed providers are reassessed every three years. All facilities and non-credentialed providers must complete this assessment application. Each section of this form must be filled out to be considered complete. If a section does not apply, please indicate with N/A. Once you attach additional documentation with this signed and dated attestation form, your attestation can begin. Failure to submit a completed application and all necessary documents will result in a delay in the assessment process.

Documentation Checklist:

- ☐ Copy of current and valid facility/group license
- ☐ Copy of current and valid certificate of insurance for both general and professional liability displaying occurrence and aggregate limits, policy numbers, and expirations
- ☐ Current copy of the facility's/group's certificate of insurance
- ☐ Roster of all providers
- ☐ The completed Assessment and Reassessment Form

Attached, please find additional details on the required items for documentation. If you have any questions, please email credentialing@healthoptions.org or call (207) 402-3323.

COMMUNITY Health Options™

Please complete each section leaving no blank spaces. Clearly state if information requested is not applicable. Attach additional documents as needed.

TYPE OF FACILITY OR GROUP (AS LISTED ON LICENSE OR ACCREDITATION)

- ☐ Ambulatory surgical center
- ☐ Home health agency
- ☐ Hospital
- ☐ Skilled nursing facility
- ☐ Dialysis
- ☐ DME
- ☐ Hospice
- ☐ Lab
- ☐ PT/OT/SLP/AUD/OD/DT
- ☐ Imaging
- ☐ Other: ___________________________

FACILITY OR GROUP INFORMATION

Legal business name (as reported to IRS): ____

Federal tax identification number (TIN): _________

Facility/group NPI number: ____________________

Facility/Group name (to be listed in our directory): ____

Street Address:________________________________ City: ________________________ State: ____ Zip Code: _____________

ASSESSMENT CONTACT

Assessment contact name: ____

Assessment contact email address: ____

Phone number: ____

STATE LICENSURE

Attach a copy of license. (If you are licensed in multiple locations, attach copies of each location's license)

License number:__________________ Initial issue date: _________________ Expiration date:__________________

License number:__________________ Initial issue date: _________________ Expiration date:__________________

License number:__________________ Initial issue date: _________________ Expiration date:__________________

COMMUNITY Health Options™

ACCREDITATION INFORMATION

Please complete this section and **attach** copies of current accreditation certificates or letters. Your certificates and/or letters should list this facility/group location as being included in the accreditation.

- ☐ The Joint Commission (TJC)
- ☐ Center for Medicare and Medicaid Services Survey (CMS)
- ☐ Ambulatory Healthcare Accreditation (AAAHC)
- ☐ Community Health Accreditation Partner (CHAP)
- ☐ Home Health & Hospice Accreditation (ACHC)
- ☐ Clinical Laboratory Improvement Amendments (CLIA)
- ☐ National Committee for Quality Assurance (NCQA)
- ☐ Intersocietal Accreditation Commission (IAC)
- ☐ American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
- ☐ Healthcare Facilities Accreditation Program (HF AP)
- ☐ American College of Radiology Accreditation (ACR)
- ☐ Commission on Accreditation of Rehabilitation Facilities (CARP)
- ☐ College of American Pathologists Accreditation (CAP)
- ☐ Durable Medical Equipment, Prosthetics, Orthotics and Supplies Accreditation I(DMEPOS)
- ☐ The American Association of Birth Centers (AABC)
- ☐ Other

Date of last accreditation/certification: ________________________________

Expiration date of accreditation/certification: ___________________________

LIABILITY INSURANCE INFORMATION

Complete this section and **attach** a copy of the facility's/group's insurance certificate(s):

Name of carrier:____

Carrier address, city, state, zip: ____

Carrier telephone number: ____

Policy number:___________________________ Policy expiration date: ____________________

Amount of liability coverage (occurrence/ aggregate): __________________

PRACTIONERS

Does the facility/group validate, for each licensed practitioner employed or contracted at the facility/group, the credentials necessary to perform health care services?

If yes, indicate how the facility/group conducts the credentialing process for each practitioner. Health Options reserves the right to request copies of practitioner's licensure, certification, and malpractice insurance certificate): _____________

____

If no, please explain:____

____

COMMUNITY
Health Options™

ATTESTATION

Please answer the following questions by checking the appropriate boxes. If the answer to any question is yes, please provide a complete description of the facts on a separate attached sheet.

1. Has the facility/group license to do business ever been denied, restricted, suspended, reduced or been voluntarily given up by the facility/group? ☐ Yes ☐ No
2. Has this facility/group ever had or currently have pending any legal actions against it excluding medical malpractice? ☐ Yes ☐ No
3. Has this facility/group ever had its accreditation revoked or suspended? ☐ Yes ☐ No
4. Were any deficiencies cited during the last survey? ☐ Yes ☐ No
5. If yes, have all the deficiencies been corrected? ☐ Yes ☐ No

   If yes, provide and **attach** copy of Corrective Action Plan (CAP)

   If no, provide explanation and your plan to correct all deficiencies.

6. Has this facility's/group's liability insurance ever, for any reason, been denied, cancelled, non-renewed, or reduced? ☐ Yes ☐ No

Explanation, including dates and outcomes, for questions answered "Yes."

FACILITY AND NON-CREDENTIALED PROVIDERS ATTESTATION/CONSENT & RELEASE FORM

By signing below, I attest that I am the duly authorized representative of the facility, and/or group, that all information on the application pertains to the above named facility, and/or group, and that such information is current, complete and correct.

Facility/group name: ____

Printed name of authorized representative: ______________________________

Title of authorized representative: ____________________________________

Signature of authorized representative: _________________________________

Date signed: ____________________

Please email completed form to dataintegrity@healthoptions.org and credentialing@healthoptions.org.