MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT & COMPLIANCE

MO HEALTHNET PROVIDER ENROLLMENT APPLICATION – PERSONAL CARE

THIS FORM IS MANDATORY FOR ALL PROVIDERS; READ AND ANSWER ALL QUESTIONS CAREFULLY.

Failure to provide this information is grounds for denial of this application and/or termination of provider participation. A SEPARATE form MUST be completed for each provider identifier. EACH form MUST contain an ORIGINAL SIGNATURE. Answer all questions. Attach an additional sheet to provide complete information for any question. Enrollment inquires may be directed to the MMAC Contracts Unit via e-mail at MMAC.IHSContracts@dss.mo.gov.

Provider's Legal Business Name as listed with IRS and SOS	Doing Business as (DBA) Name - (if applicable)
Provider's Physical Address	Provider's E-mail Address

Contact Person's Name:	Business Phone Number	Business Fax Number

All applying providers must submit a separate Business Organizational Structure form to comply with federal and state Medicaid regulations requiring disclosure of all individuals and/or business organizations that have direct or indirect ownership, management and/or control interests. Those federal and state Medicaid regulations are attached to this application.

In addition to submitting the Business Organizational Structure form, providers may utilize separate attachments (i.e. organizational chart, spreadsheet, etc.) to identify individuals and businesses with ownership or control interests and all "managing employees" as defined in 13 CSR 65-2.010(25). Those attachments must contain the full name (First, middle, last and suffix Jr., Sr., etc.), date of birth, and social security number of each individual who has 5% or greater direct/indirect ownership, controlling interest, partnership interest; any contractor or subcontractor; managing employees; officers or directors; or the legal business name and federal EIN of any organization(s) having direct or indirect ownership or controlling interest.

1. Is this application being made as a result of one or more of the following changes? Yes ☐ No ☐

If yes, check all that apply and complete required section below:

Ownership Change ☐ Merger ☐ Asset Change ☐ New clinic formed at same location ☐
Corporate Structure Change ☐ Replacement Facility ☐ Other ☐
If other, explain the change(s):

Former owner's name(s), provider identifier(s), and facility name(s):

New owner's name and address, facility names(s):

EFFECTIVE DATE OF CHANGE:

Future Record Retention Information: Records must be stored for 5 years after the effective date above
Location where the records will be stored:

Future contact person name:

Future contact person E-mail:

Future contact person Phone number:

A new MO HealthNet provider record is not created for changes; the preceding record is updated. Receiving new identifiers from other agencies/sources does not constitute creating a new MO HealthNet provider record. Payments go to the provider currently indicated on the Provider Enrollment Master File at the time the claim is processed. The provider is responsible for resubmitting any denials or crossover claims for any Medicaid/MO HealthNet services that do not crossover electronically, before and after the change is made to the Provider Enrollment Master File. If a new provider record is created in error due to provider information being withheld at the time of the application, the new record will be made inactive, the preceding record will be updated, and the provider may be subject to sanctions.

2. For services provided under this application, in which settings will you see patients? Explain if other is chosen.
Office ☐ Hospital ☐ Nursing Home ☐ School ☐ Patient's Home ☐ Other ☐ Please explain

NUMBERS 3 THROUGH 12 – IF YOU ARE AN AUTHORIZED REPRESNTATIVE COMPLETING THIS APPLICATION FOR A HEALTH CARE ORGANIZATION, YOU SHOULD ANSWE EACH QUESTION ON BEHALF OF ALL INDIVIDUALS WHO HAVE BEEN IDENTIFIED AS HAVING OWNERSHIP OR CONTROLLING INTEREST, AND THOSE IDENTIFIED AS MANAGING EMPLOYEES. IF ANSWER IS YES TO ANY OF THESE QUESTIONS, AN EXPLANATION, DATE, STATE, CITY AND COUNTY, MUST BE COMPLETED. INCLUDE ADDITIONAL SHEETS AND/OR ATTACHMENTS IF NECESSARY.

3. Has the applying provider, any managing employee, or any person having an ownership or control interest; ever been personally terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by Medicare, Medicaid, MO HealthNet, or ANY state or federal programs in ANY state? Yes ☐ No ☐
Incidents where notice of program deficiency resulted in voluntary withdrawal must be included.

4. Has the applying provider, any managing employee, or any person having an ownership or control interest for the applying provider; ever had an ownership, indirect ownership, controlling interest, or been administrator of a facility or agency that has been terminated, denied enrollment, suspended, restricted by agreement, other otherwise sanctioned by Medicare, Medicaid, MO HealthNet or ANY state or federal programs in ANY state? Yes ☐ No ☐
Incidents where notice of program deficiency resulted in voluntary withdrawal must be included.

5. Has license of the applying provider, any managing employee, or any person having an ownership or control interest; ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by ANY licensing authority in ANY state? Yes ☐ No ☐

6. Is there any proceeding currently pending to revoke, suspend, censure or restrict by probation or agreement, the license of the applying provider, any managing employee, or any person having an ownership or control interest in Missouri or in ANY state? Yes ☐ No ☐

7. Does the applying provider, any managing employee, or any person having an ownership or control interest; have any outstanding criminal fines, restitution orders, or overpayments in Missouri or ANY other state? Yes ☐ No ☐

8. Has the applying provider, any managing employee, or any person having an ownership or control interest ever been convicted of a crime, excluding minor traffic citations? Yes ☐ No ☐
If yes, list conviction(s), when, and where:

9. Are there any criminal proceedings, restitution orders, or overpayments currently pending for the applying provider, any managing employee, or any person having an ownership or control interest; or any individual involved with the applying provider's practice, clinic, group, corporation or any other association? Yes ☐ No ☐
If yes, list pending changes and location:

10. Is the applying provider, any managing employee, or any person having an ownership or control interest; related, including but not limited to, a spouse, parent, child, sibling, etc., to any owner, officer, agent, managing employee, director or shareholder that has been convicted of a crime pertaining to health care services? Yes ☐ No ☐
If yes, list conviction, date and location:

11. Does the applying provider have any pending enrollment applications with any other state or federal program, other than this application? Yes ☐ No ☐ If yes, list state and program:

12. Does the applying provider, any managing employee, or any person having an ownership or control interest; have any pending complaint investigations being reviewed by any professional boards?
Yes ☐ No ☐ If yes, explain:

13. Does the applying provider, any managing employee, or any person having an ownership or control interest; or any individual involved with the applying provider's practice, clinic, group, corporation or any other association, have any outstanding overpayments to Medicare, Medicaid, or any other federal/state health care programs?
Yes ☐ No ☐ If yes, explain:

☐ By checking this block, I certify that I have reviewed the federal and state disclosure regulations for all applying Medicaid providers which are attached to this enrollment application. I also certify that all individuals and/or business organizations with direct or indirect ownership, management and/or control interests have been fully disclosed.

To the best of my knowledge, the information supplied on this application is accurate, complete and is hereby released to the Missouri Department of Social Services. I also understand that pursuant to 13 CSR 65-2, I must advise the Department, in writing, of any changes affecting the provider's enrollment record.

Signature of Authorized Personnel:	**Date signed:**
Name of Authorized Personnel:	**Title:**

Submit this enrollment application and all attachments to:
Missouri Medicaid Audit & Compliance
Attn: PEU Contracts Unit
3418 Knipp Drive, Suite F, Jefferson City, MO 65109

Questions regarding this enrollment packet should be submitted to MMAC.IHSContracts@dss.mo.gov