STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Partnership for Children Program
Intensive in Community Rehab Centers
Behavior Assistance Application Packet

Application package consists of:

1. Signature Authorization Form
2. Provider Application FD-20
3. Provider Agreement FD-62
4. Disclosure of Ownership and Control Interest Statement (HCFA-1513)

Signature Authorization Form

Dear Provider:

Please furnish below the full names of those individuals you have authorized to sign and certify Medicaid claims and supporting documents. **If the authorized individual is the Medicaid Provider, he/she must sign the Authorization Form**. In addition to the above, this form should only be completed by an authorized representative(s) who is an employee of your office. Should your office utilize a billing firm or agency, a letter signed by yourself must be submitted indicating the name(s) of those individuals you have authorized to sign. The name(s) should be typed and then the actual signature affixed by that individual. The letter should contain the name of the billing firm or agency which has been approved to provide your billing.

Date:_____

Provider Name _____

Provider Address _____

_____

_____

Provider Number _____

PLEASE PRINT OR TYPE:

Full Name	Actual Signature(s)

For Unisys Internal Use Only

Provider Name: _____

Doc Type: _____ Provider Type: _____ Provider Specialty: _____

Tax ID: _____ Social Security: _____

Provider Number: _____

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
Division of Medical Assistance and Health Services

PROVIDER APPLICATION

1. Legal Name of Provider — 2. Provider Type

2A. Type of Business or Facility ☐ Sole Proprietor ☐ Corporation ☐ Partnership ☐ Other (Specify)

3. Business Name, if Different from Above — 4. Employer/Tax ID Number/Social Security Number

5. Telephone Number/Extension — 6. Length of time at Practice address in New Jersey

7. Name of Administrator, Chief Executive Officer, Other Responsible Official

8. **Practice Address** (Do not use P.O. Box)

9. Street

10. City — 11. State — 12. County — 13. Zip

14. **Pay To Address** (for Checks/Remittance Advice)

15. Street

16. City — 17. State — 18. Zip

19. **Mail To Address** (for Newsletters/Correspondence)

20. Street

21. City — 22. State — 23. Zip

24. E-mail Address — 25. Fax #

26. Indicate NJ Charity Care Provider ____Yes _____No (Questions 26-26H are for NJ acute care hospitals only)

26A. **Charity Care Pay To Address** (Remittance Advice)

26B. Street

26C. City — 26D. State — 26E. Zip

26F. Charity Care Telephone Number/Extension — 26G. Charity Care Fax #

26H. Charity Care E-mail Address

27. Indicate legal status of your organization: Profit _____ Non-Profit_____ Private_____ Public_____
If other, please specify_____

28. List the specific service(s) for which you are requesting approval for reimbursement under the programs administered in whole or in part by the Division of Medical Assistance and Health Services. **Behavioral Assistance Provider or Intensive In-Community Provider, or both, please indicate.**

29. Do you operate from more than one location? _____Yes _____No. If yes, list name, service address and Medicaid Provider Number, if applicable.

1. _____

2. _____

3. _____

Please attach additional sheet if necessary.

29A. Please indicate if you are a member of a chain organization. ____Yes ____ No. If yes, indicate name_____

30. Do you require a Certificate of Need under the Health Facilities Planning Act from the New Jersey Department of Health and Senior Services? _____Yes _____ No. If yes, attach a copy of the Certificate of Need. If no, explain why you do not require a certificate.

31. If your business or facility requires a current license/permit, indicate type _____ and number _____
Please attach a copy of the current license/permit, e.g., Independent Laboratory Certification.

32. CERTIFICATION, ACCREDITATION OR APPROVAL: Specify type and attach copy, for example, JCAHO (hospitals); New Jersey Department of Health and Senior Services (clinics); Division of Mental Health Services (mental health clinics); State Board of Dentistry (dental clinics); State Board of Pharmacy (providers offering pharmaceutical services); American Board for Certification in Prosthetics and Orthotics (Prosthetist and/or Orthotist). See Item 33.

33. Approved by Medicare? _____Yes _____No. If yes, please indicate Medicare provider number _____ and attach copy of your Medicare approval.

34. If Out-of-State Provider: Are you approved by Medicaid in your State? _____ Yes _____ No. If yes, please indicate Medicaid Provider Number_____.

35. List the names, SSA Number, License/Permit Number and Degree(s) for all professional staff in the organization. Include physicians, dentists, psychologists, pharmacists, registered nurses, licensed practical nurses, registered physical therapists, optometrists, etc. If more space is needed, attach additional sheets. (NOTE: Not required for health care providers certified for Medicaid and/or Medicare participation by the State Department of Health and Senior Services and/or The Centers for Medicare and Medicaid Services (CMS)

Name	SSA Number	License/Permit Number	Degree, e.g., MD, DO, DDS, RPT, PhD, OD, RN, LPN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

36. Have any of the entities named in response to question 1, 3, or 29, or their officers, directors, shareholders, partners, or employees, or any of the individuals named in response to questions 7 or 35:

a. Ever been an approved provider of services under the New Jersey Medicaid Program or the Medicaid Program of any other state or jurisdiction, or any other programs administered in whole or in part by DMAHS? ____ Yes ____ No. If Yes, list type of services provided and current status. If you were approved at one time and you no longer participate, explain the reason(s).

b. Ever been the subject of any license suspension, revocation, fine, reprimand, probation or other adverse licensure action in this State or any other jurisdiction? ____ Yes ____ No. If yes, please explain.

c. Ever been indicted, charged, convicted of, or pled guilty or no contest to any federal or state crime or disorderly persons offense in this State or any other jurisdiction? ____ Yes ____ No. If yes, please explain.

d. Ever been the subject of any suspension, debarment, disqualification or recovery action involving Medicaid (Title XIX), Medicare (Title XVIII), any other federally or state-funded health care program, any private or non-profit health insurance plan or program in this state or any other jurisdiction, or any other programs administered in whole or in part by DMAHS? ____ Yes ____ No. If yes, please explain, and indicate current status of action.

e. Ever owned or had any financial interest in any other provider participating in the New Jersey Medicaid (Title XIX) Program of any other State or jurisdiction? ____ Yes ____ No. If Yes, please list provider name and nature of relationship.

37. Do you charge for goods and/or services? TO ALL _____ or TO CERTAIN GROUPS ONLY _____.
If you charge to all or only certain groups, please explain your arrangement.
(Attach a copy of your fee schedule)

38. List days and hours of operation.

39. For the purpose of establishing eligibility to receive direct payment for services to beneficiaries under the New Jersey Medicaid (Title XIX) Program or any other program administered in whole or in part by DMAHS, I certify that the information furnished on this application is true, accurate, and complete. I am aware that if any of the statements made by me in this application are willfully false, I am subject to punishment, including but not limited to suspension, debarment or disqualification from the New Jersey Medicaid Program and the other programs administered in whole or in part by DMAHS in accordance with N.J.A.C. 10:49-11.1(d)22. I agree to notify the Fiscal Agent Provider Enrollment Unit of all future additions or changes to any of the responses to question 35-38.

40. There are federal and state statutes and regulations governing kickbacks and referral practices which may apply to the applicant and to those individuals and entities listed in this application. These statutes and regulations include, but are not limited to: The Federal Medicare and Medicaid Anti-Kickback Statute (42 USC 1320a-7b(b)); the Federal Safe Harbor Regulations (42 CFR 1001.952); the Stark Laws (42 USC 1395nn, 42 USC 1396b(s) and implementing regulations); the State Medicaid Anti-Kickback Statute (NJSA 30:4D-17(c)); and the Codey Law (NJSA 45:9-22.4 et. seq.) and its implementing regulations (NJAC 13:35-6.17)). Applicants should carefully review and understand these legal requirements and prohibitions, because signing this Agreement is a representation that there is full compliance with all of these statutes and regulations.

Signature of Provider Representative | Print Name and Title | Date

FOR DIVISION AND OR FISCAL AGENT USE ONLY

[ ] Approve [ ] Disapprove [ ] Other Initial_____ Date_____

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

[NEW JERSEY HEALTH SERVICES PROGRAM
TITLE XIX (MEDICAID)]

PROVIDER AGREEMENT
BETWEEN
NEW JERSEY DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
AND

_____
PROVIDER NAME

PROVIDER AGREES:

1. To comply with all applicable State and Federal Medicaid laws, and policies, rules and regulations promulgated pursuant thereto;

2. To keep such records as are necessary to fully disclose the extent of services provided to individuals receiving assistance under the [Medicaid] programs administered in whole or in part by the Division of Medicaid Assistance and Health Services (DMAHS), and to provide any authorized DMAHS employee or agent with copies of requested records free of all copy fees and related duplication charges;

3. To furnish DMAHS, the Secretary of the U.S. Department of Health and Human Services and the Medicaid Fraud Section of the Division of Criminal Justice with such information as may be requested from time to time, regarding any payments claimed for providing services under the programs administered in whole or in part by DMAHS;

4. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 2428 which makes it a crime and sets the punishment for persons who have been found guilty of making any false statement or representation of a material fact in order to receive any benefit or payment under the Medical Assistance Program. (The Department of Human Services is required by Federal regulation to make this law known and to warn against false statements in an application/ agreement or in a fact used in determining the right to a benefit, or converting a benefit to the use of any person other than one for whom it was intended).

5. To comply with the disclosure requirements specified in 42 CFR 455.100 through 42 CFR 455.106.

6. To accept Title XIX payments as payment in full, and not institute collection activities, including but not limited to, billing, balance billing and litigation, against Title XIX beneficiaries for the payment of claims that have been denied in whole or in part by DMAHS or its fiscal agent, except as permitted by NJSA 30:4D-6.c.

The provider or DMAHS may, on 60 days written notice to the Division, terminate this Agreement.

_____ _____
DATE SIGNATURE OF PROVIDER OR REPRESENTATIVE

_____
PRINT NAME AND TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB No 0938-0086

INSTRUCTIONS FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT (HCFA-1513)

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete Part II(a) and (b) of this form. Only those Title XX providers rendering medical, remedial, or health related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III.

General Instructions

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V	- 42CFR 51a.144
Title XVIII	- 42CFR 420.200-206
Title XIX	- 42CFR 455.100-106
Title XX	- 45CFR 228.72-73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original and second and third copies to the State agency; retain the first copy for your files.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

Item I (a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade of corporation.
(b) **For Regional Office Use Only.** If the yes box is checked for Item VII the Regional Office will enter the 5-digit number assigned by HCFA to chain organizations.

Item II - Self-explanatory.

Item III - List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership interest in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity: the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity: the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV-VII - Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV-VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV - (a & b)If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V- If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI - If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII - A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable, or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII - If yes, list the actual number of beds in the facility now and the previous number.

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0086

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

(a). Name and Entity	D/B/A	Provider No.	Vendor No.	Telephone No.
Street Address		City, County, State		Zip Code

(b) *(To be completed by HCFA Regional Office)* Chain Affiliate No. ☐☐☐☐☐ LB1

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

Yes ☐ No ☐ LB2

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

Yes ☐ No ☐ LB3

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

Yes ☐ No ☐ LB4

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN
		LB5

(b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation LB6
☐ Unincorporated Associations ☐ Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

☐ Yes ☐ No LB7

Name	Address	Provider Number

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0086

IV. (a) Has there been a change in ownership or control within the last year?
If yes, give date _____

☐ Yes ☐ No LB8

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? _____

☐ Yes ☐ No LB9

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? _____

☐ Yes ☐ No LB10

V. Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations _____

☐ Yes ☐ No LB11

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year?

☐ Yes ☐ No LB12

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)
Name EIN #

☐ Yes ☐ No LB13

Address

LB14

VII. (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain?
(If YES, list Name, Address of Corporation and EIN)
Name EIN #

☐ Yes ☐ No LB18

Address

LB19

VIII. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?

☐ Yes ☐ No LB15

If yes, give year of change _____
Current beds _____ LB16 Prior beds _____ LB17

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed)	Title

Signature	Date

Remarks