1991 Marcus Avenue, Suite M107, Lake Success, NY 11042
agewellnewyork.com | Toll Free **1.866.237.3210** | TTY/TDD **1.800.662.1220**

Dear Provider/Facility:

Thank you for your interest in becoming a network provider/facility for AgeWell New York, LLC. In accordance with our commitment to the quality of health care services delivered to our members, we have a well-defined and structured credentialing process in place that you will need to undergo before we may confirm you as a participating provider/facility.

Please see below the following criteria we require and information to become part of our network. Please complete and submit the information requested in this form within ten (10) business days, and return it to us by mail to the following address:

AgeWell New York
Provider Relations
1991 Marcus Avenue
Suite M107
Lake Success, NY 11042

In addition to the information contained in the application, please be sure to include a copy of supporting documents:

- **Completed Application**
- **Attestation Signed and Dated**
- **Copy of License (DOH operating Certificate)**
- **W9 Form**
- **Tax ID Number/NPI Number**
- **Copy of CLIA (If applicable)- All contracted laboratory testing sites are required to maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification**
- **Professional & General Malpractice Insurance Certificate (Please indicate AgeWell New York as the certificate holder).**
- **Workers Compensation: (Attach Coverage Certificate – indicating AgeWell New York as a Certificate Holder)**
- **Evidence of JCAHO or other accreditation**
- **If the facility is not accredited by JCAHO or other accreditation agency, please send a recent State Survey (i.e.; DOH, CMS) along with a statement of deficiency and a plan of correction**
- **The American with Disabilities Ace Attestation signed and dated.**

Thank you again for applying to become a participating provider/facility for AgeWell New York, LLC.

GENERAL INFORMATION:

Facility/ Provider Type: ______________________________

Facility / Organization Name: ______________________________

Service Location Address: ______________________________

Primary Contact Person: ______________________________

Primary Contact Person Email: ______________________________

Primary Telephone #: ______________________________

Primary Fax #: ______________________________

Geographic Areas Served:

Bronx ___ Manhattan___ Queens___ Brooklyn___
Suffolk___ Nassau ____ Westchester___

Hours of Operation:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

NPI #:______________________ Tax Identification Number: ________________
(Attach copy of W-9)

On a bus route: __Y __N Name of bus route(s), if applicable: _________________

Is the location accessible to the disabled? Internally: Yes __ No __ Externally: Yes __ No __

CERTIFICATION, LICENSURE AND ACCREDITATION:

Medicare Certification/Participant Yes No N/A Medicare Provider Number: ______________________________

Medicaid Certification/Participant Yes No N/A Medicaid Provider Number: ______________________________

NYS Article 28? Yes No N/A

New York State License Number: _____________ PFI#______ Exp Date_________
(Attach copy of Certificate)

JCAHO or other accreditation? Yes No N/A (Include copy of certificate)

Institutional (Non-Individual) Providers Only

1. In the past ten (10) years, has your institution ever been indicted for criminal activity?
   __Y **__N** (If "Yes", please attach a separate sheet with a full explanation.)

2. In the past ten (10) years, has your institution ever been subject to any investigation of your business practices (e.g., Attorney General, OMIG**?)** **__Y** **__N**

   (If "Yes", please attach a separate sheet with a full explanation. Routine normal-course-of-business audits need not be disclosed unless resulting in a payback/recoupment to Medicare, Medicaid or other payors in excess of $500,000 with respect to any single audit.)

3. In the past ten (10) years, has your institution lost, or had suspended, any accreditation, certification, permit, approval or license relating to your operations, or been placed on probation or sanctioned in any way**?** **__Y** **__N**

   (If "Yes", please attach a separate sheet with a full explanation.)

4. In the past ten (10) years, has your institution been denied membership or renewal of membership at any health plan, or is such action pending? **Yes ___ No ___**

   (If "Yes", please attach a separate sheet with a full explanation).

5. Do you subcontract for medical services with other organizations or individuals**?**
   ___Yes __No

   If yes, please provide their names and addresses and describe your relationship(s):

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Do you have a quality improvement process in place? **____Yes** **___No**
If yes, please attach a brief summary as an attachment.

Do you have a process in place to measure and collect patient satisfaction? **__Yes** **___No**
If yes, please describe your most recent patient satisfaction measure and instrument used.

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CONTACT INFORMATION:

Owner/Principal ______________________________

Title: ____________________ Phone: ____________________

Email: ____________________ Fax: ____________________

Administration: ______________________________

Title: ____________________ Phone: ____________________

Email: ____________________ Fax: ____________________

Services/Intake: ______________________________

Title: ____________________ Phone: ____________________

Email: ____________________ Fax: ____________________

Finance/Billing: ______________________________

Title: ____________________ Phone: ____________________

Email: ____________________ Fax: ____________________

EDI AND INTERNET:
Electronic Claims Submission ___Y ___N
Does this business have internet access? __Y __N
If no to either, please explain: ______________________________

Skilled Nursing Facilities and Home Health Care Agencies: If you respond “No” to the above question regarding an Advance Directives Policy, please include a copy of the specific section of your institutional policy/process which addresses Advance Directives.

PROFESSIONAL LIABILITY INSURANCE COVERAGE
Do you have Professional Liability (Malpractice) Insurance coverage in force? ____ Yes ____No

Liability Insurance (Attach Coverage Certificate)
Insurance Carrier: ______________________________
Limits of Liability: ________________ Policy Period: ____________

GENERAL LIABILITY INSURANCE COVERAGE
Do you have General Liability insurance coverage in force? ____Yes ____No

Liability Insurance (Attach Coverage Certificate)
Insurance Carrier: ______________________________________
Limits of Liability: _______________Policy Period: _______________

In the past ten (10) years, have you ever had any Professional Liability coverage canceled, declined or modified, has any renewal ever been refused, or have you voluntarily given up coverage?
__Y ___N (If "Yes", please attach a separate sheet with a full explanation.)

WORKERS COMPENSATION: ______________________________________
Workers Compensation (Attach Coverage Certificate)

LANGUAGES:
Languages spoken by Staff:
___ Chinese ___ Russian ___ Spanish ___ Korean

___ Italian ___ French Creole

Other: Please list all that apply:______________________________________

SERVICES:
Please check the applicable services below that describe your service type and circle applicable accreditation or certification. If applicable, please provide copy of certificate.

__ Acute Inpatient Hospital
__ Skilled Nursing Facility
__ Home Care Agency
__ DME
__ Comprehensive Outpatient Rehabilitation Facility
__ Outpatient Physical Therapy
__ Outpatient Speech Pathology
__ Outpatient Occupational Therapy
__ Assisted Living Program
__ Adult Day Health
__ Lung Transplant Program
__ Cardiac Surgery Program
__ Critical Care Services
__ Outpatient Dialysis
__ Surgical Services (Outpatient or ASC)
__ Diagnostic Radiology
__ Heart/Lung Transplant
__ Kidney Transplant Program
__ Cardiac Catheterization Program
__ Home Health Aides
__ Home Health Nursing
__ Acute Inpatient Hospital
__ Home Maintenance Services
__ Medical Social Services
__ Nutrition Services
__ Personal Care
__ Personal Emergency Response Services
__ Respite Care
__ Social Day Care
__ Mammography
__ Inpatient Psychiatric Facility Services
__ Orthotics and Prosthetics
__ Outpatient Infusion/Chemotherapy
__ Heart Transplant Program
__ Liver Transplant Program
__ Pancreas Transplant Program
__ Other: ___________________________

MISCELLANEOUS:

Is there anything else you would like us to know about your organization? Are there any special services that your organization provides that you would like us to know about?

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Declaration

I understand that AgeWell New York, LLC is responsible for the evaluation of our professional competence and qualifications and has the obligation to inquire into license, accreditation and professional conduct. I consent to communication of information and documents between AgeWell New York, LLC and our institution and understand that AgeWell New York, LLC may verify New York State License and Malpractice Coverage.

I hereby affirm that the information provided by our institution to AgeWell New York, LLC is accurate to the best of my knowledge and is furnished in good faith. I understand that willful and substantial omissions or misrepresentations may result in denial or suspension from providing services to AgeWell New York, LLC members.

I present this information and arrange for the submission of other information as part of the credentialing process, in the expectation that this information will be kept confidential and will be released or disclosed only as part of current and future credentialing, peer review and quality assessment process.

I hereby affirm that our institution has a quality management plan and agrees to cooperate with the quality management activities of AgeWell New York, LLC, including giving AgeWell New York, LLC access to medical records to the extent permitted by New York State law. If required, our agency will provide an employee profile showing evidence of employee certification, orientation completion, required inservice, physical examination, and criminal verification check.

I hereby formally apply for our institution to be a member of the AgeWell New York, LLC Facility Provider Network and agree to abide by the AgeWell New York, LLC policies, guidelines and quality assurance and performance improvement plan.

Signature: ____ **Date:** _________________

Name (Print or Type) ____

Title: ____