

**Entire application must be completed. If entire application is not completed, it will be returned to sender as incomplete. If a question does not apply, please use N/A.**

General information			
Corporate name (as assigned on IRS Form W-9)			
Doing business as (if applicable)			
Practice/facility name to appear in directory			
Primary street address			
City	County	State	ZIP+4 code
Phone number		Fax number	
Credentialing contact name		Email address	
Credentialing street address (if different from primary address)			
City	County	State	ZIP+4 code
Phone number		Fax number	
National Provider Identifier (NPI) (if applicable)			
Business type <input type="checkbox"/> For-profit <input type="checkbox"/> Not-for-profit <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Estate/trust <input type="checkbox"/> Partnership <input type="checkbox"/> Government-owned <input type="checkbox"/> Public service corporation			
Primary taxonomy code		Secondary taxonomy code	
Payment/remittance information			
Check payable to:			
Taxpayer Identification Number (TIN)			
Street address			
City	State	ZIP+4 code	
Billing contact name			
Email address			
Phone number		Fax number	
<b>Document needed: Please provide a copy of the IRS W-9 form.</b>			
<b>Document needed:</b> Are Clinical Laboratory Improvement Amendments (CLIA) certificate and Pennsylvania Department of Health lab permit associated with this service location? If yes, please provide a copy of both with this application. <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Document needed:</b> Drug Enforcement Administration (DEA) number (include a legible copy of DEA certificate, if applicable)			
Individual practitioner name (if applicable)			
Individual practitioner gender (if applicable)			
Individual practitioner Social Security number (if applicable)			
Individual practitioner date of birth (if applicable)			
Title/degree as it appears on the license			
Handicap accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No			
1. Does the office have exterior or interior steps leading to the main entrance doorway? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check which type applies. <input type="checkbox"/> Interior <input type="checkbox"/> Exterior			
2. If yes to question 1, does the office have a permanent or portable wheelchair ramp? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check which type applies. <input type="checkbox"/> Permanent <input type="checkbox"/> Portable			
3. If yes to question 1, is there an alternate entrance that has no exterior or no interior steps or has a wheelchair ramp? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check which type applies. <input type="checkbox"/> No interior <input type="checkbox"/> No exterior <input type="checkbox"/> Permanent ramp <input type="checkbox"/> Portable ramp			

**General information (continued)**

In addition to English, do you or your staff communicate in any other language? If yes, list languages

**Office hours (use HH:MM format)**

Day	Start	AM/PM	End	AM/PM	Day	Start	AM/PM	End	AM/PM
Monday					Saturday				
Tuesday					Sunday				
Wednesday					<input type="checkbox"/> 24/7				
Thursday									
Friday									

**Licensure/certification/accreditation**

**Documents needed:** Please provide a copy of all licenses, accreditation, and certificates including city or state.

State license number (if applicable)	Issue date	Expiration date
Additional license number (if applicable)	Issue date	Expiration date
Title/degree as it appears on license		
Is the facility accredited? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accreditation name	
Effective date	Expiration date	
Is the practitioner/facility/contractor certified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Certification name	
Effective date	Expiration date	
Medicare number		
Is the practitioner/facility/contractor a participating Medicare provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		
PROMISe™ Provider Identification Number (PPID) or Medicaid number (9 digits + 4-digit extension) _____		
OR		
<b>Document needed:</b> Copy of PPID application (first page and signature pages only) <input type="checkbox"/> Application attached		

**Liability insurance**

**Document needed:** Please provide a copy of your current professional or general liability insurance.

Insurance carrier name	Policy number
Effective date	Expiration date
Dollar amount per occurrence	Dollar amount aggregate
Site visit requirements (if applicable)	

**Document needed:** Attach a copy of most recent onsite survey for each location (with Corrective Action Plan [CAP] if citations were issued) OR attach cover letter from government agency stating facility is in substantial compliance for each location.

Do you have a Home Health Agency license from the Pennsylvania Department of Health? <input type="checkbox"/> Yes <input type="checkbox"/> No
If enrolling as an individual <b>only</b> , do you have a license from the Department of State for an individual specialty? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please select the service(s). <input type="checkbox"/> Home health <input type="checkbox"/> Personal assistance services (PAS) <input type="checkbox"/> Therapy and counseling <input type="checkbox"/> Respite
Do you have an Adult Day Care license from the Pennsylvania Department of Human Services (DHS) or the Department of Aging? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please select the service(s). <input type="checkbox"/> Adult daily living
Does the agency specialize in services that assist consumers with obtaining new skills in order to be a part of their community? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please select the service(s). <input type="checkbox"/> Employment supports <input type="checkbox"/> Community integration



**Liability insurance**

Does the agency specialize in a vendor service?  Yes  No

If yes, please select the service(s).

- Assistive technology  
  Community transition services  
  Home adaptations  
  Home-delivered meals  
 Non-medical, non-emergency transportation  
  Personal Emergency Response System (PERS)  
 Specialized medical equipment and supplies  
  TeleCare services  
  Vehicle modifications

Has your agency achieved Commission on Accreditation of Rehabilitation Facilities (CARF) Brain Injury Home and Community Services accreditation?  Yes  No

**Provider type**

- Durable medical equipment (DME)  
  Home health  
  Hospice  
  Skilled nursing facility  
 HCBS facility (59)  
  County nursing home

Select the counties where your agency is willing to provide services for your **primary** location only.

- |   |                                     |                                     |                                     |                                     |   |                                       |
|---|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> All counties in Pennsylvania | <input type="checkbox"/> Butler     | <input type="checkbox"/> Clinton    | <input type="checkbox"/> Franklin   | <input type="checkbox"/> Lawrence   | <input type="checkbox"/> Montour        | <input type="checkbox"/> Somerset     |
| <input type="checkbox"/> Adams                        | <input type="checkbox"/> Cambria    | <input type="checkbox"/> Columbia   | <input type="checkbox"/> Fulton     | <input type="checkbox"/> Lebanon    | <input type="checkbox"/> Northampton    | <input type="checkbox"/> Sullivan     |
| <input type="checkbox"/> Allegheny                    | <input type="checkbox"/> Cameron    | <input type="checkbox"/> Crawford   | <input type="checkbox"/> Greene     | <input type="checkbox"/> Lehigh     | <input type="checkbox"/> Northumberland | <input type="checkbox"/> Susquehanna  |
| <input type="checkbox"/> Armstrong                    | <input type="checkbox"/> Carbon     | <input type="checkbox"/> Cumberland | <input type="checkbox"/> Huntingdon | <input type="checkbox"/> Luzerne    | <input type="checkbox"/> Perry          | <input type="checkbox"/> Tioga        |
| <input type="checkbox"/> Beaver                       | <input type="checkbox"/> Centre     | <input type="checkbox"/> Delaware   | <input type="checkbox"/> Indiana    | <input type="checkbox"/> Lycoming   | <input type="checkbox"/> Philadelphia   | <input type="checkbox"/> Union        |
| <input type="checkbox"/> Bedford                      | <input type="checkbox"/> Chester    | <input type="checkbox"/> Dauphin    | <input type="checkbox"/> Jefferson  | <input type="checkbox"/> McKean     | <input type="checkbox"/> Pike           | <input type="checkbox"/> Venango      |
| <input type="checkbox"/> Berks                        | <input type="checkbox"/> Clarion    | <input type="checkbox"/> Elk        | <input type="checkbox"/> Juniata    | <input type="checkbox"/> Mercer     | <input type="checkbox"/> Potter         | <input type="checkbox"/> Warren       |
| <input type="checkbox"/> Blair                        | <input type="checkbox"/> Clearfield | <input type="checkbox"/> Erie       | <input type="checkbox"/> Lackawanna | <input type="checkbox"/> Mifflin    | <input type="checkbox"/> Schuylkill     | <input type="checkbox"/> Washington   |
| <input type="checkbox"/> Bradford                     |                                     | <input type="checkbox"/> Fayette    | <input type="checkbox"/> Lancaster  | <input type="checkbox"/> Monroe     | <input type="checkbox"/> Snyder         | <input type="checkbox"/> Wayne        |
| <input type="checkbox"/> Bucks                        |                                     | <input type="checkbox"/> Forest     |                                     | <input type="checkbox"/> Montgomery |   | <input type="checkbox"/> Westmoreland |
|   |                                     |                                     |                                     |                                     |   | <input type="checkbox"/> Wyoming      |
|   |                                     |                                     |                                     |                                     |   | <input type="checkbox"/> York         |



**Types of services provided at primary location only** (please check all that apply).

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Adult Daily Living/Adult Day Services – Full Day(410)</li> <li><input type="checkbox"/> Adult Daily Living/Adult Day Services – Half Day(410)</li> <li><input type="checkbox"/> Adult Daily Living Enhanced (staff to individual ratio is 2:1) – Full Day (411)</li> <li><input type="checkbox"/> Adult Daily Living Enhanced (staff to individual ratio is 2:1) – Half Day (411)</li> <li><input type="checkbox"/> Assisted Living Facility</li> <li><input type="checkbox"/> Assistive Technology (544)</li> <li><input type="checkbox"/> Employment-Benefits Counseling (502)</li> <li><input type="checkbox"/> Career Assessment (503)</li> <li><input type="checkbox"/> Community Integration (525)</li> <li><input type="checkbox"/> Community Transition Services --Health Safety (551)</li> <li><input type="checkbox"/> Community Transition Services – Household Supplies (551)</li> <li><input type="checkbox"/> Community Transition Services – Moving Expenses (551)</li> <li><input type="checkbox"/> Community Transition Services – Security Deposit (551)</li> <li><input type="checkbox"/> Community Transition Services – Set-up Fees (551)</li> <li><input type="checkbox"/> Durable Medical Equipment and Supplies (250)</li> <li><input type="checkbox"/> Durable Medical Equipment and Supplies (250) Prosthetics and Orthotics</li> <li><input type="checkbox"/> Employment Skills Development – 1:1 (505)</li> <li><input type="checkbox"/> Employment Skills Development – 1:1 to 1:3 (505)</li> <li><input type="checkbox"/> Employment Skills Development – 1:15 (505)</li> <li><input type="checkbox"/> Enrollment (210)</li> <li><input type="checkbox"/> Job Coaching – 1:1 (504)</li> <li><input type="checkbox"/> Job Coaching – 1:2 to 1:4 (504)</li> <li><input type="checkbox"/> Job Coaching --1:1 Intensive (504)</li> <li><input type="checkbox"/> Job Coaching – 1:2 to 1:4 Intensive (504)</li> <li><input type="checkbox"/> Job Finding (530)</li> <li><input type="checkbox"/> Non-Medical Transportation (267)</li> <li><input type="checkbox"/> Participant-Directed Community Supports</li> <li><input type="checkbox"/> Participant-Directed Goods and Services</li> <li><input type="checkbox"/> Personal Emergency Response System (PERS) (25)</li> <li><input type="checkbox"/> Personal Emergency Response System – Monthly Maintenance (PERS) (28)</li> <li><input type="checkbox"/> Personal Care-Individual-Personal Assistance Services – Agency (360)</li> <li><input type="checkbox"/> Personal Assistance Services Agency (362)</li> <li><input type="checkbox"/> Personal Assistance Services Consumer (362)</li> <li><input type="checkbox"/> Pest Eradication (501)</li> <li><input type="checkbox"/> Residential Habilitation 1-3 (510)</li> <li><input type="checkbox"/> Residential Habilitation 1-3 Supp 1:1 (510)</li> <li><input type="checkbox"/> Residential Habilitation 1-3 Supp 2:1 (510)</li> <li><input type="checkbox"/> Residential Habilitation 4-8 (510)</li> <li><input type="checkbox"/> Residential Habilitation 4-8 Supp 1:1 (510)</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Residential Habilitation 4-8 Supp 2:1 (510)</li> <li><input type="checkbox"/> Respite Agency (512)</li> <li><input type="checkbox"/> Respite – Consumer-Directed (512)</li> <li><input type="checkbox"/> Service Coordination (219)</li> <li><input type="checkbox"/> Structured Day Habilitation – Group (528)</li> <li><input type="checkbox"/> Structured Day Habilitation – Group 1:1 (528)</li> <li><input type="checkbox"/> Structured Day Habilitation – Group 2:1 (528)</li> <li><input type="checkbox"/> TeleCare Equipment Installation and Removal (29)</li> <li><input type="checkbox"/> TeleCare Activity and Sensor Monitoring On Going (29)</li> <li><input type="checkbox"/> TeleCare Equipment Installation and Removal w/Training (29)</li> <li><input type="checkbox"/> Telecare Specialized Supplies for Remote Monitoring (29)</li> <li><input type="checkbox"/> TeleCare Specialized Supplies DME for Remote Monitoring (29)</li> <li><input type="checkbox"/> TeleCare Health Status Measuring and Monitoring Remote (29)</li> <li><input type="checkbox"/> Telecare Medication Dispensing and Monitoring (29)</li> <li><input type="checkbox"/> Therapeutic and Counseling Services – Behavioral Therapy (209)</li> <li><input type="checkbox"/> Therapeutic and Counseling Services – Cognitive Rehabilitation (207)</li> <li><input type="checkbox"/> Therapeutic and Counseling Services – Counseling, non-medical (231)</li> <li><input type="checkbox"/> Therapeutic and Counseling Services – Nutritional Counseling (230)</li> <li><input type="checkbox"/> Transitional Service Coordination - Transition Support Coordination (219)</li> <li><input type="checkbox"/> Vehicle Modification (255)</li> <li><input type="checkbox"/> Exceptional Durable Medical Equipment and Supplies</li> <li><input type="checkbox"/> ISO-Fiscal/Employer Agent – Financial Management Services (541)</li> <li><input type="checkbox"/> ISO-Fiscal/Employer Agent – Financial Management Services – Start-up (541)</li> <li><input type="checkbox"/> ISO-Fiscal/Employer Agent – Services My Way (541)</li> <li><input type="checkbox"/> Architectural Modification – Home Adaptations (&lt;6000) (440)</li> <li><input type="checkbox"/> Home-Delivered Meals – Emergency Pack (460)</li> <li><input type="checkbox"/> Home-Delivered Meals – Frozen Entrée (460)</li> <li><input type="checkbox"/> Home-Delivered Meals – Hot Entrée (460)</li> <li><input type="checkbox"/> Home-Delivered Meals – Sandwich (460)</li> <li><input type="checkbox"/> Home-Delivered Meals – Special Meal (460)</li> <li><input type="checkbox"/> Home Health Agency – Nursing/Therapies (50)</li> <li><input type="checkbox"/> Home Health Aide</li> <li><input type="checkbox"/> Home Health Nursing L.P.N. (161)</li> <li><input type="checkbox"/> Home Health Nursing R.N. (160)</li> <li><input type="checkbox"/> Home Health Services Occupational Therapy (171)</li> <li><input type="checkbox"/> Home Health Services Occupational Therapy Assistant (171)</li> <li><input type="checkbox"/> Home Health Services Physical Therapy (170)</li> <li><input type="checkbox"/> Home Health Services Physical Therapy Assistant (170)</li> <li><input type="checkbox"/> Home Health Services Speech and Language Therapy (173)</li> <li><input type="checkbox"/> Hospice</li> </ul> |
|---|--|

1. Has the facility had a post-licensing onsite visit by a government agency such as the Department of the Health or CMS within the past 36 months?
  - Yes. Date of most recent standard survey (MM/DD/YYYY)\_\_\_\_\_ (Please submit copy with application.)
  - No. Successful completion of a health plan onsite visit will be required to complete credentialing.
  
2. Were any deficiencies cited during the last full survey?  Yes  No  N/A - no recent survey
  - If yes, have all deficiencies been corrected?
    - Yes. Provide evidence of state acceptance of your CAP. Note - Please submit with application
    - No. Provide explanation and your plan to correct all deficiencies.

**If no deficiencies were cited during the last full survey, please submit verification of no deficiencies.**

**Responses are required. If no responses are given, the application will be returned.**



**Disclosure questions:** For any "Yes" answers, please provide (on page 8) a detailed explanation of the cause, any action you may have taken, and the results.

### Licensure

1.  Yes  No  N/A Has your license to practice ever been restricted, reduced, or revoked in this or any state or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to license or certification or the quality of services provided, or entered into a Consent Order issued by a licensing, certifying, or professional standards board or agency?
2.  Yes  No  N/A Has there been any challenge to your licensure, registration, or certification?

### Medicare, Medicaid, or other governmental program participation

3.  Yes  No  N/A Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?

### Other sanctions or investigations

4.  Yes  No  N/A Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined, or resigned in exchange for no investigation or adverse action within the past year for sexual harassment or other illegal misconduct?
5.  Yes  No  N/A Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or health care facility of any military agency?
6.  Yes  No  N/A Has the practitioner/facility ever been convicted of a crime, excluding misdemeanors?
7.  Yes  No  N/A At any time, has any third-party payer ever revoked, reduced, denied, or suspended your or the facility's participation due to inappropriate utilization management or any quality of care issues?
8.  Yes  No  N/A To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?
9.  Yes  No  N/A Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agency (e.g., CLIA, OSHA, etc.)?

### Professional liability insurance information and claims history

10.  Yes  No  N/A Has your professional liability coverage ever been cancelled, restricted, declined, or not renewed by the carrier, based on your individual liability history?
11.  Yes  No  N/A Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your liability history?

### Malpractice claims history

12.  Yes  No  N/A Have you had any professional liability actions (pending, settled, arbitrated, mediated, or litigated) within the past five years? If yes, provide information for each case.

### Criminal/civil history

13.  Yes  No  N/A Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?
14.  Yes  No  N/A In the past 10 years, have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse, or a sexual offense or sexual misconduct?
15.  Yes  No  N/A Have you ever been court martialled for actions related to your duties as a medical professional?



**Disclosure questions (continued)**

**Ability to perform job**

- 16.  Yes  No  N/A Are you currently engaged in the illegal use of drugs? (“Currently” refers to sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one’s ability to practice Medicine. “Illegal use of drugs” refers to drugs whose possession or distribution is unlawful under the Controlled Dangerous Act, 21 U.S.C. § 812.22.)
- 17.  Yes  No  N/A Do you use any chemical substances that would in any way impair or limit your ability to practice medicine or perform the functions of your job with reasonable skill and safety?
- 18.  Yes  No  N/A Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?
- 19.  Yes  No  N/A Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?

**Staffing**

Does the facility validate the credentials for each licensed practitioners and/or staff member employed or contracted at the facility?

Yes  No

If yes, indicate how the facility validate the credentials for each staff member employed or contracted at the facility:

Validations are performed internally.

Validations are outsourced to: \_\_\_\_\_

Other, specify: \_\_\_\_\_

If no, please explain: \_\_\_\_\_

**Exclusion certification**

I hereby certify that the online exclusion lists for the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) and the General Services Administration (GSA) are checked for all new hires and monthly for existing employees to ensure that no excluded employees work on any jobs related to any federal health care programs. I also hereby certify that I will remove any employee found on one of the above-referenced lists from any work related to a federal health care program. The OIG exclusion list is available at <http://exclusions.oig.hhs.gov/>. The GSA exclusion list is available at [www.sam.gov/](http://www.sam.gov/).

Authorized signature for facility	Date
Print name	Title

**Release of information, including background checks and authorization**

I hereby certify that, to the best of my knowledge, the responses and information contained in this application are complete, correct, and current. I acknowledge that any misstatements or omissions constitute cause for denial of admission to, or summary dismissal from, membership in the AmeriHealth Caritas Pennsylvania Community HealthChoices provider network.

I hereby authorize AmeriHealth Caritas Pennsylvania Community HealthChoices and its designated agents and representatives to conduct a comprehensive review of the background and credentials of those named on this application. I acknowledge that such review may cause a consumer report and/or an investigative consumer report to be generated. I understand that the scope of the consumer report/investigative consumer report may include, but is not necessarily limited to, the following areas: verification of Social Security number/taxpayer identification number; credit reports; current and previous residences; employment history; education background; character references; drug testing; civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records; birth records; and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me and any others I have presented on this application, to AmeriHealth Caritas Pennsylvania Community HealthChoices and its agents. I further authorize the complete release of any records or data pertaining to me or others I have presented on this application which the individual company, firm, corporation or public agency may have to include information or data received from other sources. AmeriHealth Caritas Pennsylvania Community HealthChoices and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicant’s personal information, including, but not limited to, addresses, Social Security numbers, and dates of birth.

I warrant that I have the authority to sign this authorization and to thereby authorize the release of information and the performance of a background check, on behalf of all parties named on this application.

Signature	Date
Print name	Title



**Disclosure question explanations for malpractice claims**

For any “Yes” answers to Disclosure Questions **10**, **11**, and **12** on page 5, please provide the date of occurrence, status of claim, detailed explanation of the claim, any action you may have taken, and the results. Please indicate “N/A” if not applicable.

Date of occurrence (MM/DD/YYYY):
Status of claim ( <b>Note:</b> If case is pending, select Open.) <input type="checkbox"/> Open <input type="checkbox"/> Close
Explanation

Date of occurrence (MM/DD/YYYY):
Status of claim ( <b>Note:</b> If case is pending, select Open.) <input type="checkbox"/> Open <input type="checkbox"/> Close
Explanation

Date of occurrence (MM/DD/YYYY):
Status of claim ( <b>Note:</b> If case is pending, select Open.) <input type="checkbox"/> Open <input type="checkbox"/> Close
Explanation



**Additional disclosure question explanations**

For any other “Yes” answers to Disclosure Questions on pages 5 and 6, please provide a detailed explanation of the cause, any action you may have taken, and the results. Please indicate “N/A” if not applicable.

Question number
Explanation

Question number
Explanation

Question number
Explanation

Question number
Explanation





**Attachment A: LTSS/HCBS Health Services Addendum**

Please copy this page, prior to completing, for all additional sites. (Note: This is for sites under the same license as the primary location. For locations under a different license, please submit another full application.)

**Additional location/site information**

Practice/facility name to appear in directory

NPI or additional NPI (if applicable)      PPID + location 4 digits

Taxpayer Identification Number (TIN) (Note: If different than primary location, a separate application is needed.)

Street address

City      County      State      ZIP+4 code

Remittance address (if different from primary location/site):

Phone number      Fax number

Handicap accessible?  Yes  No

1. Does the office have exterior or interior steps leading to the main entrance doorway?  Yes  No  
If yes, please check which type applies.  Interior  Exterior

2. If yes to question 1, does the office have a permanent or portable wheelchair ramp?  Yes  No  
If yes, please check which type applies.  Permanent  Portable

3. If yes to question 1, is there an alternate entrance that has no exterior or no interior steps or has a wheelchair ramp?  Yes  No  
If yes, please check which type applies.  No interior  No exterior  Permanent ramp  Portable ramp

In addition to English, do you or your staff communicate in any other language? If yes, list languages.

**Office hours (use HH:MM format)**

Day	Start	AM/PM	End	AM/PM	Day	Start	AM/PM	End	AM/PM
Monday					Saturday				
Tuesday					Sunday				
Wednesday					<input type="checkbox"/> 24/7				
Thursday									
Friday									

Select the counties where your agency is willing to provide services for this location.

- |   |                                     |   |                                       |
|---|-------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> All counties in Pennsylvania | <input type="checkbox"/> Clinton    | <input type="checkbox"/> Lancaster      | <input type="checkbox"/> Schuylkill   |
| <input type="checkbox"/> Adams                        | <input type="checkbox"/> Columbia   | <input type="checkbox"/> Lawrence       | <input type="checkbox"/> Snyder       |
| <input type="checkbox"/> Allegheny                    | <input type="checkbox"/> Crawford   | <input type="checkbox"/> Lebanon        | <input type="checkbox"/> Somerset     |
| <input type="checkbox"/> Armstrong                    | <input type="checkbox"/> Cumberland | <input type="checkbox"/> Lehigh         | <input type="checkbox"/> Sullivan     |
| <input type="checkbox"/> Beaver                       | <input type="checkbox"/> Delaware   | <input type="checkbox"/> Luzerne        | <input type="checkbox"/> Susquehanna  |
| <input type="checkbox"/> Bedford                      | <input type="checkbox"/> Dauphin    | <input type="checkbox"/> Lycoming       | <input type="checkbox"/> Tioga        |
| <input type="checkbox"/> Berks                        | <input type="checkbox"/> Elk        | <input type="checkbox"/> McKean         | <input type="checkbox"/> Union        |
| <input type="checkbox"/> Blair                        | <input type="checkbox"/> Erie       | <input type="checkbox"/> Mercer         | <input type="checkbox"/> Venango      |
| <input type="checkbox"/> Bradford                     | <input type="checkbox"/> Fayette    | <input type="checkbox"/> Mifflin        | <input type="checkbox"/> Warren       |
| <input type="checkbox"/> Bucks                        | <input type="checkbox"/> Forest     | <input type="checkbox"/> Monroe         | <input type="checkbox"/> Washington   |
| <input type="checkbox"/> Butler                       | <input type="checkbox"/> Franklin   | <input type="checkbox"/> Montgomery     | <input type="checkbox"/> Wayne        |
| <input type="checkbox"/> Cambria                      | <input type="checkbox"/> Fulton     | <input type="checkbox"/> Montour        | <input type="checkbox"/> Westmoreland |
| <input type="checkbox"/> Cameron                      | <input type="checkbox"/> Greene     | <input type="checkbox"/> Northampton    | <input type="checkbox"/> Wyoming      |
| <input type="checkbox"/> Carbon                       | <input type="checkbox"/> Huntingdon | <input type="checkbox"/> Northumberland | <input type="checkbox"/> York         |
| <input type="checkbox"/> Centre                       | <input type="checkbox"/> Indiana    | <input type="checkbox"/> Perry          |                                       |
| <input type="checkbox"/> Chester                      | <input type="checkbox"/> Jefferson  | <input type="checkbox"/> Philadelphia   |                                       |
| <input type="checkbox"/> Clarion                      | <input type="checkbox"/> Juniata    | <input type="checkbox"/> Pike           |                                       |
| <input type="checkbox"/> Clearfield                   | <input type="checkbox"/> Lackawanna | <input type="checkbox"/> Potter         |                                       |



Types of services provided at this location (please check all that apply).

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Adult Daily Living/Adult Day Services – Full Day(410)</li> <li><input type="checkbox"/> Adult Daily Living/Adult Day Services – Half Day(410)</li> <li><input type="checkbox"/> Adult Daily Living Enhanced (staff to individual ratio is 2:1) – Full Day (411)</li> <li><input type="checkbox"/> Adult Daily Living Enhanced (staff to individual ratio is 2:1) – Half Day (411)</li> <li><input type="checkbox"/> Assisted Living Facility</li> <li><input type="checkbox"/> Assistive Technology (544)</li> <li><input type="checkbox"/> Employment-Benefits Counseling (502)</li> <li><input type="checkbox"/> Career Assessment (503)</li> <li><input type="checkbox"/> Community Integration (525)</li> <li><input type="checkbox"/> Community Transition Services --Health Safety (551)</li> <li><input type="checkbox"/> Community Transition Services – Household Supplies (551)</li> <li><input type="checkbox"/> Community Transition Services – Moving Expenses (551)</li> <li><input type="checkbox"/> Community Transition Services – Security Deposit (551)</li> <li><input type="checkbox"/> Community Transition Services – Set-up Fees (551)</li> <li><input type="checkbox"/> Durable Medical Equipment and Supplies (250)</li> <li><input type="checkbox"/> Durable Medical Equipment and Supplies (250) Prosthetics and Orthotics</li> <li><input type="checkbox"/> Employment Skills Development – 1:1 (505)</li> <li><input type="checkbox"/> Employment Skills Development – 1:1 to 1:3 (505)</li> <li><input type="checkbox"/> Employment Skills Development – 1:15 (505)</li> <li><input type="checkbox"/> Enrollment (210)</li> <li><input type="checkbox"/> Job Coaching – 1:1 (504)</li> <li><input type="checkbox"/> Job Coaching – 1:2 to 1:4 (504)</li> <li><input type="checkbox"/> Job Coaching --1:1 Intensive (504)</li> <li><input type="checkbox"/> Job Coaching – 1:2 to 1:4 Intensive (504)</li> <li><input type="checkbox"/> Job Finding (530)</li> <li><input type="checkbox"/> Non-Medical Transportation (267)</li> <li><input type="checkbox"/> Participant-Directed Community Supports</li> <li><input type="checkbox"/> Participant-Directed Goods and Services</li> <li><input type="checkbox"/> Personal Emergency Response System (PERS) (25)</li> <li><input type="checkbox"/> Personal Emergency Response System – Monthly Maintenance (PERS) (28)</li> <li><input type="checkbox"/> Personal Care-Individual-Personal Assistance Services – Agency (360)</li> <li><input type="checkbox"/> Personal Assistance Services Agency (362)</li> <li><input type="checkbox"/> Personal Assistance Services Consumer (362)</li> <li><input type="checkbox"/> Pest Eradication (501)</li> <li><input type="checkbox"/> Residential Habilitation 1-3 (510)</li> <li><input type="checkbox"/> Residential Habilitation 1-3 Supp 1:1 (510)</li> <li><input type="checkbox"/> Residential Habilitation 1-3 Supp 2:1 (510)</li> <li><input type="checkbox"/> Residential Habilitation 4-8 (510)</li> <li><input type="checkbox"/> Residential Habilitation 4-8 Supp 1:1 (510)</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Residential Habilitation 4-8 Supp 2:1 (510)</li> <li><input type="checkbox"/> Respite Agency (512)</li> <li><input type="checkbox"/> Respite – Consumer-Directed (512)</li> <li><input type="checkbox"/> Service Coordination (219)</li> <li><input type="checkbox"/> Structured Day Habilitation – Group (528)</li> <li><input type="checkbox"/> Structured Day Habilitation – Group 1:1 (528)</li> <li><input type="checkbox"/> Structured Day Habilitation – Group 2:1 (528)</li> <li><input type="checkbox"/> TeleCare Equipment Installation and Removal (29)</li> <li><input type="checkbox"/> TeleCare Activity and Sensor Monitoring On Going (29)</li> <li><input type="checkbox"/> TeleCare Equipment Installation and Removal w/Training (29)</li> <li><input type="checkbox"/> Telecare Specialized Supplies for Remote Monitoring (29)</li> <li><input type="checkbox"/> TeleCare Specialized Supplies DME for Remote Monitoring (29)</li> <li><input type="checkbox"/> TeleCare Health Status Measuring and Monitoring Remote (29)</li> <li><input type="checkbox"/> Telecare Medication Dispensing and Monitoring (29)</li> <li><input type="checkbox"/> Therapeutic and Counseling Services – Behavioral Therapy (209)</li> <li><input type="checkbox"/> Therapeutic and Counseling Services – Cognitive Rehabilitation (207)</li> <li><input type="checkbox"/> Therapeutic and Counseling Services – Counseling, non-medical (231)</li> <li><input type="checkbox"/> Therapeutic and Counseling Services – Nutritional Counseling (230)</li> <li><input type="checkbox"/> Transitional Service Coordination - Transition Support Coordination (219 )</li> <li><input type="checkbox"/> Vehicle Modification (255)</li> <li><input type="checkbox"/> Exceptional Durable Medical Equipment and Supplies</li> <li><input type="checkbox"/> ISO-Fiscal/Employer Agent – Financial Management Services (541)</li> <li><input type="checkbox"/> ISO-Fiscal/Employer Agent – Financial Management Services – Start-up (541)</li> <li><input type="checkbox"/> ISO-Fiscal/Employer Agent – Services My Way (541)</li> <li><input type="checkbox"/> Architectural Modification – Home Adaptations (&lt;6000) (440)</li> <li><input type="checkbox"/> Home-Delivered Meals – Emergency Pack (460)</li> <li><input type="checkbox"/> Home-Delivered Meals – Frozen Entrée (460)</li> <li><input type="checkbox"/> Home-Delivered Meals – Hot Entrée (460)</li> <li><input type="checkbox"/> Home-Delivered Meals – Sandwich (460)</li> <li><input type="checkbox"/> Home-Delivered Meals – Special Meal (460)</li> <li><input type="checkbox"/> Home Health Agency – Nursing/Therapies (50)</li> <li><input type="checkbox"/> Home Health Aide</li> <li><input type="checkbox"/> Home Health Nursing L.P.N. (161)</li> <li><input type="checkbox"/> Home Health Nursing R.N. (160)</li> <li><input type="checkbox"/> Home Health Services Occupational Therapy (171)</li> <li><input type="checkbox"/> Home Health Services Occupational Therapy Assistant (171)</li> <li><input type="checkbox"/> Home Health Services Physical Therapy (170)</li> <li><input type="checkbox"/> Home Health Services Physical Therapy Assistant (170)</li> <li><input type="checkbox"/> Home Health Services Speech and Language Therapy (173)</li> <li><input type="checkbox"/> Hospice</li> </ul> |
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**Application submission instructions**

Please use the application checklist as a fax cover sheet.

Fax all applicable items to the AmeriHealth Caritas Credentialing department at **1-717-651-1673**.

Or, you may scan your signed documents and submit them by secure e-mail to:

**provider.credentialinghbg@amerihealthcaritaspa.com.**

Please be sure to email or fax the checklist, application, attachments, and contract in one submission.