



# **CHECKLIST SPECIFIC PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (Louisiana Medicaid Program)**

## **NOW PROFESSIONAL (LINKING PROFESSIONALS TO HH, PCA OR SIL)**

(Enrollment packet is subject to change without notice)

## **NOW PROFESSIONAL SERVICES**

NOW Professional Services include psychological services, social work services, and nutritional/dietary services which are designed to increase the participant's independence, participation, and productivity in home, work, and community settings.

Professional Services must be delivered with the participant present and provided based on the participant's approved plan of care. Service intensity, frequency, and duration will be determined based on the participant's needs.

Professional Services are to be used only when the services are not covered under the Medicaid State Plan. Participants, age 20 and under, may access these services through the Medicaid State Plan.

### **Description of Services**

Professional services are limited to the following:

#### 1. Psychological Services - (Psychosocial Rehabilitation Services - HIPAA Code Name)

Psychological services are direct services performed by a licensed psychologist (Ph.D.), as specified by State law and licensure. These services are for the treatment of behavioral or mental conditions that address personal outcomes and goals desired by the participant and his or her support team. Services must be reasonable and necessary to preserve, improve, or maintain adaptive behaviors or to decrease maladaptive behaviors of the participant.

The service must be outlined in the participant's plan of care. Psychology services include:

- Counseling (a variety of techniques and procedures used by the therapist, i.e., structuring and reinforcement, social modeling, functional activities, etc.).
- Behavior evaluation for the purpose of therapy.
- Intervening and stabilizing a crisis situation.
- Ongoing therapeutic support.
- Ongoing behavior training for staff and/or families.
- Administering and interpreting tests and measurements within the scope of practice of behavior therapy.
- Administering, evaluating, and modifying treatment and consulting within the scope of practice of behavior therapy.
- Adapting environments specifically for the participant.
- Consultative services and recommendations.

#### 2. Social Worker Services - (Psychosocial Rehabilitation Services (HIPAA Code Name)

Social worker services are highly specialized direct counseling services furnished by a Licensed Clinical Social Worker (LCSW), designed to meet the unique counseling needs of participants with development disabilities. Counseling may address areas such as human sexuality, depression, anxiety disorders, and social skills. Services must only address the participant's personal outcomes and goals listed in his/her approved plan of care.

#### 3. Nutritional/Dietary Services

Nutritional/Dietary services are medically necessary direct services provided by a Licensed Registered Dietician. Dietary services may include planning food and nutrition programs to help prevent and treat illnesses by promoting healthy eating habits through education, evaluating the participant's diet, and as necessary suggesting modifications to the participant's diet.

Reimbursement will be for the direct service provided directly to the participant performed by a dietician or nutritionist only, and not for the supervision of a dietician or nutritionist directly performing the hands-on service.

### **Non-Billable Provider Activities**

- Friendly visiting, attending meetings.
- Time spent on paperwork or travel.
- Time spent writing reports and progress notes.
- Time spent on general staff training not related to training for the natural or paid support regarding the participant's program plan.
- Time spent on billing of services.
- Other non-Medicaid reimbursable activities.

### **Restrictions with Other Services**

1. A participant may receive two or more professional services on the same day; however, these two professional services will not be authorized at the same time.
2. This service cannot be provided or billed for during the same hours on the same day as: Day Habilitation, Transportation for Day Habilitation, Supported Employment models, Transportation for supported employment models, Employment Related Training, Individual and Family Support – Day/Night/Shared Supports, Skilled Nursing Services, or Center-Based Respite.

### **Service Units and Limitations**

1. To bill for this service, the participant must be present when the professional rendered the service.
2. This service is capped at \$2,250 per participant per plan of care year for all professional services.

### **Additional Provider Responsibilities**

Providers of these services must:

1. Perform an initial evaluation to assess the participant's need for services;
2. Develop an Individual Service Plan for each individual participant;
3. Implement the participant's therapy plan in accordance with appropriate licensing and certification standards;
4. Within 10 working days, complete progress notes for each session, and provide these notes to the designated support coordinator every three months, or as specified in the plan of care;
5. Maintain both current and past records and make them available upon request to OCDD, service providers, support coordinators, the Centers for Medicare and Medicaid Services (CMS), and/or Legislative Auditors;
6. Bill for only for services rendered, based on the participant's approved plan of care and Prior Authorization.
7. Comply with DHH standards for payment, Medical Assistance Program Integrity Law (MAPIL), Health Insurance Portability and Accountability Act (HIPAA), Americans with Disabilities Act (ADA), and licensing requirements.

### **Agency Provider Type**

Providers must be licensed by the Louisiana Department of Health and Hospitals and enrolled as a Medicaid Home and Community Based Waiver Services provider of Personal Care Attendant, Supported Living, or Home Health Services. Each professional rendering service(s) must possess a valid Louisiana license and have one-year post licensure experience in their field of expertise.

Agencies enrolled as both Supported Living and Personal Care Attendant provider types shall bill these professional services under their Personal Care Attendant number in accordance with the Fiscal Intermediary requirements. Agencies enrolled as only Supported Living or Home Health would bill under their Supported Living or Home Health provider number.

# **ATTENTION!!**

**Waiver service providers are required to comply with all documentation requirements contained in:**

- 1. The provider manuals.**
- 2. The information located on the DHH/OCDD website at**

**<http://www.dhh.louisiana.gov/offices/publications.asp?ID=191>**

## CHECKLIST OF FORMS TO BE SUBMITTED For NOW Professional Waiver Services Program

The following checklist shows all documents that must be submitted to the Molina Medicaid Solutions Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as an Individual NOW Professional provider:

Completed	Document Name
<input type="checkbox"/> **	1. The NOW Professional Waiver Services Provider Enrollment Form (NOW-1).
<input type="checkbox"/> **	<p>2. Louisiana Medicaid Ownership Disclosure Information Forms for Individual. <b>(Only the Disclosure of Ownership portion of this enrollment packet can be done online by choosing Option 1.)</b></p> <p><b>Option 1</b> (preferred): Provider Ownership Enrollment Web Application. Go to <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> and click on the Provider Enrollment link on the left sidebar. After entering ownership information online, the user is prompted to print the Summary Report; the authorized agent must sign page 3 of the Summary Report and include both pages 2 and 3 with the other documents in this checklist.</p> <p style="text-align: center;"><b>-or-</b></p> <p><b>Option 2</b> (not recommended): If you choose not to use the Provider Ownership Enrollment web application, then submit the hardcopy Louisiana Medicaid Ownership Disclosure Information Forms for Individual.</p>
<input type="checkbox"/>	3. Printout of online medical license verification from the governing license board of your profession. This verification must contain the license numbers, the effective date of issuance, and the current status of the license. A temporary permit is only good until the expiration date.
<input type="checkbox"/> **	4. Completed Link/Unlink and Working Relationship Form.
<input type="checkbox"/>	5. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 4R (Registered Dietician), 4D (Psychologist), 4E (Social Worker).

\*\* Forms are included here.

**PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT. ATTACHED FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS)**

**Please submit all required documentation to:  
Molina Medicaid Solutions - Provider Enrollment Unit  
PO Box 80159  
Baton Rouge, LA 70898-0159**

# Louisiana's Medicaid Program NOW PROFESSIONAL WAIVER SERVICES

Provider Number: <small>(Leave Blank If Applying For New Number)</small>							
Individual Provider Name:							
National Provider Identifier:							
Provider Street Address:							
Provider City:							
Provider State:					Provider Zip:		
Provider Phone Number:	( )	-	Fax Number:		( )	-	
Social Security Number:							
Professional License Number: <small>(attach copy of license)</small>							
Specialty <small>(refer to attached lists):</small>	<b>Registered Dietician (4R)</b> <input type="checkbox"/> <b>Psychologist (4D)</b> <input type="checkbox"/> <b>Social Worker (4E)</b> <input type="checkbox"/>						
Requested Effective Date:							
Provider Signature:					Date of Signature:		

**PROVIDER VERIFICATION FOR DELIVERY OF NOW WAIVER SERVICES**

I hereby certify under oath that all statements I have made on this application and the attachments thereto are true and correct. I affirm I have a minimum of one-year post-licensure experience in my field of expertise and I hold a current Louisiana License for the Professional Type indicated:

Registered Dietician (4R)       Psychologist (4D)       Social Worker (4E)

**PROVIDER VERIFICATION FOR CONSULTATION SERVICE FOR NOW WAIVER PROGRAM**

I hereby certify under oath that all statements I have made on this application and the attachments thereto are true and correct. I affirm I have a minimum of one-year post-licensure experience in my field of expertise and I hold a current Louisiana License for the Professional Type indicated:

Registered Dietician (4R)       Psychologist (4D)       Social Worker (4E)

**I hereby certify that all information is true and that I have a minimum of one-year experience in my field of expertise and hold a current Louisiana License.**

\_\_\_\_\_  
Print Individual Provider's Name

\_\_\_\_\_  
Individual Provider's Signature

\_\_\_\_\_  
Date

**Please submit all required documentation to:**  
**Molina Medicaid Solutions - Provider Enrollment Unit**  
**PO Box 80159**  
**Baton Rouge, LA 70898-0159**

# Louisiana Medicaid Ownership Disclosure Information

**Please note: It is recommended that the Internet be used to report ownership information instead of filling out the form that follows.**

- **Using the Provider Ownership Enrollment web application to report ownership data eliminates rejection of enrollment application due to improperly reported ownership data.**

**To use the Provider Ownership Enrollment web application, please go to [www.lamedicaid.com](http://www.lamedicaid.com) and click on the “Provider Enrollment” link on the left-hand sidebar. Then click on the “Applications for New Enrollments, Reactivations, and Change of Ownership” link.**

- **If you use the web application to register ownership information, DO NOT complete or submit the paper form.**

**After reporting your ownership information on the Louisiana Medicaid web site, you must print and sign the signature page that the application provides for you, and submit the signature page along with the other enrollment documents identified on the appropriate checklist to:**

**Molina Medicaid Solutions Provider Enrollment  
P.O. Box 80159  
Baton Rouge, LA 70898-0159**

# Instructions for Louisiana Medicaid Ownership Disclosure Information Individual

**PLEASE NOTE: This is a multi-page form. All of the pages must be completely filled out and submitted or the application cannot be accepted. Please review the instructions in their entirety before completing the form. The following fields MUST be completed:**

## Section I – Enrolling Individual Information

**Information** - Please read the provided information regarding disclosure, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL).

**Louisiana Medicaid Provider Number** – enter your seven- (7) digit Medicaid provider number. If this application is for a new Medicaid provider number, leave this field blank.

**Tax-Payer ID Number** – enter the nine- (9) digit Tax ID number for this provider.

**National Provider Identifier** – enter your ten- (10) digit National Provider Identifier (NPI). This number can be obtained by going to <https://nppes.cms.hhs.gov>

**SS# of Individual** - enter SS# of individual - **Notice Regarding Disclosure of Social Security Numbers: As part of the application for enrollment in Louisiana Medicaid, social security numbers are required for each individual with Direct or Indirect Ownership or Control Interest of 5% or more, each individual Corporate Officer, Director, Partner or Shareholder, and each individual Managing Employee or Agent who exercises operation or managerial control or who directly or indirectly manages the conduct of day to day operations, pursuant to Louisiana Medicaid rules and regulations and 42 U.S.C. § 1320a-3. Social security numbers are required and the application will be returned if the social security numbers are not reported.**

**Date of Birth:** This is a required field.

**This enrollment packet is for a** – check the appropriate box from among New Enrollment, Currently Enrolled, or Re-Enroll.

**Provider Type** – enter the Louisiana Medicaid Provider Type for this Individual.

**Area Code and Telephone Number(s) of Enrolling Individual** - enter the area code and telephone number(s) at the street address of this enrolling individual

**Name of Enrolling Individual** – enter the legal name of the individual, including the maiden name and all married names.

**Doing Business As** – enter the DBA Name to be enrolled with, if applicable.

**Business Street Address** - Enter the physical business street address of the individual requesting enrollment

**City, State, Zip** - Enter the city, state and zip code of the physical business street address

**E-Mail Address** - Enter the Individuals email address.

**Citizenship** - Is this individual a citizen of the United States, answer Yes or No. If “No”, you must follow the instructions given.

## SECTION II – PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP, IF DIFFERENT FROM THE ENROLLING INDIVIDUAL

List the full name, social security number, date of birth, job title, address, telephone number, and email address of person completing this form if different than the enrolling individual. Also, check one box specifying the position of the person completing the form for the enrolling individual (Staff, Third Party Independent Agent, other). If you check other, please specify by writing the relationship in the space provided.

## SECTION III – ENROLLING INDIVIDUAL CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

**A. - D.** Read all questions carefully and respond by checking the appropriate boxes. If yes to any question, attach or list the required documentation, as directed.

### Section IV – ENROLLMENT IN HEALTHCARE PROGRAMS

**A.** Identify if you have held a professional practitioner license in any other State.

**B.** Identify if you “practicing” as a Medicaid, Medicare, or other Government Funded Healthcare provider in any other State

**C.** If you answered “YES” to A and/or B, please list each State and your Medicaid/Medicare/Government Healthcare provider ID numbers for each state.

**Note:** Government Funded Healthcare is any healthcare plan, program, or insurance that is wholly or partially paid for by a government entity, usually the Federal Government or the State Government. Medicare and Medicaid are the two most familiar forms of Government Funded Healthcare, but other forms may apply (see the table on the form).

**D. Has the Social Security Number and/or Tax ID number(s) listed on this enrollment application been used to enroll in any other healthcare plans located in Louisiana that are funded by a government agency?** If yes, check off the plans, and then list the DBA Name(s), the Tax ID(s), the Social Security Number(s), and all the plan number(s).

**E.** Identify any direct, indirect, or controlling ownership interest of 5% or more in any Government Funded Healthcare providers or businesses. If yes, check off the plans, and then list the DBA Name(s), the Tax ID(s), the Social Security Number(s), and all the plan number(s).

### SECTION V – MANAGEMENT/AGENT INFORMATION

List all persons who are part of the management/agent structure for this individual. Be sure to make a photocopy of the form before you fill it out the first time; you need one page for each manager/agent. For more information, please see the guide on the page just before Section V.

**Information** - Please read the provided information regarding disclosure, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL) which is located at the beginning of Section I.

**Manager** – defined under 42 §CFR 455.101 as “a general manger, business manager/agent, administrator, director, or other individual who exercises operational or manager/agent control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency”.

**Agent** - Defined under 42 §CFR 455.101 as any person who has been delegated the authority to obligate or act on behalf of a provider.

**Manager/Agent Information:** Complete the title/Job Position, social security number, First, Middle, Maiden (if applicable), and Last Name, current address of manager/agent, and telephone number with area code.

**A. – E.** Read all questions carefully and respond by checking the appropriate boxes. If yes to any question, complete and attach the required documentation.

**F.** Does the above-named person have ownership in any entity/business that is currently enrolled in a government-funded program? If yes, in the table provided, check off the plans and list all plan numbers assigned to the Taxpayer ID Number.

**G.** For an out-of-state individual enrolling in Louisiana Medicaid, please provide the Medicaid and Medicare provider numbers issued to this individual by the domicile state.

### SECTION VI – INFORMATION ON SUBCONTRACTORS

For the individual identified in Section I, list any subcontractor (whether individual, agency, or organization) which the individual has contracted with or delegated some of its manager/agent functions or responsibilities for providing medical services to patients. For more information please see the guide on the page just before Section VII.

**A. – D.** Read all questions carefully and respond by checking the appropriate boxes. If you checked yes on any boxes, you shall provide requested information for each subcontractor.

If you had more than two subcontractors, make a photocopy of the form first, and submit as many pages as you need.

### SECTION VII – PROVIDER SIGNATURE

Carefully review all sections of the Disclosure of Ownership. Requires original signature of the authorized representative (no stamps or initials) and the date.

# LOUISIANA MEDICAID OWNERSHIP DISCLOSURE INFORMATION INDIVIDUAL

Under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. *(See Federal Regulations 42 CFR § 455.104(a) (1), (2).* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(a)(2).* Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest. *(See Federal Regulations 42 CFR § 455.104(a) (3)* [http://www.access.gpo.gov/nara/cfr/waisidx\\_01/42cfr455\\_01.html](http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html)

In addition, Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (**MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A**) and Administrative Rules, (*Louisiana Register, Vol. 29, No. 4, April 20, 2003*), as well as **Louisiana Provider Update January/February 2009** (available at LAMEDICAID.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers.

## SECTION I – ENROLLING INDIVIDUAL INFORMATION

<b>Louisiana Medicaid Provider Number (7 digits)</b> (Leave blank if applying for new number)	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table>										
<b>Taxpayer ID Number (9 digits)</b>	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 11.1%;"></td><td style="width: 11.1%;"></td><td style="width: 11.1%;"></td><td style="width: 11.1%;"></td><td style="width: 11.1%;"></td><td style="width: 11.1%;"></td><td style="width: 11.1%;"></td><td style="width: 11.1%;"></td><td style="width: 11.1%;"></td><td style="width: 11.1%;"></td> </tr> </table>										
<b>National Provider Identifier (NPI) (10 digits)</b>	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td> </tr> </table>										
<b>SS# of Individual (Required)</b>	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td> </tr> </table>										
<b>Date of Birth (Required)</b>	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%; text-align: center;">/</td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%; text-align: center;">/</td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td> </tr> </table>			/			/				
		/			/						

This enrollment packet is for a <input type="checkbox"/> New Enrollment <input type="checkbox"/> Currently Enrolled <input type="checkbox"/> Re-Enroll	<b>Provider Type:</b>											
<b>Telephone Number(s) of Enrolling Individual</b>	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%; text-align: center;">-</td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%; text-align: center;">-</td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table>				-				-			
			-				-					

## ENROLLING INDIVIDUAL PROVIDER INFORMATION

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Doing Business As					
Business Street Address			City	State	Zip
Email Address (s)					
<b>Is the enrolling individual a U.S. Citizen?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you answered "No" above, attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States. For assistance, contact the United States Citizenship and Immigration Services (USCIS) at 1-800-375-5283, or visit the website at <a href="http://www.uscis.gov">www.uscis.gov</a> . List the country(s) of the individuals' citizenship below.					
1.	2.	3.			

## SECTION II – PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP, IF DIFFERENT FROM THE ENROLLING INDIVIDUAL

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Social Security Number (required)		Date of Birth (required)		Job Title	
The person completing this form is (please check one): <input type="checkbox"/> Staff <input type="checkbox"/> Third Party/Independent Agent <input type="checkbox"/> Other (explain) _____					
Address			City	State	Zip
Telephone Number(s)			Email Address(es)		

## SECTION III – ENROLLING INDIVIDUAL CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

### Has the enrolling individual listed in Section I ever:

A. Been convicted of a healthcare related felony or other criminal offense, State and/or Federal, under this name or any other name in any state or U.S. Territory, regardless of a post trial motion, a plea of guilty or *nolo contendere* or participation in a First Offense pardon program?  Yes  No

If yes, attach explanation details of conviction or plea, including date of occurrence and state in which conviction occurred. Court documentation required.

B. Had any disciplinary action taken against any professional license or certification held in any state or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, voluntary surrender of a license or certification?  Yes  No

If yes, attach a copy of the license sanction document (consent decree, revocation, suspension order or surrender notice) with an explanation, providing details, including the date and state in which this action occurred, regarding the disciplinary action for all individuals/entities/agents/subcontractors, and/or businesses involved. Reinstatement letter required.

C. Been denied enrollment, suspended or excluded from Medicare, Medicaid or other healthcare program in any state or U.S. Territory, or employed by a corporation, entity/business, or professional association that has ever been suspended or excluded from Medicare, Medicaid or other healthcare program in any state or U.S. Territory?  Yes  No

If yes, attach documents (notice of rejection, suspension, exclusion) with an explanation providing details, including date and state in which action occurred, for all individuals/entities/businesses involved. Reinstatement letter required.

D. Used or been known by any name other than the legal name or the Doing Business As (DBA) name documented in this application?  Yes  No

If yes, list all names and Tax IDs below:

1. DBA Name	Legal Name	Tax ID
2. DBA Name	Legal Name	Tax ID
3. DBA Name	Legal Name	Tax ID

E. Ever used or been known by any other name including married, maiden, hyphenated, or alias?  Yes  No

If yes, enter name(s) below:

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

## SECTION IV – ENROLLMENT IN HEALTHCARE PROGRAMS

A. Do you currently or have you ever held a professional license in any other state?  Yes  No

B. Are you currently practicing as a Medicare/Medicaid healthcare provider in any other state?  Yes  No

C. If you answered yes to questions A or B, please list the state(s), License Number, and Medicare/Medicaid provider numbers below:

1. Domicile State:	Medicare Provider Number:	Medicaid Provider Number:	Professional License #:
2. Domicile State:	Medicare Provider Number:	Medicaid Provider Number:	Professional License #:
3. Domicile State:	Medicare Provider Number:	Medicaid Provider Number:	Professional License #:

D. Has the Social Security Number and/or Tax ID number(s) listed on this enrollment application been used to enroll in any other healthcare plans located in Louisiana that are funded by a government agency (as listed below)?  Yes  No

If yes, check off the plans, list the DBA Name(s), the Tax ID(s), the Social Security Number(s), and all the plan number(s):

Plan	Doing Business As (DBA) Name(s)	Tax ID(s)	Social Security Number(s)	Plan Number(s) or Identifier(s)
<input type="checkbox"/> Louisiana Medicaid				
<input type="checkbox"/> Medicare Part A				
<input type="checkbox"/> Medicare Part B				
<input type="checkbox"/> Medicare Part C				
<input type="checkbox"/> Medicare Part D (Pharmacies only)				
<input type="checkbox"/> CHAMPUS				
<input type="checkbox"/> Other Government Funded Program				

E. Does the enrolling individual have any direct, indirect or controlling ownership interest of 5% or more in any other Government Funded healthcare provider/businesses?  Yes  No

If yes, check off the plans, list the DBA Name(s), the Tax ID(s), the Social Security Numbers, and all the plan numbers:

Plan	Doing Business As (DBA) Name(s)	Tax ID(s)	Social Security Number(s)	Plan Number(s) or Identifier(s)
<input type="checkbox"/> Louisiana Medicaid				
<input type="checkbox"/> Medicare Part A				
<input type="checkbox"/> Medicare Part B				
<input type="checkbox"/> Medicare Part C				
<input type="checkbox"/> Medicare Part D (Pharmacies only)				
<input type="checkbox"/> CHAMPUS				
<input type="checkbox"/> Other Government Funded Program				

**Please Read before proceeding to  
Section V – Management/Agent Information:**

**Be sure to make a photocopy of the form on the next page before you fill it out the first time; you need one page for each manager/agent.** If you have a five-person management team, you need to submit five completed Section V forms. You may **NOT** submit a list of names; each manager/agent must be reported with a full page of information (no attachments—use the form provided).

Section V seeks to identify the management structure of this enrolling individual.

**Manager**– defined under 42 §CFR 455.101 as “a general manger, business manager/agent, administrator, director, or other individual who exercises operational or manager/agential control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency”.

**Agent** - Defined under 42 §CFR 455.101 as any person who has been delegated the authority to obligate or act on behalf of a provider.

Medicaid requires that an enrolling individual fully disclose **ALL** persons that provide management expertise to the enrolling individual.

Members of management, or agents, are non-owners who are part of a chain of command within a company and may perform tasks similar to the ones shown below:

- Analyze performance
- Develop directional policy
- Direct and control management activities
- Manage risk
- Oversee operations
- Participate in the election and/or removal of officers and employees
- Supervise

This list is not all-conclusive, and other activities that imply or assume similar powers or responsibilities may apply.

Members of management, or agents, may hold job titles similar to the ones shown below:

- Administrator
- Board of directors
- Board of trustees
- Chairman or chairperson
- Chief Business Officer (CBO)
- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Chief Operating Officer (COO)
- Director
- Manager/agent
- Officer
- Trustee

When reporting a name, use the individual’s FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or *Jenny Rae Jones-Smith*, not *J.R. Jones-Smith* or *Jenny Jones-Smith*.

## SECTION V – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Under Federal Regulations, a provider must disclose to the Medicaid agency, prior to enrolling, the name and address of each person who is a managing employee (General Manager, Business Manager, Administrator or other individual who exercises operational or managerial control or conducts day to day operations of the agency) or Agent (any person with authority to obligate or act on behalf of the disclosing entity. See Federal Regulations 42 CFR § 455.104(a)(1) and 42 CFR § 455.104(a)(3) at [http://www.access.gpo.gov/nara/cfr/waisidx\\_01/42cfr455\\_01.html](http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html).

In addition, Louisiana Medicaid policy, including Louisiana’s Medical Assistance Programs Integrity Law (**MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A**) and Administrative Rules, (**Louisiana Register, Vol. 29, No. 4, April 20, 2003**), as well as **Louisiana Provider Update January/February 2009** (available at LAMEDICAID.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers.

### Copy and complete a separate form for each individual with management duties.

Does this enrolling individual employ Management/Agent staff? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the following information for each management/agent staff. If no, please proceed to the next section.
--

MANAGER/AGENT		Title/Job Position within this Organization				Social Security Number (required)										
									-							
First Name	Middle Name	Maiden Name	Last Name		-	Hyphenated Last Name (if applicable)										
		Date of Birth (MM/DD/YYYY):						/			/					
Current Address of Manager/Agent																
City																
State																
Zip Code				Area Code/Telephone Number:							-					

A. Is this individual or agent with management duties a U.S. citizen?  Yes  No

If you answered “No” above, attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States. For assistance, contact the United States Citizenship and Immigration Services (USCIS) at 1-800-375-5283, or visit the website at [www.uscis.gov](http://www.uscis.gov). List the country(s) of the Manager/Agent’s citizenship below:

1.	2.	3.
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### Has the manager/agent named above ever:

B.. Been convicted of a healthcare related felony or any other criminal offense, State or Federal, under this name or any other name in any state or U.S. Territory, regardless of a post trial motion, a plea of guilty or *nolo contendere* or participation in a First Offense pardon program? Court documentation required.  Yes  No

If yes, attach explanation of conviction or plea, including date of conviction and state in which it occurred.

C. Had any disciplinary action taken against any professional license or certification held in any state or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification?  Yes  No

If yes, attach a copy of the license sanction document (consent decree, revocation, suspension order or surrender notice) with an explanation, providing details, including the date and State in which this action occurred, regarding the disciplinary action for each individual/entity/agent/subcontractor, managing employees/businesses involved. Reinstatement letter required.

D. Been denied enrollment, suspended, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory, or employed by a corporation, entity/business, or professional association that has ever been denied enrollment, suspended, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory?  Yes  No

If yes, attach documents (notice of rejection, suspension, exclusion) with an explanation providing details, including date and state in which action occurred, for all individuals/entities/businesses involved. Reinstatement letter required.

E. Used or been known by any other name including married, maiden, hyphenated, alias, or Doing Business As (DBA) name(s)  Yes  No

If yes, enter name(s) below:

DBA Name:			DBA Name:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

F. Does this manager/agent have ownership in any healthcare entities/businesses **located in Louisiana** that are currently enrolled in any government-funded programs such as those listed below?  Yes  No

If yes, in the chart below, check off all the plans and list the plan numbers assigned to these entities/businesses.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers or Identifiers
<input type="checkbox"/> Louisiana Medicaid			
<input type="checkbox"/> Medicare Part A			
<input type="checkbox"/> Medicare Part B			
<input type="checkbox"/> Medicare Part C			
<input type="checkbox"/> Medicare Part D (Pharmacies only)			
<input type="checkbox"/> CHAMPUS			
<input type="checkbox"/> Other Government Funded Program			

G. Does this manager/agent reside out-of-state (not in Louisiana?)  Yes  No

If yes, has this out-of-state owner been issued any Medicaid or Medicare provider numbers by the domicile state?  Yes  No

If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:
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**Please Read before proceeding to  
Section VI –Subcontractor Information:**

**Be sure to make a photocopy of the form on the next page before you fill it out the first time; you need one page for each subcontractor.** You may **NOT** submit a list of names; each subcontractor or wholly owned supplier must be reported with a full page of information (no attachments—use the form provided).

**Section VI** seeks to identify the ownership of any **subcontractors or wholly owned suppliers** with whom this enrolling individual has done business within the past 5 years.

Medicaid requires that an enrolling individual must disclose ownership information on:

- A. Any subcontractor with which the individual had business transactions totaling \$25,000 or more within the past 12 months.
- B. Any wholly owned supplier or subcontractor with which the individual had significant business transactions of \$75,000 or more, within the past 5 years.

**DEFINITIONS:**

**Subcontractor-**

1. An individual, agency or organization that you have:
  - a. contracted with or
  - b. delegated some of your management functions or responsibilities of providing medical care to your patients.
2. An individual, agency or organization with which you have entered into a contract, agreement, purchase order, or lease to obtain:
  - a. equipment,
  - b. supplies,
  - c. space, including real estate, or
  - d. services provided under the Medicaid agreement.

**Wholly Owned Supplier-**

A supplier (i.e., an individual, agency or organization from which a Medicaid provider purchases goods and services used in carrying out its responsibilities under Medicaid, e.g., a commercial laundry, manufacturer of hospital beds, pharmaceutical firm) whose total ownership interest is held by a Medicaid provider or by a person, persons, or other entity with an ownership or control interest in a Medicaid provider.

**SECTION VI – INFORMATION ON SUBCONTRACTORS**

Under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of any subcontractor in which the provider or disclosing entity has direct or indirect ownership of 5 percent or more. (See Federal Regulations 42 CFR § 455.104(a)(1) A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether the provider or disclosing entity and any of the disclosed subcontractors are related to one another as spouse, parent, child, or sibling. (See Federal Regulations 42 CFR § 455.104(a)(2)

**Copy and complete a separate form for each subcontractor.**

Does this enrolling individual employ a Management/Agent staff? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the following information for each management/agent staff. If no, please proceed to the next section.
--

A. Is this individual with contractor duties a U.S. citizen?  Yes  No

If you answered "No" above, attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States. For assistance, contact the United States Citizenship and Immigration Services (USCIS) at 1-800-375-5283, or visit the website at [www.uscis.gov](http://www.uscis.gov). List the country(s) of the contractor's citizenship.

1.	2.	3.
----	----	----

B-1 Has this individual contracted with or delegated any management functions or responsibilities for providing medical care to its patients to a Subcontractor (individual, agency or organization)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
B-2 If yes, did any of these subcontractor transactions total \$25,000 or more within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, the following information must be provided for each subcontractor:	
<b>Individual Subcontractor</b>	
Social Security Number (required)	
First Name	Middle Name
Maiden Name	Last Name
Hyphenated Last Name (if applicable)	
Current Address of Subcontractor	
City	
State	Zip Code
Telephone Number	Email
<b>Type of Function Performed:</b> <input type="checkbox"/> Healthcare Services <input type="checkbox"/> Equipment <input type="checkbox"/> Supplies <input type="checkbox"/> Space or real estate	

<b>Entity/Business Subcontractor</b>	
Full Legal Name	DBA Name
Tax ID Number (required)	
Current Address of Subcontractor	
City	
State	Zip Code
Telephone Number	Email
<b>Type of Function Performed:</b> <input type="checkbox"/> Healthcare Services <input type="checkbox"/> Equipment <input type="checkbox"/> Supplies <input type="checkbox"/> Space or real estate	

C-1 Has this enrolling individual entered into a contract, agreement, purchase order or lease with any Wholly Owned Supplier or Subcontractor to provide healthcare services or for equipment, supplies, or space used to provide healthcare services?  Yes  No

C-2 If yes, did any of these subcontractor transactions total \$75,000 or more within the past 5 years?  Yes  No

If yes, the following information must be provided for each subcontractor:

Individual Subcontractor			Social Security Number (required)							-			-			
First Name	Middle Name	Maiden Name	Last Name			-	Hyphenated Last Name (if applicable)									
Current Address of Subcontractor																
City																
State								Zip Code								
Telephone Number								Email								
Type of Function Performed:			<input type="checkbox"/> Healthcare Services				<input type="checkbox"/> Equipment		<input type="checkbox"/> Supplies		<input type="checkbox"/> Space or real estate					

Entity/Business Subcontractor			DBA Name				Tax ID Number (required)						
Full Legal Name			DBA Name				Tax ID Number (required)						
Current Address of Subcontractor													
City													
State						Zip Code							
Telephone Number						Email							
Type of Function Performed:			<input type="checkbox"/> Healthcare Services				<input type="checkbox"/> Equipment		<input type="checkbox"/> Supplies		<input type="checkbox"/> Space or real estate		

D. Are the enrolling individual and any Subcontractor(s) in which the enrolling individual has direct or indirect ownership of 5% or more related to each other as spouse, parent, child or sibling?  Yes  No

If yes, list all individuals involved

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

## SECTION VII – PROVIDER SIGNATURE

With my signature below, I attest:

1. That I have disclosed all necessary information;
2. That I am the individual identified in Section I and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3. That I have reviewed the information on this Individual Disclosure form and attest that it is true, accurate and complete;
4. That I understand that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of any request to participate in Louisiana's Medicaid Program, or where the individual already participates, a termination of the provider agreement or contract with the State Agency or the Secretary, as appropriate;
5. That I understand that a denial or termination of the provider agreement or contract with the State Agency or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6. That I understand that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to the State Agency or the Secretary may be prosecuted under applicable federal or state laws;
7. That I understand it is my responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That I understand that the failure to maintain current and correct information may result in payments being delayed or closure of my Medicaid provider number;
9. That I understand if my number is closed due to inaccurate information, I will have to complete a new Provider Enrollment Packet in its entirety to reactivate my provider number;
10. That I understand that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, I must provide Social Security numbers for each of the following persons:
  - All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
  - All Individuals acting as Board of Director;
  - All Individual Corporate Officers, Directors, Partners, or Shareholders;
  - All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day to day operations.
11. I attest that I am a United States citizen or have legal status and work privilege in the US and I understand that it is my responsibility to ensure that all my managers, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
12. I understand that it my responsibility to ensure that I have disclosed on this form if I, or any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Manager, Employee, Agent or Affiliate, have ever:
  - been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
  - been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
  - been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program in any state; or been convicted of any crimes.
13. I understand that I shall report any of the above conditions to the Department of Health and Hospitals (DHH), and once enrolled, I understand that upon discovery of any of the above conditions, it is my responsibility to report them immediately in writing to DHH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
14. I understand if I answered "Yes" to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, suspended, or voluntarily withdrawn to avoid disciplinary action from any federally funded healthcare program, I am required to submit this information and the requested documentation.
15. I understand that I am being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs, and I understand that this criminal statute means that if I, or any managers, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future from participation in the Medicare, Medicaid, or any other Federally or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program.
16. I also understand that "participation" includes providing any services which will be billed, directly or indirectly, to Medicaid, and "participation" also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to Louisiana's Medicaid Program;
17. I also understand that this new crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of \$20,000.00; and
18. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

Please sign in colored ink (not black)

\_\_\_\_\_  
Print Name of Individual Provider

\_\_\_\_\_  
Signature of Provider

\_\_\_\_\_  
Date of Signature

# Louisiana Medicaid Group Link/Unlink and Working Relationship Form

**PURPOSE**

This form is used when an individual provider is requesting to be linked to a Professional Group or Entity. The form permits Linkage/Unlinkage for two separate professional groups. When linking to a group, the estimated number of hours is required. The form also serves as documentation that a working relationship exists between an individual and a professional group. For this form to be valid, an **ORIGINAL SIGNATURE AND DATE ARE REQUIRED.**

Individual Provider Name:													
Individual Provider Number:		LA Medicaid Provider #						National Provider Identifier (NPI)					
Professional Group Name:													
Professional Group Provider Number:		LA Medicaid Provider #						National Provider Identifier (NPI)					
<input type="checkbox"/> LINK	Effective Date:					<input type="checkbox"/> UNLINK	Termination Date:						
Approximate Number of Hours Worked at this Group Per Week (required)													
Professional Group Name:													
Professional Group Provider Number:		LA Medicaid Provider #						National Provider Identifier (NPI)					
<input type="checkbox"/> LINK	Effective Date:					<input type="checkbox"/> UNLINK	Termination Date:						
Approximate Number of Hours Worked at this Group Per Week (required)													
Contact Person for questions regarding this form:													
Contact Person Phone Number:		(            )            -											

**WORKING RELATIONSHIP AGREEMENT**

I am a medical professional who has a written contractual agreement to see patients for the above named professional group(s). I have recorded the approximate number of hours to be worked at each group per week in the space(s) provided above. (I understand that upon request I must provide DHH a copy of the written contractual agreement.)

\_\_\_\_\_  
Print Individual Provider's Name

\_\_\_\_\_  
Individual Provider's Signature

\_\_\_\_\_  
Date

Original signature only – colored ink (please don't use black ink)

Mail Completed Forms To: Molina Medicaid Solutions Provider Enrollment Unit, PO Box 80159, Baton Rouge, LA 70898-0159