ALTERWOOD HEALTH
Quality Care. Better Health.

FACILITY / ANCILLARY APPLICATION

Provider Identification

Legal Business Name:			
Doing Business As: (if applicable)			
Contact Person:	Email:	Phone:	Fax:
Tax ID #:	Medicaid #:	Medicare #:	NPI #:

Provider Type

Facility __ Hospital __ Inpatient Rehab Hospital __ Hospice

__ Ambulatory Surgery Center __ Skilled Nursing Facility __ Sub Acute

Ancillary (*check all that apply*)

☐	Acupuncture	☐	Hospice (Outpatient)	☐	Durable Medical Equipment
☐	Ambulance	☐	Laboratory	☐	Home Health
☐	Audiology	☐	Sleep Disorders Clinic	☐	Home Infusion
☐	Birthing Center	☐	Orthotics and Prosthetics	☐	Dialysis
☐	Physical Therapy	☐	Occupational Therapy	☐	Speech Therapy
☐	Urgent Care Center	☐	Other		
☐	Imaging Facility	( ) MRI/MRA, ( ) Open MRI, ( ) CT Scan, ( ) PET/CT, ( ) Nuclear Medicine, ( ) Ultrasound, ( ) Mammography, ( ) Flouroscopy, ( ) X-Ray, ( ) DEXA, ( ) Calcium Scoring			

Serves the following counties: (List all that apply)

Maryland

☐	Allegany	☐	Calvert	☐	Charles	☐	Harford	☐	Prince George's	☐	Talbot
☐	Anne Arundel	☐	Caroline	☐	Dorchester	☐	Howard	☐	Queen Anne's	☐	Washington
☐	Baltimore City	☐	Carroll	☐	Frederick	☐	Kent	☐	Somerset	☐	Wicomico
☐	Baltimore	☐	Cecil	☐	Garrett	☐	Montgomery	☐	St Mary's	☐	Worcester

Washington DC ☐

Delaware:

☐	New Castle	☐	Kent	☐	Sussex

Primary Office / Service Address			
Practice Location Name:			
Address:			
Contact Person:	Email:	Phone:	Fax:
Office Hours: _____ Sun _____ Mon _____ Tues _____Wed _____ Thurs _____ Fri _____ Sat			
List any non-English languages spoken:			
Does this office location meet ADA accessibility requirements? __ Y __ N			
Check All That Apply: Handicap Accessible: __ Building __ Parking __ Restroom Services for Disabled: __ Text Telephone __ Sign Language __ Mental/Physical Impairment Transportation Accessible: __ Bus __ Regional Train __ Subway			
Secondary Office / Service Address			
Practice Location Name:			
Address:			
Contact Person:	Email:	Phone:	Fax:
Office Hours: _____ Sun _____ Mon _____ Tues _____Wed _____ Thurs _____ Fri _____ Sat			
List any non-English languages spoken:			
Does this office location meet ADA accessibility requirements? __ Y __ N			
Check All That Apply: Handicap Accessible: __ Building __ Parking __ Restroom Services for Disabled: __ Text Telephone __ Sign Language __ Mental/Physical Impairment Transportation Accessible: __ Bus __ Regional Train __ Subway			

Billing Information			
Name (Billing Name):			
Payment Address:			
City: State: ZIP: Do you bill electronically? __ Y __ N			
Contact Person:	Email:	Phone:	Fax:

Licensure			
State:	Date of License:	License #:	Expiration Date:
State:	Date of License:	License #:	Expiration Date:
CLIA Certificate #: (if applicable)			

Accreditation / Certification		
Type of Accreditation:	Date of Accreditation:	Next Survey Date:
If Not Accredited: Have you had an on-site survey by CMS or a State Agency? __ Y __ N Date of Last Survey: ___/___/___		
Credentialing		
Does your organization credential providers? __Y __ N		
Does your organization monitor credentialed staff for exclusions from the Medicaid/Medicare Programs? __ Y __ N		

General and Professional Liability Insurance	
General Liability Coverage	
Current Carrier Name:	
Policy Number:	Coverage Type: ___ Occurrence Based ___ Claims Based
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $
Professional Liability Coverage	
Current Carrier Name:	
Policy Number:	Coverage Type: ___ Occurrence Based ___ Claims Based
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $

ATTACHMENTS

Please submit all applicable documents from the list below, with your completed and signed application and contract.

1. Copy of all licenses required to operate as a health care facility (by location)
2. Copy of accreditation certificate or letter
3. Certificate of Insurance Coverage
4. Copy of most recent CMS or state survey including your corrective action plan if deficiencies were cited, or cover letter from CMS/State Agency stating facility is in substantial compliance
5. Copy of CLIA Certificate for each location, if applicable
6. A completed W-9 for each Tax ID

Standard Authorization, Attestation and Release

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with Alterwood Health (hereinafter referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification , corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations , managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions , military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics , behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary pro-ceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and with- out malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s) , or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization , Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization , Attestation and Release , all references to the Entity, its Agent(s) , and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true , correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing , and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s) . I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules, and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature: _____ Print Name: _____

Date: _____

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
0MB NO. 0938-0086

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

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

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

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

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

D Yes D No LB2

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

D Yes D No LB3

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

D Yes D No LB4

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

Name	Address	EIN
		LB5

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

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

Check appropriate box for each of the following questions:

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

D Yes D No LB?

Name	Address	Provider Number

IV. (a) Has there been a change in ownership or control within the last year?
If yes, give date _____ D Yes ☐ No LBS

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? _____ D Yes ☐ No LB9

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? _____ ☐ Yes ☐ No LB10

V. Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations _____ D Yes ☐ No LB11

VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?
D Yes ☐ No LB12

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)
Name EIN # D Yes ☐ No LB13

Address

LB14

VII. (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain?
(If yes, list Name, Address of Corporation, and EIN)
Name EIN # D Yes D No LB18

Address

LB19

VIII. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years?
D Yes D No LB15

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

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

Name of Authorized Representative (Typed)	Title

Signature	Date

Remarks