Children with Special Health Care Needs (CSHCN) Services Program Provider Enrollment Application

TMHP
Texas Medicaid & Healthcare Partnership

A STATE MEDICAID CONTRACTOR

Rev. XXVIII

Introduction

Dear Health-care Professional:

Thank you for your interest in becoming a Children with Special Health Care Needs (CSHCN) Services Program provider. Participation by providers in the CSHCN Services Program is vital to the successful delivery of services to the clients of the CSHCN Services Program, and we welcome your application for enrollment.

This application must be completed in its entirety as outlined in the instructions below and will be reviewed by the Department of State Health Services (DSHS) and the claims contractor Texas Medicaid & Healthcare Partnership (TMHP).

Providers are encouraged to review the current *CSHCN Services Program Provider Manual* for information about provider responsibilities, claims filing procedures, filing deadlines, benefits and limitations, and much more. The provider manual is updated monthly, and the current and archived provider manuals can be accessed on the TMHP web site at **www.tmhp.com**. Select "CSHCN Provider Manual" from the CSHCN Providers page.

There is no guarantee your application will be approved for processing or you will be assigned a CSHCN Services Program Texas Provider Identifier (TPI) number. If you make the decision to provide services to a CSHCN Services Program client prior to approval of the application, you do so with the understanding that, if the application is denied, claims will not be payable by the CSHCN Services Program.

Affordable Care Act (ACA) Requirements

In compliance with the Affordable Care Act of 2010 (ACA), all Medicare and Medicaid providers are subject to ACA screening procedures for newly enrolling and re-enrolling providers. Providers that have fulfilled the ACA requirements through their Texas Medicaid enrollment are considered ACA compliant for all subsequent program enrollments. Providers who enroll only in the CSHCN Services Program (medical foods providers and hospice providers) are also required to undergo the ACA screening procedures, pursuant to 25 Texas Administrative Code (TAC) §38.6(a)(8).

Refer to: Code of Federal Regulations (CFR) Title 42, Ch. IV, Part 455, Subpart E-Provider Screening and Enrollment; and Texas Administrative Code (TAC) Title 1, Part 15, Chapter 352, for the statutory provisions for these requirements.

Application Correspondence

All correspondence related to this application (i.e., enrollment denials, deficiency letters) will also be mailed to the physical address listed on your application unless otherwise requested in the Contact Information section of this application.

Contact Information

For information about CSHCN Services Program provider identifier requirements, the status of your enrollment, or claims submission, call TMHP-CSHCN Services Program Contact Center toll-free at 1-800-568-2413.

Thank you for your applying to become a CSHCN Services Program provider.

Table of Contents

Instructions

PREREQUISITE: With the exception of Medical Foods and Hospice providers, all providers rendering Medicaid services must be enrolled with Texas Medicaid as a prerequisite to enrolling in the CSHCN Services Program. Call the TMHP Contact Center at 1-800-925-9126 for information about Texas Medicaid and provider enrollment criteria.

To avoid any delay of the enrollment process, use this sheet as a checklist. For assistance with completing these forms, call the TMHP CSHCN Services Program Contact Center at 1-800-568-2413 and select option 2 to speak with a TMHP provider enrollment representative.

☐ **Deemed Enrollment:** Under certain circumstances, a provider who is actively enrolled in Medicaid in good standing may be deemed enrolled in the program without completing the usual application process. Providers applying for Deemed Enrollment should check the Deemed Enrollment box and submit this page, along with a signed CSHCN Services Program Provider Enrollment Agreement, found on pages 29 - 32.

ALL PROVIDERS – Forms and Attachments

To complete the CSHCN Services Program enrollment application process, the following forms must be completed and returned for processing:

- ☐ CSHCN Services Program Provider Enrollment Application
- ☐ Application Payment Form
- ☐ CSHCN Services Program Identification Form
- ☐ Provider Agreement with the Texas Health and Human Services Commission (HHSC) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program *(original signature is required)*
- ☐ Provider Information Form (PIF-1) *(If applying for CSHCN Services Program enrollment more than one year from your Texas Medicaid enrollment date)*
- ☐ Principal Information Form (PIF-2) *(If applying for CSHCN Services Program enrollment as an Individual, Group, or Facility more than one year from your Texas Medicaid enrollment date)*
- ☐ Disclosure of Ownership and Control Interest Statement Form *(If applying for CSHCN Services Program enrollment as an Individual, Group, or Facility more than one year from your Texas Medicaid enrollment date)*
- ☐ IRS W-9 Form *(If applying for CSHCN Services Program enrollment as an Individual, Group, or Facility more than six months from your Texas Medicaid enrollment date)*

The following attachments must be submitted with the enrollment application when applicable:

- ☐ Required Information for Enrollment as a CSHCN Services Program Dental Orthodontia Provider
- ☐ Required Information for Customized Durable Medical Equipment (DME) Providers

Important: *Retain a copy for your records of all documents submitted for enrollment.*

Mail your application to the following address:

Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
P.O. Box 200795
Austin, TX 78720-0795

PERFORMING PROVIDER

If the performing provider is the applicant, and the applicant is to be added to an existing group, the applicant must complete the following sections of this CSHCN Services Program Provider Enrollment Application:

- Section A. Provider of Service Information
- Section D. Provider Information Form (PIF-1)
- Provider Agreement with the Texas Health and Human Services Commission (HHSC) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program (original signature required)

If the group is the applicant, each performing provider that is listed in Section C of this application must also complete a PIF-1 and a Provider Agreement with the Texas Health and Human Services Commission (HHSC) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program. All completed forms must be submitted with the group's CSHCN Services Program Provider Enrollment Application.

INSTRUCTIONS – Completing the Application and Other Forms

Complete the CSHCN Services Program Provider Enrollment Application using the following information:

Item	Instructions
Application Payment Form	Certain providers are required to submit the application fee. This application cannot be processed if the application fee is required and is not submitted with the application. Refer to the TMHP Affordable Care Act website at www.tmhp.com to determine if you are required to pay the application fee.
CSHCN Services Program Identification Form	To ensure proper enrollment, check the appropriate boxes below to indicate all services you will provide. An enrollment application must be submitted for each provider type requested.
Type of Enrollment:	Choose the appropriate box to indicate if this is a new enrollment for a new provider, new practice location, etc. or if this enrollment is in response to an enrollment revalidation letter.
Requesting Enrollment as:	Choose one as defined below: **Individual enrollment.** This type of enrollment applies to an individual health-care professional who is licensed or certified in Texas, and who is seeking enrollment under the name, and social security or tax identification number of the individual. An individual may also enroll as an employee, using the tax identification number of the employer. Certain provider types must enroll as individuals, including dieticians, occupational therapists, and speech therapists. **Group enrollment.** This type of enrollment applies to health-care items or services provided under the auspices of a legal entity, such as a partnership, corporation, limited liability company, or professional association, and the individuals providing health-care items or services are required to be certified or licensed in Texas. The enrollment is under the name and tax identification number of the legal entity. For any group enrollment application, there must also be at least one enrolling performing provider.

Item	Instructions
Requesting Enrollment as (*continued*):	**Performing Provider enrollment.** This type of enrollment applies to an individual health-care professional who is licensed or certified in Texas, and who is seeking enrollment under a group. The enrollment is under the tax identification number of the group, and payment is made to the group. If a health-care professional is required to enroll as an individual, as explained above, but the person is an employee and payment is to be made to the employer, the health-care professional does not enroll as a performing provider. Instead, the health-care professional enrolls as an individual provider under the tax identification number of their employer. **Facility enrollment:** This type of enrollment applies to situations in which licensure or certification applies to the entity. Although individuals working for or with the entity may be licensed or certified in their individual capacity, the enrollment is based on the licensure or certification of the entity. For this reason, facility enrollment does not require enrollment of performing providers.
CSHCN Services Program Provider Enrollment Application	
A.1 - A.3 Provider of Services Information	This section is for provider demographic information. Provide complete and correct information as required. Telemonitoring Services - Indicate if you are a home health agency or hospital, and you provide telemonitoring services.
Section B - Disclosure of Ownership and Control Interest Statement	Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles V, XVIII, XIX and XX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the appropriate State agency to enter into an agreement or contract with any such institution in termination of existing agreements.
B.1 PIF-2	A separate copy of the Principal Information Form (PIF-2) must be completed in full for each Principal or Subcontractor of the Provider, before enrollment.
Section C – Group Practice	Group practice information. If this enrollment if for a group practice, please complete Section C, and provide complete and correct information as required.
Section D - PIF-1	Each Provider must complete the Provider Information Form (PIF-1), before enrollment.
Provider Agreement with the Texas Health and Human Services Commission (HHSC) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program	Complete the required information at the beginning of the form, read the agreement information, and sign and date the agreement to indicate that you have read and agree with the terms of enrollment as required by the CSHCN Services Program.
IRS W–9 Form	Provide complete and correct information as required. **This form is available for download on the TMHP website at www.tmhp.com.**

CONTACT INFORMATION – Point of Contact for this Application

Provide a point of contact for questions about this application, and include an alternate address if deficiency letters should be mailed somewhere other than the physical address on this application.

Contact Name: *Last*	*First*	*Middle Initial*

Contact Telephone Number:	**Contact Fax** *(if applicable)*:

Email Address *(if applicable)*:

Address: *Number*	*Street*	*Suite No.*	*City*	*State*	*ZIP Code*

Application Payment Form

In accordance with ACA and 42 CFR §455.460, and in accordance with the health and safety code, title 2, §35.009, and 25 TAC §38.6(a)(8), certain providers are subject to an application fee for all applications, including, but not limited to:

- Initial applications for new enrollment
- Applications for a new practice location
- Applications received in response to re-enrollment

Choose one of the following:

☐ I am submitting the application fee by paper check, money order, or cashier's check with this application.

☐ I attest that I have already paid the application fee on or after March 25, 2011, to Medicare or another state Medicaid or CHIP program, and have been approved for enrollment in Medicare or the other state Medicaid or CHIP program. My proof of payment and enrollment is attached to this application. I understand that if my proof of payment to Medicare or another State Medicaid or CHIP program is found to be unacceptable for any reason, I may be required to pay an application fee towards my Texas Medicaid enrollment application.

Important: *Proof of payment must be attached to this application.*

☐ I have received a hardship waiver from CMS for a Medicare enrollment application. I understand that I must submit proof of my Medicare application fee waiver approval notification. A copy of my approved Medicare waiver is attached to this application.

☐ I am requesting an application fee waiver due to hardship. My documentation that supports the need for the request is attached to this application. I understand that I must submit a letter (and supporting documentation) with my enrollment application that details the reason(s) I am unable to pay an application fee. I understand that if the waiver request is denied, I will be required to submit an application fee if I wish to proceed with the enrollment process.

Note: *If a hardship waiver was issued by another state, you must also request a waiver from the CSHCN Services Program.*

☐ The application fee is not applicable for my provider type.

CSHCN Services Program Identification Form

REQUIRED: All providers rendering Medicaid services must be enrolled with Texas Medicaid as a prerequisite to enrolling in the CSHCN Services Program. Call the TMHP Contact Center at **1-800-925-9126** for information about Texas Medicaid and provider enrollment criteria.

Type Of Enrollment:

☐ New enrollment (new provider, practice location, etc.) ☐ Provider re-enrollment

Requesting Enrollment As:

Select only one of the following options. Selecting more than one of the following options may result in a delay in processing this enrollment application.

☐ Individual ☐ Facility ☐ Group ☐ Performing Provider

Provider Type:

To ensure proper enrollment, check the appropriate box below to indicate all services you will provide. An enrollment application must be submitted for each provider type requested.

Select only one of the following options. Selecting more than one of the following options may result in a delay in processing this enrollment application.

Durable Medical Equipment

- ☐ Augmentative Communicative Devices Supplier
- ☐ Custom Durable Medical Equipment (DME) Supplier (Custom DME is medical equipment made or modified specifically to address the individual client's needs.)
- ☐ Expendable Medical Supplies
- ☐ Medical Foods Supplier (Medicaid enrollment is not required for this provider type)
- ☐ Medical Nutritional Products Supplier
- ☐ Non Custom Durable Medical Equipment (DME) Supplier
- ☐ Total Parenteral Nutrition (TPN) Services Supplier

Other Facilities

- ☐ Federally Qualified Health Center (FQHC)
- ☐ Federally Qualified Lookalike (FQL)
- ☐ Federally Qualified Satellite (FQS)
- ☐ Freestanding Surgical Centers
- ☐ ▲ Hospice
- ☐ ▲ Home Health (skilled nursing) Agency
- ☐ Independent Diagnostic Testing Facility (IDTF)
- ☐ Independent Lab
- ☐ ▲ Renal Dialysis Facility
- ☐ Rural Health Center- Hospital, Freestanding
- ☐ Supplier of Hemophilia Blood Factor Products
- ☐ Radiation Treatment Facility
- ☐ Pharmacy
- ☐ ▲ Pharmacist administering immunizations
- ☐ ▲ Prescribed Pediatric Extended Care Center
- ☐ ▲ Ambulance / Air Ambulance

Hospital

- ☐ ▲ Hospital—Acute Care
- ☐ ▲ Hospital—Psychiatric
- ☐ ▲ Hospital—Rehabilitation
- ☐ ▲ Hospital Ambulatory Surgical Center (HASC)

Physicians and Nurses

- ☐ ▲ Physician (MD, DO)
- ☐ ▲ Physician Assistant
- ☐ ▲ Nurse Practitioner/Clinical Nurse Specialist
- ☐ ▲ Certified Registered Nurse Anesthetist (CRNA)

Dental Services

- ☐ ▲ Dentist
- ☐ ▲ Orthodontist

Hearing and Vision Services

- ☐ ▲ Audiologist
- ☐ ▲ Hearing Aid
- ☐ Dispensing Optical Company
- ☐ Optician
- ☐ ▲ Optometrist (OD)

Prosthetists and Orthotists

- ☐ ▲ Orthotist
- ☐ ▲ Prosthetist
- ☐ Prosthetic-Orthotic Services (choose if licensed as both)

Other Professionals

- ☐ ▲ Anesthesiologist Assistant
- ☐ ▲ Dietitian
- ☐ ▲ Geneticist
- ☐ ▲ Licensed Clinical Social Worker (LCSW)
- ☐ ▲ Licensed Professional Counselor (LPC)
- ☐ ▲ Occupational Therapist (OT)
- ☐ ▲ Physical Therapist (PT)
- ☐ ▲ Podiatrist
- ☐ ▲ Psychologist
- ☐ ▲ Respiratory Care Practitioner
- ☐ ▲ Speech-Language Pathologist (SLP)

▲ Providers are required to submit a copy of their license/certification with the enrollment application. A provider cannot be enrolled if his or her license/certification is due to expire within 30 days of the date of application.

CSHCN Services Program Provider Enrollment Application

- All information must be completed or marked "N/A".
- Original signatures are required. Copies or stamped signatures will not be accepted.
- Use blue or black ink.
- Providers must inform the CSHCN Services Program, in writing, within 10 calendar days of any change or if additional information becomes available. If you have any questions, call the TMHP CSHCN Services Program Contact Center at 1-800-568-2413 and select option 2.

Section A: Provider of Service Information

All applicants, complete the following information.

A.1 Provider Type Specific Information

The applicant (individual, facility, group, or performing provider) must complete the following questions as applicable:

Hearing aid providers only:	**Do you provide hearing services for children?**	☐ Yes ☐ No
	Will you be fitting and dispensing hearing aids?	☐ Yes ☐ No
Home health agencies and hospitals only:	**Do you offer telemonitoring services?**	☐ Yes ☐ No

A.2 Provider Specialty/Taxonomy Information

The applicant (individual, facility, group, or performing provider) must complete the following questions as applicable.

Primary Specialty:	**Sub-Specialty: (if applicable)**
Primary Taxonomy Code:	

If the applicant is a performing provider, complete the following:

Group TPI: (if enrolling as a performing provider into an existing group)

A.3. Demographic Information

The applicant (individual, facility, group, or performing provider) must complete the following questions as applicable:

Existing Texas Provider Identifiers (TPIs): *(List all TPIs associated with the individual/group enrolling)*
List NPI and Primary Taxonomy Code:

Group/Company or Last Name First Initial Title/Degree: *(list performing provider information in Section C)*		
Provider business e-mail: *(optional)*	**Provider website address:** *(optional)*	
Telephone number:	**Social Security Number:** *(for individual enrollment only)*	
Professional License Number:	**Initial issue date:** MM/DD/YYYY	**Expiration date:** MM/DD/YYYY
Legal name according to the IRS: *(must match the legal name field on the W-9 & Disclosure of Ownership)*	**Date of birth:** MM/DD/YYYY	**Federal Tax ID number:**

Physical address: *(where health care is rendered)*

Number Street Suite City State ZIP

Accounting/billing address: *(if applicable)*

Number Street Suite City State ZIP

Physical address FAX number:	**Accounting/billing address FAX number:** *(optional)*

Accepting new clients:	**Gender served:**	**Client age restrictions:**
☐ Yes ☐ No	☐ Male ☐ Female ☐ All	

Counties served:

Indicate your reason for applying to enroll with the Texas State Health-Care Programs: *(Select one)*

- ☐ Access to an online application
- ☐ Adding a new location
- ☐ Adding performing provider to an existing group
- ☐ Electronic claims processing
- ☐ Improved administrative processes
- ☐ Incentive programs
- ☐ Learned about Texas State Health-Care Programs at a conference
- ☐ Learned about Texas State Health-Care Programs at a provider workshop
- ☐ Recruited by Texas State Health-Care Programs staff
- ☐ Recruited by TMHP Provider Relations representative
- ☐ Re-enrolling a provider under an existing provider identifier
- ☐ Reimbursement increases
- ☐ Timely reimbursement

Section B: Disclosure of Ownership and Control Interest Statement

B.1 Disclosure of Ownership Instructions

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

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

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

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

ITEM I – Identifying Information
(a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, and name of trade or corporation.

ITEM II – Self–explanatory.

ITEM III – Owners, Partners, Officers, Directors, and Principals
List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity. 501 (c) (3) nonprofit and state-owned entities must list the officers or directors that have a control interest in the entity and managing employees in Section III(a). Since there will be no entries for any person with an ownership interest (Section III[b]), the percentage of ownership will always be less than 100 percent.

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

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if "A" owns 25 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, "A's" interest equates to a 20 percent indirect ownership and must be reported.

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

Note: *All individuals listed in Section III(a) must submit a PIF-2.*

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

For items IV through VII, if the **Yes** box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

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

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

ITEM VI – Staffing
If the answer is **Yes**, identify which has changed (Administrator, Medical Director or Director of Nursing) and the date the change was made. Be sure to include name of the new administrator, Director of Nursing or Medical Director, as appropriate.

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

ITEM VIII – Capacity
If the answer is **Yes**, list the actual number of beds in the facility now and the previous number.

ITEM IX - Disclosure of Relationship
Please disclose any of familial relationships between principals and/or the provider (i.e., Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling).

B.2 Disclosure of Ownership Form (3 Pages)

This form is required for all individuals, groups, and facilities (exclude performing providers and SHARS providers).

I.	Identifying information		
(a)	**Legal Name:** *(according to the IRS)*	**DBA:**	**Telephone number:**
	Physical/Corporate Address: Number Street Suite City State ZIP		

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 the Disclosure of Ownership and Control Interest Statement form. Identify each item number to be continued.*	
(a)	**Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations, in any of the programs established by Titles XVIII, XIX, or XX?**	☐ Yes ☐ No
(b)	**Does this provider have any current employees in the position of manager, accountant, auditor, or in a similar capacity and who were previously employed by this provider's fiscal intermediary or carrier within the last 12 months?** *(Medicare providers only)*	☐ Yes ☐ No

III.	Owners, Partners, Officers, Directors, and Principals *All individuals and entities identified in this section are required to complete a PIF-2 which must be submitted with this enrollment application.*	
(a)	**Identify individuals who are sole proprietors or owners, partners, officers, directors, and principals (as defined in the Principal Information Form [PIF-2]) of the applicant and list the percentage of ownership, if applicable. Total ownership should equal 100 percent unless otherwise noted in the instructions (see previous page). If ownership does not total 100 percent, the provider must submit a letter explaining the discrepancy. As it relates to owners, include all individuals with 5 percent or more ownership in the company, whether this ownership is direct or indirect.** ***(Add additional pages if necessary.)***	
	1. Name:	**Percentage Owned:**
	2. Name:	**Percentage Owned:**
	3. Name:	**Percentage Owned:**
	4. Name:	**Percentage Owned:**

(b)	**Identify the entities with ownership of a controlling interest in the applicant (whether such ownership of the controlling interest is direct or indirect). Provide the entity's name and federal tax identification number.** *See Instructions for Completing the Disclosure of Ownership and Control Interest Statement. List any additional names and addresses under Remarks on the Disclosure of Ownership and Control Interest Statement. 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:**	**Federal Tax ID:**

(c)	**Do you currently have a creditor with a security interest in a debt that is owed by you?** **Is the creditor(s) security interest protected by at least 5 percent of your property?**		☐ Yes ☐ No ☐ Yes ☐ No
	List each creditor with a security interest in a debt that is owed by you if the creditor's security interest is protected by at least 5 percent of your property. *All listed creditors must also complete a Principal Information Form (PIF-2).*		
	Last Name/Company Name:	**First Name:**	**Percent of Security Interest:**
(d)	**Type of Entity:** *Select only one - must match entity on W9*		
	☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Limited liability company. (*Enter the tax classification [C=C corporation, S=S corporation, P=partnership]*) _____ ☐ Trust/estate ☐ Other *(specify)* _____ _____		
(e)	**If the disclosing entity is a corporation, list names, addresses of the directors and EINs for corporations in remarks.** ***Note:*** *Each director identified in this section must also complete a PIF-2. All PIF-2 documents must be submitted with this application. Attach additional pages if needed.*		
	Remarks:		

IV.	**Ownership**		
(a)	**Has there been a change in ownership or control within the last year?**		☐ Yes ☐ No
	If **Yes**, *give date:*		
(b)	**Do you anticipate any change of ownership or control within the year?**		☐ Yes ☐ No
	If **Yes**, *give date:*		
(c)	**Do you anticipate filing for bankruptcy within the year?** *(see provider agreement for additional information)*		☐ Yes ☐ No
	If **Yes**, *give date:*		
(d)	**Are any of the new owners related to any of the former owners?**		☐ Yes ☐ No
(e)	**Did any former owners transfer their ownership interest to any new owners in anticipation of or following the assessment of a civil monetary penalty?** *If yes, please list the name of the former owners below.*		☐ Yes ☐ No
	Last Name:	**First Name:**	Middle Initial:

V.	**Management**	
	Does the provider identified in Section I. above comprise or include a facility that is operated by a management company, or a facility that is leased in whole or in part by another organization?	☐ Yes ☐ No
	If **Yes**, *give date of change in operations:*	

VI.	Staffing	
(a)	**Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?**	☐ Yes ☐ No

VII.	Affiliation	
(a)	**Is the provider identified in Section I. above chain affiliated?**	☐ Yes ☐ No
	If **Yes**, *provide the name, address, and Federal Tax ID number of the chain's corporate/home office:* Name Address Federal Tax ID	

VIII.	Capacity	
(a)	**Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last two years?** *(For Hospitals only)*	☐ Yes ☐ No
	If **Yes**, *give:* **Year of change:** **Current Beds:** **Prior Beds:**	

IX.	Disclosure of Relationship		
(a)	**Please disclose any of the following familial relationships between principals and/or the provider (Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling):**		
	Provider/Principal 1:	**Has a Relationship as:**	**To Provider/Principal Name 2:**

Please Note: When claiming "Corporation" providers must complete and return the following forms:

- Corporate Board of Directors Resolution Form, original signature and notarized.
- Certificate of Formation, Certificate of Filing, Certificate of Authority, or Certificate of Registration.
- Franchise Tax Account Status, available at https://mycpa.cpa.state.tx.us/coa/Index.html.

Do you have a 501(c)(3) Internal Revenue Exemption? ☐ Yes ☐ No

Providers who answer "yes" to the question "Do you have a 501©(3) Internal Revenue Exemption" must submit a copy of their IRS Exemption Letter with submission of this application's signature page. Providers who have a 501(c)(3) Internal Revenue Exemption are not required to submit a copy of the Franchise Tax Account Status from the State Comptroller's Office.

B.3 Principal Information Form (PIF-2) (6 Pages)

Required for any person or entity that meets the definition of a "Principal" or "Subcontractor" as defined below.

A separate copy of this Principal Information Form (PIF-2) must be completed in full for each Principal or Subcontractor of the Provider, before enrollment.

A **Principal** of the Provider is defined as follows:

- All owners with a direct or indirect ownership or control interest of 5 percent or more.
- All corporate officers and directors, all limited and non-limited partners, and all shareholders of a provider entity (including a professional corporation, professional association, or limited liability company).
- All managing employees or agents who exercise operational or managerial control, or who directly or indirectly manage the conduct of day-to-day operations.
- All individuals, companies, firms, corporations, employees, independent contractors, entities or associations who have been expressly granted the authority to act for or on behalf of the provider.
- All individuals who are able to act on behalf of the provider because their authority is apparent.

A **Subcontractor** of the Provider is defined as follows:

- An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies

All spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Principal or Subcontractor.

All owners that have a 5 percent or more direct or indirect ownership interest in a provider that is assigned a high-categorical risk level must submit fingerprints for enrollment or revalidation in Texas Medicaid.

The Provider or provider's duly authorized representative must personally review each copy of this completed form and certify to the validity and completeness of the information provided by signing the Provider Agreement.

Check person or entity: ☐ Person ☐ Entity *If **Entity**, please complete the following information.*				
Tax ID number as shown on the W9 IRS form:		**Legal name as shown on the W9 IRS form:**		
Company Name:				
Address as shown on the W9 IRS form: Number Street	Suite	City	State	ZIP
How is the entity organized to conduct business activities? *Examples include: Sole Proprietor (Unincorporated), Professional Association, General Partnership, Limited Partnership, Limited Liability Partnership, Limited Liability Company, Corporation, Nonprofit, Governmental*				
Do you conduct business under an assumed name? *If **Yes**, provide the assumed name below.*			☐ **Yes** ☐ **No**	
Assumed Name:				

*If you selected **Person** above, please complete the following information.*	
Last Name:	**First Name/Middle Initial:**
Maiden Name:	**List any other alias, name, or form of your name ever used:**

The following information must be completed by all Principals, Subcontractors, and Creditors. For additional names or addresses, attach pages as necessary.

Check **principal** or **subcontractor** ☐ Principal ☐ Subcontractor

Physical address: Number	Street	Suite	City	State	ZIP

Accounting/billing address: Number	Street	Suite	City	State	ZIP

If your accounting address is different than your physical address, indicate your relationship to the accounting address:

☐ Billing agent ☐ Management company ☐ Employer ☐ Self ☐ Other *(explain below)*

If you chose **Other**, *please explain:*

Social Security Number:	**Federal Tax ID number:**
Specialty of practice: *(i.e., pediatrics, general practice, etc.)*	**Medicare intermediary:** *(if applicable)*
Medicare provider number: *(if applicable)*	**Medicare effective date:** MM/DD/YYYY *(if applicable)*

Driver's license number:	**State:**	**Driver's license expiration date:** MM/DD/YYYY

Date of birth: MM/DD/YYYY		**Gender:**	☐ Male ☐ Female

Do you have one or more professional licenses, accreditations, or certifications?		
☐ Yes ☐ No *If Yes, provide the following information.*		
1.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (MM/DD/YYYY):	**Expiration Date** (MM/DD/YYYY):
2.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (MM/DD/YYYY):	**Expiration Date** (MM/DD/YYYY):
3.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (MM/DD/YYYY):	**Expiration Date** (MM/DD/YYYY):
4.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date (MM/DD/YYYY):	**Expiration Date** (MM/DD/YYYY):

Previous Physical address: Number	Street	Suite	City	State	ZIP
Previous Accounting address: Number	Street	Suite	City	State	ZIP

Your title in the provider organization for which enrollment is being sought:
Your duties to the provider organization: *(attach additional sheets if necessary)*

Your role in the provider organization: *Examples are Accountant, Agency, Attorney, Banker, Bookkeeper, Business, Care Giver, Consultant, Contractual, Corporate Officer, Director, Doctor, Elected Official, Employee, Employer, Government Official , Individual (Contracted), Individual (Fiscal Agent), Limited Partner, Managing Employee, Medical Director, Non-Limited Partner, Nurse, Official, Owner (Direct), Owner (Indirect) Parent, Recruiter, Representative, Shareholder, Subcontractor, or Unknown: (attach additional sheets if necessary)*
Effective date of your role in the provider organization: MM/DD/YYYY

Do you have a relationship with a separate provider?	☐ Yes ☐ No	**If "Yes," explain relationship with the separate provider below:**

List all TPIs, provider names, and physical locations under which you have billed or in which your were a principal. Include current and previous TPIs : *(attach additional sheets if necessary)*

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. *(attach additional sheets if necessary)*

1.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
2.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
3.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
4.	**Name:**	**Social Security Number:**	**Date of birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.	
Have you ever been sanctioned (as defined above) in any state or federal program?	☐ Yes ☐ No

If **Yes**, *fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (attach additional sheets if necessary)*

Is your professional license or certification currently revoked, suspended or otherwise restricted?	☐ Yes ☐ No
Have you ever had your professional license or certification revoked, suspended, or otherwise restricted?	☐ Yes ☐ No
Are you currently, or have you ever been, subject to a licensing or certification board order?	
Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action?	☐ Yes ☐ No
(You may be subject to a license or certification verification/status check with your licensing or certification board.)	☐ Yes ☐ No

If **Yes** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (attach additional sheets if necessary)*

Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State or Federally funded program?	☐ Yes ☐ No
Do you currently have any outstanding debt in relation to any State or Federally funded program?	☐ Yes ☐ No

If ***Yes*** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, and name of the board or agency. (attach additional sheets if necessary)*

"Convicted" means that:

(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:

(1) There is a post-trial motion or an appeal pending, or

(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;

(b) A Federal, State or local court has made a finding of guilt against an individual or entity;

(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or

(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? *To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.*	☐ Yes ☐ No
Have you been arrested for a crime but not yet charged?	☐ Yes ☐ No
Is there an outstanding warrant for arrest?	☐ Yes ☐ No

If **Yes**, *fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*

Are you currently subject to court ordered child support payments?	☐ Yes ☐ No
If **Yes**, *please provide details.*	
Are you currently behind 30 days or more on court ordered child support payments?	☐ Yes ☐ No
If **Yes**, *provide details of how these past-due payment obligations will be met. (attach additional sheets if necessary)*	
Are you a citizen of the United States?	☐ Yes ☐ No
If **No**, *provide the country of which you are a citizen.*	
If you are not a citizen of the United States, do you have a legal right to work in the United States? *If* **Yes**, *attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.*	☐ Yes ☐ No

Section C: Group Practice

This section is only for applicants that are enrolling as a group practice.

Note: *All performing providers listed here must complete a separate PIF-1 and the Provider Agreement with the Department of State Health Services (DSHS) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program. See the instructions for additional information.*

If the applicant is enrolling as a single-specialty group or a clinic/group practice, list all performing providers that will be enrolled as part of the group:

1.	**Name:**	**Date of birth:** MM/DD/YYYY	**Social Security Number:**	**Title/Degree:**
	TPI number(s): *(only applicable for existing performing providers)*	**Professional license number:**	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY
2.	**Name:**	**Date of birth:** MM/DD/YYYY	**Social Security Number:**	**Title/Degree:**
	TPI number(s): *(only applicable for existing performing providers)*	**Professional license number:**	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY
3.	**Name:**	**Date of birth:** MM/DD/YYYY	**Social Security Number:**	**Title/Degree:**
	TPI number(s): *(only applicable for existing performing providers)*	**Professional license number:**	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY
4.	**Name:**	**Date of birth:** MM/DD/YYYY	**Social Security Number:**	**Title/Degree:**
	TPI number(s): *(only applicable for existing performing providers)*	**Professional license number:**	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY
5.	**Name:**	**Date of birth:** MM/DD/YYYY	**Social Security Number:**	**Title/Degree:**
	TPI number(s): *(only applicable for existing performing providers)*	**Professional license number:**	**Professional license initial issue date:** MM/DD/YYYY	**Pharmacist certification issue date:** MM/DD/YYYY

Notification of your assigned CSHCN Services Program TPI will be mailed to the Physical address listed on your application. All correspondence related to this application (i.e. enrollment denials, deficiency letters) will also be mailed to the physical address listed on your application unless otherwise requested.

Section D: Provider Information Form (PIF-1) (6 Pages)

Each Provider must complete this Provider Information Form (PIF-1), before enrollment. A provider is any person or legal entity that meets the definition below.

Each Provider must also complete a Principal Information Form (PIF-2), for each person who is a Principal of the Provider (see the PIF-2 form for a complete definition of every person who is considered to be a Principal of the Provider).

All questions on this form must be answered by or on behalf of the Provider, by ALL provider types (all spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Provider).

All high-categorical risk level providers must submit fingerprints for enrollment or revalidation in Texas Medicaid.

The Provider or provider's duly authorized representative must personally review this completed form and certify to the validity and completeness of the information provided by signing the HHSC Medicaid Provider Agreement or other State Health-Care Program Agreement.

"Provider" - Any person or legal entity, including a managed care organization and their subcontractors, furnishing Medicaid services under a State Health-Care Program provider agreement or contract in force with a State Health-Care Program, and who has a provider number issued by the Commission or their designee to:

1. provide medical assistance under contract or provider agreement with HHSC, DSHS or its designee; or
2. provide third party billing services under a contract or provider agreement with HHSC, DSHS or its designee.

A "Third-Party Biller" is a type of "Provider" under the above definition and is a person, business, or entity that submits claims on behalf of an enrolled health care provider, but is not the health care provider or an employee of the health care provider. For these purposes, an employee is a person for which the health care provider completes an IRS Form W-2 showing annual income paid to the employee.

Name of Provider Enrolling: (*Group/Company name or Last, First, Middle Initial*)	**Maiden Name:**

List any other alias, name, or form of your name ever used:	**National Provider Identifier (NPI):** *(10-digit)*

Primary Taxonomy Code: *(10-digit)*

Secondary Taxonomy Code: *(10-digit – the provider may indicate up to 15 taxonomy codes; attach additional pages if needed)*

Non-Texas-enrolled Taxonomy Code: *(these codes are informational and describe services the provider performs but for which the provider does not currently bill Texas Medicaid)*

For additional names or addresses, attach pages as necessary.

Physical Address (where health care is rendered): *Providers MUST enter the physical address where the services are rendered to clients. If the accounting, corporate, or mailing address is entered in this physical address field, the application may be denied.*					
Number	Street	Suite	City	State	ZIP
Accounting/Billing Address:					
Number	Street	Suite	City	State	ZIP

If your accounting address is different than your physical address, indicate your relationship to the accounting address:
☐ Third Party Biller ☐ Management Company ☐ Employer ☐ Self ☐ Other *(explain below)*

If you chose **Other**, *please explain:*

Supervising /Consulting/Referring Physician License Number and State: (if required by your licensing or certification board:	Issue Date: MM/DD/YYYY	Expiration Date: MM/DD/YYYY

Social Security Number:	Federal Tax ID Number:
Specialty of Practice: *(i.e., pediatrics, general practice, etc.)*	**Medicare Intermediary:** *(if applicable)*
Medicare Provider Number: *(if applicable)*	**Medicare Effective Date:** MM/DD/YYYY *(if applicable)*

Driver's License Number:	State:	Driver's License Expiration Date: MM/DD/YYYY

Date of Birth: MM/DD/YYYY		Gender:	☐ Male ☐ Female

Do you have one or more professional licenses, accreditations, or certifications?

☐ Yes ☐ No *If Yes, provide the following information.*

1.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date: MM/DD/YYYY	**Expiration Date: MM/DD/YYYY**
2.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date: MM/DD/YYYY	**Expiration Date: MM/DD/YYYY**

3.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date: MM/DD/YYYY	**Expiration Date: MM/DD/YYYY**
4.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date: MM/DD/YYYY	**Expiration Date: MM/DD/YYYY**

CLIA Certification Number: *(attach a copy of the CLIA certification, if applicable)*
Hospitals providing laboratory services, and independent laboratories (including those located in physician's offices), must answer all CLIA certification questions. The CLIA rules and regulations are available on the CMS website at www.cms.gov.

CLIA Certification Address: *(list the address listed on the CLIA Certificate, if applicable)*
Number Street Suite City State ZIP

CLIA Certification Effective Date (*if applicable*):	**CLIA Certification Expiration Date (*if applicable*):**

Previous Physical Address:
Number Street Suite City State ZIP

Previous Accounting Address:
Number Street Suite City State ZIP

Do you plan to use a Third Party Biller to submit your health-care claims?

☐ Yes ☐ No *If* **Yes**, *provide the following information about the billing agent.*

Billing Agent Name:	**Address:**
Federal Tax ID Number:	
Contact Person Name:	**Telephone Number:**

List all Providers and medical entities that you have a contractual relationship with and, if known, the NPI/API and TPI of each provider or entity. *(attach additional sheets if necessary)*

1.	**Name:**	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
2.	**Name:**	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
3.	**Name:**	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
4.	**Name:**	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**
5.	**Name:**	**Social Security Number:**	**Date of Birth:** MM/DD/YYYY
	Physical Address: Number Street Suite City State ZIP		
	Federal Tax ID:	**TPI:**	**NPI/API:**

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action.	
Have you ever been sanctioned (as defined above) in any state or federal program?	☐ Yes ☐ No

If **Yes**, *fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (attach additional sheets if necessary)*

Is your professional license or certification currently revoked, suspended or otherwise restricted?	☐ Yes ☐ No
Have you ever had your professional license or certification revoked, suspended, or otherwise restricted?	☐ Yes ☐ No
Are you currently, or have you ever been, subject to a licensing or certification board order?	☐ Yes ☐ No
Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action?	☐ Yes ☐ No
(You may be subject to a license or certification verification/status check with your licensing or certification board.)	

If **Yes** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (attach additional sheets if necessary)*

Have you ever enrolled in or applied to any other State's Medicaid or CHIP program?	☐ Yes ☐ No
Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State or Federally funded program?	☐ Yes ☐ No
Do you currently have any outstanding debt in relation to any State or Federally funded program?	☐ Yes ☐ No

If **Yes** *was answered to any of the questions, fully explain the details including date, and the state if applicable.*

"Convicted" means that: **(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:** **(1) There is a post-trial motion or an appeal pending, or** **(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;** **(b) A Federal, State or local court has made a finding of guilt against an individual or entity;** **(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or** **(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.**	
Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? *To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.*	☐ Yes ☐ No
Have you been arrested for a crime but not yet charged?	☐ Yes ☐ No
Is there an outstanding warrant for your arrest?	☐ Yes ☐ No
If **Yes**, *fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*	
Are you currently subject to court-ordered child support payments?	☐ Yes ☐ No
If **Yes**, *provide details.*	
Are you currently behind 30 days or more on court ordered child support payments?	☐ Yes ☐ No
If **Yes**, *provide details of how these past-due payment obligations will be met. (attach additional sheets if necessary)*	
Are you a citizen of the United States?	☐ Yes ☐ No
If **No**, *provide the country of which you are a citizen.*	
If you are not a citizen of the United States, do you have a legal right to work in the United States? *If* **Yes**, *attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.*	☐ Yes ☐ No

Fingerprint Criminal Background Check (FCBC) for High-Categorical Risk Providers

☐ I acknowledge that I am required to submit proof of fingerprinting.

Provider Agreement with the Health and Human Services Commission (HHSC) for Participation in the Children with Special Health Care Needs (CSHCN) Services Program

Name of provider enrolling:	
Medicaid TPI:	**CSHCN Services Program TPI (*if applicable*):**
Physical address: Number Street Suite City State ZIP	
Mailing address: *(if applicable)* Number Street Suite City State ZIP	

The provider agrees, in accordance with the state laws, rules and regulations pertaining to the Texas Health and Human Services Commission (HHSC), CSHCN Services Program, and as a condition for participation in this program, to the terms and conditions set forth below:

1. A copy of the current *CSHCN Services Program Provider Manual* may be accessed via the internet at www.tmhp.com. Provider has a duty to become familiar with the contents and procedures contained in the provider manual. Provider agrees to comply with all the requirements of the provider manual, as well as all state and federal laws and amendments, governing or regulating CSHCN Services Program. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the provider manual and all state and federal laws and amendments governing or regulating CSHCN Services Program.

2. To maintain and retain for a period of five years from the date of service, or until audit and all audit exceptions are resolved, whichever period is longer, such records as are necessary to fully disclose the extent of the services provided to the clients receiving assistance under the CSHCN Services Program and any information relating to payments claimed by the Provider. Providers must cooperate and assist HHSC or its designee, Office of Inspector General, and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Provider must also allow these agencies and/or their designees access to its premises. If litigation is involved, the records must be retained until litigation is ended or for five (5) years as cited above, whichever is longer.

3. To provide unconditionally, upon request, free copies of and access to all records pertaining to the services for which claims are submitted to CSHCN Services Program or its designees.

4. To accept CSHCN Services Program payment as payment in full for service. Provider may collect allowable insurance or health maintenance organization co–payments in accordance with those plan provisions.

5. Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes and provides such information, on request, to HHSC, Office of the Inspector General, and the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the CSHCN Services Program current by informing HHSC or its designee in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, phone number, or provider business addresses, within 30 days of the change. Provider also agrees to notify HHSC or its designee within 30 business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services, and Provider must submit to HHSC complete information related to any such suspension or restriction.

   Provider agrees to disclose all convictions of Provider and Provider's principals within 10 business days of the date of conviction. For purposes of this disclosure, Provider must use the definition of "Convicted" contained in Title 42, Code of Federal Regulations (CFR) §1001.2. All principals of the Provider include an owner with a direct or indirect ownership or control interest of 5% or more, is an agent or managing employee of the Provider, is a corporate officer or director, general or limited partner, agent, managing employee (including a general manager, business manager, administrator or director) who exercises operational or managerial control over the entity or part thereof, or directly or indirectly conducts the day-to-day operations of the entity or part thereof.

6. The Office of Inspector General, internal and external auditors for the state/federal government, and/or HHSC may conduct interviews of the Provider employees, subcontractors and their employees, witnesses, and clients without the Provider's representative or Provider's legal counsel present. Provider's employees, subcontractors and their employees, witnesses, and clients must not be coerced by the Provider or Provider's representative, to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied with in the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control, cooperate fully in any investigation conducted by the Office of Inspector General. Subcontractors are those persons or entities that provide medical goods or services for which the Provider bills the CSHCN Services Program or who provide billing, administrative, or management services in connection with CSHCN Services Program covered services.
7. Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by HHSC, or their designee, including electronic claims. Provider certifies that information submitted regarding claims will be true, accurate, and complete, and that the Provider's records and documents are accessible and validates the services and the need for services billed and represented as provided. Further, Providers understand that any falsification or concealment of a material fact may be prosecuted under state and federal laws.
8. Provider agrees to accept payments established by Texas Medicaid as payment in full for Medicaid covered services for those clients who are assisted by this resource. The provider acknowledges that CSHCN Services Program does not pay a provider for any services that could have been reimbursed by Texas Medicaid.
9. To utilize CSHCN Services Program as a resource for payment when clients are eligible for program assistance.
10. Provider acknowledges that it/they have executed an HHSC Medicaid Provider Agreement and the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts, unless the provider is enrolling only in CSHCN Services Program and is not eligible to enroll in Medicaid. All of the provisions of the HHSC Medicaid Provider Agreement and the Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts are hereby incorporated by reference in this Provider Agreement for participation in the Children with Special Health Care Needs (CSHCN) Services Program.
11. To utilize Texas Medicaid, Medicare, Children's Health Insurance Program (CHIP), and/or private insurance (including HMO coverage) and the United States Department of Defense or Department of Veterans Affairs benefit plans as sources for reimbursement because they are primary to CSHCN Services Program payments.
12. To not bill the client/family for the cost of any charges not paid for by CSHCN Services Program due to the provider's failure to request the required authorization and/or failure to submit a claim for reimbursement within the appropriate submission deadline.
13. To not charge the client/family any pre–admission or pretreatment charges or deposits if services are reimbursable by CSHCN Services Program.
14. To refund the client/family any pre–admission or pretreatment charges when services are authorized and collection occurred prior to program application and eligibility determination.
15. To request authorization from CSHCN Services Program, before the date of service, for all services requiring prior authorization.
16. To request authorization from CSHCN Services Program for all services requiring authorization before the date of service or up to 95 days after the date of service.
17. That claims submitted by the provider, or on behalf of the provider, for payment by the CSHCN Services Program shall be for services or items actually provided by the provider or under his/her personal supervision to the eligible client for which the provider is entitled to payment. Claims must be submitted in the manner and in the form set forth in the CSHCN Services Program Provider Manual and within the time limits established by HHSC for submission of claims. The provider understands that payment and satisfaction of such claims will be from federal and/or state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and /or state laws. Fraud is a felony, which can result in fines and imprisonment.
18. Provider agrees to submit notice of the initiation and termination of a contract with any person or entity for the purpose of billing Provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on that person. This notice must be submitted within 5 working days of the initiation and termination of the contract and submitted in accordance with requirements pertaining to Third Party Billing Vendors. Provider understands that any delay in the required submittal time or failure to submit may result in delayed payments to the Provider and recoupment from the Provider for any overpayments resulting from the Provider's failure to provide timely notice.

    Provider must have a written contract with any person or entity for the purpose of billing Provider's claims, unless the person or entity is submitting claims as an employee of the Provider and the Provider is completing an IRS Form W-2 on the person. The contract must be signed and dated by the Principal of the Provider and the Biller. It must also be retained in the Provider's and Biller's files according to the CSHCN Services Program records retention policy. The contract between the Provider and Biller may contain any provisions they deem necessary, but, at a minimum, must contain the following provisions:

    - Biller agrees they will not alter or add procedures, services, codes, or diagnoses to the billing information received from the Provider, when billing the CSHCN Services Program.
    - Biller understands that they may be criminally convicted and subject to penalties or recoupment of overpayments for submittal of false, fraudulent, or abusive billings.
    - Provider agrees to submit to Biller true and correct claim information that contains only those services, supplies, or equipment Provider has actually provided to clients. Provider understands that they may be criminally convicted and subject to penalties or recoupment of overpayments for submittal of false, fraudulent, or abusive billings directly or indirectly, to the Biller or to the CSHCN Services Program or its contractor.

- Provider and Biller agree to establish a reimbursement methodology to Biller that does not contain any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the CSHCN Services Program.
- Biller agrees to enroll and be approved by the CSHCN Services Program as a Third Party Billing Vendor prior to submitting claims to the CSHCN Services Program on behalf of the Provider.
- Biller and Provider agree to notify the CSHCN Services Program within 5 working days of the initiation and termination, by either party, of the contract between the Biller and the Provider.

19. Provider has an affirmative duty to verify that claims and encounters submitted for payment are true and correct, are received by HHSC or its designee within CSHCN Services Program deadlines, and to implement an effective method to track submitted claims against payments made by HHSC or its designee.

20. Provider has an affirmative duty to verify that payments received are for actual services rendered and medically necessary. Provider must refund to CSHCN Services Program any overpayments, duplicate payments, and or erroneous payments to which entitlement is not authorized under CSHCN Services Program rules and regulations that are paid to Provider by CSHCN Services Program or its designee as soon as the payment error is discovered.

21. To comply with Title VI of the Civil Rights Act of 1964 (Public Law 88–352), Sections 504 of the Rehabilitation Act of 1973 (Public Law 93–112), the Americans with Disabilities Act of 1990 (Public Law 101–336), and all amendments to each, and all requirements imposed by the regulations issued pursuant to these acts. In addition, the provider agrees to comply with Title 40, Chapter 73, of the TAC. These provide, in part, that no persons in the United States shall, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion be excluded from participation in, or denied, any aid, care, service or other benefits provided by federal and/or state funding, or otherwise be subjected to discrimination. To comply with Texas Health and Safety Code, Section 85.113 (relating to workplace and confidentiality guidelines regarding AIDS and HIV).

22. Provider agrees to not discriminate against the individual on the basis the person is a CSHCN Services Program client by means of pricing differentials or other means of discriminatory treatment. Provider must not exclude or deny aid, care, service, or other benefits available under CSHCN Services Program or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to CSHCN Services Program clients in the same manner, by the same methods, and at the same level and quality as provided to the general public. Provider agrees to apply to CSHCN Services Program clients all discounts and promotional offers provided to the general public. Provider agrees and understands that free services to the general public must not be billed to the CSHCN Services Program for CSHCN Services Program clients and discounted services to the general public must not be billed to CSHCN Services Program for a CSHCN Services Program client as a full price, but rather the Provider agrees to bill only the discounted amount that would be billed to the general public.

23. To provide language assistance that may be required for effective communication with CSHCN Services Program clients who demonstrate limited English proficiency to insure they have equal access to services.

24. To comply with all requirements of CSHCN Services Program regulations, rules, standards, and guidelines published by CSHCN Services Program or its designee. The CSHCN Services Program laws, regulations, and program instructions are available through the claims contractor. Provider understands that payment of a claim by the CSHCN Services Program is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions, and on the provider's compliance with all applicable conditions of participation in the CSHCN Services Program.

25. To maintain the confidentiality of records and other information relating to clients in accordance with applicable state and federal laws, rules, and regulations.

26. To promptly (within 30 calendar days) report change of address and/or change in status, including but not limited to change in name, loss of license, change in certification status, or change in Medicaid provider status.

27. To maintain provider enrollment and participation in Texas Medicaid, unless the provider is not eligible to enroll in Medicaid, as a condition to participate in the CSHCN Services Program. Should Texas Medicaid status be terminated, participation in CSHCN Services Program shall be terminated effective the date of Medicaid termination.

28. That this agreement may be terminated by either party upon thirty (30) days written notice to the other party, except that termination may be earlier for submitting false or fraudulent claims, failing to provide and maintain quality services or medically acceptable standards, failure to comply with the provider agreement signed at the time of application or renewal for CSHCN Services Program participation, disenrollment as a Medicaid provider or violation of the standards of CSHCN Services Program rules and regulations or parts thereof. Provider specifically agrees to the sections of this Agreement concerning client record retention, access by HHSC to records pertaining to CSHCN Services Program services, and confidentiality of client records and information shall remain in effect and binding upon provider if the remainder of this Agreement is terminated for any reason.

29. HHSC and the CSHCN Services Program expect providers to comply with the provisions of State law as set forth in Chapter 261, Texas Family Code, related to the reporting of child abuse and neglect.

30. **PRIVACY, SECURITY, AND BREACH NOTIFICATION.** "Confidential Information" means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to the Provider electronically or through any other means that consists of or includes any or all of the following:

    (a) Protected Health Information in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information (as defined in 45 CFR 160.103 and 45 CFR 164.402);

    (b) Sensitive Personal Information (as defined in Texas Business and Commerce Code section 521.002);

    (c) Federal Tax Information (as defined in IRS Publication 1075);

(d) Personally Identifiable Information (as defined in OMB Memorandum M-07-16);

(e) Social Security Administration data;

(f) All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

31. Any Confidential Information received by the Provider under this Agreement may be disclosed only in accordance with applicable law. By signing this agreement, the Provider certifies that the Provider is, and intends to remain for the term of this agreement, in compliance with all applicable state and federal laws and regulations with respect to privacy, security, and breach notification, including without limitation the following:

(a) The relevant portions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. Chapter 7, Subchapter XI, Part C;

(b) 42 CFR Part 2 and 45 CFR Parts 160 and 164;

(c) The relevant portions of The Social Security Act, 42 U.S.C. Chapter 7;

(d) The Privacy Act of 1974, as amended by the Computer Matching and Privacy Protection Act of 1988, 5 U.S.C. § 552a;

(e) Internal Revenue Code, Title 26 of the United States Code, including IRS Publication 1075;

(f) OMB Memorandum M-07-16;

(g) Texas Business and Commerce Code Chapter 521;

(h) Texas Health and Safety Code, Chapters 181 and 611;

(i) Texas Government Code, Chapter 552, a applicable; and

(j) Any other applicable law controlling the release of information created or obtained in the course of providing the services described in this Agreement.

32. The Provider further certifies that the Provider will comply with all amendments, regulations, and guidance relating to those laws, to the extent applicable.

33. Provider will ensure that any subcontractor of Provider who has access to Confidential Information will sign a HIPAA-compliant Business Associate Agreement with Provider, and Provider will submit a copy of that Business Associate Agreement upon request by HHSC, the CSHCN Services Program, or its designee.

34. Provider understands and agrees that any signature on a submitted document certifies, to the best of the provider's knowledge, the information in the document is true, accurate, and complete. Submitted documents with electronic signatures may be accepted by mail or fax when the sender has met the national and state standards for electronic signatures set by the Health and Human Services and the Texas Uniform Electronic Transactions Act (UETA).

35. Provider understands and agrees that both the provider and the provider's representative whose signature is on an electronic signature method bear the responsibility for the authenticity of the information being certified to.

I certify that the information I have supplied in this provider enrollment application constitutes true, correct, and complete information. I agree to inform HHSC or its designee, in writing, of any changes or if additional information becomes available. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law. Fraud is a felony, which can result in fines and imprisonment. I understand that any falsification or misrepresentation that, if known, would have resulted in a denial of the application will result in all paid services declared as an overpayment and subject to recoupment. I also understand that other administrative sanctions may be imposed that includes payment hold, exclusion, debarment, contract cancellation, and monetary penalties.

Name of Applicant: _____

Applicant's Signature: _____ Date: _____

For applicants that are entities, facilities, groups, or organizations, and an authorized representative is completing this application with authority to sign on the applicant's behalf, the authorized representative must sign above and print their name and title where indicated below.

Representative's Name: _____

Representative's Position/Title: _____

IT IS RECOMMENDED THAT YOU RETAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS.