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STATE OF HAWAII
KA MOKU'ĀINA O HAWAI'I
DEPARTMENT OF HUMAN SERVICES
KA 'OIHANA MĀLAMA LAWELAWE KANAKA
Med-QUEST Division
Health Care Services Branch
Quality and Member Relations Improvement Section
P. O. Box 700190
Kapolei, Hawaii 96709-0190

December 23, 2022

MEMORANDUM

MEMO NO.
QI-2222

TO: Adult Day Care Providers Adult Day Health Providers
Assisted Living Facility Providers
Community Care Family Foster Home Providers
Expanded Adult Residential Care Home Providers
1915(c) Intellectual and Developmental Disabilities Providers for Residential Habilitation and Adult Day Health Services

FROM: Judy Mohr Peterson, PhD JMP
Med-QUEST Division Administrator

SUBJECT: DHS 1139 MEDICAID PROVIDER ENROLLMENT FORM AND HOME AND COMMUNITY-BASED SERVICES SETTINGS FINAL RULE

The Med-QUEST Division (MQD) is issuing this memorandum to inform all Home and Community-Based Services (HCBS) providers that the DHS 1139 Provider Enrollment Form has been updated and will become effective December 23, 2022

The update to the provider enrollment form can be found on page 22, numbers 2 and 3, under the "**Provider Participation Agreement** between DHS MQD and Provider". The update requires that all HCBS providers comply with the requirements of HCBS Settings Final Rule as stated in 42 CFR §441.301(c)(4) and 42 CFR §441.710(a)(1). MQD advises HCBS providers to review the new rules. Please note that compliance with federal rules is always expected, and that this includes new federal rules such as the new HCBS rules.

Should you have questions, please contact the Provider Hotline Monday through Friday during standard business hours, 7:45am - 4:30pm HST at (808) 692-8099 or email HCSBInquiries@dhs.hawaii.gov.

Enclosures

E Komo Mai!

Welcome to the Department of Human Services (DHS), Med-QUEST Division's (MQD) Provider Enrollment Form (DHS 1139). **Provider enrollment, revalidation, and/or change requests are available online through our web-based provider system HOKU. Use of the online portal is recommended and ensures priority and timely processing.** If you are unable to complete your application form online, this paper application will be accepted.

HOKU Website Links:

- Create HOKU Username and Password – medquest.hawaii.gov/hokuregistration
- Logon to HOKU – hoku.hawaii.gov

Reminders:

1. Please do not duplicate entries. If you submit multiple entries, this may cause a system error and the application, revalidation, and/or modification process will be delayed.
2. All fields in this form marked by asterisk (*) are considered required information. Failure to complete all of the required data will cause processing delays.
3. If you need additional pages of the Provider Service Locations, Associate Billing Provider/Other Associations, Adverse Actions, License/Certifications/Other, or Provider Controlling Interest/Ownership, see the appendix for additional forms you may duplicate. You may elect to send a spreadsheet. **The spreadsheet must mirror all required fields on these forms to be considered.**
4. Be sure to review and complete the checklists/questionnaire at the beginning of this application.
5. Please view the documents that are required and need to be included with this application. Go to the HOKU website at: medquest.hawaii.gov/HOKU and click on the 'Resources' tab. Select the link: '**Required and Optional Licenses, Certificates and Documents by Provider Type**.'
6. Throughout this application you will see two (2) category keys at the bottom of applicable pages. These keys will be important as you complete the application.
7. A Provider Participation Agreement is required to accompany all applications.

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization (FAO), Atypical Agency

Category Key	Description
I	Individual
C	Corporation

Completed Forms: Email or Mail completed and signed forms to:

Email:

HCSBInquiries@dhs.hawaii.gov
[Please add "DHS 1139" to the Subject]

Mail:

Med-QUEST Division
Health Care Services Branch, Provider Enrollment
601 Kamokila Boulevard, Room 506A
Kapolei, Hawaii 96707

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Table of Contents

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Before You Begin Checklist

This checklist will help you prepare to complete this application by having the necessary data available as you complete this application.

Use the checklist based on your enrollment type:

1. Group Biller
2. Contractor/MCO
3. Individual (Individual/Sole Proprietor or Rendering/Servicing) and Atypical Individual
4. Facility/Agency Organization (FAO) and Atypical Agency

Reminder: If you have already submitted a paper or online application, do not duplicate your request. Duplication may result in errors or delays in processing your request.

1. Group Biller

☒	Description
☐	Add First and Last name or DBA to the bottom of each page
☐	National Provider Identification (NPI)
☐	Med-QUEST ID (if applicable)
☐	Profit Type
☐	W-9 (You must attach a completed W-9 form. This can be found at https://www.irs.gov).
☐	Practice address details & hours of operation
☐	Pay to details
☐	Correspondence address
☐	Controlling interest/ownership details, managing employee, and owner relationship
☐	Owners Adverse action(s) information
☐	Taxonomy
☐	Copies of all required documents are attached (Reminder - Item #5 on pg. 1)
☐	Authorized signor for Provider Participation Agreement

2. Contractor/MCO

☒	Description
☐	Add First and Last name or DBA to the bottom of each page
☐	Med-QUEST ID (if applicable)
☐	Profit Type
☐	W-9 (You must attach a completed W-9 form. This can be found at https://www.irs.gov).
☐	Practice address details & hours of operation
☐	Pay to details
☐	Correspondence address
☐	Controlling interest/ownership details, managing employee, and owner relationship
☐	Owners Adverse action(s) information
☐	Copies of all required documents are attached (Reminder - Item #5 on pg. 1)
☐	Authorized signor for Provider Participation Agreement

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

3. Individual/Atypical Individual

☒	Description
☐	Add First and Last name or DBA to the bottom of each page
☐	National Provider Identification (NPI) **(except for Atypical Individual)**
☐	Med-QUEST ID (if applicable)
☐	Profit Type **(except for individual rendering/servicing providers)**
☐	W-9 (You must attach a completed W-9 form. This can be found at https://www.irs.gov).
☐	Primary Service Location - address details & hours of operation
☐	Pay to details
☐	Correspondence address
☐	Provider type and specialty if applicable
☐	Associate Billing Provider
☐	Authorized Representatives (if applicable)
☐	Controlling interest/ownership details, managing employee, and owner relationship **(except for individual rendering/servicing providers)**
☐	Owners Adverse action(s) information **(except for individual rendering/servicing providers)**
☐	Taxonomy **(except for atypical individual)**
☐	Copies of all required documents are attached (Reminder - Item #5 on pg. 1)
☐	Authorized signor for Provider Participation Agreement
☐	Appendix K – Early and Periodic Screening, Diagnosis, and Treatment Provider Agreement (if applicable)
☐	Appendix L – Psychiatry/Psychology Credentialing Attachment (if applicable)

4. FAO/Atypical Agency

☒	Description
☐	Add First and Last name or DBA to the bottom of each page
☐	National Provider Identification (NPI) **(FAO Only)**
☐	Med-QUEST ID (if applicable)
☐	Profit Type
☐	W-9 (You must attach a completed W-9 form. This can be found at https://www.irs.gov).
☐	Primary Service Location - address details & hours of operation
☐	Pay to details
☐	Correspondence address
☐	Provider type and specialty if applicable
☐	Associate Billing Provider details
☐	Bed unit information (if applicable)
☐	Authorized Representatives (if applicable)
☐	Controlling interest/ownership details, managing employee, and owner relationship
☐	Owners Adverse action(s) information
☐	Taxonomy **(FAO Only)**
☐	Copies of all required documents are attached (Reminder - Item #5 on pg. 1)
☐	Authorized signor for Provider Participation Agreement
☐	Appendix M – Non-Emergency Ground Transportation – Taxi Cabs Attachment
☐	Appendix N – Home Health Services Attachment **(FAO Only, if applicable)**
☐	Appendix O – Acute Hospital Attachment **(FAO Only, if applicable)**
☐	Appendix P – Nursing Facility Attachment **(FAO Only, if applicable)**
☐	Appendix Q – Intermediate Care Facility for The Developmentally Disabled/Intellectually Disabled Individuals (ICF-DD/ID) Attachment **(For Provider Type H1-DD/ID)**

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Enrollment Action and Type

- You must select an applicable Enrollment Action (New Enrollment, Revalidation, or Change Request.
- If you do not have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.
- If you have a provider number or provider Med-QUEST ID, you are required to disclose this information. If you do not have a provider number or provider Med-QUEST ID, select the N/A box ☒.
- Select one Enrollment Type (and Subtype if applicable) from either Section I-A or I-B.

SECTION I		
Select **ONE** Enrollment Action.		
☐ New Enrollment	☐ Revalidation	☐ Change Request
Complete only if you are currently registered and have a Provider Number/Provider Med-QUEST ID. * Provider Number/Med-QUEST ID:_____ ☐ N/A		
If you **do not** have an NPI, select the N/A box ☒ and select either Atypical Individual, Atypical Agency or Contractor/MCO for the enrollment type. NPI:_____ ☐ N/A (NPI is required for Individual/Sole Proprietor, Individual Rendering/Servicing Provider, Facility/Agency Organization and Group Biller Enrollment Types.)		

Select ONE Enrollment Type from either Section I-A or I-B.		
SECTION I-A		
☐ Individual/ Sole Proprietor	☐ Individual Rendering/ Servicing Provider	☐ Atypical Individual (non-medical) Provider (Community Care Foster Family Home)
SECTION I-B		
☐ Facility/Agency Organization (FAO- Hospital, Nursing Facility, Various Entities)	☐ Atypical Agency (non-medical) Provider (Adult Day Health, DD/ID, Home Help/Personal Care Agency, Transportation Company etc.)	
☐ Group Practice (Corporation, Partnership, LLC entities, etc.)	☐ Contractor/ MCO Managed Care Organization	

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Facility/Agency Organization (FAO), Atypical Agency, Group Practice, Contractor/MCO

Basic Provider Information

- Complete all required fields.
  Use the Category Key at the bottom of the page to determine required fields by the letter following the asterisk. For example: First Name*A; would be a required field for enrollment types; Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual.
- For the W-9 Entity type field, select the entity type (item #3 on the IRS W-9 form). You will also need to complete the IRS W-9 form available at https://www.irs.gov/.
- In the Profit Type field, select the applicable type. For "other," please fill in the accurate information. The Profit Type is not applicable when the individual only practices as a part of a group (rendering/servicing).

SECTION II
Complete required fields based on enrollment type, using the Category Key at the bottom of this page.

First Name*A	Middle Initial ☐N/A	Last Name*A

Suffix*A	Gender*A	SSN*A	Date of Birth*A
			/ /

Legal Entity Name*B	Entity Business Name (Doing Business As) *B

Home Address*A	City*A	State*A	Zip Code*A

EIN/TIN*B	Requested enrollment effective begin date *A&B
	/ /

W-9 Entity Type*A&B
☐ Individual/Sole Proprietor or single-member LLC
☐ C Corporation ☐ S Corporation
☐ Partnership ☐ Trust/estate
☐ Limited Liability Company
LLC Tax Classification:
☐ C Corporation ☐ S Corporation ☐ Partnership
☐ Other:
_____

You must also attach a completed W-9 form. This can be found at https://www.irs.gov/.

Profit Type*A&B
☐ 501(C)(3) NON-PROFIT
☐ For Profit Closely Held
☐ For Profit, Publicly Traded
☐ Other _____
☐N/A – The individual only practices as part of a group

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Facility/Agency Organization (FAO), Atypical Agency, Group Practice, Contractor/MCO

Primary Service Location

- This section is for the primary service location only.
- The primary service location may also be the home address, if applicable.
- Primary service Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III				
☐ Primary Service Location*A&B			End Date* (if applicable) A&B	
Address Line 1*A&B				
Address Line 2 ☐ N/A				
Address Line 3 ☐ N/A				
City/Town* A&B	State/Province* A&B	County* A&B	Country* A&B	Zip Code* A&B
Web Page: _____				

Location Specific Information for the Primary Service Location is required. *

Enter the business hours of operation. The business hours of operations are required for each day. Write "closed" on days the business is closed. Circle AM or PM where applicable.

	SUN	MON	TUES	WED	THURS	FRI	SAT
Open	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Close	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

Language(s) Spoken:

☐ English ☐ Bisayan/Visayan ☐ Chinese (which includes Mandarin or Cantonese)
☐ Chuukese (Trukese) ☐ Hawaiian ☐ Ilocano ☐ Japanese ☐ Korean ☐ Marshallese
☐ Samoan ☐ Spanish ☐ Tagalog ☐ Tongan ☐ Vietnamese
☐ Other(s) (specify):

Other Details (as applicable):

☐ Accepting New Clients ☐ Handicap Accessible ☐ Pediatric Services ☐ FQHC
☐ Offers OB-Gyn Services
If yes, select services: ☐ Obstetrics ☐ Gynecology ☐ Both

Maximum Clients: _____

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Facility/Agency Organization (FAO), Atypical Agency, Group Practice, Contractor/MCO

Pay-To Information

- Pay-To information is required for all provider types.
- If the Pay -To Address is the same as the Primary Service Location, select this option ☒.

SECTION IV				
Pay-To Address*A&B ☐ Same as Primary Service Location			End Date*A&B	
Address Line 1*A&B				
Address Line 2 ☐ N/A				
Address Line 3 ☐ N/A				
City/Town* A&B	State/Province* A&B	County* A&B	Country* A&B	Zip Code* A&B

Correspondence Address

- The Correspondence Address is required for all provider types.
- If the Correspondence Address is the same as the Primary Service Location, select this option ☒.
- All correspondence for this provider will be sent to the correspondence address or email provided.
- Be sure to select only one option as the method of communication (email or standard mail).
- Selecting more than one option or not selecting any option will default to standard U.S. mail.

SECTION V				
Correspondence Address*A&B ☐ Same as Primary Service Location		Phone Number*A&B		Fax Number
Communication Preference*A&B Only select 1 option ☐ Email ☐ Standard Mail		Email Address*A&B		End Date
Address Line 1*A&B				
Address Line 2 ☐ N/A				
Address Line 3 ☐ N/A				
City/Town* A&B	State/Province* A&B	County* A&B	Country* A&B	Zip Code* A&B

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Facility/Agency Organization (FAO), Atypical Agency, Group Practice, Contractor/MCO,

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Provider Type and Specialty

- This section is required for all provider types.
- Physicians, Dentists, Podiatrists, Osteopaths, and Registered Nurse Practitioners must select a specialty type.
- All other provider types are not required to select a specialty.
- Refer to Appendix H for provider types and Appendix J for specialty codes.

SECTION VI		
Provider Type	Specialty (if applicable)	End Date
1. _____	1.	
	2.	

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf. List all Billing Providers/Other Associations.
- If you are a rendering/servicing provider, this section is required.
- To associate, all billing providers must be in a ***pending*** or ***active*** status (affiliation to a terminated or suspended provider is not allowed).
- Enter Med-QUEST ID or NPI of Billing Provider/Other Associations.
- Additional space for additional Authorized Representatives can be found in Appendix B.

SECTION VII	
☐ Med-QUEST ID or ☐ NPI ID/NPI*_____	Start Date: * / / End Date: * / /
Associate Billing Provider Name: *	
☐ Med-QUEST ID or ☐ NPI ID/NPI*_____	Start Date: * / / End Date: * / /
Associate Billing Provider Name: *	
☐ Med-QUEST ID or ☐ NPI ID/NPI*_____	Start Date: * / / End Date: * / /
Associate Billing Provider Name: *	
☐ Med-QUEST ID or ☐ NPI ID/NPI*_____	Start Date: * / / End Date: * / /
Associate Billing Provider Name: *	

License/Certification/Other List

- This section is required for all enrollment types, except group.
- All fields are required for each license/certificate.
- Include a copy of all your licenses/certifications (e.g., DCCA, CLIA, DEA, Liability, etc.)
- Additional space for additional License/Certifications/Others can be found in Appendix C.

SECTION VIII		
License/Certification/Other Type:	License/Certification Number:	
Issuing Agency:	Effective Date: / /	Expiration Date: / /
License/Certification/Other Type:	License/Certification Number:	
Issuing Agency:	Effective Date: / /	Expiration Date: / /
License/Certification/Other Type:	License/Certification Number:	
Issuing Agency:	Effective Date: / /	Expiration Date: / /
License/Certification/Other Type:	License/Certification Number:	
Issuing Agency:	Effective Date: / /	Expiration Date: / /
License/Certification/Other Type:	License/Certification Number:	
Issuing Agency:	Effective Date: / /	Expiration Date: / /

Authorized Representative, Bed Information and NPI List

Authorized Representative List:

- This section is optional for applicable enrollment types.
- Additional space for additional Authorized Representatives can be found in Appendix D.

First Name*	Middle Name:	Last Name*
Start Date: * / /	End Date: / /	
First Name*	Middle Name:	Last Name*
Start Date: * / /	End Date: / /	

Bed Information:

- This section is specific to enrollment types of FAO and Atypical Agency only.

SECTION IX			
Select Bed Type	Number of Bed Units	Begin Date	End Date
☐ Acute Care Bed(s)			
☐ Licensed LTC Unit(s)			
☐ Licensed Medicaid Bed(s)			
☐ Licensed Medicare Bed(s)			
☐ Licensed Medicaid/Medicare Bed(s)			
☐ Medicaid Surgery Bed(s)			
☐ Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
☐ Psych Bed(s)			
☐ Rehab Bed(s)			
☐ Skilled Nursing Bed(s)			
☐ Substance Abuse Bed(s)			
☐ Swing Bed(s)			
☐ Temporarily Non-Available Bed(s)			
☐ Ventilator Dependent Unit(s)			

NPI List:

- This section is specific to enrollment types Group and FAO only.
- Additional space for additional NPIs can be found in Appendix D.

NPI: *	Start Date: * / /	End Date: / /
NPI: *	Start Date: * / /	End Date: / /

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Provider Controlling Interest/Ownership

Provider Enrollment Information – including home address, date of birth, and Social Security Number (SSN) – are required. This includes other disclosed individuals (e.g., owners, managing employees, agents, etc.).

REQUIRED DISCLOSURE INFORMATION

Providers (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation, and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include (as applicable) the primary business address, every business location, and P.O. Box address.
- Date of birth and SSN (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a 5% or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a 5% or more interest is related to another person with ownership or control interest as a spouse, parent, child, or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and SSN of any managing employee.

REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- If any of the following 10 owner types are selected: Corporate-Charitable 501[c]3, Corporate-Non Charitable, Corporate-Publicly Traded, Corporate-Not Publicly Traded, Holding Company, Indirect Owner, Limited Liability Company, Subcontractor, Foreign, Nonresident Alien for the keyed Tax ID, then at least 1 of the following 5 owner types must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer.
- If you select any of the following ownership types: Managing Employee, Board of Directors, Chief Executive Officer, Chief Information Officer, Chief Operating Officer, or Chief Financial Officer, you must add at least one additional ownership type that is not from among that list.
- For the Contractor/MCO Enrollment Type, three ownership records must be added:
  (1) Agent
  (2) Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer
  (3) Managing Employee

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Provider Controlling Interest/Ownership – Individual / Corporation

- For Corporate entities, enter primary business address and every business location and P.O Box. ***Use Appendix E or submit a spreadsheet. The spreadsheet must include all required information (*).***
- Providers (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership.
- The name of any other fiscal agent or managed care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.

SECTION X-I – Select One* ☐ Individual or ☐ Corporation			
Type*I&C ☐ Board of Directors ☐ Chief Executive Officer ☐ Chief Financial Officer ☐ Chief Information Officer ☐ Chief Operating Officer ☐ Partnership ☐ Individual/Sole Proprietor ☐ Sub-Contractor ☐ Agent ☐ Corporate-Non-Charitable ☐ Corporate-Charitable 501[c]3 ☐ Corporate-Publicly Traded ☐ Foreign, Nonresident Alien ☐ Corporate-Not Publicly Traded ☐ Government-Federal ☐ Government-State ☐ Government-City ☐ Government-County ☐ Holding Company ☐ Indirect Owner ☐ Limited Liability Company			
Percentage Owned*I&C	SSN*I	EIN/TIN*C	Owner NPI
Legal Entity Name	Entity Business Name		DOB*I
First Name*I	Last Name*I		Suffix
Phone Number*	Email		
Start Date*	End Date		
Home address for individual or business address for Corporation*			
Address Line 1*I&C			
Address Line 2			
Address Line 3			
City/Town*I&C	State/Province*I&C	County*I&C	Country*I&C	Zip Code*I&C

Category Key	Description
I	Individual
C	Corporation

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Provider Controlling Interest/Ownership – Managing Employee

- A Managing Employee is required for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- You must provide the home address of this provider. Failure to do so may result in your application or modification being denied.

SECTION X-II **Managing Employee***				
First Name*		Last Name*		Suffix
Percentage Owned*I&C	SSN*	DOB*	Owner NPI	
Phone Number*		Email		
Start Date*		End Date		
Managing Employee Home Address*				
Address Line 1*				
Address Line 2				
Address Line 3				
City/Town*	State/Province*A&B	County*	Country*	Zip Code*

Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)? ☐ No ☐ Yes

If yes, list their names of each owner, the associated owner, and the relationship type.

SECTION X-III		
Owner	Assoc. Owner	Relationship Type
If additional space is needed see Appendix F.		

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Owners Adverse Actions

As required by the Affordable Care Act (42 CFR §455 Subpart B) and Hawaii Administrative Rules (§17-1736-20 & §17-1736-21) the following information must be submitted to the Med-QUEST Division prior to certification or renewal as a provider under Medicaid. For provider groups or sole proprietors, failure to provider provide accurate and complete disclosure information will render this application incomplete. THIS FORM IS REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR §455.101, §455.105 and §455.106 and HAR §17-1736-19). Note: See the instructions of this form for definitions of underlined terms according to 42 CFR §455.101, §455.104, §455.105, and HAR §17-1736-19

The Department of Human Services (DHS) may refuse to enter a contract and may suspend or terminate an existing agreement if the provider fails to disclose ownership or controlling information and related party transactions.

Purpose

The disclosure of this information to the Medicaid Agency is a federal requirement. The information must be furnished to the Medicaid Agency within 35 days of a written request per federal regulations (§455.104(3), §455.105(b), and §455.106). For provider groups or sole proprietors, failure to provide accurate and complete disclosure information will render this application incomplete.

Indirect Ownership Interest - means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Ownership Interest - means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an Ownership or Control Interest - means a person or corporation that:

1. Has an ownership interest totaling 5% or more in a disclosing entity.
2. Has an indirect ownership interest equal to 5% or more in a disclosing entity?
3. Has a combination of direct of and indirect ownership interests equal to 5% or more in a disclosing entity;
4. Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity;
5. Is an officer or director of a disclosing entity that is organized as a corporation; or,
6. Is a partner in a disclosing entity that is organized as a partnership.

Other Disclosing Entity - means any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes: Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII). Any Medicare intermediary or carrier.

Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health- related services for which it claims payment under any plan or program established under Title V or Title XX or the Act.

"Agent" means any person who has been delegated the authority to obligate or act on behalf of a provider.

"Convicted" means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

"Disclosing entity," means a Medicaid provider and/or Medicaid applicant.

"Fiscal agent" means a contractor that processes or pays vendor claims on behalf of the Department of Human Services.

"Indirect ownership interest" means an ownership interest in any entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

"Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

"None" means no information to disclose.

"Not applicable" (N/A) means the same as "None."

"Other Disclosing Entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid; but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V (Maternal & Child Health Services), Title XVIII (Medicare), or Title XX (Grants to States for Social Services).

This includes:

Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare.

Any Medicare intermediary or carrier, and

Any entity that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XIX (Medicaid) of the Social Security Act.

"Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or controlling interest means a person or corporation that:
Has an ownership interest totaling five (5) percent or more in a disclosing entity.
Has an indirect ownership interest equal to five (5) percent or more in a disclosing entity;
Has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if the interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;
Is an officer or director of a disclosing entity that is organized as a corporation; or
Is a partner in a disclosing entity that is organized as a partnership?

"Significant business transaction" means any business transaction or series of transactions that, during one fiscal year exceed the lesser of $25,000 and five (5) percent of an offeror's total operating expenses.

"Subcontractor" means:
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, equipment, or services provided under the DHS agreement.

"Supplier" means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under its DHS agreement (e.g., a commercial laundry firm, a manufacturer of hospital beds, or a pharmaceutical firm).

"Wholly owned subsidiary supplier," means a subsidiary or supplier whose total ownership interest is held by the Medicaid provider/applicant or by a person, persons, or other entity with an ownership or controlling interest in the Medicaid provider/applicant.

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY
Do any of the owners, under any current or former name or business identity, ever had a final adverse legal action imposed against them?

Please answer 'Yes' or 'No' for each owner in Section X-IV below. If selected 'Yes' to any, please leave a response in the comment box and provide any supportive documentation.

SECTION X-IV		
Owner Name	Response	Comments
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
If additional space is needed see Appendix G. Supporting documentation is required for all adverse actions.		

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Taxonomy

- This is not required for atypical enrollment types.
- The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website at: https://npiregistry.cms.hhs.gov/.

SECTION XI	
Taxonomy Code:	Description
Start Date: * / /	End Date: / /

Application Fee

Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider. States must collect the applicable enrollment fee prior to executing a provider agreement from a prospective or reenrolling provider. The application fee increases each calendar year based on the consumer price index.

SECTION XII		
	Options	**Description**
☐	Pay Fee	Select this option in order to pay the fee to Med-QUEST. Please submit a cashier's check payable to State Director of Finance along with the DHS 1139 application.
☐	Fee Paid to Medicare	Select this option if you have paid the enrollment fee to the Centers for Medicare Services This is subject to federal and state approval. Confirmation # | Date:
☐	Fee Paid to Medicaid in another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Identify the program name, payment date, and confirmation number in the section below. Receipt or documentation of payment must be sent in with this application. This is subject to federal and state approval. Paid To: | Date: Confirmation # | Note:
☐	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit A "Hardship Letter" must be written and sent in with this application. You can continue submitting the enrollment application/modification request This is subject to federal and state approval.
☐	Med-QUEST Prior Payment	Select this option if you have paid the fee to Med-QUEST within the last 12 months from the current date for a related provider entity within your organization. Confirmation # | Date:

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Provider Enrollment Checklist/Questionnaire

Read through the questions and answer 'Yes' or 'No.' Each question must be answered. If you answered 'Yes' to any question, a comment is required in the 'Comments' box.

Question	Answer	Comments
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the Comments box to be considered.	☐ Yes ☐ No	
Do you wish to end date your enrollment? If Yes, enter the date in the Comments box.	☐ Yes ☐ No	
Are you currently excluded from any Hawai'i or other state program? If Yes, provide the state of exclusion and program in the Comments box.	☐ Yes ☐ No	
Are you currently excluded from any federal program? If Yes, provide the program and date in the Comments box.	☐ Yes ☐ No	
Have you ever had a criminal or healthcare program-related conviction? If Yes, provide the type of conviction and date in the Comments box.	☐ Yes ☐ No	
Have you ever had a judgment under any false claims act? If Yes, list the judgment and date in the Comments box.	☐ Yes ☐ No	
Have you ever been enrolled in another State Medicaid Program? If Yes, list each state and the effective date of enrollment in the Comments box.	☐ Yes ☐ No	
Have you ever had a program exclusion/debarment? If Yes, list the program and date in the Comments box.	☐ Yes ☐ No	
Have you ever had a civil monetary penalty? If Yes, provide the penalty type and date. Also, please specify the federal or state in the Comments box.	☐ Yes ☐ No	
Are you trying to reactivate a provider previously active with Med-QUEST whose status became inactive or lapsed for any reason? If Yes, please add the previous Med-QUEST ID in the Comments box.	☐ Yes ☐ No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes,	☐ Yes ☐ No	

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Question	Answer	Comments
provide the details in the **Add Owners Relationship** step in this application.		
Have you had any malpractice settlement, judgment, or agreement? If Yes, list the dollar amount and dates in the Comments box.	☐ Yes ☐ No	
If this enrollment is for a Change of Ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the Comment box.	☐ Yes ☐ No	
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐ Yes ☐ No	
Are you a Home Health Agency, DME provider, Home and Community Based provider (HCBS) or nonemergency medical transportation provider? Have you had the required fingerprinting completed? If yes, with what state and date, also upload fingerprinting documentation.	☐ Yes ☐ No	

Provider Participation Agreement

Between
DHS Med-QUEST and Provider

I/We,_____, hereby apply to become a provider under the Hawaii State Medicaid Program and agree to the following terms and conditions if accepted:

1. I/We agree to abide by the applicable provisions of the Hawaii State Medicaid Program set forth in the Hawaii Administrative Rules, Title 17, Subtitle 12, and applicable provisions set forth in the Code of Federal Regulations (C.F.R.) related to the Medical Assistance Program. Upon certification by the Hawaii State Medicaid Program, I/We also agree to abide by the policies and procedures contained in the Hawaii State Medicaid Manual. If I/We are a provider for the 1915(c) waiver for participants with Developmental Disabilities (DD) or Intellectual Disabilities (ID), I/We agree to abide by the policies and procedures contained in the Medicaid Waiver Provider Standards Manual.
2. If I/we are a provider for the QUEST 1115 Home and Community-Based Services (HCBS) waiver for QUEST individuals at the nursing home level of care, I/we agree to abide by the provisions specified in 42 C.F.R §441.301 and QUEST 1115 Medicaid Waiver.
3. If I/we are a provider for the 1915(c) Home and Community-Based Services Waiver for individuals with Intellectual and/or Developmental Disabilities (I/DD), I/we agree to abide by the provisions specified in 42 C.F.R §441.301, 1915(c) Medicaid Waiver, and policies/procedures contained in the Waiver Standards Manual.
4. I/We agree to comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352), Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), and the Age Discrimination Act of 1975 (P.L. 94-135), and all the requirements issued pursuant to the respective title, section and/or act, as promulgated by the regulations of the Department of Health and Human Services and hereby give assurance that I/We will immediately take any measures necessary to enact this agreement, to the effect that no person shall on the grounds of the applicable categories such as race, color, national origin, sex, age or handicap, be excluded from participation in, or be denied the benefits of, or be otherwise subjected to discrimination under any program and/or activity of the service provider that is funded in its entirety or in part directly or indirectly by Federal Financial Assistance.
5. I/We agree to keep all such records necessary to disclose fully, upon request, the extent of care and/or services provided by me/we to eligible Medicaid beneficiaries and to furnish the Hawaii State Department of Human Services, the Secretary of Health and Human Services, or the Medicaid Investigations Division, such information from those records regarding any payments that have been claimed by me/we under the program as the Hawaii State Department of Human Services may, from time to time, require as authorized by 42 C.F.R. §431.107(b)(2).
6. I/We agree to disclose full and complete information regarding ownership information as described in 42 C.F.R. §455 Subpart B. This includes but is not limited to disclosure of information on ownership and control (42 C.F.R. §455.104), information related to business transactions (42 C.F.R. §455.105), and information on persons convicted of crimes (42 C.F.R. §455.106) upon execution of this provider agreement during re-validation of the enrollment process, within thirty-five (35) days of any change in ownership of the disclosing entity and at the request of the Hawaii State Department of Human Services, the Secretary of Health and Human Services, or the Medicaid Investigations Division in the Department of Attorney General.
7. I/We understand that the Hawaii State Medicaid Program may refuse to enter into or renew an

agreement with me/we if any person, who has an ownership or control interest in the provider, or who is an agency or managing employee, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare and Medicaid Program (Title XIX) as stipulated in 42 C.F.R. §455.106.

8. I/We agree to accept, as payment in full, the applicable amount or amounts established by the Hawaii State Medicaid Program in Chapter 1739, Hawaii Administrative Rules, plus any deductible, coinsurance, or copayment required by the Hawaii State Medicaid Program to be paid by the Medicaid recipient as stipulated in 42 C.F.R. §447.15. I/We am aware that it is violation of Federal law to accept or require additional payments over and beyond those established by the Hawaii State Department of Human Services for services rendered under the Hawaii State Medicaid Program. I/We understand the reimbursement rates shall be in accordance with payment methodologies pursuant to Chapter 1739, Hawaii Administrative Rules.
9. I/We understand that when changes in Hawaii State Department of Human Services and Hawaii State Medicaid Program policies and procedures become necessary due to changes in State or Federal laws or regulations, that such change will take effect within thirty (30) days of receipt of written notice from the Hawaii State Department of Human Services or the Hawaii State Medicaid Program to me/we.
10. I/We understand that (1) Any information provided by the Hawaii State Department of Human Services and the Hawaii State Medicaid Program to a provider and by a provider to the Department or Medicaid Program, shall be treated confidentially and shall not be released to other agencies or persons without the written consent of the recipient except in accordance with Subtitle 12, Chapter 17- 1702 of the Hawaii Administrative Rules; (2) Any information about Medicaid Providers and recipients shall be confidential and shall not be disclosed except in accordance with Subtitle 12, Chapter 1702-5 of the Hawaii Administrative Rules. Such confidential information includes, but is not limited to the names and addresses of individuals, social and economic circumstances of an individual, evaluations, and medical, psychological or psychiatric information about the individual; (3) The records of any person, including all communications or specific medical or epidemiological information contained therein, that indicates that a person has or has been tested for HIV/AIDS shall be strictly confidential and shall only be released in accordance with Chapter 325-101, Hawaii Revised Statutes; (4) Information regarding an individual's records and reports with respect to mental health and substance abuse services are confidential and may only be disclosed in accordance with Chapter 334-5, Hawaii Revised Statutes; (5) Any information pertaining to the provision of services related to pregnancy, family planning or venereal disease shall be treated as confidential and may be released in accordance with Chapter 577A-3, Hawaii Revised Statutes.
11. I/We shall comply with the provisions of the Federal Drug Free Act of 1988 (P.L. 100-690), Title V Subtitle D, which requires that the provider maintain a drug-free workplace.
12. I/We shall comply with the provisions of HIPAA. In this Agreement "HIPAA" means the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, Pub L. No. 104-191. PROVIDER is a "health care provider" under HIPAA. A "covered entity" is a health care provider that transmits information in a standard electronic transaction under 45 C.F.R. Parts 160 and 162. If PROVIDER is or becomes a "covered entity", then PROVIDER must comply with all the rules adopted to implement HIPAA, including rules for privacy of individually identifiable information, security of electronic protected health information, transactions, and code sets, and national employer and provider identifiers. Refer to 45 C.F.R. Parts 160, 162 and 164.
13. I/We agree to have criminal history record check(s) conducted on myself/my employees consistent with State and Federal law and DHS Standards.

I/We understand that I/We may be suspended or terminated from participation in the Hawaii State Medicaid Program for non-adherence to any of the preceding program requirements and for violation of any of the provisions of H.A.R. Subtitle 12, Chapter 17-1704 (Provider Fraud) and Chapter 17-1736 (Provider Provisions) which includes but is not limited to the following:

(1) Any provider's practice which is deemed harmful to public health, safety and welfare of Medicaid beneficiaries; (2) Not providing full and accurate disclosure of the identify of any person or persons who as been convicted of a criminal offense relating to Medicaid or Medicare; (3) Fraud against the Hawaii State Medicaid Program including, but not limited to, the claiming and receipt of payment or payments for services not rendered, submission of a duplicate claim to the Medicaid program with intent to defraud and acceptance of payments for services already paid, or deliberate preparation of a claim in a manner which causes higher payment than the amount entitled to; (4) Requiring and/or accepting any payment from a Medicaid beneficiary for services paid for by the Hawaii State Medicaid Program, except in cases where the Hawaii State Department of Human Services has identified a cost share to be paid by the beneficiary and where the beneficiary remits an amount equal to his or her cost share; (5) Requiring and receiving payment from a beneficiary to make up for the difference between the Hawaii State Department of Human Services' applicable fee schedule or rate and the provider's charges; (6) Revocation of the provider's license by the Hawaii State Department of Commerce and Consumer Affairs; (7) Withdrawal, expiration or termination of facility certification by the Hawaii State Department of Health; (8) Action taken by the provider's professional group or organization disapproving the provider's methods of treatment or care or a determination that care/services rendered by the provider are not in accordance with accepted practices of the profession or harmful to a beneficiary's health and safety; (9) Violation of the non-discrimination provisions; and (10) Notification from the Secretary of Health and Human Services, or person designated by him/her that an individual, hospital or nursing facility has withdrawn from participation in Medicare without refunding money it owes to Medicare or when the provider agreement has been terminated for defrauding Medicare.

IN THE CASE OF PROVIDERS WHO ARE INDIVIDUALS:

I agree that all services for which I make a claim against the Hawaii State Medicaid Program (Title XIX) will be personally rendered by me. Services such as administration of injections, immunizations, minimal dressings, and drawing of blood samples may be rendered by qualified support nursing staff.

IN THE CASE OF PROVIDERS WHICH ARE BUSINESSES, GROUPS, HOSPITALS, CORPORATIONS OR OTHER ENTITIES:

(1) I/We and each of us agree that all services for which our organization makes a claim against the Hawaii State Medicaid Program (Title XIX) shall be only for services rendered by persons who are properly licensed and/or qualified for the service they provide for which the claims are submitted; (2) If any real property or structure thereon is provided or improved either directly or indirectly by Federal Financial Assistance from the Department of Health and Human Services, this Assurance shall obligate the service provider, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal Financial Assistance is extended or for another purpose involving the provision of similar services and/or benefits. If any personal property is so provided, this Assurance shall obligate the service provider for the period during which it retains ownership or possession of the property. In all other cases this Assurance shall obligate the service provider for the period during which the Federal Financial Assistance is extended to it either directly or indirectly by the Department of Health and Human Services; (3) This Assurance is given by the service provider in consideration of and for the purpose of receiving or benefiting from either directly or indirectly any or all Federal Financial Assistance that is extended after the date hereof by the Department of Health and Human Services, through the Hawaii State Department of Human Services.

The service provider recognizes and agrees that such Federal Financial Assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States and/or the State of Hawaii shall have the right to seek judicial enforcement of the Assurance. This Assurance is binding on the service provider, its successors, transferees, and assignees, and to the person authorized to sign this Assurance on behalf of the service provider whose signatures appear below.

RETROACTIVE CERTIFICATION:

I/We agree that retroactive provider certification shall be limited to no more than twelve (12) months back to the date on which the application was received in the Hawaii State Department of Human Services/Med-QUEST Division/Health Care Services Branch office subject to the discretion of the Med-QUEST Division Administration. The month in which the application was received shall be counted as the first month.

ELECTRONIC SIGNATURE: This Acknowledgement is to let you know that by submitting an electronic signature, you are providing an electronic mark, that is held to the same standard as a legally binding equivalent of a handwritten signature provided by you on behalf of your organization. For purposes of the acknowledgement, a digital mark is considered a typed legal First and Last name (legal name may include middle name, initial or suffix) followed by the typed date. Any document requiring an electronic signature may contain a signature acknowledgment statement provided in the same area requiring the electronic signature.

AGREEMENT & ACKNOWLEDGEMENT: I agree that my electronic signature is the legally binding equivalent to my handwritten signature. Whenever I execute an electronic signature, it has the same validity and meaning as my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding. Likewise, I, on behalf of the organization that I am authorized to represent, consent to do business electronically. This electronic signature will function as acknowledgement that I am authorized to represent and bind the organization for which this documentation is submitted. An electronic record will be kept of the documentation with which the electronic signature is associated. This electronic record will be retained and capable of being reproduced for future use. It is also acknowledged that this electronic signature meets the standard identified for uniqueness, verification, sole control, and record linkage.

The undersigned attest that they have entered into an agreement effective on the date indicated below. Both parties agree an authorized representative of the enrolling entity has the authority to sign and submit this electronic agreement and to maintain enrollment information through Med-QUEST Provider Enrollment.

I/We have read all of the Provider Agreement and Condition of Participation in the Hawaii State Medicaid Program and fully understand and agree to its terms.

Print Name of Disclosing Entity (Provider) or Authorized Representative

Signature Name of Disclosing Entity (Provider) or Authorized Representative

Date

Appendix A – Additional Service Locations

- This page is for Providers who have more than one service location.
- If you have multiple provider service locations, you may duplicate this page or send a spreadsheet. **NOTE:** The spreadsheet must contain all the required location details.
- This page is applicable to all enrollment types.

Additional Service Location				
All fields with an asterisk symbol (*) are required information.			End Date* (if applicable) A&B	
Address Line 1*A&B				
Address Line 2 ☐ N/A				
Address Line 3 ☐ N/A				
City/Town* A&B	State/Province* A&B	County* A&B	Country* A&B	Zip Code* A&B
Web Page: _____				

Location Specific Information for additional Service Locations is required

Enter the business hours of operation. The business hours of operations are required for each day. Write "closed" on days the business is closed. Circle AM or PM where applicable.

	SUN	MON	TUES	WED	THURS	FRI	SAT
Open	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Close	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

Language(s) Spoken:

☐ English ☐ Bisayan/Visayan ☐ Chinese (which includes Mandarin or Cantonese)
☐ Chuukese (Trukese) ☐ Hawaiian ☐ Ilocano ☐ Japanese ☐ Korean ☐ Marshallese
☐ Samoan ☐ Spanish ☐ Tagalog ☐ Tongan ☐ Vietnamese
☐ Other(s) (specify):

Other Details (as applicable):

☐ Accepting New Clients ☐ Handicap Accessible ☐ Pediatric Services ☐ FQHC
☐ Offers OB-Gyn Services
If yes, select services: ☐ Obstetrics ☐ Gynecology ☐ Both

Maximum Clients: _____

Appendix B – Associate Billing Provider / Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/service providers.
- To associate, all providers must be in ***pending*** or ***active*** status (affiliation to a terminated or suspended provider is not allowed).
- If additional space is needed, you may attach a spreadsheet and <u>must</u> include all of the required fields.

SECTION VII	
☐ Med-QUEST ID or ☐ NPI ID/NPI*___________________	Start Date: * / / End Date: * / /
Associate Billing Provider Name: *	
☐ Med-QUEST ID or ☐ NPI ID/NPI*___________________	Start Date: * / / End Date: * / /
Associate Billing Provider Name: *	
☐ Med-QUEST ID or ☐ NPI ID/NPI*___________________	Start Date: * / / End Date: * / /
Associate Billing Provider Name: *	
☐ Med-QUEST ID or ☐ NPI ID/NPI*___________________	Start Date: * / / End Date: * / /
Associate Billing Provider Name: *	
☐ Med-QUEST ID or ☐ NPI ID/NPI*___________________	Start Date: * / / End Date: * / /
Associate Billing Provider Name: *	

Appendix C – License / Certification / Other List

- **Important:** Include a copy of all your licenses/certifications (e.g., DCCA, CLIA, DEA, Liability, etc.)
- All fields are required for each license/certificate.

SECTION VIII		
License/Certification/Other Type:	License/Certification Number:	
Issuing Agency:	Effective Date: / /	Expiration Date: / /
License/Certification/Other Type:	License/Certification Number:	
Issuing Agency:	Effective Date: / /	Expiration Date: / /
License/Certification/Other Type:	License/Certification Number:	
License/Certification/Other Type:	License/Certification Number:	
Issuing Agency:	Effective Date: / /	Expiration Date: / /
License/Certification/Other Type:	License/Certification Number:	
Issuing Agency:	Effective Date: / /	Expiration Date: / /
License/Certification/Other Type:	License/Certification Number:	
Issuing Agency:	Effective Date: / /	Expiration Date: / /
License/Certification/Other Type:	License/Certification Number:	
Issuing Agency:	Effective Date: / /	Expiration Date: / /
Issuing Agency:	Effective Date: / /	Expiration Date: / /

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Appendix D – Authorized Representatives and NPI List

Authorized Representative List:

- This section is optional for all enrollment types.

First Name*	Middle Name:	Last Name*
Start Date: * / /	End Date: / /	
First Name*	Middle Name:	Last Name*
Start Date: * / /	End Date: / /	
First Name*	Middle Name:	Last Name*
Start Date: * / /	End Date: / /	
First Name*	Middle Name:	Last Name*
Start Date: * / /	End Date: / /	

NPI List:

- This section is specific to enrollment types Group and FAO only.

NPI: *	Start Date: * / /	End Date: / /
NPI: *	Start Date: * / /	End Date: / /
NPI: *	Start Date: * / /	End Date: / /
NPI: *	Start Date: * / /	End Date: / /
NPI: *	Start Date: * / /	End Date: / /

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Appendix E – Provider Controlling Interest/Ownership

SECTION X-I – Select One* ☐ Individual or ☐ Corporation			
Type*I&C ☐ Board of Directors ☐ Chief Executive Officer ☐ Chief Financial Officer ☐ Chief Information Officer ☐ Chief Operating Officer ☐ Partnership ☐ Individual/Sole Proprietor ☐ Sub-Contractor ☐ Agent ☐ Corporate-Non-Charitable ☐ Corporate-Charitable 501[c]3 ☐ Corporate-Publicly Traded ☐ Foreign, Nonresident Alien ☐ Corporate-Not Publicly Traded ☐ Government-Federal ☐ Government-State ☐ Government-City ☐ Government-County ☐ Holding Company ☐ Indirect Owner ☐ Limited Liability Company			
Percentage Owned*I&C	SSN*I	EIN/TIN*C	Owner NPI
Legal Entity Name	Entity Business Name		DOB*I
First Name*I	Last Name*I		Suffix
Phone Number*	Email		
Start Date*	End Date		

Home address for individual or business address for Corporation*				
Address Line 1*I&C				
Address Line 2				
Address Line 3				
City/Town*I&C	State/Province*I&C	County*I&C	Country*I&C	Zip Code*I&C

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Appendix F – Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)? ☐ No ☐ Yes

If yes, list their names of each owner, the associated owner, and the relationship type.

SECTION X-III		
Owner	Assoc. Owner	Relationship Type

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Appendix G – Owners Adverse Actions

- For supporting disclosures and details see Adverse Action Section X-IV.
- Supporting documentation is required for all adverse actions.

SECTION X-IV		
Owner Name	Response	Comments
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Appendix H – Provider Types

NPI, Site Visit, and/or Enrollment Fee Required by Provider Type				
Provider Type	**Provider Type Name**	**National Provider Identifier (NPI)**	**Site Visit**	**Fee Payment**
C1	ACUPUNCTURIST	Y	N	N
27	ADULT DAY HEALTH	N	Y	Y
50	ADULT RESIDENTIAL SETTINGS (CCFFH & E-ARCH)	N	Y	N
43	AMBULATORY SURGICAL CENTER	Y	N	Y
49	ASSISTED LIVING CENTER-UNITS ONLY	N	Y	Y
36	ASSISTED LIVING HOME/HCBS	N	Y	Y
62	AUDIOLOGIST	Y	N	N
51	BEHAVIORAL/MENTAL HEALTH COUNSELOR	Y	N	N
BC	BOARD CERTIFIED BEHAVIOR ANALYST	Y	N	N
56	BOARDING HOME	N	Y	Y
34	CASE MANAGEMENT SERVICES	N	Y	Y
86	CERTIFIED MARRIAGE/FAMILY THRAPST (CMFT)	Y	N	N
09	CERTIFIED NURSE-MIDWIFE	Y	N	N
12	CERTIFIED REGISTERED NURSE ANESTHETIST	Y	N	N
16	CHIROPRACTOR	Y	Y	N
05	CLINIC	Y	N	Y
29	COMMUNITY/RURAL HEALTH CENTER	Y	N	Y
H1	DD/ID	N	Y	Y
07	DENTIST	Y	N	N
D1	DENTIST - ENDODONTIST	Y	N	N
D3	DENTIST - ORAL SURGEON	Y	N	N
D2	DENTIST - PEDODONTIST	Y	N	N
64	DETOX CENTER	Y	Y	Y
80	DHS MHS PROVIDER	N	Y	N
41	DIALYSIS CLINIC	Y	N	Y
30	DME SUPPLIER	Y	Y	Y
31	DO-PHYSICIAN OSTEOPATH	Y	N	N
63	DRUG AND ALCOHOL REHAB	Y	Y	Y
06	EMERGENCY TRANSPORTATION	Y	Y	Y
99	EVS/NON-SERVICE PROVIDER	N	N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	N	Y
01	GROUP-PAYMENT ID	Y	N	N
70	HOME DELIVERED MEALS	N	Y	Y

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

NPI, Site Visit, and/or Enrollment Fee Required by Provider Type				
Provider Type	**Provider Type Name**	**National Provider Identifier (NPI)**	**Site Visit**	**Fee Payment**
23	HOME HEALTH AGENCY	Y	Y	Y
35	HOSPICE	Y	Y	Y
02	HOSPITAL	Y	N	Y
42	HOSPITAL AFFILIATED CLINIC	N	N	Y
55	HOTELS	N	Y	Y
95	INTERPRETER SERVICES	N	N	Y
04	LABORATORY	Y	N	Y
21	MASSAGE THERAPIST	Y	Y	N
08	MD-PHYSICIAN	Y	N	N
52	MENTAL HEALTH CLINIC	N	N	Y
77	MENTAL HEALTH REHABILITATION	N	Y	N
78	MENTAL HEALTH RESIDENTIAL TREATMENT CNTR	Y	Y	Y
75	MHS SOCIAL WORKER	Y	N	N
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	N	Y	Y
46	NURSE (PRIVATE-RN/LPN)	Y	N	Y
22	NURSING HOME	Y	N	Y
48	NUTRITIONIST	Y	N	N
13	OCCUPATIONAL THERAPIST	Y	Y	N
69	OPTOMETRIST	Y	N	N
Z1	OUT OF STATE	Y	N	N
OD	OUT OF STATE DME PROVIDER	Y	Y	Y
24	PERSONAL CARE ATTENDANT (HOME CARE)	N	Y	Y
03	PHARMACY	Y	N	Y
14	PHYSICAL THERAPIST	Y	Y	N
18	PHYSICIANS ASSISTANT	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
90	QMB ONLY PROVIDER	N	Y	N
47	REGISTERED DIETICIAN	Y	N	N
19	REGISTERED NURSE PRACTITIONER	Y	N	N
57	RESIDENTIAL TREATMENT FACILITY	N	Y	Y
A7	RESPITE	N	Y	Y
S1	SPECIALIZED SERVICES	N	Y	Y
15	SPEECH/HEARING THERAPIST	Y	N	N
79	VISION CENTER	Y	N	Y

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Appendix I – Enrollment Types

Provider Type	Provider Type Name	Enrollment Type
C1	ACUPUNCTURIST	INDIVIDUAL
27	ADULT DAY HEALTH	ATYPICAL AGENCY, FAO
50	ADULT RESIDENTIAL SETTINGS (CCFFH & E-ARCH)	INDIVIDUAL, ATYPICAL-INDIVIDUAL
43	AMBULATORY SURGICAL CENTER	FAO
49	ASSISTED LIVING CENTER-UNITS ONLY	ATYPICAL-AGENCY, FAO
36	ASSISTED LIVING HOME/HCBS	ATYPICAL-AGENCY, FAO
62	AUDIOLOGIST	INDIVIDUAL
51	BEHAVIORAL/MENTAL HEALTH COUNSELOR	INDIVIDUAL
BC	BOARD CERTIFIED BEHAVIOR ANALYST	INDIVIDUAL
56	BOARDING HOME	ATYPICAL-AGENCY, FAO
34	CASE MANAGEMENT SERVICES	ATYPICAL AGENCY, FAO
86	CERTIFIED MARRIAGE/FAMILY THRAPST (CMFT)	INDIVIDUAL
09	CERTIFIED NURSE-MIDWIFE	INDIVIDUAL
12	CERTIFIED REGISTERED NURSE ANESTHETIST	INDIVIDUAL
16	CHIROPRACTOR	INDIVIDUAL
05	CLINIC	FAO
29	COMMUNITY/RURAL HEALTH CENTER	FAO
H1	DD/ID	ATYPICAL-AGENCY, FAO
07	DENTIST	INDIVIDUAL
D1	DENTIST - ENDODONTIST	INDIVIDUAL
D3	DENTIST - ORAL SURGEON	INDIVIDUAL
D2	DENTIST - PEDODONTIST	INDIVIDUAL
64	DETOX CENTER	FAO
80	DHS MHS PROVIDER	FAO, ATYPICAL-AGENCY, INDIVIDUAL, ATYPICAL-INDIVIDUAL,
41	DIALYSIS CLINIC	FAO
30	DME SUPPLIER	FAO
31	DO-PHYSICIAN OSTEOPATH	INDIVIDUAL
63	DRUG AND ALCOHOL REHAB	FAO
06	EMERGENCY TRANSPORTATION	FAO
99	EVS/NON-SERVICE PROVIDER	MCO
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	FAO
01	GROUP-PAYMENT ID	GROUP
24	HOME CARE/PERSONAL CARE	ATYPICAL AGENCY, FAO
70	HOME DELIVERED MEALS	ATYPICAL-AGENCY, FAO

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Provider Type	Provider Type Name	Enrollment Type
23	HOME HEALTH AGENCY	FAO
35	HOSPICE	FAO
02	HOSPITAL	FAO
42	HOSPITAL AFFILIATED CLINIC	ATYPICAL-AGENCY, FAO
55	HOTELS	ATYPICAL-AGENCY, FAO
95	INTERPRETER SERVICES	ATYPICAL-AGENCY, FAO
04	LABORATORY	FAO
21	MASSAGE THERAPIST	INDIVIDUAL
08	MD-PHYSICIAN	INDIVIDUAL
52	MENTAL HEALTH CLINIC	ATYPICAL-AGENCY, FAO
77	MENTAL HEALTH REHABILITATION	ATYPICAL-AGENCY, FAO
78	MENTAL HEALTH RESIDENTIAL TREATMENT CNTR	FAO
75	MHS SOCIAL WORKER	INDIVIDUAL
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	ATYPICAL-AGENCY, FAO
46	NURSE (PRIVATE-RN/LPN)	FAO
22	NURSING HOME	FAO
48	NUTRITIONIST	INDIVIDUAL
13	OCCUPATIONAL THERAPIST	INDIVIDUAL
69	OPTOMETRIST	INDIVIDUAL
Z1	OUT OF STATE	FAO, ATYPICAL AGENCY, INDIVIDUAL, GROUP
OD	OUT OF STATE DME PROVIDER	FAO
24	PERSONAL CARE ATTENDANT (HOME CARE)	ATYPICAL-AGENCY, FAO
03	PHARMACY	FAO
14	PHYSICAL THERAPIST	INDIVIDUAL
18	PHYSICIANS ASSISTANT	INDIVIDUAL
10	PODIATRIST	INDIVIDUAL
11	PSYCHOLOGIST	INDIVIDUAL
90	QMB ONLY PROVIDER	FAO, ATYPICAL-AGENCY, INDIVIDUAL, ATYPICAL-INDIVIDUAL,
47	REGISTERED DIETICIAN	INDIVIDUAL
19	REGISTERED NURSE PRACTITIONER	INDIVIDUAL
57	RESIDENTIAL TREATMENT FACILITY	ATYPICAL-AGENCY, FAO
A7	RESPITE	ATYPICAL-AGENCY, FAO
S1	SPECIALIZED SERVICES	ATYPICAL-AGENCY, FAO
15	SPEECH/HEARING THERAPIST	INDIVIDUAL
79	VISION CENTER	FAO

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Appendix J – Specialty Codes

Specialty Codes			
Code	**Description**	**Code**	**Description**
175	ACUPUNCTURIST	964	PAIN CONTROL
951	ADDICTION MEDICINE	530	PATHOLOGY
180	ADMINISTRATIVE MEDICINE	967	PATHOLOGY, RADIOISOTOPIC
176	ADOLESCENT MEDICINE	157	PEDIATRIC ALLERGIST
011	ALLERGIST	151	PEDIATRIC CARDIOLOGIST
010	ALLERGIST/IMMUNOLOGIST	156	PEDIATRIC ENDOCRINOLOGIST
952	ANATOMIC PATHOLOGY	152	PEDIATRIC HEMATOLOGIST
135	ANATOMICAL/ CLINICAL PATHOLOGY	963	PEDIATRIC HEMATOLOGY-ONCOLOGY
020	ANESTHESIOLOGIST	154	PEDIATRIC NEPHROLOGIST
900	ANY CERTIFIED LABORATORY	076	PEDIATRIC NEUROLOGIST
925	AUDIOLOGIST	159	PEDIATRIC PULMONARY DISEASE
464	BLOOD GROUPING/RH TYPING	150	PEDIATRICIAN
927	CARDIOLOGIST	804	PEDODONTIST
062	CARDIOVASCULAR MEDICINE	188	PHARMACOLOGIST
954	CHEMICAL DEPENDENCY	160	PHYSICAL MEDICINE/ REHABILITATION
251	CRITICAL CARE MEDICINE	798	PHYSICIAN ASSISTANT
800	DENTIST-GENERAL	484	PODIATRIST
040	DERMATOLOGIST	650	PODIATRIST
143	DERMATOPATHOLOGY	182	PREVENTIVE MEDICINE
956	DIABETES	805	PROSTHODONTIST
913	DIALYSIS	098	PSYC/MENTAL HEALTH NURSE PRACTITIONER
504	EKG SERVICES	191	PSYCHIATRIST
250	EMERGENCY MEDICINE	192	PSYCHIATRIST
901	EMERGENCY ROOM PHYSICIANS	195	PSYCHIATRIST AND NEUROLOGIST
063	ENDOCRINOLOGIST	965	PSYCHOANALYSIS
802	ENDODONTIST	083	PSYCHOLOGIST
714	EYE (LOW VISION SPECIALIST)	189	PSYCHOSOMATIC MEDICINE
050	FAMILY MEDICINE	184	PUBLIC HEALTH
064	GASTROENTEROLOGIST	068	PULMONARY DISEASES
055	GENERAL PRACTICE	200	RADIOLOGY
019	GENETICIST	158	RADIOLOGY PEDIATRIC
082	GERONTOLOGIST	968	RADIOLOGY, ONCOLOGY
958	GYNECOLOGICAL ONCOLOGY	201	RADIOLOGY-DIAGNOSTIC
090	GYNECOLOGIST	205	RADIOLOGY-THERAPEUTIC
065	HEMATOLOGIST	974	REHABILITATION MEDICINE
970	HEMATOLOGY & ONCOLOGY	093	REPRODUCTIVE ENDOCRINOLOGIST
620	HOSPICE AND PALLIATIVE MEDICINE	069	RHEUMATOLOGIST
971	INDUSTRIAL MEDICINE	097	RN ADULT NURSE PRACTITIONER
066	INFECTIOUS DISEASES	084	RN FAMILY NURSE PRACTITIONER

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Specialty Codes			
Code	**Description**	**Code**	**Description**
060	INTERNAL MEDICINE	088	RN GERIATRIC NURSE PRACTITIONER
092	MATERNAL AND FETAL MEDICINE	094	RN MIDWIFE
969	MEDICAL TOXICOLOGY	086	RN PEDIATRIC NURSE ASSOCIATE
400	MICROBIOLOGY	087	RN PEDIATRIC NURSE PRACTITIONER
071	MSW SOCIAL WORKER	511	ROUTINE CHEMISTRY
096	NEONATAL NURSE PRACTITIONER	085	SCHOOL NURSE PRACTITIONER
155	NEONATAL/PERINATAL MEDICINE	162	SPORTS MEDICINE
067	NEPHROLOGIST	210	SURGERY
075	NEUROLOGIST	977	SURGERY, ORAL & MAXILLOFACIAL
141	NEUROPATHOLOGY	211	SURGERY-ABDOMINAL
080	NUCLEAR MEDICINE	212	SURGERY-CARDIOVASCULAR
962	NUCLEAR RADIOLOGY	030	SURGERY-COLON/RECTAL
187	NUTRITIONIST	219	SURGERY-GYNECOLOGICAL
091	OBSTETRICIAN	213	SURGERY-HAND
089	OBSTETRICIAN AND GYNECOLOGIST	070	SURGERY-NEUROLOGY
183	OCCUPATIONAL MEDICINE	441	SURGERY-OPHTHALMOLOGICAL
241	ONCOLOGIST	110	SURGERY-ORTHOPEDIC
100	OPHTHALMOLOGY	153	SURGERY-PEDIATRIC
015	OPTICIAN	170	SURGERY-PLASTIC
600	OPTOMETRIST	220	SURGERY-THORACIC
808	ORAL SURGEON	216	SURGERY-TRAUMA
801	ORTHODONTURE	217	SURGERY-UROLOGICAL
950	ORTHOPEDIST	218	SURGERY-VASCULAR
972	OSTEOPATHIC MANIPULATIVE MEDICINE	166	THERAPIST-OCCUPATIONAL
161	OSTEOPATHIC MANIPULATIVE THERAPY	167	THERAPIST-PHYSICAL
999	OTHER	165	THERAPIST-SPEECH
073	OTHER IMMUNOHEMATOLOGY	524	URINALYSIS
120	OTOLARYNGOLOGIST	230	UROLOGIST
124	OTOLOGIST	095	WOMEN'S HC/OB-GYN NP
935	OTORHINOLARYNGOLOGIST (ENT)		

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Appendix K – Early and Periodic Screening, Diagnosis, and Treatment Provider Agreement

INSTRUCTIONS

Purpose

To provide preventive, diagnostic, and screening services for children in accordance with Title 17, Chapter 1737 of the Hawaii Administrative Rules.

1. This agreement applies only to the following provider types who will be servicing EPSDT recipients:
   a. Internal Medicine;
   b. Dental;
   c. Family Medicine.
2. Full Signature of Provider:

   The original signature is required by the submitting applicant who will be providing services **OR** an authorized business agent (e.g., billing agent) who will be handling claims processing.
3. Enter date signed.
4. Print legibly:
   a. Provider's name in full.
   b. Medicaid Provider No.
5. Effective Date Requested: enter the start date for participation in the Medicaid program.
6. For DHS Official Use Only – do not complete.

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PROVIDER AGREEMENT

I, as a Primary Care Provider (PCP) agree to provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services in accordance with Title 17, Chapter 1737, Subchapter 6, Section 53 to 62 of the Hawaii Administrative Rules.

I HAVE READ AND UNDERSTAND THE AGREEMENT:

_____ _____
(Full Signature of Provider) (Date)

(Leave Blank if New Provider)

_____ _____
(Print Provider's Name in Full) (Medicaid Provider No.)

EFFECTIVE DATE REQUESTED:

_____

FOR DHS OFFICIAL USE ONLY

APPROVED: _____ _____
Provider Data Technician Date

EFFECTIVE DATE OF PROVIDER PARTICIPATION: _____
MONTH/DAY/YEAR

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Appendix L – Psychiatry/Psychology Credentialing Attachment

INSTRUCTIONS

PURPOSE:

Form DHS 1139A shall be used by health care providers who have specialties of psychiatry/psychology. This form shall be submitted with a completed DHS 1139, Medicaid Application/Change Request Form.

INSTRUCTIONS:

1.	Name:	Self-explanatory
2.	Business Address:	Self-explanatory
3.	Place of Birth/Birth date:	Self-explanatory
4.	Hawaii Resident:	Self-explanatory
5.	Confirmation of Certification & Licensing: • If yes, then provide State of Certification	Self-explanatory
6.	Denial of Certification & licensing: • If yes, then list State of denial	Self-explanatory
7.	Suspension or Revoked License: • If yes, attach statement	Self-explanatory
8.	Education:	Self-explanatory
9.	Experience:	Self-explanatory
10.	Do you hold an American Board Certification for your specialty? : • If yes provide date of certification	Self-explanatory
11.	Are you an A. P. A. Member? : • If yes what type of membership?	Self-explanatory
12.	Hospital privileges?	Self-explanatory
13.	Affiliation with any clinic?	Self-explanatory
14.	Private Practitioner?	Self-explanatory

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

STATE OF HAWAII
Department Of Human Services

Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

CONFIDENTIAL **PLEASE PRINT OR TYPE**

PSYCHIATRY/PSYCHOLOGY CREDENTIALING ATTACHMENT

1. Name: _____
   First Middle Last
2. Business Address: _____
   Number Street Suite
   _____ _____ _____ _____
   City State/Country Zip Code Telephone Number
3. Place of Birth: _____ Birth Date: ____/____/____
   City State/Country Month/Day/Year
4. Are you a resident of Hawaii?
   ☐ Yes ☐ No How long: _____
5. Have you been certified or licensed to practice medicine/psychology in another State?
   ☐ Yes ☐ No If "YES," what State(s): _____
6. Have you ever been denied a certificate or license as a practicing physician/psychologist?
   ☐ Yes ☐ No If "YES," what State(s): _____
7. Has any certificate or license been suspended or revoked?
   ☐ Yes ☐ No If "YES," attach a statement of explanation: _____
   _____
8. EDUCATION (List most recent first, please include residency.)

NAME OF INSTITUTION	MAJOR COURSE OF STUDY	DATE OF GRADUATION	DEGREE CONFERRED

9. EXPERIENCE (List most recent first.)

FROM	TO	POSITION	DUTIES	NAME & ADDRESS OF EMPLOYER

10. Do you hold a diplomat certificate in good standing from the American Board of Examiners in Professional Psychiatry and Neurology? ☐ Yes ☐ No If "YES," date you were certified? _____
11. Are you a member of A.P.A.? ☐ Yes ☐ No If "YES," what type of membership:
    _____
12. Do you have any hospital privileges? ☐ Yes ☐ No Which hospital? _____
13. Are you affiliated with or employed by any clinic? ☐ Yes ☐ No
    Which clinic? _____ How many hours per week? _____
14. Are you an independent private practitioner? ☐ Yes ☐ No How many hours per week? _____

_____ _____
Signature of Provider Date Signed

DHS PSYCHIATRIC CONSULTANT REVIEW

Reviewed By: _____
Date Reviewed: _____ Approved ☐ Disapproved ☐
Reason: _____

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

Appendix M – Non-Emergency Ground Transportation – Taxi Cabs Attachment

INSTRUCTIONS

PURPOSE:

Non-Emergency Ground Transpiration – Taxi Cabs attachment shall be used by health care providers who provide non-emergency ground transportation. This form shall be submitted with a completed DHS 1139, Medicaid Application/Change Request Form.

INSTRUCTIONS:

1.	Name of Business:	Self-explanatory
2.	Print name legibly:	Self-explanatory
3.	Signature:	Self-explanatory
4.	Date Signed:	Self-explanatory

NON-EMERGENCY GROUND TRANSPORTATION – TAXI CABS ATTACHMENT

I/We, _____, hereby certify and agree that all providers, representatives, or agents of the individual/organization indicated here in this Attachment, for the provision of transportation services, or any other service under this agreement, is informed that payments are made from Federal and State funds. All individuals covered, or in any way associated with the organization indicated in this Part A who provide services and receive payment for such services, are also informed that this program is administered by the Hawaii State Department of Human Services under the authority of Federal Regulations 42 C.F.R.

§431.50 and Hawaii Revised Statues §346-40. Any violation of these conditions is subject to Federal and State penalties.

I/We also certify that services will be provided in accordance with city ordinance ROH Section 12-1.10, or any applicable replacements, that govern taxi cabs and metered rates unless otherwise specifically agreed to in writing.

_____
Print Name of Provider/Authorized Business Agent

_____
Signature of Provider/Authorized Business Agent

_____
Date Signed

Appendix N – Home Health Services Attachment

INSTRUCTIONS

PURPOSE:

Home Health Services attachment shall be used by health care providers who provide home health services. This form shall be submitted with a completed DHS 1139, Medicaid Application/Change Request Form.

INSTRUCTIONS:

1.	Print Name of Provider:	Self-explanatory
2.	Signature:	Self-explanatory
3.	Date Signed:	Self-explanatory

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

HOME HEALTH SERVICES ATTACHMENT

Scope of Services

The PROVIDER shall provide home health services in conformance with, as described in Title 17, Subtitle 12, §17-1737-45, Hawaii Administrative Rules, and the applicable sections under 42 C.F.R. Part 484.

Reimbursement

(a) DHS shall reimburse the PROVIDER for authorized home health services provided to Medicaid eligible recipients. Reimbursements shall be limited to services provided by the PROVIDER licensed by the State Department of Health as a Home Health Agency under 42 C.F.R. Part 484.

(b) DHS shall make payments through its fiscal agent in accordance with time limits specified in §17-1739.1-16, Hawaii Administrative Rules. DHS reserves the right not to make payments for claims which are submitted more than twelve (12) months after the month in which service was rendered.

Penalties

The DHS shall allocate to the PROVIDER any and all Federal financial penalties assessed by the Center for Medicare & Medicaid Services (CMS) for the PROVIDER'S failure to meet requirement set forth in this Agreement. The penalties shall be assumed and paid by the PROVIDER upon notification from DHS.

I/We have read all of the above and fully understand and agree to its terms.

_____
Print Name of Provider/Authorized Business Agent

_____
Signature of Provider/Authorized Business Agent

_____
Date Signed

Appendix O – Acute Hospital Attachment

INSTRUCTIONS

PURPOSE:

Acute Hospital attachment shall be used by health care facilities who provide acute inpatient hospital services. This form shall be submitted with a completed DHS 1139, Medicaid Application/Change Request Form.

INSTRUCTIONS:

1.	Print Name of Provider:	Self-explanatory
2.	Signature:	Self-explanatory
3.	Date Signed:	Self-explanatory

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

ACUTE HOSPITAL ATTACHMENT

Scope of Services

(a) The FACILITY shall provider acute inpatient hospital services in conformance with and as described in Title 17, Subtitle 12, Subchapter 2 of Chapter 17-1737, Hawaii Administrative Rules and the applicable sections under 42 C.F.R. Part 482, to those patients who have been determined by the Department of Human Services (DHS) to be Medicaid eligible.

(b) The FACILITY, its employees and agents, shall comply with retaliatory acts provisions §349-23, Hawaii Revised Statues, in assuring that no patient seeking advocacy assistance or who makes a complaint concerning the FACILITY, its employees or agents is subject to retaliation by the FACILITY, its employees or agents.

Reimbursement

(a) DHS shall make payments through its fiscal agent in accordance with time limits specified in §17-1739.1-16, Hawaii Administrative Rules. DHS reserves the right not to make any payments for claims which are submitted more than twelve (12) months after the month in which services were rendered.

(b) DHS and the FACILITY mutually agree that for the purposes of this Agreement, a "patient day" shall include the day of admission or the day of discharge from the FACILITY, but not both.

(c) The FACILITY agrees that in coding the diseases for reporting on the billing forms, the International Classification of Diseases, 10th Revision, Clinical Modification (ICD- 10 CM) seven-digit code will be used.

Penalties

The DHS shall allocate to the FACILITY any and all Federal financial penalties assessed by Centers for Medicare & Medicaid Services (CMS) for the FACILITY's failure to meet requirements set forth in this Agreement. The penalties shall be assumed and paid by the FACILITY upon notification from DHS.

Reports

(a) The FACILITY shall authorize the State Department of Health to transmit its copy of the utilization review plan, and any future amendments to the plan, which may have direct bearing on the conduct and extent of utilization review for inpatients that are Medicaid eligible.

(b) The FACILITY shall submit its statement of services for each Medicaid patient to the DHS fiscal agent no later than the thirtieth (30th) calendar day following discharge of the patient. In the event that the hospitalization continues for a full calendar month, the FACILITY shall bill the fiscal agent within thirty (30) days from the end of each month of service.

ACUTE HOSPITAL ATTACHMENT

I/We have read all of the above and fully understand and agree to its terms.

_____
Print Name of Provider/Authorized Business Agent

_____
Signature of Provider/Authorized Business Agent

_____
Date Signed

Appendix P – Nursing Facility Attachment

INSTRUCTIONS

PURPOSE:

Nursing Facility attachment shall be used by health care facilities who provide nursing facility services. This form shall be submitted with a completed DHS 1139, Medicaid Application/Change Request Form.

INSTRUCTIONS:

1.	Print Name of Provider:	Self-explanatory
2.	Signature:	Self-explanatory
3.	Date Signed:	Self-explanatory

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

NURSING FACILITY ATTACHMENT

Scope of Services

(a) The FACILITY shall provide Nursing Facility (NF) services in conformance with and as described in Title 17, Subtitle 12, Subchapter 4 or Chapter 17-1737, Hawaii Administrative Rules, and the applicable sections under 42 C.F.R. Part 483. In the event certain items or services prescribed by the recipient's physician are not available within the FACILITY, the FACILITY shall promptly arrange with others for such items or services.

(b) The FACILITY, its employees and agents, shall comply with retaliatory acts provisions §349-23, Hawaii Revised Statues, in assuring that no patient seeking advocacy assistance or who makes a complaint concerning the FACILITY, its employees or agents is subject to retaliation by the FACILITY, its employees or agents.

Reimbursement

(a) DHS shall reimburse the FACILITY for authorized NF services provided to residents. Reimbursements shall be limited to services rendered in the areas of the FACILITY, which are licensed by the State Department of Health as a NF under 42 C.F.R. Part 483.

(b) DHS and the FACILITY mutually agree that a "resident day" shall include the date of admission or the date of discharge, but not both.

(c) DHS shall make payments through its fiscal agent in accordance with time limits specified in §17-1739.1-16, Hawaii Administrative Rules. DHS reserves the right not to make any payments for claims which are submitted more than twelve (12) months after the month in which services were rendered.

(d) The FACILITY shall submit for each Medicaid eligible resident a statement of services to DHS' fiscal agent no later than the thirtieth (30th) calendar day following discharge of the resident. In the event, the resident's care continues for a full calendar month, the FACILITY shall then bill the fiscal agent within thirty (30) days from the end of each month of service. Charges for x-rays, clinical laboratory tests, prescription medications covered by the DHS drug formulary, and other ancillary services prescribed by the attending physician and recorded in the resident's chart, shall be billed separately by the provider (except for County/State facilities).

Penalties

The DHS shall allocate to the FACILITY any and all Federal financial penalties (FFP) assessed by the Centers for Medicare & Medicaid Services (CMS) for the FACILITY's failure to meet requirements set forth in this Agreement. The penalties shall be assumed and paid by the FACILITY upon notification from DHS.

Reports

(a) In addition to the federally required PASRR reports (42 C.F.R. Part 483, Subpart C), the FACILITY shall prepare and submit all required monthly and quarterly reports on DHS 1137. The reports include but are not limited to all Medicaid admissions, discharges, including deaths, and periods of absence from the facility due to hospitalization and overnight passes, and quarterly reports of separate lists for Acuity Level C and Acuity Level A inpatients up to March 31, June 30, September 30, and December 31.

The DHS 1137 shall be submitted to the Med-QUEST Division Administration by the fifteenth (15th) of the month following the reporting period.

(b) The FACILITY shall make available, at the request of DHS, a listing of residents who were approved for temporary absences from the FACILITY, together with information on the destination, number of days absent, and specific dates absent by the residents.

I/We have read all of the above and fully understand and agree to its terms.

_____
Print Name of Provider/Authorized Business Agent

_____
Signature of Provider/Authorized Business Agent

_____
Date Signed

Appendix Q – Intermediate Care Facility for The Developmentally Disabled/Intellectually Disabled Individuals (ICF-DD/ID) Attachment

INSTRUCTIONS

PURPOSE:

The Intermediate Care Facility for The Developmentally Disabled/Intellectually Disabled Individuals (ICF-DD/ID) Attachment form shall be used by health care facilities who provide intermediate care facility services for the developmentally disabled or the intellectually disabled individuals. This form shall be submitted with a completed DHS 1139, Medicaid Application/Change Request Form.

INSTRUCTIONS:

1.	Print Name of Provider/Authorized Business Agent	Self-explanatory
2.	Name of Health Care Facility	Self-explanatory
3.	Signature of Provider/Authorized Business Agent:	Self-explanatory
4.	Date Signed:	Self-explanatory

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.

INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED/INTELLECTUALLY DISABLED INDIVIDUALS (ICF-DD/ID) ATTACHMENT

SCOPE OF SERVICES

(a) The FACILITY shall provide intermediate care facility services for the developmentally disabled/intellectually disabled individuals in conformance with and as described in Title 17, Subtitle 12, Subchapter 4, Chapter 17-1737, Hawaii Administrative Rules (HAR), and the applicable sections under C.F.R. 42, Part 483, Subpart I to those patients who have been determined by the Department of Human Services (DHS) to be Medicaid eligible.

(b) The FACILITY, its employees and agents, shall comply with retaliatory acts provisions of §349-14, Hawaii Revised Statutes, in assuring that no patient seeking advocacy assistance or who makes a complaint concerning the FACILITY, its employees or agents is subject to retaliation by the FACILITY, its employees or agents.

REIMBURSEMENT

(a) DHS shall reimburse the FACILITY for authorized ICF-DD/ID services provided to residents. Reimbursements shall be limited to services rendered in the areas of the FACILITY, which are licensed by the State Department of Health as a nursing facility (NF) under C.F.R. 42 Part 483, Subpart I.

(b) DHS and the FACILITY mutually agree that for the purposes of this Agreement, a "resident day" shall include the day of admission or the day of discharge from the FACILITY, but not both.

(c) DHS shall make payments through its fiscal agent in accordance with time limits specified in HAR§§17-1739.1-15 and 17-1739.1-16. DHS reserves the right not to make any payments for claims which are submitted more than twelve (12) months after the month in which services were rendered.

(d) The FACILITY shall submit its statement of services for each Medicaid patient to the DHS fiscal agent no later than the thirtieth (30th) calendar day following discharge of the patient. In the event that the resident's care continues for a full calendar month, the FACILITY shall then bill the fiscal agent within (30) days from the end of each month of service.

PENALTIES

The DHS shall allocate to the FACILITY any and all Federal financial penalties (FFP) assessed by the Centers for Medicare & Medicaid Services (CMS) for the FACILITY's failure to meet requirements set forth in this Agreement. The penalties shall be assumed and paid by the FACILITY upon notification from DHS.

REPORTS

(a) The FACILITY shall prepare and submit all required monthly and quarterly reports on the DHS 1137 Census Report Medicaid Resident Movement form. The reports include, but are not limited to all Medicaid admissions, discharges, including deaths, and periods of absence from the FACILITY due to deaths, hospitalization and overnight passes. The DHS 1137 form shall be submitted to the Med- QUEST Division's Administration by the fifteenth (15th) of the month following the reporting period.

(b) The FACILITY shall make available, at the request of DHS, a listing of all residents who were approved for temporary absences from the FACILITY, including information on the destination, number of days of absence, and specific dates absent by the resident.

I/We have read all of the above and fully understand and agree to its terms.

(Print Name of Provider/Authorized Business Agent)	(Name of Health Care Facility)
(Signature of Provider/Authorized Business Agent)	(Date Signed)