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Facility/Agency/Organization Enrollment
HOKU New Application Path

Hawaii Train-the-Trainer Materials
Created February 28, 2020

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Selecting FAO Enrollment Type

- If the provider being enrolled is a medical or health care Facility, Agency, or Organization (FAO), that has an NPI, please select the FAO Enrollment Type.
- FAO providers include:
  - ☐ Hospitals
  - ☐ Nursing Facilities
  - ☐ Assisted Living Facilities
  - ☐ Rural Health Clinics
  - ☐ Federally-Qualified Health Clinics
  - ☐ Laboratories and Imaging Centers
  - ☐ Rehabilitation Centers
  - ☐ Mental Health Facilities
  - ☐ Dialysis Centers
  - ☐ Outpatient Surgical Centers

Select the FAO Enrollment Button

Step 1: Provide Basic Information

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Basic Information: Enter required fields and click Finish button.

⠿ **Basic Information**   ⌃

Legal Entity Name: [Ohana] ✱ (As shown on the Income Tax Return)

Entity Business Name: [Ohana] ✱ (Doing Business As)   EIN/TIN: [526362498] ✱

NPI: [1417957416] ✱

Do you already have an Med-QUEST ID?✱: ○Yes ◉No [   ]

Do you have any other application ID for this entity?✱: ○Yes ◉No [   ]

⠿ **W9 Information**   ⌃

W-9 Entity Type: [▼] ✱   W-9 Entity Type (If Other): [   ]

Profit Status: [▼] ✱

View Screening Result   Confirm   ✔ Finish   ⊗ Cancel

Page ID: dlgAddBasicInformationStep1(Provider)

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Application ID: 20200225447257   **Name:** Ohana

Basic Information

You have successfully completed the basic information on the Enrollment Application.

Your Application ID is: **20200225447257**

Please make note of this Application ID. This is the number you will be required
to use to track the status of your enrollment application. Without this number,
you will not be able to access your application and your information will be deleted.

Please make sure to complete your application and submit it for State Review within 30
calendar days OR your application will be deleted.

Ok

Page ID: dlgAddBasicInformationStep3(Provider)

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Enrollment Steps

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/25/2020	02/25/2020	Complete	
Step 2: Add Locations	Required			Incomplete	
Step 3: Add Correspondence Address	Required			Incomplete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required			Incomplete	
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Additional Information	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Fee Payment	Optional			Incomplete	
Step 11: Upload Documents	Optional			Incomplete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

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Step 2: Add Locations

Add Primary Practice Address

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Application ID: 20200225447257   **Name:** Ohana

⦙⦙⦙ Add Provider Location   ⌃

Location Type: [Primary Practice Location ▾] *
Doing Business As: [_____]   **End Date:** [_____ 📅]

If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address Line 1: [_____] *   **Address Line 2:** [_____]
(Enter Street Address or PO Box Only)

Address Line 3: [_____]   **City/Town:** [OTHER ▾] *
                                                                                           [_____]

State/Province: [OTHER ▾] *   **County:** [OTHER ▾]
                   [_____]   [_____]

Country: [UNITED STATES ▾] *   **Zip Code:** [_____] * - [_____] ↻ Validate Address

Web Page: [_____]

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	[▾] *	AM PM *	[▾] *	AM PM *	Thursday:	[▾] *	AM PM *	[▾] *	AM PM *
Monday:	[▾] *	AM PM *	[▾] *	AM PM *	Friday:	[▾] *	AM PM *	[▾] *	AM PM *
Tuesday:	[▾] *	AM PM *	[▾] *	AM PM *	Saturday:	[▾] *	AM PM *	[▾] *	AM PM *
Wednesday:	[▾] *	AM PM *	[▾] *	AM PM *					

Handicap Accessible: [No ▾]   **Language(s) Spoken:** [English / Bisayan/Visayan / Chinese (which includes Mandarin or Cantonese) ▾]

(For Multiple Selection, use Ctrl Key)

✔ OK   ⊗ Cancel

Page ID: dlgEnrlAddLocation(Provider)

Add Pay To Address

Add Pay To Address

Add Pay To Address

Add Pay To Address

Step 3: Add Correspondence Address

Add Correspondence Address

Add Correspondence Address

Add Correspondence Address

Step 4: Add Provider Type/Specialties/Subspecialties

Add Provider Type/Specialties/Subspecialties

Add Provider Type/Specialties/Subspecialties

🖨 Print ❓ Help

Application ID: 20200225447257   **Name:** Ohana

▦ Add Provider Type/Specialty ⌃

Provider Type: [HOSPITAL ▼] *

Specialty: [NO SPECIALTY REQUIRED ▼] *

Select 'No Specialty' if applicable.

End Date: [　　　📅]

▦ Add Subspecialty ⌃

Available Subspecialties   **Associated Subspecialties** *

       [　]   [»]   No Subspecialty

             [«]

Select 'No Subspecialty' if applicable.

✔ OK   ⊗ Cancel

Page ID: dlgEnrlAddSpecialties(Provider)

Add Provider Type/Specialties/Subspecialties

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🏠 › MyInbox › New Enrollment › FAO Enrollment

Application ID: 20200225447257   **Name:** Ohana

⊗ Close   ⊕ Add

▦   **Provider Type/Specialty/Subspecialty List**   ⌃

Filter By ▾ | | | ⊙ Go   💾 Save Filters   ▼ My Filters▾

	Specialty/Subspecialty ▲▼	Provider Type ▲▼	End Date ▲▼
☐	NO SPECIALTY REQUIRED/No Subspecialty	HOSPITAL	12/31/2999

🗑 Delete | View Page: 1 | ⊙ Go | 📄 Page Count | 📊 SaveToXLS | Viewing Page: 1 | « First | ‹ Prev | › Next | » Last

Page ID: pgLctnSpcltyListForEnrlmnt(Provider)   Environment: HI_SYSTST R10c-1.1   Server Time: 02/25/2020 12:35:10 MST

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Step 5: Associate Billing Provider

Associate Billing Provider

Associate Billing Provider

Step 6: Add License/Certification

Add License/Certification

Add License/Certification

Add License/Certification

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Application ID: 20200225447257   **Name:** Ohana

[⊗ Close] [⊕ Add]

⊞ **License/Certification/Other List** ^

Filter By [▾] [ ] [ ] [⊙ Go]   [💾 Save Filters] [▼ My Filters ▾]

	License/Cert./Other Type ▲▼	License/Cert./Other # △▼	Valid Flag ▲▼	Effective Date ▲▼	End Date ▲▼
☐	HI Board of Nursing	123789456	No	02/25/2020	12/31/2999
☐	HCFA/CLIA	456123789	No	02/25/2020	12/31/2999
☐	H&CB Case Management Agency	789456123	No	02/25/2020	12/31/2999

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Page ID: pgLicenseListForEnrlmnt(Provider)   Environment: HI_SYSTST R10c-1.1   Server Time: 02/25/2020 12:52:13 MST

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Step 7: Add Additional Information

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👤   ▾   📄 Note Pad   🌐 External Links ▾   ★ My Favorites ▾   🖨 Print   ❓ Help

🏠 › MyInbox › New Enrollment › FAO Enrollment

Application ID: 20200225447257   **Name:** Ohana

⊘ Close

⊞   **Enroll Provider - FAO**   ⌃

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/25/2020	02/25/2020	Complete	
Step 2: Add Locations	Required	02/25/2020	02/25/2020	Complete	
Step 3: Add Correspondence Address	Required	02/25/2020	02/25/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/25/2020	02/25/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/25/2020	02/25/2020	Complete	
Step 6: Add License/Certification/Other	Optional	02/25/2020	02/25/2020	Complete	
Step 7: Add Additional Information	Optional			Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Required			Incomplete	
Step 10: Fee Payment	Required			Incomplete	Please add Fee Payments.
Step 11: Upload Documents	Required			Incomplete	Please upload required documents.
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1   ⊙ Go   📄 Page Count   📊 SaveToXLS   Viewing Page: 1   ≪ First   ‹ Prev   › Next   ≫ Last

Page ID: pgBPWOrganizationStart(Provider)   Environment: HI_SYSTST R10c-1.1   Server Time: 02/25/2020 12:53:02 MST

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Add Additional Information

Step 8: Add Controlling Interest/Ownership Details

Add Controlling Interest/Ownership Details

Add Owner

Add Ownership

Print Help

Application ID: 20200225447257   **Name:** Ohana

Provider Controlling Interest/Ownership

Type:	---SELECT--- *	Percentage Owned: *
SSN:		EIN/TIN:
Legal Entity Name:	(As shown on the Income Tax Return)	Entity Business Name: (Doing Business As)
Owner NPI:		
First Name:		Last Name:
Suffix:		DOB:
Phone Number:	* Extn:	Email:
Start Date:	*	End Date:

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address Line 1:	* (Enter Street Address or PO Box Only)	Address Line 2:
Address Line 3:		City/Town: OTHER *
State/Province:	OTHER *	County: OTHER
Country:	UNITED STATES *	Zip Code: * - Validate Address

✔ OK   ⊘ Cancel

Page ID: dlgEnrlmntAddOwner(Provider)

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Add Ownership

🖨 Print   ❓ Help

Application ID: 20200225447257   **Name:** Ohana

⋮⋮⋮ **Provider Controlling Interest/Ownership**   ⌃

Type:	Managing Employee ▾ * ℹ	**Percentage Owned:**	50 *
SSN:	126538456 *	**EIN/TIN:**	
Legal Entity Name:		**Entity Business Name:**	
	(As shown on the Income Tax Return)		(Doing Business As)
Owner NPI:			
First Name:	Anne *	**Last Name:**	Jones *
Suffix:	▾	**DOB:**	02/25/1970 📅 *
Phone Number:	(555) 555-5555 * **Extn:**	**Email:**	
Start Date:	02/25/2020 📅 *	**End Date:**	📅

Please ensure you are providing the home address of this provider. Failure to do so may result in this application/modification being denied.

Address Type: Home Address

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address validation successful

Address Line 1:	515 E 100 S *	**Address Line 2:**	
	(Enter Street Address or PO Box Only)		
Address Line 3:		**City/Town:**	Salt Lake City ▾ *
State/Province:	UTAH ▾ *	**County:**	Salt Lake ▾
Country:	UNITED STATES ▾ *	**Zip Code:**	84102 * - 4211 ✔ Validate Address

✔ OK   ⊘ Cancel

Page ID: dlgEnrlmntAddOwner(Provider)

Add Owners Relationship

Complete Adverse Actions

Disclose Adverse Actions

Taxonomy Details

Add Taxonomy

NUCC Taxonomy Code List

Step 10: Fee Payment

Fee Payment

Fee Payment

🖶 Print ❓ Help

Application ID: 20200225447257   **Name:** Ohana

⊞ Fee Payment   ⌃ ⌄

Payment Reason: New Enrollment

	Options	Description
○	Pay Fee	Select this option in order to pay the fee to Med-QUEST. Once the Med-QUEST ID is received via correspondence or if there is an existing Med-QUEST ID, please submit a cashier's check payable to: State Director of Finance, c/o Med-QUEST Division, Health Care Services Branch, Provider Enrollment, 601 Kamokila Boulevard, Room 506A Kapolei, HI 96707. Mail check to: Med-QUEST Division, Health Care Services Branch, Provider Enrollment, 601 Kamokila Blvd., Room 506A, Kapolei, HI 96707.
○	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.
○	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. Select the program name and payment date in the section below. Upload your receipt or documentation of payment in the "Upload Documents" step. This is subject to federal and state approval.
○	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit. A "Hardship Letter" must be written and uploaded in the "Upload Documents" step. 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.

Fee Paid To: [⌄]   **Payment Date:** [📅]

Payment Status: **Confirmation Number:** [   ]

✔ Ok   ⊗ Cancel

Step 11: Upload Documents

Upload Documents

Upload Documents

Upload Documents

Step 12: Enrollment Checklist

Application ID: 20200225447257   **Name:** Ohana

Close

Enroll Provider - FAO

Business Process Wizard - Provider Enrollment (FAO). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	02/25/2020	02/25/2020	Complete	
Step 2: Add Locations	Required	02/25/2020	02/25/2020	Complete	
Step 3: Add Correspondence Address	Required	02/25/2020	02/25/2020	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/25/2020	02/25/2020	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	02/25/2020	02/25/2020	Complete	
Step 6: Add License/Certification/Other	Optional	02/25/2020	02/25/2020	Complete	
Step 7: Add Additional Information	Optional	02/25/2020	02/25/2020	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/25/2020	02/25/2020	Complete	
Step 9: Add Taxonomy Details	Required	02/25/2020	02/25/2020	Complete	
Step 10: Fee Payment	Required	02/25/2020	02/25/2020	Complete	
Step 11: Upload Documents	Required	02/25/2020	02/25/2020	Complete	
Step 12: Complete Enrollment Checklist	Required			Incomplete	
Step 13: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1   Go   Page Count   SaveToXLS   **Viewing Page: 1**   First   Prev   Next   Last

Page ID: pgBPWOrganizationStart(Provider)   Environment: HI_SYSTST R10c-1.1   Server Time: 02/25/2020 01:35:23 MST

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Enrollment Checklist

Step 13: Submit Application

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Review Provider Participation Agreement

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🏠 › MyInbox › New Enrollment › FAO Enrollment

Application ID: 20200225447257   **Name:** Ohana

⊗ Close   ⊘ Submit Application   After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.

PROVIDER AGREEMENT AND CONDITION OF PARTICIPATION (PART B)

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

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© 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.

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.

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).

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.

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.

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.

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.

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.

Page ID: pgEnrlTermsAndConditions(Provider)   Environment: HI_SYSTST R10c-1.1   Server Time: 02/25/2020 01:39:55 MST

Review Provider Participation Agreement

Submission Complete

Thank You!

Persistence, Perseverance and Passion as always remains our credo.

Contact Med-QUEST

Office:

601 Kamokila Blvd., Room 506A

Kapolei, HI 96707

email: hcsbinquiries@dhs.hawaii.gov

phone: 808-692-8099

fax: 808-692-8087

https://medquest.hawaii.gov/en/plans-providers/Provider-Management-System-Upgrade.html

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