



# **CNSI** innovation@work

Facility/Agency/Organization Enrollment **HOKU New Application Path** 

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





## 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

evoBrex < My Inbox + Admin + Provider +					>
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A > MyInbox > New Enrollment					
Enrollment Type					^
Select the Applicable Enrollment Type					
O Individual/Sole Proprietor					
Group Pacific (Constraine Patheresis) 11.C et 2					
Graditiv/Agency/Organization (FAO-Hospital Aursing Facility, Various Entities)					
Managed Care Organization					
○ Atypical (non-medical) provider (Choose this option if you do not have a NPI)					
O Individual (Community Care Foster Family Home CCFFH)					
○ Agency (Adult Day Health, DD/ID, Home Help/Personal Care Agency, Transportation Company etc.)					
Page ID: onNauE-trollBack-Stan/Drovider> Environment: HI SVSTST P10r-1 1			Senver Time: 02/25	2020 11:36:11	MST
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## **Step 1: Provide Basic Information**

🚔 Print 🛛 Help			
Basic Information: Enter required fields and click Finish button.			
III Basic Information			^
Legal Entity Name:	Ohana * (As shown on the Income Tax Return)		
Entity Business Name:	Ohana * (Doing Business As)	EIN/TIN: 526362498	1
NPI:	1417957416 *		
Do you already have an Med-QUEST ID?*:	OYes  No		
Do you have any other application ID for this entity?*:	OYes No		
III W9 Information			^
W-9 Entity Type:	*	W-9 Entity Type (If Other):	
Profit Status:	*		
Page ID: dlgAddBasicInformationStep1(Provider)			ew screening Result Comm

## **Application ID**

≜ Print	
Application ID: 20200225447257 Name: Ohana	
III 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.	
	<b>✔</b> Ok
Page ID: dlgAddBasicInformationStep3(Frovider)	

## **Enrollment Steps**

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A > MyInbox > New Enrollment > FAO Enrollment								
Application ID: 2020026747267	Name: Ohana							
Application ID: 20200225447257	Name: Onana							
C Close								
Enroll Provider - FAO								^
		Busin	ess Process Wizard -	Provider Enro	Ilment (EAO) Click	on the Sten # unde	r the Sten	Column
Step	Required	Start Date	End Date	Stat	us	Step Remark	i the step	column.
Step 1: Provider Basic Information	Required	02/25/2020	02/25/2020	Com	plete	-		
Step 2: Add Locations	Required			Inco	mplete			
Step 3: Add Correspondence Address	Required			Inco	mplete			
Step 4: Add Provider Type/Specialties/Subspecialties	Required			Inco	mplete			
Step 5: Associate Billing Provider/Other Associations	Optional			Inco	mplete			
Step 6: Add License/Certification/Other	Optional			Inco	mplete			
Step 7: Add Additional Information	Optional			Inco	mplete			
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Inco	mplete			
Step 9: Add Taxonomy Details	Required			Inco	mplete			
Step 10: Fee Payment	Optional			Inco	mplete			
Step 11: Upload Documents	Optional			Inco	mplete			
Step 12: Complete Enrollment Checklist	Required			Inco	mplete			
Step 13: Submit Enrollment Application for Approval	Required			Inco	mplete			
View Page: 1 O Go Page Count SaveToXLS	Viewing Page: 1					K First	> Next	» Last
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Page ID: pgBPWOrganizationStart(Provider)	Environment HT_SYSTST R10c-1.1					Server Time: 02/25	2020 11:52:2	20 MST

## Step 2: Add Locations

	Provider -				>
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A > MyInbox > New Enrollment > FAO Enrollment					
Application ID: 20200225447257	Na	ame: Ohana			
O Close Add Pay to address is required for Prima	y Practice Location. To Add/Modify Pay	to address, click on Primary Practic	e Location hyperlink		
III Locations List					^
Filter By	Go			Save Filters	s <b>▼</b> My Filters▼
Doing Business As	Location Type	Location Details		End Date	
	$\Delta \overline{\mathbf{v}}$	<b>▲</b> ▼		<b>▲</b> ▼	
	No Re	cords Found !			
Page ID: pol ecotion intEarEndmot/Dravider)	Environment			Sonior Timo: 02/20	TON 01-01-01-00
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## **Add Primary Practice Address**

🚔 Print 🤨 Help							Address
Application ID: 20200225447257		Name: Of	ana				
III Add Provider Location							^
	Location Type: Primary Practic Doing Business As:	e Location 💽 *			End Date:		
	If a department or drawer number is n required, please enter the information	equired enter the information in line TWO. (For in Line THREE. (For example: ATTN: Billing De	example: DEPT 222 or DEPART pt.)	MENT 222, DRAWR 1111 or DRAWER 1111	I) If an attention line is		
		ATTENTION: Address Submission only remaining address fields will be popular returned.	requires Address Line 1 and Zip C red and validated by the USPS. If <i>i</i>	ode, then click the VALIDATE ADDRESS butto ddress Line 1 and Zip Code combination is no	on. Once clicked, the ot valid, an error will be		
	Address Line 1: (Enter Street Add	* dress or PO Box Only)			Address Line 2:		
	Address Line 3:				City/Town:	OTHER 🖌 *	
	State/Province: OTHER	*			County:	OTHER	
	Country: UNITED STATE	S V *			Zip Code:	* - Validate Address	
	Web Page:						
	Onen Atr	Please enter the hours your office is open for ea	ch day. If you are closed on a g	iven day select "Closed" in the "Open At"	drop down.		
	Day: Open At: Sunday: 💌 *	AM * * *	AM/PM *	Day: Open At: Thursday:	AM *	AMPIN * AMPIN *	
	Monday: *	AM PM ∗ ▼*	AM PM *	Friday: 💌 *	AM *	× AM PM *	
	Tuesday: 💙 * Wednesday: 💙 *	AM PM AM *	AM PM *	Saturday:	PM *	× AM PM *	
	Handicap Accessible: No 🔽		I'IVI		Language(s) Spoken:	English Bisavan/Visavan	
						Chinese (which includes Mandarin or Cantonese) ¥ (For Multiple Selection, use Ctrl Key)	
Page ID: dlgEnrlAddLocation(Provider)							✓ OK Ocancel

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<b>1</b> -				>
			🖺 Note Pad 🛛 🥥 External Links 🕶 🛨 My Favorites 👻 🚔 Print	🕄 Help
Solution > New Enrollment > FAO Enrollment				
Application ID: 20200225447257		Name: Ohana		
Close Add Pay to address is required for F	Primary Practice Location. To Add/Modify Pay to address, click on Pr	imary Practice Location hyperlink		
III Locations List				^
Filter By	Go		Bave Filters TMy	Filters▼
Doing Business As	Location Type	Location Details	End Date	
▲▼	۵.	Δ.Ψ.	<u>۸</u> ۳	
	Primary Practice Location	515 E 100 S, Salt Lake City, UTAH 84102	12/31/2999	
Delete View Page: 1 OGo	Page Count SaveToXLS	Viewing Page: 1	K First Prev Next	» Last

	Provider <del>-</del>	>
± +		皆 Note Pad 🛛 🚱 External Links 🕶 🖈 My Favorites 🕶 🚔 Print 😔 Help
A S MyInbox S New Enrollment S FAO Enrollment S General		
Application ID: 20200225447257	Name: Ohana	
Close Save To add additional addresses, click "	dd Address" button.	
III Location Details		*
Doing Business As:		Location Type: Primary Practice Location
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: Close 🖌 * PM * PM * Thursday: Close V	PM * PM * PM *
	Monday: Close * AM * Friday: Close * Friday:	' * AM * ₩ * AM *
	Tuesday: Close * AM * Saturday: Close *	· · · · · · · · · · · · · · · · · · ·
	Wednesday: 08:00 🗸 * AM PM * 05:00 🖌 * AM PM	
Handicap Accessible:	No V	
	Language(s) Spoken:	
	(For Multiple Selection, use Ctrt Key) Chinese (which includes	Mandarin or Cantonese) 🚩
End Date:	12/31/2999	
III Address List		*
O Add Address		
Address Type	Address	End Date
	4♥ 515 F 100 S. Sali Lake City, 117.0H 84102	▲▼ 12/31/2000
Delete View Page: 1 O Go	Count SaveToXLS Viewing Page: 1	≪ First ≪ Prev > Next >> Last
Page ID: pgEnrollmentLocationGeneral(Provider)	Environment HLSYSTST R10c-1.1	Server Time: 02/25/2020 12:10:53 MST

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Application ID: 20200225447257	Name: Ohana		
III Add Provider Location Address			^
Type of Address:	Pay To	End Date:	
Location Address: If a department or drawer number enter the information in Line THRE	Copy This Location Address s required enter the information in line TWO.(For example: DEPT 222 or DEPARTMENT 222, I E. (For example: ATTN: Billing Dept.)	RAWR 1111 or DRAWER 1111) If an attention line is required, please	
	ATTENTION: Address Submission only requires Address Line 1 and Zi remaining address fields will be populated and validated by the USPS. returned.	p Code, then click the VALIDATE ADDRESS button. Once clicked, the If Address Line 1 and Zip Code combination is not valid, an error will be	
Address Line 1:	(Enter Street Address or PD Box Only)	Address Line 2:	
Address Line 3:		City/Town:	OTHER *
State/Province:	OTHER V	County:	OTHER
Country:	UNITED STATES V *	Zip Code:	* - Validate Address
Page ID: dlgEnrlLocationAddress(Provider)			✓OK OCancel

	Provider -											>
+								🔓 Note Pad 🛛 🥝 Ex	xternal Links <del>-</del>	★ My Favorites <del>▼</del>	🖨 Print	? Help
A > MyInbox > New Enrollment > FAO Enrollment > General												
Application ID: 20200225447257			Name: Oha	na								
Close Bave To add additional addresses, click "A	Add Address" button.											
III Location Details												^
Doing Business As:								Loci	ation Type: Pri	mary Practice Location	1	
Web Page:		Please enter the hours vo	our office is open for each	day. If you are closed on a give	n dav select "Cio	sed" in the "Open	At" drop down					
F	Day: Open At:	AM/PM	Close At:	AM/PM	Dav:	Open At:	AM/PM	Close At:	AM/PM			
	Sunday: Close V *	AM *	*	AM *	Thursday:	Close 🗸 *	AM *	*	AM	*		
	Monday: Close ¥	AM +	*	AM *	Friday		AM +	*	PM	*		
		PM *		PM	Fludy.		PM *		PM	<b>^</b>		
	Tuesday: Close 💙 *	PM *	*	PM *	Saturday:	Close ¥	PM *	*	PM	*		
	Wednesday: 08:00 🗸 *	AM PM *	05:00 🗸 *	AM PM *								
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End Date:	12/31/2999											
												•
III Address List												~
Add Address												
Address Type	Address								End Date			
	▲♥ 515 E 100 S. Salt La	ke City UTAH 84102							▲▼ 12/31/2999			
	515 E 100 S, Salt La	ke City, UTAH 84102							12/31/2999			
Delete View Page: 1 O Go Page	Count SaveToXLS			Viewing Pag	e: 1					<b>«</b> First <b>&lt;</b> Prev	> Next	Last
Page ID: pgEnrollmentLocationGeneral(Provider)			Er	wironment: HI_SYSTST R10c-1.1						Server Time: 02/2	5/2020 12:14:35	5 MST

## Step 3: Add Correspondence Address

evoBrex < My Inbox - Admin - Provider -							;
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> MyInbox > New Enrollment > FAO Enrollment							
Application ID: 20200225447257	Name: Ohana						
Enroll Provider - FAO							^
			Business Process Wizard -	Provider Enrollment (FAO). Click	on the Step # unde	er the Step Colu	amn.
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			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			
View Page: 1 O Go Page Count SaveToXLS	Viewing Page: 1				≪ First	> Next >> L	Last
Page ID: pgBPWOrganizationStart(Provider)	Environment: HI_SYSTST R10c-1.1				Server Time: 02/25	5/2020 12:17:25 MS	ST

## Add Correspondence Address

	Provider <del>•</del>						>
±			hote Pad	External Links •	★ My Favorites ▼	🖨 Print	? Help
A > MyInbox > New Enrollment > FAO Enrollment > General							
Application ID: 20200225447257		Name: Ohana					
Close Add							
III Correspondence Address List							^
Address Type		Address		End Date			
		<b>▲</b> ▼		<b>AV</b>			
		No Records Found !					
Page ID: pgCorrespondenceListForEnrImnt(Provider)		Environment: HI_SYSTST R10c-1.1	1		Server Time: 02	2/25/2020 12:1	18:59 MST

## Add Correspondence Address

🚔 Print 🔮 Help			
Application ID: 20200225447257	Name: Ohana		
III Add Correspondence Address			*
Phone Number: Communication Preference:	* Extn:	Fax Number: Email Address:	
End Date: If a department or drawer nu required, please enter the in	mber is required enter the information in line TWO.(For example: DEPT 222 ormation in Line THREE. (For example: ATTN: Billing Dept.)	or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is	
	ATTENTION: Address Submission only requires A remaining address fields will be populated and val be returned.	dress Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the dated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will	
Address Line	:*	Address Line 2:	
Address Line		City/Town:	OTHER V*
State/Province	OTHER *	County:	OTHER
Country	UNITED STATES V	Zip Code:	* - Validate Address
Page ID: disEndCorrespondenceAddrace/Drouidee			✓ OK ⓒ Cancel
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## Add Correspondence Address

•       •	evoBrex < My Inbox + Admin + Provider +				
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Appleted 10: 00: 00: 00: 00: 00: 00: 00: 00: 00:	A > MyInbox > New Enrollment > FAO Enrollment > General				
	Application ID: 20200225447257	Namo	e: Ohana		
Bit     Contraction     Contraction<	Close Add				
Address         End date           of         of         of         of         of           of         of         of         of         of         of           of         of         of         of         of         of         of           of         of         of         of         of         of         of         of           of one         of	III Correspondence Address List				
• • • • • • • • • • • • •	Address Type	Address			End Date
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	Page ID: pgCorrespondenceListForEnrImnt(Provider)		Environment HI_SYSTST R10c-1.1		Server Time: 02/25/2020 12:23:20 MST

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### Step 4: Add Provider Type/Specialties/Subspecialties

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1 ·				💾 Note Pad 🛛 🥝 External Links 🔻	★ My Favorites ▼	🖨 Print	Help
> MyInbox > New Enrollment > FAO Enrollment							
Application ID: 20200225447257 Name: Ohar	na						
O Close							
Enroll Provider - FAO							^
			Business Process Wizar	d - Provider Enrollment (FAO). Click	on the Step # unde	r the Step C	olumn.
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			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			
View Page: 1 O Go Page Count SaveToXLS	Viewing Page: 1				K First Prev	> Next	🗱 Last
Page ID: pgBPWOrganizationStart(Provider) En	ivironment: HI_SYSTST R10c-1.1				Server Time: 02/25	5/2020 12:25:1	4 MST

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### Add Provider Type/Specialties/Subspecialties

	Provider -				>
1 ·		h Note Pad	External Links •	★ My Favorites ▼ 🛛 📕	Print 🕐 Help
A > MyInbox > New Enrollment > FAO Enrollment					
Application ID: 20200225447257	Nam	ie: Ohana			
Close Add					
III Provider Type/Specialty/Subspecialty List					^
Fitter By	Go			Save Filters	▼ My Filters▼
Specialty/Subspecialty		Provider Type		End Date	
		<b>▲</b> ▼		▲▼	
	No Reco	ords Found !			
Page ID: pgLctnSpcHyListForEnrImnt(Provider)	Environment: H	LSYSTST R10c-1.1		Server Time: 02/25/	2020 12:30:26 MST

## Add Provider Type/Specialties/Subspecialties

🚔 Print 🔮 Help	
Application ID: 20200225447257	Name: Ohana
III Add Provider Type/Specialty	*
Provider Type: Specialty:	HOSPITAL V *
End Date:	
III Add Subspecialty	*
	Available Subspecialties *
Page ID: dlgEntfAddSpecialties(Provider)	▼ OK © Cancel

## Add Provider Type/Specialties/Subspecialties

		>
1 ·		皆 Note Pad 🛛 🥝 External Links 🕶 🔺 My Favorites 🕶 🚔 Print 😨 Help
> MyInbox > New Enrollment > FAO Enrollment		
Application ID: 20200225447257	Name: Ohana	
Close Add		
III Provider Type/Specialty/Subspecialty List		*
Filter By		Save Filters My Filters
Specialty/Subspecialty	Provider Type	End Date
	Δ.Υ	AT
NO SPECIALTY REQUIRED/No Subspecialty	HOSPITAL Viewing Page: 1	12/31/2999
Delete View Page. 1 O'Go Page Count		First Prev Next Last

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## Step 5: Associate Billing Provider

<u>1</u> · ·					🔓 Note Pad	😧 External Links 🕶	★ My Favorites ▼	🚔 Print	😧 Help
> MyInbox > New Enrollment > FAO Enrollment									
Application ID: 20200225447257	Name: Ohana								
<b>O</b> .Ol									
III Enroll Provider - FAO									^
				Business Process W	Vizard - Provider Enro	llment (FAO). Click	on the Step # unde	er 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			Incomplete					
Step 6: Add License/Certification/Other	Optional			Incomplete					
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 P	ayments.			
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Step 12: Complete Enrollment Checklist	Required			Incomplete					
Step 13: Submit Enrollment Application for Approval	Required			Incomplete					
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Page ID: pgBPWOrganizationStart(Provider)	Environm	nent: HI_SYSTST R10c-1.1					Server Time: 02/25	5/2020 12:36:3	87 MST

## **Associate Billing Provider**

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## **Associate Billing Provider**

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Associate Billing Provider/Other Associations			
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Start Date:	*	End Date:	
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## Step 6: Add License/Certification

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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			Incomplete					
Step 7: Add Additional Information	Optional			Complete					
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete					
Step 9: Add Taxonomy Details	Required			Incomplete					
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Step 11: Upload Documents	Required			Incomplete	Please upload re	quired documents.			
Step 12: Complete Enrollment Checklist	Required			Incomplete					
Step 13: Submit Enrollment Application for Approval	Required			Incomplete					
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## Add License/Certification

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## Add License/Certification

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## Add License/Certification

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## Step 7: Add Additional Information

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## Add Additional Information

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## Step 8: Add Controlling Interest/Ownership Details

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p 3: Add Correspondence Address	Required	02/25/2020	02/25/2020	Complete					
ap 4: Add Provider Type/Specialties/Subspecialties	Required	02/25/2020	02/25/2020	Complete					
p 5: Associate Billing Provider/Other Associations	Optional	02/25/2020	02/25/2020	Complete					
p 6: Add License/Certification/Other	Optional	02/25/2020	02/25/2020	Complete					
p 7: Add Additional Information	Optional	02/25/2020	02/25/2020	Complete					
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p 12: Complete Enrollment Checklist	Required			Incomplete					
ap 13: Submit Enrollment Application for Approval	Required			Incomplete					
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### Add Controlling Interest/Ownership Details

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Application ID: 20200225447257	Name:	Ohana					
Close Actions -							
III Per Medicaid Provider Manual							^ ^
PROVIDER OWNERSHIP AND CONTROL DISCLOSURES							
Provider Enrollment Information, including home address, date of birth, and Social Security Number,	is required from providers and other disclosed individu	uals (e.g., owners, managing employees, agents, e	c.).				
REQUIRED DISCLOSURE INFORMATION							
Provider (including fiscal agents and managed care entities) are required to disclose the following inf	ormation on ownership and control during enrollment,	revalidation and within 35 days after any change in	ownership:				
<ul> <li>The name and address of any person (individual or corporation) with ownership or control intere</li> <li>Date of birth and Social Security Number (in the case of an individual).</li> </ul>	st. The address for corporate entities must include, as	applicable, primary business address, every busin	ess location and P.O. Box address.				
Other Tax Identification Number, in the case of corporation, with an ownership or control interest     Whether the person (individual or corporation) with an ownership or control interest is related to	t or of any subcontractor in which the disclosing entity another person with ownership or control interest as a	has a five percent or more interest. spouse parent, child or sibling or whether the per	son (individual or corporation) with an ownership or	control interest of any subcont	ntractor in which the disclosing e	ntity has a five percent	or
more interest is related to another person with ownership or control interest as a spouse, parent	child or sibling.			,			
<ul> <li>The name of any other fiscal agent of manage care entity in which an owner has an ownership of</li> <li>The name, address, date of birth and Social Security Number of any managing employee.</li> </ul>	or control interest in an entity that is reimbursable by M	iedicald and/or Medicare.					
REQUIRED OWNERS							
Managing Employee is mandatory for all enrollment types.							
<ul> <li>There must be at least one other ownership type in addition to Managing Employee.</li> <li>If any of the following 10 owner types are selected: Corporate-Charitable 501[cl3, Corporate-No</li> </ul>	n Charitable, Corporate-Publicly Traded, Corporate-No	ot Publicly Traded, Holding Company, Indirect Own	er, Limited Liability Company, Subcontractor, Foreig	m, Nonresident Alien for the ke	keved Tax ID, then at least 1 of	he following 5 owner ty	pes
must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Financial Of	ficer, Chief Information Officer, or Chief Operating Offi	icer.		· · ·			
If you select any of the following ownership types: Managing Employee, Board of Directors, Chie     For the Contractor/MCO Enrollment Type, 3 ownership records must be added:	a Executive Onicer, Chief Information Onicer, Chief O	perating Onicer, or Chief Financial Onicer, you mus	t add at least 1 additional ownership type that is not	i from among that list.			
(1) Agent (2) Board of Directors, Chief Executive Officer, Chief Einancial Officer, Chief Informatic	n Officar, or Chief Operating Officar						
(3) Managing Employee	officer, or other operating officer						
III Owners List							•
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Owner SSN/EIN/TIN Owner Information	Owner Type Address	Start Date End Date	Relationship Status	Adverse Action	Percentage owne	d	
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### Add Owner

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PROVIDEI Owners Relation	ROL D	ISCLOSURES												
Provider E Owners Adverse	Action ding hor	ne address, da	e of birth, and Socia	I Security Number	is required from provider	s and other disclosed in	dividuals (e.g., owners, ma	inaging employees, agent	s, etc.).					
REQUIRED DISCLUSURE I	NFURMATION													
Provider (including fiscal age     The name and address	nts and managed	l care entities) : dividual or com	are required to disclo pration) with owners	ise the following in	formation on ownership a	nd control during enrolln prate entities must includ	nent, revalidation and withi	n 35 days after any chang usiness address, every bi	e in ownership: Isiness location and P.O. Box address					
Date of birth and Social	Security Number	(in the case of	an individual).				io, ao appiloanio, printary n			-				
<ul> <li>Other Tax Identification</li> <li>Whether the person (ind</li> </ul>	Number, in the ca ividual or corpora	ase of corporati ition) with an ov	on, with an ownersh vnership or control ir	p or control interes iterest is related to	t or of any subcontractor another person with own	in which the disclosing e ership or control interes	entity has a five percent or t as a spouse, parent, child	more interest. I or sibling: or whether the	person (individual or corporation) with	n an ownership or control interest of an	subcontractor in which	the disclosing entity has	a five percent o	ar.
more interest is related	o another person	with ownership	or control interest a	is a spouse, paren	, child or sibling.		,,,,,,,					j,		
<ul> <li>The name of any other f</li> <li>The name, address, dat</li> </ul>	iscal agent or ma e of birth and Soo	nage care entit ial Security Nu	y in which an owner mber of any managi	has an ownership ng employee.	or control interest in an er	ntity that is reimbursable	by Medicaid and/or Medic	are.						
REQUIRED OWNERS			_											
Managing Employee is      There must be at least of	nandatory for all ne other owners!	enroliment type hip type in addit	s. ion to Managing Em	ployee.										
<ul> <li>If any of the following 10</li> </ul>	owner types are	selected: Corp	orate-Charitable 501	[c]3, Corporate-No	n Charitable, Corporate-I	Publicly Traded, Corpora	ate-Not Publicly Traded, Ho	olding Company, Indirect C	Owner, Limited Liability Company, Sub	ocontractor, Foreign, Nonresident Alien	for the keyed Tax ID, th	en at least 1 of the follow	ing 5 owner type	BS
<ul> <li>If you select any of the f</li> </ul>	ollowing ownersh	ip types: Mana	ging Employee, Boa	d of Directors, Chi	ef Executive Officer, Chie	f Information Officer, Ch	ief Operating Officer, or Cf	hief Financial Officer, you	must add at least 1 additional ownersl	hip type that is not from among that list.				
For the Contractor/MCC     (1) Apoent	Enrollment Type	, 3 ownership r	ecords must be add	ed:										
(1) Agent (2) Board of D	rectors, Chief Ex	ecutive Officer,	Chief Financial Offic	er, Chief Informati	on Officer, or Chief Opera	ating Officer								
(3) Managing	Employee													
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## Add Ownership

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III Provider Controlling Interest/Ownership				
Туре:	SELECT 💙 * 🤕	Percentage Owned:	*	^
SSN:		EIN/TIN:		
Legal Entity Name:		Entity Business Name:		
	(As shown on the Income Tax Return)		(Doing Business As)	
Owner NPI:				
First Name:		Last Name:		
Suffix:		DOB:		
Phone Number:	* Extn:	Email:		
Start Date:	*	End Date:		
	ATTENTION: Address Submission only req remaining address fields will be populated be returned.	uires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will	e 1	
Address Line 1:	*	Address Line 2:		
Address Line 3:	(Enter Street Address or PO Box Only)	City/Town:	OTHER *	
State/Province:	OTHER *	County:	OTHER 🔽	
Country:	UNITED STATES 🖌 *	Zip Code:	* - Validate Address	
				✓ OK ③ Cancel
Page ID: dlgEnrlmntAddOwner(Provider)				

## Add Ownership

🚔 Print 🛛 Help					
Application ID: 20200225447257	Name: Ohana				
III Provider Controlling Interest/Ownership					
Туре:	Managing Employee 💽 * 👔	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:				) <b></b>	
First Name:	Anne *	Last Name:	Jones	*	
Suffix:		DOB:	02/25/1970 *		
Phone Number:	(555) 555-5555 <b>* Extn:</b>	Email:		J	
Start Date:	02/25/2020	End Date:			
	Please ensure you are providing the he	me address of this provider. Failure to do so may result in this application/mo	odification being denied.		
Address Type:	Home Address				
	ATTENTION: Address Submission only requires Addres remaining address fields will be populated and validate	is Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the d by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will			
	be returned.				
	Address valid	tion 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:		County:	Salt Lake		
Country:	UNITED STATES *	Zip Code:	84102 * - 4211	Validate Address	
Page ID: dlgEndmntAddOwner(Provider)					Cancel

## Add Owners Relationship

evoBr *					>
1 ·				皆 Note Pad 🛛 🥝 External	I Links ▼ 🔺 My Favorites ▼ 🚔 Print 😨 Help
👫 > MyInbox > New Enrollment > FAO Enrollment > General					
Application ID: 20200225447257	Name: Ohana	a			
Close Actions -					
Import Owner					^
PROVIDEL Owners Relationships ROL DISCLOSURES					
Provider E Owners Advarse Action and Social Security N	umber, is required from providers and other disclosed individuals (e	e.g., owners, managing employees, agents, (	etc.).		
Provider (including fiscal agents and managed care entities) are required to disclose the follow	wing information on ownership and control during enrollment, revali	dation and within 35 days after any change i	n ownership:		
The name and address of any person (individual or corporation) with ownership or control	ol interest. The address for corporate entities must include, as appli-	cable, primary business address, every busin	ess location and P.O. Box address.		
<ul> <li>Date of birth and Social Security Number (in the case of an individual).</li> <li>Other Tay Identification Number in the case of corporation with an ownership or control</li> </ul>	interest or of any subcontractor in which the disclosing entity has a	five percent or more interest			
Whether the person (individual or corporation) with an ownership or control interest is rel	ated to another person with ownership or control interest as a spou	se, parent, child or sibling; or whether the pe	rson (individual or corporation) with an ownership or contr	ol interest of any subcontractor	in which the disclosing entity has a five percent or
more interest is related to another person with ownership or control interest as a spouse,	parent, child or sibling.				
<ul> <li>The name of any other fiscal agent or manage care entity in which an owner has an own</li> <li>The name address date of birth and Social Security Number of any managing employed</li> </ul>	ership or control interest in an entity that is reimbursable by Medica	id and/or Medicare.			
	•				
REQUIRED OWNERS					
<ul> <li>Managing Employee is mandatory for all enrollment types.</li> </ul>					
<ul> <li>There must be at least one other ownership type in addition to Managing Employee.</li> <li>If any of the following 10 owner types are selected: Corporate-Charitable 501[c]3. Corporate-Charitable 501[c]3.</li> </ul>	rate.Non Charitable, Cornorate.Publicly Traded, Cornorate.Not Pub	slich Traded Holding Company Indirect Ow	ner Limited Liability Company, Subcontractor, Foreign, N	nnesident Alien for the keyed T	av ID then at least 1 of the following 5 owner types
must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Final	ncial Officer, Chief Information Officer, or Chief Operating Officer.	siciy Haded, Holding Company, Indirect Ow	ier, Einned Elability Company, Subcontractor, Foreign, Ho	inesident Allen for the keyed f	ax 12, then acted at 1 of the following 5 owner types
If you select any of the following ownership types: Managing Employee, Board of Director	rs, Chief Executive Officer, Chief Information Officer, Chief Operati	ng Officer, or Chief Financial Officer, you mu	st add at least 1 additional ownership type that is not from	among that list.	
<ul> <li>For the Contractor/MCO Enrollment Type, 3 ownership records must be added: (1) Agent</li> </ul>					
<ul> <li>(1) Agent</li> <li>(2) Board of Directors. Chief Executive Officer. Chief Financial Officer. Chief Int</li> </ul>	formation Officer, or Chief Operating Officer				
(3) Managing Employee					
III Owners List					^
Filter By	Indicator	<b>O</b> Go			Save Filters ▼ My Filters ▼
Owner SSN/EIN/TIN Owner Information	Owner Type Address	Start Date End Date	Relationship Status	Adverse Action	Percentage owned
□ 126538456 Jones,Anne	Managing Employee 515 E 100 S	02/25/2020 12/31/299	9 Not Completed	Not Completed	50
☐ 759856966 Jones,John	Agent 515 E 100 S	02/25/2020 12/31/299	9 Not Completed	Not Completed	50
https://hi-trg-evo.cns-inc.com/evoBrix/CNSIControlServlet	Env	rironment: HI_SYSTST R10c-1.1			Server Time: 02/25/2020 01:07:26 MST

## Add Owners Relationship

Appleted ID: 200225447257 brief of the Owners Auere the following relationship (Doughletr. Doughletr. Doughlet	🚔 Print 💿 Help				
Image: State in the Add Relationship	Application ID: 20200225447257		Name: Ohana		
be any of the Colouring relationship (Daughter, Daughter, Tal. Law, Fabher, Mother in Law, Sobing, Son, Son ha Law, Self, Spouse ? Or the Order (Sick Save to update)   Ourser Lats     Sond Owner:     Selected Owner:     SSNEENTIN     Type     Relation to Jones, Jone     Status: Not Completed     Selected Owner:     SSNEENTIN:     Type     Relation to Jones, Jone     Status: Not Completed     Selected Owner: Jones, Anne     SSNEENTIN:     Type     Relation to Jones, Jone     Status: Not Completed     Status: Not C	III Add Relationship				*
Shore List     Selected Owner-Jones, Anna     SNELIN/TIN     Type     Relation to Joner, John     Relation to Joner, Joner, Anna     SNFEIN/TIN-126538456 <td>Do any of the Owners have the following relationship (Daughter</td> <td>, Daughter-In Law, Father, Father-In Law, Mother, Moth</td> <td>eer-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? OYes ONo (Click Save to update)</td> <td></td> <td></td>	Do any of the Owners have the following relationship (Daughter	, Daughter-In Law, Father, Father-In Law, Mother, Moth	eer-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? OYes ONo (Click Save to update)		
Show Owner     All     Show Comer   Shielkin IN     Sheeted Owner-Jones, John     Sheeted Owner-Jones, Anne     She	Owner List				
Selected Owner.Jones, John SSNEIN/TIN-175985966 Status:Not Completed     Anso:: Owner SSNEIN/TIN     12533456 Managing Employee     1 Oracle        Viewing Page: 1  Anso:: Owner                                    Anso:: Owner  Solution to Jones: Jone Solution to Jones: Jone Solution to Jones: Jone Solution to Jones: Jone Solution to Jone Solutio to Jone Solution to Jone Solutiont	Show Owners All O Go				Save Filters ▼ My Filters ■
Assoc.Ower SSNEIN/TIN Type Relation to Jones, John Relation to Jones, Cower   Jones, Anne 126538456 Managing Employee Spouse Imaging Employee   Viewing Page: 1 Imaging Employee Imaging Employee Imaging Employee   Selected Owner-Jones, Anne SSNEIN/TIN-126538456 Status:Not Completed	✓ Selected Owner:Jones, John SSN/EIN/TIN:7598569	6 Status:Not Completed			
Jones.Anne 12653465 Managing Employee Spouse V Viewing Page: 1 O Go Page Count & SeveraxLS Viewing Page: 1 Viewing Page: 1 O SeveraxLS S	Assoc. Owner SSN/EIN/TIN	Туре	Relation to Jones, John	Relation to Assoc. Owner	
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Selected Owner,Jones, Anne SSW/EIN/TIN:126538456 Status:Not Completed	View Page: 1 O Go Page Count Save	ToXLS	Viewing Page: 1		K First Prev Next S Last
	Selected Owner:Jones, Anne SSN/EIN/TIN:12653845	6 Status:Not Completed			
Bave O Close					Bave OClose
Page ID: dlgAddModifyOwnerRelationship(Provider)	Page ID: dlgAddModifyOwnerRelationship(Provider)				

## **Complete Adverse Actions**

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between the standing of the	H > MyInbox	> New Enrollmen	t > FAO Enrollm	ient > General														
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Protect (adding facial gerts and managed case eathers) are requested to dictore the following information on one enterph and control during early facial gerts and managed case, serters backers and P.O. Box address. 4. and address of any percent (indicad a composition) with an enterph any control interest of any subcontracted in the media address of address	REQUIREL	Owners Advelo		nie audress, ua	te ol biltil, allu Social S	ecunty Nu	niber, is required ironing	noviders and our		iis (e.g., ow	ners, managing emp	noyees, agents, etc.).						
<ul> <li>In terms and address dark persons (individual or coparation) with ownerships or control interest. The address for corparate within such that disclosing entity has a fixe percent or new interest.</li> <li>In terms and address dark persons with ownerships or control interest as a spouse, parent, did ar sbings or control interest as</li></ul>	Provider (in	cluding fiscal age	nts and manage	ed care entities)	are required to disclose	the follow	ing information on own	ership and control	during enrollment, re	evalidation a	and within 35 days a	fter any change in ownersh	ip:					
<ul> <li>Def to the indication of the indication</li></ul>	The na	me and address	of any person (ir	ndividual or corp	oration) with ownership	or control	interest. The address f	or corporate entiti	es must include, as a	ipplicable, p	orimary business add	dress, every business locati	on and P.O. Box address.					
<ul> <li>• Whether the person (individual or coproration) with an ownership or control interest as a spouse, parent, did or skeling, or whether the person (individual or coproration) with an ownership or control interest as a pouse, parent, did or skeling, or whether the person (individual or coproration) with an ownership or control interest as a pouse, parent, did or skeling, or whether the person (individual or coproration) with an ownership or control interest as a pouse, parent, did or skeling, or whether the person (individual or coproration) with an ownership or control interest as a pouse, parent, did or skeling, or whether the person (individual or coproration) with an ownership or control interest as a pouse, parent, did or skeling, or whether the person (individual or coproration) with an ownership or control interest as a pouse, parent, did or skeling, or whether the person (individual or coproration) with an ownership or control interest as a pouse, parent, did or skeling, or whether the person (individual or coproration) with an ownership or control interest as a pouse, parent, did or skeling, or whether the person (individual or coproration) with an ownership or control interest as a pouse, parent, did or skeling, or whether the person (individual or coproration) with an ownership or control interest as a pouse, parent, did or skeling.</li> <li>• Team or the and addition of the anging employne, Bart of the skeling or whether the person (individual or coproration) with an ownership or control interest as a pouse, parent, did or skeling, coprorate bother ownership is contradius of pouse, parent, did or skeling, coprorate bother ownership or control interest as a pouse, parent, did or coprorate bother ownership end of the and top of the control interest as a pouse, parent, did or coprorate bother ownership end of the control interest as a pouse, parent, did or coprorate bother ownership end of the control interest as a pouse, parent, did or coprorate bother ownership end of the control interest as a</li></ul>	Date o     Other	Forth and Social Tax Identification	Security Numbe Number, in the (	er (in the case of case of corporati	an Individual). ion, with an ownership (	or control in	nterest or of any subcor	ntractor in which t	he disclosing entity h	as a five pe	cent or more intere	st.						
ne mane d any other fice any other fice any other fice any other any other other any othera any othera any othera any othera any othera any othera any othe	Wheth	er the person (ind	ividual or corpor	ration) with an o	wnership or control inte	rest is relat	ted to another person w	ith ownership or	control interest as a s	pouse, par	ent, child or sibling; (	or whether the person (indiv	idual or corporation) with an owne	ership or control interest of	f any subcontractor in which	n the disclosing entity ha	s a five percent	or
<ul> <li>The name, address, date of birth and Social Security Number of any managing employee.</li> <li>Hanging Engloyee is maintatudy for all enrolment types.</li> <li>Inhaging Engloyee is maintatudy is are selected. Corporate-Name Charattable, Social Security Officer, Chief Financial Officer, Chief Financial Officer, Chief Financial Officer, or Chief Operating Officer.</li> <li>I'y or y or the following To waver type are selected. Corporate-Name Chief Financial Officer, or Chief Operating Officer.</li> <li>I'y or y or the following To waver type are selected. Corporate-Name Chief Financial Officer, or Chief Operating Officer.</li> <li>I'y or y or the following To waver type are selected. Corporate-Name Chief Financial Officer, or Chief Operating Officer.</li> <li>I'y or y or the following To waver type are selected. Corporate-Name Chief Financial Officer, or Chief Operating Officer.</li> <li>I'y or y or the following To waver type are selected. Corporate-Name Chief Financial Officer, or Chief Operating Officer.</li> <li>I'y or y or the following To waver type are selected. Corporate-Name Chief Financial Officer, or Chief Operating Officer.</li> <li>I'y or y or the following To waver type are selected. Corporate-Name Chief Financial Officer, or Chief Operating Officer.</li> <li>I'y or y or the following To waver type are selected.</li> <li>I'y or y or the following To waver type are selected.</li> <li>I'y or y or the following To waver type are selected.</li> <li>I'y or y or the following To waver type are selected.</li> <li>I'y or y or the following To waver type are selected and the selected</li></ul>	The na	me of any other f	iscal agent or m	anage care entit	ly in which an owner ha	s an owne	rship or control interest	in an entity that is	s reimbursable by Me	dicaid and/	or Medicare.							
REVUREED OWNERSE     A langing Enployees imandatory for all entrols	<ul> <li>The na</li> </ul>	me, address, dat	e of birth and So	ocial Security Nu	imber of any managing	employee.												
<ul> <li>A Manging Employee is mandatory for all enrothment types.</li> <li>A more must be at least one other ownership types are selected. Toporate-Non Chartable, Corporate-Noth Chartable, Chartable, South Chartable, Chartable</li></ul>	REQUIRED	OWNERS																
	• Manag	ing Employee is i	mandatory for al	l enrollment type	9S.													
must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Information Officer, or Chief Operating Officer, or Chief Operating Officer, or Chief Operating Officer, or Chief Pinancial Officer, Chief Information Officer, or Chief Operating Officer, or Chief Operating Officer, or Chief Operating Officer, or Chief Pinancial Officer, Chief Information Officer, or Chief Operating Officer, or Chief Pinancial Officer, Chief Information Officer, or Chief Operating Officer, or Chief Operating Officer, or Chief Operating Officer, Chief Pinancial Officer, or Chief Operating Officer, Chief Information Officer, or Chief Operating Officer, Officer Operating Offic	There     If any of	must be at least o of the following 10	ne other owners owner types ar	ship type in addi e selected: Corp	tion to Managing Emplo porate-Charitable 501[c]	iyee. 3, Corpora	te-Non Charitable, Cor	porate-Publicly Tr	aded, Corporate-Not	Publicly Tr	aded, Holding Comp	any, Indirect Owner, Limite	d Liability Company, Subcontracto	or, Foreign, Nonresident	Alien for the keyed Tax ID, th	nen at least 1 of the follo	wing 5 owner ty	pes
<ul> <li>I you seed any on the toowing ownership types. Managing Employee, soald of Directory, Chief Executive Officer, Chief Financial Officer, or Chief Pinancial Officer, or Chief Operating Officer         <ul> <li>(1) Agent</li> <li>(2) Board of Directors, Chief Executive Officer, Chief Financial Officer, or Chief Operating Officer</li> <li>(3) Managing Employee</li> </ul> </li> <li> <ul> <li><b>Filter By</b></li> <li><b>And</b></li> <li>Indicator</li> <li><b>Owner SSN/EIN/TIN</b></li> <li><b>Owner filter Managing Employee</b></li> <li><b>Stare Filters</b></li> <li><b>Atv</b></li> <li><b>Atv</b></li></ul></li></ul>	must a	Iso be selected in	addition: Board	of Directors, Ch	nief Executive Officer, C	hief Finan	cial Officer, Chief Inform	nation Officer, or	Chief Operating Offic	er.		0.6	and distant summaries in a distant					
(1) Agent (2) Board of Directors, Chief Executive Officer, Chief Information Officer, or Chief Operating Officer (3) Managing Employee	For the	elect any of the f Contractor/MCC	Enrollment Typ	nip types: Mana e, 3 ownership r	ging Employee, Board records must be added:	or Directors	s, Chiel Executive Offic	er, Chief informat	ion Onicer, Chier Ope	erating Omo	cer, or Chier Financia	al Onicer, you must add at i	east 1 additional ownership type tr	mat is not from among tha	t list.			
(2) Board of Ulrectors, Chief Fundancial Officer, Chief Fundancial Of		(1) Agent			01.15		r o <i>r</i> r oi:											
Movers List         And Indcator         O columnation         Movers SNEIN/TIN         Owner Information         And owner Type         Address         Ard         A		(2) Board of D (3) Managing I	rectors, Chief E Employee	xecutive Officer,	, Chiet Financial Officer	, Chiet Into	rmation Officer, or Chie	er Operating Office	er									
Model       And       Indicator       Oracle       End Date       Relationship Status       Adverse Action       Percentage owned         Owner SSN/EIN/TIN       Owner Information       Owner Type       Address       Atv       Av       Av <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><th></th><th></th><td></td></t<>																		
Filter By       And       Indicator       Order       Oddress       Start Date       Relationship Status       Adverse Action       Percentage owned            • V more SSN/EIN/TNN         • Av	₩ Ow	ners List																^
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▲▼         ▲▼	Owner	SSN/EIN/TIN		Owner Info	ormation		Owner Type		Address		Start Date	End Date	Relationship Status	Adve	se Action	Percentage owned		
Constraint         Constraint         Managing Employee         S15 E 100 S         02/25/020         12/31/2999         Completed         Not Completed         S0         P           759856966         Jones, John         Agent         515 E 100 S         02/25/020         12/31/2999         Completed         Not Completed         50         P	□ △▼			A.					<b>▲</b> ▼		<b>AV</b>	A.A.	A.			* <b>*</b>		
	126538	456		Jones, Anno	e		Managing Employee		515 E 100 S		02/25/2020	12/31/2999	Completed	Not C	ompleted	50		~
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## **Disclose Adverse Actions**

		Name: Ohana		
s a combination of direct and indirect ownership interests e	nore in a disclosing entity; qual to five (5) percent or more in a disc	closing entity;		
	da - d - d daviek da			
is an interest of five (5) percent of more in any mortgage, on officer or director of a disclosing entity that is organized a	Jeed of trust, note, or other obligation se is a corporation; or	ecured 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;	
partner in a disclosing entity that is organized as a partner	ship?			
nificant business transaction" means any business transar	tion or series of transactions that, durin	ng one fiscal year exceed the lesser of \$25,000 and five (5) percent	t of an offeror¿s total operating expenses.	
contractor" means:				
dividual, agency, or organization to which a disclosing en	ity has contracted or delegated some o	of its management functions or responsibilities of providing medical	care to its patients; or	
dividual, agency, or organization with which a fiscal agent	has entered into a contract, agreement	t, purchase order, or lease (or leases of real property) to obtain spa	ace, supplies, equipment, or services provided under the DHS agreement.	
plier" means an individual, agency, or organization from ${\tt w}$	/hich a provider purchases goods and s	services used in carrying out its responsibilities under its DHS agree	ement (e.g. a commercial laundry firm, a manufacturer of hospital beds, or a pharmaceu	tical firm).
olly owned subsidiary supplier," means a subsidiary or sur	oplier whose total ownership interest is !	held by the Medicaid provider/applicant or by a person, persons, or	r other entity with an ownership or controlling interest in the Medicaid provider/applicant.	
L ADVERSE LEGAL ACTION/CONVICTION ACTION H	STORY			
	cinace identity, over bad a final adverse			
ny of the owners, under any current or former name or bu	silless identity, ever had a linar adverse	e legal action listed above imposed against them? Please answer i	n the "Owners with Adverse Action" section below for each owner.	
ny of the owners, under any current or former name or bu Owners with Adverse Action	siness identity, even nad a initial adverse	e legal action listed above imposed against them? Please answer ii	n the 'Owners with Adverse Action' section below for each owner.	
Owners with Adverse Action		e legal action listed above imposed against them? Please answer i	n the 'Owners with Adverse Action' section below for each owner.	
ory of the owners, under any current or former name or bu Owners with Adverse Action ter By		e legal action listed above imposed against them? Please answer i	n the 'Owners with Adverse Action' section below for each owner.	Save Filters ♥ My Filters▼
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any of the owners, under any current or former name or bu Owners with Adverse Action Iter By Iter Name at Anne		e legal action listed above imposed against them? Please answer in Response	n the 'Owners with Adverse Action' section below for each owner.	Save Filters VMy Filters
any of the owners, under any current or former name or bu Owners with Adverse Action ter By All er Name s,Anne	O Go     SSN/EIN/TIN     X*     126538456	e legal action listed above imposed against them? Please answer in Response	Comments	Save Filters VMy Filters
ny of the owners, under any current or former name or bu Owners with Adverse Action ter By  All er Name s,Anne s,John	O Go     SSN/EIN/TIN     T26538456     759856966	Response Types Information Note: The Second Se Second Second Sec	Comments	Save Filters V Filters
any of the owners, under any current or former name or bu Owners with Adverse Action itter By All ner Name es,John ew Page: 1 O Go Page Count C S	O Go     SSN/EIN/TIN     T26538456     759856966     sveToXLS	e legal action listed above imposed against them? Please answer in Response ▲▼ ○Yes ●No ○Yes ●No	Comments	Save Filters Thy Filters K First Prev Next S Last

## Step 9: Taxonomy Details

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A > MyInbox > New Enrollment > FAO Enrollment									
Application ID: 20200225447257	Name: Obana								
Appreadon 10. 20200223441231	Hume. Onana								
O Close									
III Enroll Provider - FAO									^
				Business Process Wiz	ard - Provider Enro	llment (FAO). Click	on the Step # unde	er 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			Incomplete					
Step 10: Fee Payment	Required			Incomplete	Please add Fee I	Payments.			
Step 11: Upload Documents	Required			Incomplete	Please upload re	quired documents.			
Step 12: Complete Enrollment Checklist	Required			Incomplete					
Step 13: Submit Enrollment Application for Approval	Required			Incomplete					
View Page: 1 O Go Page Count SaveToXLS		Viewing Page: 1					≪ First	> Next	» Last
Page ID: pgBPWOrganizationStart(Provider)	Environme	ent: HI_SYSTST R10c-1.1					Server Time: 02/2	5/2020 01:16:	:35 MST

## **Taxonomy Details**

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## Add Taxonomy

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## NUCC Taxonomy Code List

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HOME × ANNOUNCEMENTS NUCC STRUCTURE × CALENDAR 1500 CLAIM FORM × CODE SETS × DEFINITIONS         RESOURCES         Use the browser's find feature (CrtI-F) to search for values. Taxonomy codes are self-selected. Choose the code that best identifies you as a provider.       Cicking a [definition] link to the left displays code value.         I Individual or Groups (of Individuals)       Group [definition]       *         I Individual or Groups (of Individuals)       Forge [definition]         I Multi-Specially - 193200000X [definition]       *         Multi-Specially - 193200000X [definition]	<u>File Edit V</u> iew	F <u>a</u> vorites <u>T</u> ools <u>H</u> elp	
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## Step 10: Fee Payment

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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			Incomplete	Please add Fee	Payments.			
Step 11: Upload Documents	Required			Incomplete	Please upload re	equired documents.			
Step 12: Complete Enrollment Checklist	Required			Incomplete					
Step 13: Submit Enrollment Application for Approval	Required			Incomplete					
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## Fee Payment

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# Fee Payment

Application ID: 20200225447257

Name: Ohana

#### III Fee Payment

#### Payment Reason: New Enrollment

	Options	Description
0	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.
0	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.
0	Fee Paid to Medicaid in Another State	Select this option if you can supply documentation demonstrating that you have already paid the enroliment 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.
0	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.
0	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:

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✓Ok Scancel

## Step 11: Upload Documents

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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			Incomplete	Please upload rei	quired documents.			
Step 12: Complete Enrollment Checklist	Required			Incomplete					
Step 13: Submit Enrollment Application for Approval	Required			Incomplete					
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## **Upload Documents**

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## **Upload Documents**

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## **Upload Documents**

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## Step 12: Enrollment Checklist

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Step 3: Add Correspondence Address	Dequired	02/25/2020	02/25/2020	Com	plete			
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Step 5: Associate Billing Provider/Other Associations	Optional	02/25/2020	02/25/2020	Com	plete			
Step 6: Add License/Certification/Other	Optional	02/25/2020	02/25/2020	Com	plete			
Step 7: Add Additional Information	Optional	02/25/2020	02/25/2020	Com	plete			
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/25/2020	02/25/2020	Com	plete			
Step 9: Add Taxonomy Details	Required	02/25/2020	02/25/2020	Com	plete			
Step 10: Fee Payment	Required	02/25/2020	02/25/2020	Com	plete			
Step 11: Upload Documents	Required	02/25/2020	02/25/2020	Com	plete			
Step 12: Complete Enrollment Checklist	Required			Incor	nplete			
Step 13: Submit Enrollment Application for Approval	Required			Incor	nplete			
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## **Enrollment Checklist**

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Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	Not Completed	~		
Do you wish to end date your enrollment? If yes, enter date in comment field.	Not Completed	~		
Are you currently excluded from any Hawaii or other state program? If yes, provide state of exclusion and program in comment field.	Not Completed	~		
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	Not Completed	~		
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	Not Completed	~		
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field	Not Completed	~		
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	Not Completed	~		
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	Not Completed	~		
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	Not Completed	~		
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 field again.	Not Completed	~		
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	Not Completed	~		
Have you had any malpractice settlement, judgment, or agreement? If yes, provide doilar amount and dates in comments field.	Not Completed	~		
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.	Not Completed	~		
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	Not Completed	~		
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.	Not Completed	~		
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## **Step 13: Submit Application**

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p 3: Add Correspondence Address	Required	02/25/2020	02/25/2020	Complete		
p 4: Add Provider Type/Specialties/Subspecialties	Required	02/25/2020	02/25/2020	Complete		
p 5: Associate Billing Provider/Other Associations	Optional	02/25/2020	02/25/2020	Complete		
p 6: Add License/Certification/Other	Optional	02/25/2020	02/25/2020	Complete		
p 7: Add Additional Information	Optional	02/25/2020	02/25/2020	Complete		
p 8: Add Provider Controlling Interest/Ownership Details	Required	02/25/2020	02/25/2020	Complete		
p 9: Add Taxonomy Details	Required	02/25/2020	02/25/2020	Complete		
p 10: Fee Payment	Required	02/25/2020	02/25/2020	Complete		
p 11: Upload Documents	Required	02/25/2020	02/25/2020	Complete		
p 12: Complete Enrollment Checklist	Required	02/25/2020	02/25/2020	Complete		
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## **Submit Application**

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		٦ I agree th	The information During th at the informati	submitted for enrollment shall be verified and reviewed by his time, any changes to the information shall not be accepte ion submitted as a part of the application is correct (Private	the State. ed. and Confidential)	).		
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## **Review Provider Participation Agreement**

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Application ID: 20200225447257	Name: Ohana					
Close Submit Application After reading the Terms and Conditions be sure to check the agreement box	ocated at the end of the document.					
III 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 f certification by the Hawaii State Medicaid Program, I/We also agree to abide by the policies I/We agree to abide by the policies and procedures contained in the Medicaid Waiver Provid	rth in the Hawaii Administrative Rules, Title 17, Subtitle 12, and applicable ind procedures contained in the Hawaii State Medicaid Manual. If I/We are er Standards Manual.	provisions set forth in the Code of Federal Regulations (C a provider for the 1915 <sup>®</sup> waiver for participants with Deve	.F.R.) related to the N lopmental Disabilities	ledical Assistance F (DD) or Intellectual	rogram. Upor Disabilities (IC	ו D),
I/We agree to comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352), Section 504 promulgated by the regulations of the Department of Health and Human Services and hereb color, national origin, sex, age or handicap, be excluded from participation in, or be denied th Financial Assistance.	f the Rehabilitation Act of 1973 (P.L. 93-112), and the Age Discrimination give assurance that I/We will immediately take any measures necessary to benefits of, or be otherwise subjected to discrimination under any progra	Act of 1975 (P.L. 94-135), and all the requirements issued to enact this agreement, to the effect that no person shall or m and/or activity of the service provider that is funded in it:	pursuant to the respe n the grounds of the s entirety or in part di	ctive title, section ar applicable categorie rectly or indirectly by	nd/or act, as s such as race Federal	e,
I/We agree to keep all such records necessary to disclose fully, upon request, the extent of Medicaid Investigations Division, such information from those records regarding any payment	are and/or services provided by me/we to eligible Medicaid beneficiaries and is that have been claimed by me/we under the program as the Hawaii Stat	nd to furnish the Hawaii State Department of Human Service Department of Human Services may, from time to time,	ces, the Secretary of equire as authorized	Health and Human S by 42 C.F.R. §431.1	Services, or the 07(b)(2).	e
I/We agree to disclose full and complete information regarding ownership information as des C.F.R. §455.105), and information on persons convicted of crimes (42 C.F.R. §455.106) upo Hawaii State Department of Human Services, the Secretary of Health and Human Services,	cribed in 42 C.F.R. §455 Subpart B. This includes but is not limited to disclu- n execution of this provider agreement during re-validation of the enrollmer or the Medicaid Investigations Division in the Department of Attorney Gene	osure of information on ownership and control (42 C.F.R. § nt process, within thirty-five (35) days of any change in own ral.	455.104), information ership of the disclosi	n related to business ng entity and at the n	transactions ( request of the	(42
I/We understand that the Hawaii State Medicaid Program may refuse to enter into or renew a to that person's involvement in any program established under Medicare and Medicaid Prog	n agreement with me/we if any person, who has an ownership or control in am (Title XIX) as stipulated in 42 C.F.R. §455.106.	terest in the provider, or who is an agency or managing er	nployee, has been co	nvicted of a criminal	offense relate	ed
I/We agree to accept, as payment in full, the applicable amount or amounts established by the Medicaid recipient as stipulated in 42 C.F.R. §447.15. I/We am aware that it is violation of Medicaid Program. I/We understand the reimbursement rates shall be in accordance with path.	e Hawaii State Medicaid Program in Chapter 1739, Hawaii Administrative I Federal law to accept or require additional payments over and beyond the ment methodologies pursuant to Chapter 1739, Hawaii Administrative Rul	Rules, plus any deductible, coinsurance, or copayment rec ose established by the Hawaii State Department of Human les.	uired by the Hawaii S Services for services	tate Medicaid Progr rendered under the	am to be paid Hawaii State	by
I/We understand that when changes in Hawaii State Department of Human Services and Ha receipt of written notice from the Hawaii State Department of Human Services or the Hawaii	vaii State Medicaid Program policies and procedures become necessary d State Medicaid Program to me/we.	ue to changes in State or Federal laws or regulations, that	such change will tak	e effect within thirty (	30) days of	
I/We understand that (1) Any information provided by the Hawaii State Department of Huma agencies or persons without the written consent of the recipient except in accordance with S accordance with Subtitle 12, Chapter 1702-5 of the Hawaii Administrative Rules. Such confit psychiatric information about the individual; (3) The records of any person, including all com released in accordance with Chapter 325-101, Hawaii Revised Statutes; (4) Information rega Revised Statutes; (5) Any information pertaining to the provision of services related to pregn	Services and the Hawaii State Medicaid Program to a provider and by a p biblite 12, Chapter 17- 1702 of the Hawaii Administrative Rules; (2) Any inf ential information includes, but is not limited to the names and addresses of nunications or specific medical or epidemiological information contained the rding an individual's records and reports with respect to mental health and incy, family planning or venereal disease shall be treated as confidential and	provider to the Department or Medicaid Program, shall be to ormation about Medicaid Providers and recipients shall be of individuals, social and economic circumstances of an ince rerein, that indicates that a person has or has been tested of substance abuse services are confidential and may only be and may be released in accordance with Chapter 577A-3, H	reated confidentially a confidential and shal lividual, evaluations, or HIV/AIDS shall be e disclosed in accord awaii Revised Statut	and shall not be relea not be disclosed ex and medical, psycho strictly confidential a ance with Chapter 3 ss.	ased to other cept in logical or und shall only 34-5, Hawaii	be 🗸
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## **Review Provider Participation Agreement**

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Close Submit Application After reading the Terms and Conditions be sure to check the	agreement box located at the end of the do	ocument.							
IN THE CASE OF PROVIDERS WHICH ARE BUSINESSES, GROUPS, HOS	PITALS, CORPORATIONS OR OTH	ER ENTITIES:							^
(1) I/We and each of us agree that all services for which our organization make are submitted; (2) If any real property or structure thereon is provided or improv	es a claim against the Hawaii State M ved either directly or indirectly by Fed	edicaid Program (Title XIX) shall be o leral	only for services rendered by persor	ns who are properly licensed	and/or qualif	ied for the service	e they provide for w	hich the clain	ns
Financial Assistance from the Department of Health and Human Services, this Federal Financial Assistance is extended or for another purpose involving the property. In all other cases this Assurance shall obligate the service provider for in consideration of and for the purpose of receiving or benefiting from either dir The service provider recognizes and agrees that such Federal Financial Assist the Assurance. This Assurance is binding on the service provider, its successor	Assurance shall obligate the service vovision of similar services and/or be r the period during which the Federa ectly or indirectly any or all Federal F ance will be extended in reliance on 1 rs, transferees, and assignees, and t	provider, or in the case of any transfi nefits. If any personal property is so Financial Assistance is extended to inancial Assistance that is extended he representations and agreements o the person authorized to sign this A	er of such property, any transferee, provided, this Assurance shall oblig it either directly or indirectly by the L after the date hereof by the Departn made in this Assurance and that the Assurance on behalf of the service p	for the period during which the late the service provider for the Department of Health and Hu- nent of Health and Human Se e United States and/or the Sta rovider whose signatures app	ne real prope ne period dui iman Service ervices, throu ate of Hawaii pear below.	rty or structure is ing which it retain s; (3) This Assura gh the Hawaii Sta shall have the rig	used for a purpose is ownership or pos ance is given by the ate Department of H ight to seek judicial e	for which the esession of th e service prov Human Servic enforcement of	e rider ces. of
RETROACTIVE CERTIFICATION:									
I/We agree that retroactive provider certification shall be limited to no more tha discretion of the Med-QUEST Division Administration. The month in which the	n twelve (12) months back to the date application was received shall be cou	e on which the application was receiv inted as the first month.	ved in the Hawaii State Department of	of Human Services/Med-QUE	EST Division	Health Care Serv	rices Branch office s	subject to the	
ELECTRONIC SIGNATURE: This Acknowledgement is to let you know that by organization. For purposes of the acknowledgement, a digital mark is consider acknowledgment statement provided in the same area requiring the electronic	submitting an electronic signature, y ed a typed legal First and Last name signature.	ou are providing an electronic mark, (legal name may include middle nam	that is held to the same standard as he, initial or suffix) followed by the typ	s a legally binding equivalent ped date. Any document requ	of a handwri uiring an eleo	tten signature pro stronic signature r	vided by you on be nay contain a signa	half of your iture	
AGREEMENT & ACKNOWLEDGEMENT: I agree that my electronic signature future, repudiate the meaning of my electronic signature or claim that my elect acknowledgement that I am authorized to represent and bind the organization being reproduced for future use. It is also acknowledged that this electronic sig	is the legally binding equivalent to m onic signature is not legally binding. for which this documentation is subm nature meets the standard identified	y handwritten signature. Whenever I Likewise, I, on behalf of the organiza itted. An electronic record will be kep for uniqueness, verification, sole con	execute an electronic signature, it is tion that I am authorized to represer ot of the documentation with which the trol, and record linkage.	has the same validity and me nt, consent to do business ele ne electronic signature is ass	aning as my ectronically. <sup>-</sup> ociated. This	handwritten signa Fhis electronic sig electronic record	ature. I will not, at an nature will function will be retained an	ny time in the as d capable of	2
The undersigned attest that they have entered into an agreement effective on t Med-QUEST Provider Enrollment.	he date indicated below. Both parties	agree an authorized representative	of the enrolling entity has the author	rity to sign and submit this ele	ectronic agre	ement and to mai	intain enrollment inf	formation thro	bugh
I/We have read all of the Provider Ag	reement and Condition o	of Participation in the Ha	awaii State Medicaid Pro	ogram and fully und	lerstand	and agree (	to its terms.		
	First Name:	Last Name:	Date:						•
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## **Submission Complete**

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A > MyInbox > New Enrollment > F/	AO Enrollment										
Application ID: 20200225447257				Name: Ohana							
Your Application Number 202	00225447257 has beer	1 successfully #	submitted for State review. Return with this appli-	cation number to track the status of your application.							
Your Med-QUEST ID is 100041	1, you will receive a co	rrespondence	with the fee payment instructions. ×								
Close											
Enroll Provider - FAO											
					B	usiness Process Wizard -	Provider En	rollment (FAO), Clid	k on the Step # u	nder the Ste	p Colum
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 Addres	s			Required	02/25/2020	02/25/2020		Complete			
Step 4: Add Provider Type/Specialtie	es/Subspecialties			Required	02/25/2020	02/25/2020		Complete			
Step 5: Associate Billing Provider/Oth	her Associations			Optional	02/25/2020	02/25/2020		Complete			
Step 6: Add License/Certification/Oth	ner			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 Inter	rest/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 Check	klist			Required	02/25/2020	02/25/2020		Complete			
Step 13: Submit Enrollment Application	ion for Approval			Required	02/25/2020	02/25/2020		Complete			
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### innovation@work

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## Thank You!

Persistence, Perseverance and Passion as always remains our credo.

## Contact Med-QUEST

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