Atypical Agency Enrollment
HOKU New Application Path

October 21, 2020
Selecting Atypical Agency Enrollment Type

- If the provider being enrolled is a Facility, Agency, or Organization (FAO) providing health care or support services, and **does NOT have an NPI**, please select the Atypical Agency enrollment type.

- Atypical Agencies include:
  - Adult Day Health Centers
  - Home and Community-Based Services Providers
  - Home Help Agencies
  - Residential Treatment Facilities
  - Habilitation Providers
  - Mental Health Providers
  - Developmentally Disabled Day Cares
  - Personal Care Attendant Agencies
  - Blood Banks
  - Respite Care or Specialized Services
If you are a **new** Hawaii Medicaid provider, you will select ‘**New Enrollment**.’

If you are an **existing** Hawaii Medicaid provider and have a Med-QUEST Provider ID number, you should have received a letter with your application ID number, you will select ‘**Track Application**’ and input your application ID number on the next page and proceed to Slide 5 of this instructional slide deck.
Select the Atypical Agency Enrollment Button

To find out which enrollment type your provider type is categorized as, please visit the HOKU webpage at: medquest.hawaii.gov/HOKU. Click on the ‘Resources’ tab.

Select the link: ‘HOKU Waves and Provider Enrollment Type’

The term Atypical is used for individuals or agencies that are not required and do not have an NPI.
Step 1: Provide Basic Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Required</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Entity Name</td>
<td></td>
<td>(As shown on the Income Tax Return)</td>
</tr>
<tr>
<td>Entity Business Name</td>
<td></td>
<td>(Doing Business As)</td>
</tr>
<tr>
<td>ENTITY:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Field</th>
<th>Required</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>W-9 Entity Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Profit Status</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Application ID

Application ID: 20200226110177

Name: Hawai'i Alyrical

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

Your Application ID is: 20200226110177

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.
*Note – Step 11: Employee Details was removed from HOKU
Step 2: Add Locations

Add Locations to organization. Add a Pay to address is required for Primary Practice Location. To Add/Modify Pay to address, click on Primary Practice Location hyperlink.

No Records Found!
## Add Primary Practice Address

**Application ID:** 202002610177  
**Name:** Hawaii Atypical

### Add Provider Location

<table>
<thead>
<tr>
<th><strong>Location Type:</strong> Primary Practice Location</th>
<th><strong>End Date:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Doing Business As:** 

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

**Address Line 1:**  

**Address Line 2:**

**Address Line 3:**

<table>
<thead>
<tr>
<th><strong>State/Province:</strong> OTHER</th>
<th><strong>City/Town:</strong> OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Country:</strong> UNITED STATES</th>
<th><strong>County:</strong> OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Zip Code:**  

**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.**

<table>
<thead>
<tr>
<th><strong>Day:</strong></th>
<th><strong>Open At:</strong></th>
<th><strong>Close At:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday</td>
<td>AM PM</td>
<td>AM PM</td>
</tr>
<tr>
<td>Monday</td>
<td>AM PM</td>
<td>AM PM</td>
</tr>
<tr>
<td>Tuesday</td>
<td>AM PM</td>
<td>AM PM</td>
</tr>
<tr>
<td>Wednesday</td>
<td>AM PM</td>
<td>AM PM</td>
</tr>
</tbody>
</table>

**Handicap Accessible:** No

**Language(s) Spoken:**

- English
- Spanish
- Vietnamese

©2019 CNSI
Add Pay To Address
Add Pay To Address
Add Pay To Address
Step 3: Add Correspondence Address

*Note – Step 11: Employee Details was removed from HOKU*
Add Correspondence Address

<table>
<thead>
<tr>
<th>Name: Hames Alipal</th>
<th>Application ID: 2020020101177</th>
</tr>
</thead>
</table>

### Add Correspondence Address

- **Phone Number:**
  - *(Extn:)*
- **Fax Number:**
- **Email Address:**

**End Date:**

---

If a department or drawer number is required enter the information in Line TWO. (For example: DEPT 223 or DEPARTMENT 223, DRAWER 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:** *(Enter Street Address or PO Box Only)*
- **Address Line 2:**
- **City/Town:**
  - *(OTHER)*
- **County:**
  - *(OTHER)*
- **Zip Code:** *

---

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Step 4: Add Provider Type/Specialties/Subspecialties

*Note – Step 11: Employee Details was removed from HOKU*
Add Provider Type/Specialties/Subspecialties
Add Provider Type/Specialties/Subspecialties

Application ID: 20200226110177
Name: Hawaii Atypical

Add Provider Type/Specialty

Provider Type: —SELECT—
Specialty: *

Select 'No Specialty' if applicable.

End Date: 

Add Subspecialty

Available Subspecialties

Associated Subspecialties *

Select 'No Subspecialty' if applicable.
Add Provider Type/Specialties/Subspecialties

<table>
<thead>
<tr>
<th>Specialty/Subspecialty</th>
<th>Provider Type</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO SPECIALTY REQUIRED/No Subspecialty</td>
<td>DHS MHS PROVIDER</td>
<td>12/31/2269</td>
</tr>
</tbody>
</table>

Application ID: 20200226110177
Name: Hawaii Atypical
Associated Biller is an optional step. To complete the step, click on the Step 5 hyperlink and then click Close.

*Note – Step 11: Employee Details was removed from HOKU
Click Close if you are using your Type 2-Organization NPI to bill.
## Associate Billing Provider

**Application ID:** 20200226110177  
**Name:** Hawaii Atypical

### Associate Billing Provider/Other Associations

Enter NPI/Med-QUEST ID of Billing Provider/Other Associations and click "Confirm Provider."

| Type   |  
|--------|---------------------------------------------------------------|
| ID     | ![Input](image) |
| Start Date | ![Input](image) |
| Provider Name | ![Input](image) |
| End Date | ![Input](image) |

---

*Page ID: digBillingProviderD(Provider)*
Step 6: Add License/Certification

*Note – Step 11: Employee Details was removed from HOKU
To view the licenses and certificates that are required and need to be included with this application, go to the HOKU website at: medquest.hawaii.gov/HOKU and click on the ‘Resources’ tab.

Select the link: ‘Required and Optional Licenses, Certificates and Documents by Provider Type’
Add License/Certification

Note: The License Classification Type may be displayed if a specific DCCA License/Certification Type is selected.
Add License/Certification

![Image of the interface showing license/certification information]

**License/Certification/Other List**

- **HI Board of Psychology**
  - License/Cert/Other #: 125478595
  - Valid Flag: No
  - Effective Date: 02/29/2020
  - End Date: 12/31/2099

- **HI Board of Medical Examiners**
  - License/Cert/Other #: 459862353
  - Valid Flag: No
  - Effective Date: 02/29/2020
  - End Date: 12/31/2099
Step 7: Add Additional Information

*Note – Step 11: Employee Details was removed from HOKU
Add Additional Information

### Authorized Representative List

<table>
<thead>
<tr>
<th>Add</th>
<th>Filter By</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No Records Found!

### Bed Information

<table>
<thead>
<tr>
<th>Add</th>
<th>Filter By</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No Records Found!
Add Authorized Representative

- First Name: 
- Middle Name: 
- Last Name: 
- Start Date: 
- End Date: 

Application ID: 
Name: 

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Add Bed Information

Med-QUEST ID: 000242
NPI: 1558744870
Name: Hawaii Cares

Add Bed Information

Bed Type: <select>
Start Date:
Bed(s)/Unit(s):
End Date:
Step 8: Add Controlling Interest/Ownership Details

*Note – Step 11: Employee Details was removed from HOKU
Add Controlling Interest/Ownership Details
Add Owner

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

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

REQUIRED OWNERS

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

Owners List

Filter By

Owner Information
Owner Type
Address
Start Date
End Date
Relationship Status
Adverse Action
Percentage owned

No Records Found!
## Add Ownership

### Provider Controlling Interest/Ownership

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage Owned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing Employee</td>
<td>50%</td>
</tr>
</tbody>
</table>

#### Legal Entity Name:
(As shown on the Income Tax Return)

- **Owner Name:**
- **First Name:** Joe
- **Suffix:**
- **Phone Number:** (555) 555-5555
- **Start Date:**

#### Entity Business Name:
(Doing Business As)

- **Last Name:** Ayupri
- **DOB:** 02/26/1960
- **Email:**
- **End Date:**

---

**Address validation successful**

<table>
<thead>
<tr>
<th>Address Line 1:</th>
<th>Address Line 2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>521 N Davis Blvd</td>
<td></td>
</tr>
</tbody>
</table>

**State/Province:** UTAH

**City/Town:** Bountiful

**County:** Davis

**Zip Code:** 84010 - 1006

---

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

**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.

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Add Owners Relationship

**Provider:**
- **Owners List**
  - **Owner Type:**
    - Agent
    - Managing Employee
  - **Address:**
    - 121 N Davis Blvd
  - **Start Date:**
    - 02/05/2020
  - **End Date:**
    - 12/31/2099
  - **Relationship Status:**
    - Not Completed
  - **Adverse Action:**
    - Not Completed
  - **Percentage owned:**
    - 50

**Provider Information:**
- **Application ID:** 2020023610177
- **Name:** Hawaiian Atypical

**Requirements:**
- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- If any of the following 10 owner types are selected: Corporate-Non Charitable, Corporate-Charitable, Corporate-Charitable/3501, Corporate-Charitable/501c3, Corporate-Charitable/501c1, Corporate-Non Charitable, Corporate-Charitable/501c3, Corporate-Charitable/501c1, Corporate-Charitable/3501, Corporate-Charitable, then at least 1 of the following 5 owner types must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer.

**Note:**
- The name, address, date of birth and Social Security Number of any managing employee.
Add Owners Relationship

Add Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

- Yes
- No (Click Save to update)

Owner List

<table>
<thead>
<tr>
<th>Owner</th>
<th>SSN/ESTIN:</th>
<th>Type</th>
<th>Relation to Atypical, Joe</th>
<th>Relation to Assoc. Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atypical, Joe</td>
<td>SSN/ESTIN: 56547898</td>
<td>Agent</td>
<td>Spouse</td>
<td>Spouse</td>
</tr>
<tr>
<td>Atypical, Sally</td>
<td>SSN/ESTIN: 56547898</td>
<td>Agent</td>
<td>Spouse</td>
<td>Spouse</td>
</tr>
</tbody>
</table>

Viewing Page: 1

Page ID: digAdModify/OwnerRelationship/Provider

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Complete Adverse Actions

<table>
<thead>
<tr>
<th>Owner ID</th>
<th>Owner Information</th>
<th>Owner Type</th>
<th>Address</th>
<th>Start Date</th>
<th>End Date</th>
<th>Relationship Status</th>
<th>Adverse Action</th>
<th>Percentage Owned</th>
</tr>
</thead>
<tbody>
<tr>
<td>605474561</td>
<td>Athypical, Sally</td>
<td>Agent</td>
<td>121 N Davis Blvd</td>
<td>02/26/2020</td>
<td>12/31/2099</td>
<td>Completed</td>
<td>Not Completed</td>
<td>50</td>
</tr>
<tr>
<td>699999123</td>
<td>Athypical, Joe</td>
<td>Managing Employee</td>
<td>121 N Davis Blvd</td>
<td>02/26/2020</td>
<td>12/31/2099</td>
<td>Completed</td>
<td>Not Completed</td>
<td>50</td>
</tr>
</tbody>
</table>

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

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

**REQUIRED OWNERS**

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

**Application ID:** 20200205110117

**Name:** Hamil Atypical

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

A “significant business transaction” means any business transaction or series of transactions that, during one fiscal year exceed the lesser of $25,000 and five (5) percent of an entity’s total operating expenses.

“A Subcontractor” means:

An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases) of real property to obtain space, supplies, equipment, or services provided under the DHS agreement.

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

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

**Final Adverse Action/Conviction Action History**

Do any of the owners, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against them? Please answer in the ‘Owners with Adverse Action’ section below for each owner.

**Owners with Adverse Action**

<table>
<thead>
<tr>
<th>Owner Name</th>
<th>EIN/TIN</th>
<th>Response</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atypical, Sally</td>
<td>565474550</td>
<td>Yes (\checkmark)</td>
<td></td>
</tr>
<tr>
<td>Atypical, Joe</td>
<td>569469125</td>
<td>Yes (\checkmark)</td>
<td></td>
</tr>
</tbody>
</table>

**View Page:** 1 of 1

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Step 9: Taxonomy Details

*Note – Step 11: Employee Details was removed from HOKU
Add Taxonomy Details

Application ID: 20200226110177
Name: Hawaii Atypical

Taxonomy List

Filter By

<table>
<thead>
<tr>
<th>Taxonomy Code</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
</table>

No Records Found!

Page ID: pqTaxonomyListEnroll(Provider)
Environment: HL_SYSSTST R10c 1.1
Server Time: 02/26/2020 12:36:30 MST
Add Taxonomy

Taxonomy Code:

Description:

Start Date: Today's Date

End Date:
NUCC Taxonomy Code List
Step 10: Fee Payment

*Note – Step 11: Employee Details was removed from HOKU
Step 10: Fee Payment

![Fee Payment Screen](image)

<table>
<thead>
<tr>
<th>Payment Id</th>
<th>Payment Reason</th>
<th>Payment Amount</th>
<th>Fee Option</th>
<th>Payment Made To</th>
<th>Payment Status</th>
<th>Confirmation Number</th>
<th>Payment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No Records Found!
During the COVID-19 Public Health Emergency (PHE), Fee Payments will temporarily be waived. Select ‘COVID-19 Waiver.’ When the PHE is over, Med-QUEST will send out a correspondence informing providers to mail in their Fee Payment.
## Step 11: Upload Documents

*Note – Step 11: Employee Details was removed from HOKU. Upload Documents Step will be Step 11.*
Step 11: Upload Documents

To view the documents that are required and need to be uploaded with this application, go to the HOKU website at: medquest.hawaii.gov/HOKU and click on the ‘Resources’ tab.

Select the link: ‘Required and Optional Licenses, Certificates and Documents by Provider Type’

Fingerprint-Based Criminal Background Check (FCBC) Determination Letter will be ‘Optional’ and temporarily waived during the COVID-19 Public Health Emergency (PHE). Once the PHE is over, MedQUEST will send out a correspondence to providers that need to submit their FCBC Determination Letter.
Upload Documents

Application ID: 20200220110177
Name: Hawaii Atypical

Upload Document

Document Type:  --SELECT--
Document Name:

File Name: 
Browse...

Start Date: 
End Date: 
Remark: 

Page ID: dnpEnv/immAttachment(Provider)
Upload Documents

### Document List

<table>
<thead>
<tr>
<th>Document ID</th>
<th>Document Type</th>
<th>Document Name</th>
<th>File Name</th>
<th>Start Date</th>
<th>End Date</th>
<th>Uploaded By</th>
<th>Uploaded Date</th>
<th>Document Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>75046201</td>
<td>Fee Verification</td>
<td>Fee Payment Receipt</td>
<td>HI T3 Agenda.docx</td>
<td></td>
<td></td>
<td>Zak Farrington</td>
<td>02/26/2020</td>
<td>In Process</td>
</tr>
<tr>
<td>75046202</td>
<td>Letter</td>
<td>CMS Approval Letter</td>
<td>HI T3 Agenda.docx</td>
<td></td>
<td></td>
<td>Zak Farrington</td>
<td>02/26/2020</td>
<td>In Process</td>
</tr>
<tr>
<td>75046203</td>
<td>License</td>
<td>Hi Board Of Medical Examiners</td>
<td>HI T3 Agenda.docx</td>
<td></td>
<td></td>
<td>Zak Farrington</td>
<td>02/26/2020</td>
<td>In Process</td>
</tr>
<tr>
<td>75046204</td>
<td>Tax</td>
<td>W9 Indicator</td>
<td>HI T3 Agenda.docx</td>
<td></td>
<td></td>
<td>Zak Farrington</td>
<td>02/26/2020</td>
<td>In Process</td>
</tr>
<tr>
<td>75046205</td>
<td>License</td>
<td>Hi Board Of Psychology</td>
<td>HI T3 Agenda.docx</td>
<td></td>
<td></td>
<td>Zak Farrington</td>
<td>02/26/2020</td>
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</tr>
</tbody>
</table>

Viewing Page: 1
Step 12: Enrollment Checklist

*Note – Step 11: Employee Details was removed from HOKU. Enrollment Checklist will be Step 12.
# Enrollment Checklist

**Application ID:** 20200228110177  
**Name:** Hawaii Atypical

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.</td>
<td>Not Completed</td>
<td></td>
</tr>
<tr>
<td>Do you wish to end date your enrollment? If yes, enter date in comment field.</td>
<td>Not Completed</td>
<td></td>
</tr>
<tr>
<td>Are you currently excluded from any Hawaii or other state program? If yes, provide state of exclusion and program in comment field.</td>
<td>Not Completed</td>
<td></td>
</tr>
<tr>
<td>Are you currently excluded from any federal program? If yes, provide the program and date in comment field.</td>
<td>Not Completed</td>
<td></td>
</tr>
<tr>
<td>Have you ever had a conviction or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.</td>
<td>Not Completed</td>
<td></td>
</tr>
<tr>
<td>Have you ever had a judgment under any false claims act? If yes, list judgment and date in comment field.</td>
<td>Not Completed</td>
<td></td>
</tr>
<tr>
<td>Have you been enrolled by another State’s Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.</td>
<td>Not Completed</td>
<td></td>
</tr>
<tr>
<td>Have you ever had a program exclusion/tabernacle? If yes, provide program and date in comments field.</td>
<td>Not Completed</td>
<td></td>
</tr>
<tr>
<td>Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.</td>
<td>Not Completed</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Not Completed</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Not Completed</td>
<td></td>
</tr>
<tr>
<td>Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.</td>
<td>Not Completed</td>
<td></td>
</tr>
<tr>
<td>If this enrollment is for a change of ownership (CHOI) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.</td>
<td>Not Completed</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Not Completed</td>
<td></td>
</tr>
</tbody>
</table>
Step 13: Submit Application

*Note – Step 11: Employee Details was removed from HOKU. Submit Application step will be Step 13.
Submit Application

Application ID: 20200228110177

Name: Hawaii Atypical

Final Submission

Application ID: 20200228110177

Enrollment Type: Atypical Agency Provider

The information submitted for enrollment shall be verified and reviewed by the State.

During this time, any changes to the information shall not be accepted.

I agree that the information submitted as a part of the application is correct (Private and Confidential).

Application Document Checklist

No Records Found!
Review Provider Participation Agreement

If we, Hawaii Atypical, hereby apply to become a provider under the Hawaii State Medicaid Program and agree to the following terms and conditions if accepted:

1. 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, we also agree to abide by the policies and procedures contained in the Hawaii State Medicaid Manual. If we are a provider for the 1915b waiver for participants with Developmental Disabilities (ID) or Intellectual Disabilities (ID), we agree to abide by the policies and procedures contained in the Medicaid Waiver Provider Standards Manual.

2. 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 we will immediately take any measures necessary to enact this agreement, to the effect that no person shall be 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.

3. We agree to keep all such records necessary to disclose fully, upon request, the extent of care and/or services provided by m/e 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 m/e 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).

4. 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.

5. We understand that the Hawaii State Medicaid Program may refuse to enter into or renew an agreement with m/e 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. §455.105.

6. We agree to accept, as payment in full, the applicable amount or amounts established by the Hawaii State Medicaid Program in Chapter 1739, 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. We are 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. We understand the reimbursement rates shall be in accordance with payment methodologies pursuant to Chapter 1739, Hawaii Administrative Rules.

7. 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 m/e we.

8. 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 not 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.
Review Provider Participation Agreement

Application ID: 20200226110177
Name: Hawaii Atypical

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

(1) We and each of us agree that all services for which our organization makes a claim against the Hawaii State Medicaid Program (Title XIX) shall be only for services rendered by persons who are properly licensed and/or qualified for the service they provide for which the claims are submitted. (2) If any real property or structure therein is improved or improved either directly or indirectly by Federal

Financial Assistance from the Department of Health and Human Services, this Assurance shall obligate the service provider, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal Financial Assistance is extended or for another purpose involving the provision of similar services and/or benefits. If any personal property is so provided, this Assurance shall obligate the service provider for the period during which it retains ownership or possession of the property. In all other cases this Assurance shall obligate the service provider for the period during which the Federal Financial Assistance is extended to it either directly or indirectly by the Department of Health and Human Services. (3) This Assurance is given by the service provider in consideration of and for the purpose of receiving or benefiting from either directly or indirectly any or all Federal Financial Assistance that is extended after the date hereof by the Department of Health and Human Services, through the Hawaii State Department of Human Services. The service provider recognizes and agrees that such Federal Financial Assistance will be extended in reliance on the representations and agreements made in this Assurance and that the United States and/or the State of Hawaii shall have the right to seek judicial enforcement of the Assurance. This Assurance is binding on the service provider, its successors, transferees, and assignees, and to the person authorized to sign this Assurance on behalf of the service provider whose signatures appear below.

RETROACTIVE CERTIFICATION:

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

ELECTRONIC SIGNATURE: This Acknowledgement is to let you know that by submitting an electronic signature, you are providing an electronic mark, that is held to the same standard as a legally binding equivalent of a handwritten signature. By signing, you are confirming that you are authorized to sign this form electronically and that the form is complete and accurate. This acknowledgment statement is provided in the same area requiring the electronic signature.

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

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

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

First Name: __________________________________________ Last Name: ________________________________________ Date: ____________________________

Page ID: pgEntTermsAndConditions(Provider) Environment: HI_SYSSTST R10c-1.1 Server Time: 02/26/2020 12:59:27 MST
Submission Complete

*Note – Step 11: Employee Details was removed from HOKU
Contact Med-QUEST

https://medquest.hawaii.gov/HOKU

Email: hcsbinquiries@dhs.hawaii.gov
Phone: 808-692-8099
Fax: 808-692-8087

Office Address:
601 Kamokila Boulevard, Room 506A
Kapolei, HI 96707
Thank You!

Persistence, Perseverance and Passion as always remains our credo.