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#### 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

# **Provider Enrollment Application Selection**

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	Provider Enro	liment							^
			New Enrollment	Enroll As A New Provider					
		,	Track Application	Track Existing Provider Application					
•	If you	are a <b>new</b> ł	-lawaii Medica	aid provider, you	will s	elect ' <b>Ne</b> v	w Enroll	men	t.'

## Select the Atypical Agency Enrollment Button

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A > MyInbox 3	Enrollment T	ask List 🖒 New Enr	ollment							
III Enro	liment Typ	9								^
					Select the Applicable Enrollmer	it Type				
🔿 Individu	al/Sole Propr	ietor								
⊖ Re	gular Individu	ual/Sole Proprieto	r or Rendering	/Servicing Prov	ider					
O Group P	ractice (Corp	oration, Partners	hip, LLC, etc.)							
⊖ Facility/	Agency/Orga	nization (FAO-Hos	spital, Nursing	Facility, Variou	s Entities)					
O Contrac	tor/MCO									
⊖ Ma	naged Care (	Organization								
Atypical	(non-medica	l) provider (Choo	se this option	if you do not ha	ve a NPI)					
	ividual (Com	munity Care Fost	er Family Hom	e CCFFH)	-					
⊙ Ag	ency (Adult E	ay Health, DD/ID,	Home Help/Pe	ersonal Care Ag	ency, Transportation Company etc.)					
	To f	ind out wł we	nich enr ebpage	ollment at: <u>medo</u>	type your provider type quest.hawaii.gov/HOK	e is cate <u>U</u> . Click	gorized as, p on the 'Reso	olease visit t ources' tab.	he HO	KU
			Selec	t the link	: 'HOKU Waves and I	Provide	r Enrollmen	t Type'		
O Submit	The	term Atyp	bical is i	used for	individuals or agencie	s that ar	e not require	ed and do no	ot have	an



### **Step 1: Provide Basic Information**

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#### Basic Information: Enter required fields and click Finish button.

 Basic Information			^
Legal Entity Name:	* (As shown on the income Tax Return)		
Entity Business Name:	* (Doing Business As)	EIN/TIN: *	
 W9 Information			^
W-9 Entity Type:	*	W-9 Entity Type (If Other):	
Profit Status:	*		

Page ID: dlgAddBasicInformationStep1(Provider)

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✓ Finish S Cancel

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## **Application ID**

🚔 Print 😧 Help	
Application ID: 20200226110177	Name: Hawaii Atypical
III Basic Information	*
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.	
	✓ Ok
Page ID: dlgAddBasicInformationStep3(Provider)	

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### **Enrollment Steps**

Inbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment							
ration ID: 20200228410177	Name: Hawaii Atvoical						-
200	мань, наман хурса						
Enroll Provider - Atypical Agency							
		Business P	rocess Wizard - Provider E	nrollment (Atypical Agency). Clici	k on the Step # unde	r the Step C	olur
	Required	Start Date	End Date	Status	Step Remark		
1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete			
2: Add Locations	Required			Incomplete			
3: Add Correspondence Address	Required			Incomplete			
4: Add Provider Type/Specialties/Subspecialties	Required			Incomplete			
5: Associate Billing Provider/Other Associations	Optional			Incomplete			
5: Add License/Certification/Other	Optional			Incomplete			
7: Add Additional Information	Optional			Incomplete			
3: Add Provider Controlling Interest/Ownership Details	Required			Incomplete			
9: Add Taxonomy Details	Optional			Incomplete			
10: Fee Payment	Optional			Incomplete			
11: Employee Details -	Optional			Incomplete			
12: Upload Documents	Optional			Incomplete			
13: Complete Enrollment Checklist	Required			Incomplete			
14: Submit Enrollment Application for Approval	Required			Incomplete			
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### Step 2: Add Locations

	Provider -					>						
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A > MyInbox > Enrollment Task List > New Enrollment > Atypica	al Agency Enrollment											
Application ID: 20200226110177     Name: Hawaii Atypical												
Close Add Pay to address is required for Primary	Close Add Pay to address is required for Primary Practice Location. To Add/Modify Pay to address, click on Primary Practice Location hyperlink											
Locations List						^						
Filter By	O Go			💾 Save Filt	ers 🔻 My	Filters▼						
Doing Business As	Location Type	Location Details		End Date								
▲▼	ΔŦ	<b>▲</b> ▼		A.								
	No Re	cords Found !										
Page ID: pgLocationListForEnrImnt(Provider)	Environment	HI_SYSTST R10c-1.1		Server Time: 02	/26/2020 09	:38:09 MST						

### **Add Primary Practice Address**

🚔 Print 🔞 Help									
Application ID: 20200226110177			Name: Hawaii A	typical					
III Add Provider Location									^
	Location Type: Primary Practic Doing Business As: If a department or drawer number is r	equired enter the information in	Ine TWO. (For examp	Ie: DEPT 222 or DEPARTMENT	222, DRAWR 1	111 or DRAWER 1111) If	End Date: an attention line is	<b>1</b>	
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 Ad Address Line 3:	* dress or PO Box Only)					Address Line 2: City/Town:	OTHER *	
	State/Province: OTHER	*					County:	OTHER	
	Country: UNITED STATE	ES 🔽 *					Zip Code:	* - Validate Address	
		Please enter the hours your offi	ce is open for each da	y. If you are closed on a given	ay select "Clos	ed" in the "Open At" dro	p down.		
	Day: Open At: Sunday: * Monday: * Tuesday: * Wednesday: *	AM/PM     C       AM     *       AM     *       AM     *       AM     *       AM     *       AM     *	lose At: * * * * * * * * * *	AM/PM AM AM AM PM AM PM AM AM AM AM *	Day: Thursday: Friday: Saturday:	Open At:	AM/PM           AM           PM           AM           PM           AM           PM           AM           PM           AM           PM	Close At:         AM/PM           *         AM           *         AM	
	Handicap Accessible: No V						Language(s) Spoken:	English Bisayan/Visayan Chinese (which includes Mandarin or Cantonese)	
Page ID: digEntlAddLocation(Provider)									✓ OK Ocancel

### Add Pay To Address

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MyInbox > E	Enrollment Tas	k List > New Enrol	Ilment > Atypical	Agency Enrollment								
lication ID:	2020022611	0177			Name	: Hawaii Atypical						
Close 🖸 🔂 Ad	dd Pay to a	ddress is require	ed for Primary Pr	actice Location. To	o Add/Modify Pay to a	address, click on Pi	rimary Practic	e Location hyperlink				
Locatio	ons List											
Filter By					O Go					💾 Save F	Filters	My Filters
Doing Busir	ness As		Location Type	•		Location Details				E	End Date	
A.			A▼ Primary Practi	ce Location		▲▼ 89 S 750 E Bountifu	UTAH 84010			1	▲▼ 12/31/2999	
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### Add Pay To Address

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A > Mylnbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment > G	Seneral											
Application ID: 20200226110177	Name: H	Hawaii Atypical										
O Close To add additional addresses, click "Add 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: Ope	en At: AM/PM Close At:	AM/PM Day: C	Open At: AM/PM Close At:	AM/PM								
Sunday: Cle	ose ▼ * AM * ▼ *	AM * Thursday:	Close 💙 * AM *	* AM *								
Monday: 03:	30 ▼ * A 05:30 ▼ *	AM * Friday:	Close V * AM * V,	* AM *								
Tuesday:		AM * Saturday:		k AM +								
ruesuay.		PM * Saturday.	PM *	PM								
Wednesday:	AM *	AM * PM										
Handicap Accessible: No												
		Language(s) Spoken: English										
		(For Multiple Selection, use Ctrl Key) Bisayan/Visayan Chinese (which i	n includes Mandarin or Cantonese)									
End Date: 12/31/2999												
III Address List				^								
Add Address												
Address Type	Address			End Date								
	AV			AT								
	89 S 750 E, Bountiful, UTAH 84010	Viewing Dogos 4		12/31/2999								
Delete View Page: 1 O Go Page Count SaveToXLS		viewnig Page. I		K First Prev Next & Last								
Page ID: pgEnrollmentLocationGeneral(Provider)		Environment HI_SYSTST R10c-1.1		Server Time: 02/26/2020 09:41:58 MST								

## Add Pay To Address

🚔 Print 💿 Help		
Application ID: 20200226110177	Name: Hawaii Atypical	
III Add Provider Location Address		*
Type of Addres	End Date	:
If a department or drawer nu	iber is required enter the information in line TWO.(For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is	
required, please enter the in	rmation 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 wil be returned.	
Address Line	* Address Line: (Enter Street Address or PO Box Only)	2:
Address Line	City/Tow	: OTHER Y *
State/Provinc	OTHER * Count	
Country	UNITED STATES 🔽 * Zip Cod	* - Validate Address
Page ID: digEnrIL.ocationAddress(Provider)		✓ OK OCancel

### Step 3: Add Correspondence Address

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1 ·				皆 Note Pad 🛛 🤄 External Lin	ks ▼ 🔺 My Favorites ▼	🚔 Print	🕄 Help
> MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment							
Application ID: 20200226110177	Name: Hawaii Atypical						
D Close							
Enroll Provider - Atypical Agency							^
		Business P	rocess Wizard - Provider Enr	ollment (Atypical Agency).	Click on the Step # und	er the Step (	Column.
Step	Required	Start Date	End Date	Status	Step Remark		
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete			
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete			
Slep 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	Optional			Incomplete			
Step 10: Fee Payment	Optional			Incomplete			
Step 11: Employee Details	Optional			Incomplete			
Step 12: Upload Documents	Optional			Incomplete			
Step 13: Complete Enrollment Checklist	Required			Incomplete			
Step 14: Submit Enrollment Application for Approval	Required			Incomplete			
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*Note – Step 11:	Employee Details	was rei	moved fr	om HOł	KU		
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age ib. pgbr whypicalAgencyStan(Provider)	Environment HI_SYSTST R106-1.1				Server Time: 02/2	0/2020 09:45:0	JOINIST

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### Add Correspondence Address

	Provider -						>
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A > MyInbox > Enrollment Task List > New Enrollment > Atypic	al Agency Enrollment 🗲 Genera	I					
Application ID: 20200226110177		Name: Hawaii Atypical					
Close Add							
III Correspondence Address List							^
Address Type		Address		End Date			
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### Add Correspondence Address

🚔 Print 🤨 Help			
Application ID: 20200226110177	Name: Hawaii	Atypical	
III Add Correspondence Address			^
Phone Number:	* Extn:	Fax Number:	
Communication Preference:	*	Email Address:	
End Date:			
If a department or drawer num required, please enter the info	ber is required enter the information in line TWO.(For example: DEP rmation in Line THREE. (For example: ATTN: Billing Dept.)	T 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is	
	ATTENTION: Address Submission only requ	ires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the of validated by the USDS. If Address I ine 1 and Zip Code combination is not valid an error will	
	be returned.		
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 OCancel
Page ID: dlgEnrlCorrespondenceAddress(Provider)			

# Step 4: Add Provider Type/Specialties/Subspecialties

1 -				Note Pad 🚱 External Links 🔻	★ My Favorites ▼	🖨 Print	<b>9</b> н
MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment							
oplication ID: 20200226110177	Name: Hawaii Atypical						
Close							
Enroll Provider - Atypical Agency							
		Business P	rocess Wizard - Provider En	rollment (Atypical Agency). Click	k on the Step # unde	r the Step (	Colum
ep	Required	Start Date	End Date	Status	Step Remark		
p 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete			
p 2: Add Locations	Required	02/26/2020	02/26/2020	Complete			
ep 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete			
ep 4: Add Provider Type/Specialties/Subspecialties	Required			Incomplete			
p 5: Associate Billing Provider/Other Associations	Optional			Incomplete			
p 6: Add License/Certification/Other	Optional			Incomplete			
p 7: Add Additional Information	Optional			Incomplete			
p 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete			
ep 9: Add Taxonomy Details	Optional			Incomplete			
ap 10: Fee Payment	Optional			Incomplete			
p 11: Employee Details -	Optional			Incomplete			
ep 12: Upload Documents	Optional			Incomplete			
ep 13: Complete Enrollment Checklist	Required			Incomplete			
ep 14: Submit Enrollment Application for Approval	Required			Incomplete			
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Page ID: pgBPWAtypicalAgencyStart(Provider)

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#### Add Provider Type/Specialties/Subspecialties

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A > MyInbox > Enrollment Task I	ist > New Enrol	Iment > Atypic	al Agency Enrollme	nt							
Application ID: 202002261101	77			Na	ame: Hawaii Atypical						
Close Add											
III Provider Type/Spec	ialty/Subspe	cialty List									^
Filter By				O Go					Save Filters	▼ My Filt	ers▼
Specialty/Subspecialty					Provider Type			End Date			
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				NO RE	coras Found !						
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## Add Provider Type/Specialties/Subspecialties

0	Print 😨 Help			
Appli	cation 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.		
			<b>√</b> ОК	Cancel
Pa	ge ID: dlgEnrlAddSpecialties(Provider)			

### Add Provider Type/Specialties/Subspecialties

<u>evo</u> Br <b>i</b> x	<	My Inbox <del>-</del>	Admin <del>-</del>	Provider <del>•</del>							>
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👫 > MyInbox > Enroll	ment Tas	k List 🗲 New Enro	llment > Atypic	al Agency Enrollme	nt						
Application ID: 2020	00226110	)177				Name: Haw	aii Atypical				
Close O Add											
III Provider T	ype/Sp	ecialty/Subspe	ecialty List								^
Filter By	~				O Go				💾 Save Fil	ters <b>y</b> My	Filters▼
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### **Step 5: Associate Billing Provider**

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> MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment										
Application ID: 20200226110177	Name: Hawaii Atypical									
Q Close										
III Enroll Provider - Atypical Agency										^
			Business Proc	ess Wizard - Provider E	nrollment (Aty	pical Agency). Click	on the Step	# under the	Step Col	umn.
Step	Required	Start Date	End Date	Status	Step Remark					
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete						
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete						
Slep 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete						
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete						
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete						
Slep 6: Add License/Certification/Other	Optional			Incomplete						
Slep 7: Add Additional Information	Optional			Complete						
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete						
Step 9: Add Taxonomy Details	Optional			Incomplete						
Step 10: Fee Payment	Optional			Complete						
Step 11: Employee Details	Optional			Incomplete						
Step 12: Upload Documents	Required			Incomplete	Please upload re	quired documents.				
Step 13: Complete Enrollment Checklist	Required			Incomplete						
Step 14: Submit Enrollment Application for Approval	Required			Incomplete						
View Page: 1 O Go Page Count SaveToXLS		Viewing Page: 1					🕊 First 📢	Prev >	lext 🔉	Last

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

Page ID: pgBPWAtypicalAgencyStart(Provider)

Environment: HI\_SYSTST R10c-1.1

Server Time: 02/26/2020 11:32:12 MST

### **Associate Billing Provider**

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MyInDox > Enrollment Task L	IST > New Enrol	iment > Atypic	al Agency Enrollment						
plication ID: 202002261101	77			Name: Hawaii Atypica					
Close O Add									
Billing Provider/Oth	ner Associati	ons List							
Filter By				O Go			💾 Save F	ilters <b>T</b> M	y Filters▼
NPI/Med-QUEST ID			Provider Name	St	art Date	End Date		Status	
Δ₹			<b>▲</b> ▼	A.	7	<b>▲</b> ▼		<b>₩</b> ₩	
_ ∆₹			<b>A</b> ▼	No Records Found !	7			<b>₩</b> ₩	
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Click (	Close	if you	are using v	No Records Found !	, Organi	zation NP	'l to bill.	<b>▲</b> ▼	
□ △▼ Click (	Close	if you	are using y	No Records Found !	, Organi	zation NP	l to bill.	47	
Click (	Close	if you	are using y	No Records Found !	, Organi	zation NP	'l to bill.	47	
Click (	Close	if you	are using y	No Records Found !	Organi	zation NP	'l to bill.	47	
Click (	Close	if you	are using y	No Records Found !	, Organi	zation NP	'l to bill.	47	
or Click (	Close	if you	are using y	No Records Found !	, Organi	zation NP	'l to bill.	47	

## Associate Billing Provider

🚔 Print 🥹 Help			
Application ID: 20200226110177 Name: Hawaii Atypical			
III Associate Billing Provider/Other Associations			
Enter NPI/Med-QUEST ID of Billing Provider/Other Associations and click "Confirm Provider." Type:			
ID: * Provider Name:			
Start Date: End Date:			
Page ID: dlgBillingProviderD(Provider)	Confirm Provider	🖋 Ok	Cancel

### Step 6: Add License/Certification

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					🔓 Note Pad	🚱 External Links 🔻	★ My Favorites ▼	🖨 Print	😧 Help
> MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment									
Application ID: 20200226110177	Name: Hawaii Aty	pical							
O Close									
III Enroll Provider - Atypical Agency									^
			Business	Process Wizard - Prov	ider Enrollment (Atvr	pical Agency), Click	on the Step # und	er the Step (	Column.
Step	Required	Start Date	End Date	Status	Step Remark				
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete					
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete					
Step 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete					
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete					
Step 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	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	Optional			Incomplete					
Step 10: Fee Payment	Optional			Complete					
Step 11: Employee Details -	Optional			Incomplete					
Step 12: Upload Documents	Required			Incomplete	Please upload re	quired documents.			
Step 13: Complete Enrollment Checklist	Required			Incomplete					
Step 14: Submit Enrollment Application for Approval	Required			Incomplete					
View Page: 1 O Go Page Count SaveToXLS		Viewing Page	:1				≪ First	> Next	>> Last

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### Add License/Certification

	Admin - Provider -				
•		🔓 Note Pad	🔇 External Links 🕶	★ My Favorites 🕶 🛔	Print 😲 Help
> MyInbox > Enrollment Task List > New Enrollme	ent > Atypical Agency Enrollment				
Application ID: 20200226110177		Name: Hawaii Atypical			
Close Add					
License/Certification/Other List					^
Filter By		O Go		Save Filters	▼ My Filters ▼
License/Cert./Other Type	License/Cert./Other #	Valid Flag	Effective Date	End Da	ate
▲▼	$\Delta \overline{*}$	A₹	<b>▲</b> ▼	<b>▲</b> ▼	
To view the license application, go to	s and certificates t the HOKU website 'F	that are required and at: <u>medquest.hawai</u> Resources' tab.	l need to be ii.gov/HOKl	e included wi <u>J</u> and click o	th this n the
Select the link: <b>'R</b> o	equired and Optic P	onal Licenses, Cert Provider Type'	ificates an	d Documen	ts by
Page ID: pgLicenseListForEnrImnt(Provider)	En	vironment: HI_SYSTST R10c-1.1		Server Time: 02/26/2	020 11:39:27 MST

### Add License/Certification

🚔 Print 🔮 Help				
Application ID: 20200226110177		Name: Ha	awaii Atypical	
Add License/Certificatio	n/Other			^
License/Certification/Other Typ	e:	*	License/Certification/Other #:	
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	Note: The Lice	ense Classification Type n License/Certification	nay be displayed if a specific DCCA Type is selected.	
III Add	License/Certification/Other			
L	icense/Certification/Other Type:	HI Board of Medical Examiners	License/Certification/Other #: *	
	Valid Flag:			
	License Classification Type :	SELECT DOS-OSTEOPATHIC PHYSICIAN AND SURGEON		
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			O Confirm License/Certification/Other	✓ OK Ocancel
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### Add License/Certification

Image: Note Pad       Image: External Links → My Favorites → My Favori	Image: Cert Algency Enrollment Task List > New Enrollment > Alypical Agency Enrollment     Name: Hawaii Alypical     Ose O Add     License/Cert/fication/Other List     Itter By     Case O Cool     License/Cert/Other Type     License/Cert/Other #   Av   Av     Valid Flag   Av     Effective Date   Av     Hi Board of Psychology   Hi Board of Medical Examiners     Ave New Page Count     Ose O Cool     Viewing Page: 1     Ose O Note     Ose O Count     Viewing Page: 1     Ose O Count     Viewing Page: 1	voBr∎x™ <	My Inbox 🕶	Admin 🗸	Provider <del>•</del>								
> MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment   pplication ID: 2020226110177   Name: Hawaii Atypical   Close ● Add   II License/Certification/Other List   Filter By   ● Coo   License/Certi/Other Type   License/Certi/Other Type   License/Certi/Other Type   Av   HI Board of Psychology   125478569   No   026/2020   125478569   No   026/2020   125478569   No   0276/2020   1254785	Add       Name: Hawaii Atypical         Ictense/Certification/Other List       Coo         Itense/Cert/Other Type       Icense/Cert/Other #       Valid Flag       Effective Date       End Date         Itense/Cert/Other Type       Icense/Cert/Other #       Valid Flag       Effective Date       Icense/Cert/Other #         Itense/Cert/Other Type       Icense/Cert/Other #       Valid Flag       Effective Date       Icense/Cert/Other #         Itense/Cert/Other Type       Icense/Cert/Other #       Valid Flag       Effective Date       Icense/Cert/Other #         Itense/Cert/Other Type       Icense/Cert/Other #       Valid Flag       Effective Date       Icense/Cert/Other #         Itense/Cert/Other Type       Icense/Cert/Other #       Valid Flag       Effective Date       Icense/Cert/Other #         Itense/Cert/Other Type       Icense/Cert/Other #       Valid Flag       Effective Date       Icense/Cert/Other #         Itense/Cert/Other Type       Icense/Cert/Other #       Valid Flag       Effective Date       Icense/Cert/Other #         Itense/Cert/Other #       Icense/Cert/Other #       Valid Flag       Effective Date       Icense/Cert/Other #         Itense/Cert/Other #       Icense/Cert/Other #       Icense/Cert/Other #       Icense/Cert/Other #       Icense/Cert/Other #       Icense/Cert/Other #       Icense/Cert	1 ·						Note Pad	🚱 External Links 🕶	★ My Fa	avorites 🕶	🚔 Prin	: 😢 He
Name: Hawaii Atypical     Close Add     License/Certification/Other List     Filter By Image: Close     License/Certi/Other Type License/Certi/Other #   Av Valid Flag Effective Date End Date   Av Av Av Av     HI Board of Psychology 125478569 No 02/26/2020 12/31/2999   HI Board of Medical Examiners 459862353 No 02/26/2020 12/31/2999	ication ID: 20200226110177 Name: Hawaii Atypical See  Add License/Certification/Other List Itter By	> MyInbox > Enrollment Task	List > New Enroll	ment > Atypica	al Agency Enrolln	nt							
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### Step 7: Add Additional Information

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👫 > MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment									
Application ID: 20200226110177	Name: Hawaii Atypical								
O Close									
III Enroll Provider - Atypical Agency									^
			Business Proc	ess Wizard - Provider F	nroliment (Atv	nical Agency), Click	on the Step # unde	r the Step C	olumn
Step	Required	Start Date	End Date	Status	Step Remark	finder Agentoy). Onlow	on the otep # unde	i ilic otep e	olulli.
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete					
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete					
Step 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete					
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete					
Step 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete					
Step 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete					
Step 7: Add Additional Information	Optional			Complete					
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete					
Step 9: Add Taxonomy Details	Optional			Incomplete					
Step 10: Fee Payment	Optional			Complete					
Step 11: Employee Details -	Optional			Incomplete					
Step 12: Upload Documents	Required			Incomplete	Please upload re	quired documents.			
Step 13: Complete Enrollment Checklist	Required			Incomplete					
Step 14: Submit Enrollment Application for Approval	Required			Incomplete					
View Page: 1 O Go Page Count Save ToXLS		Viewing Page: 1					<b>≪</b> First <b>♦</b> Prev	> Next	>> Last
*Note – Step 11: Emplo	oyee D	etails w	as rem	noved f	rom	ΗΟΚΙ	J		
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### Add Additional Information

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A > MyInbox > Enrollment Task List > New Enrollment	> Atypical Agency Enrollment			
Application ID: 20200226110177		Name: Hawaii Atypical		
Close				
III Authorized Representative List				*
O Add				
Filter By	O Go			Save Filters YMy Filters
Representative Name		Start Date	End Date	
▲▼ 		No Records Found !	<b>▲</b> ▼	
iii Bed Information				^
O Add				
Filter By	O Go			Save Filters Wy Filters
Bed Type	Bed(s)/Unit(s)	Start Date	End Date	
▲ ¥	۸Ÿ	No Records Found !	۸Ÿ	

#### Add Authorized R

🚔 Print 💿 Help			
Application ID:	Name:		
Add Authorized Representative			^
First Name:	*	Last Name:	*
Middle Name:			
Start Date:	*	End Date:	
			✓ OK SCancel
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### Add Bed Information

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	Add Bed Information					^
	Bed Type:	SELECT * *	,	Bed(s)/Unit(s):	*	
	Start Date:	*		End Date:		

✓OK Scancel

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### Step 8: Add Controlling Interest/Ownership Details

yInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment									
cation ID: 20200226110177	Name: Hawaii Aty	pical							
	-								
se									
Enroll Provider - Atypical Agency									
			Business	Process Wizard - Prov	ider Enrollment (Aty	pical Agency). Click	on the Step # unde	r the Step	Coli
	Required	Start Date	End Date	Status	Step Remark				
: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete					
Add Locations	Required	02/26/2020	02/26/2020	Complete					
Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete					
Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete					
Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete					
Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete					
Add Additional Information	Optional	02/26/2020	02/26/2020	Complete					
Add Provider Controlling Interest/Ownership Details	Required			Incomplete					
Add Taxonomy Details	Optional			Incomplete					
0: Fee Payment	Optional			Complete					
1: Employee Details -	Optional			Incomplete					
2: Upload Documents	Required			Incomplete	Please upload re	quired documents.			
3: Complete Enrollment Checklist	Required			Incomplete					
4: Submit Enrollment Application for Approval	Required			Incomplete					
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#### Add Controlling Interest/Ownership Details

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> MyInbox > Enrollment Task List > New F	Enrollment > Atypical Agency Enrollment	> General									
Application ID: 20200226110177			N	ame: Hawaii Atypical							
O Close O Actions -											
III Per Medicaid Provider Manu	al										^ ^
PROVIDER OWNERSHIP AND CONTROL	DISCLOSURES										
Provider Enrollment Information, including	home address, date of birth, and Social	Security Number, is required from provi	ders and other disclosed i	ndividuals (e.g., owners, ma	anaging employees, agen	its, etc.).					
REQUIRED DISCLOSURE INFORMATIO	N										
The name and address of any person     Date of birth and Social Security Num     Other Tax Identification Number, in th     Whether the person (individual or cory     more interest is related to another per     The name of any other fiscal agent or     The name, address, date of birth and	(individual or corporation) with ownershi ber (in the case of an individual). e case of corporation, with an ownership ororation) with an ownership or control int soon with ownership or control interest as manage care entity in which an owner h Social Security Number of any managing	ip or control interest. The address for co or control interest or of any subcontrac erest is related to another person with o a s apouse, parent, child or sibling, ias an ownership or control interest in an g employee.	rporate entities must inclu tor in which the disclosing wmership or control intere n entity that is reimbursabl	de, as applicable, primary b entity has a five percent or it as a spouse, parent, child a by Medicaid and/or Medic	ousiness address, every b more interest. d or sibling; or whether the care.	usiness location and P.O. Box address. e person (individual or corporation) with ar	ownership or control interest of any su	bcontractor in which th	e disclosing entity has	a five percent o	or
REQUIRED OWNERS  • Managing Employee is mandatory for • There must be at least one other own • If any of the following 10 owner types must also be selected in addition: Boa • If you select any of the following owne • For the Contractor/MCOE Enrolment T (1) Agent (2) Board of Directors, Chilef (3) Managing Employee	all enrollment types. srship type in addition to Managing Emp are selected: Corporate-Charitable 501[ rd of Directors, Chief Exacutive Officer, rship types: Managing Employee, Board ype, 3 ownership records must be added Executive Officer, Chief Financial Office	loyee. cl3, Corporate-Non Charitable, Corpora Chief Financial Officer, Chief Informatio of Directors, Chief Executive Officer, C d: r, Chief Information Officer, or Chief Op	te-Publicly Traded, Corpor n Officer, or Chief Operati hief Information Officer, C verating Officer	ate-Not Publicly Traded, H ng Officer. nief Operating Officer, or C	olding Company, Indirect hief Financial Officer, you	Owner, Limited Liability Company, Subcor I must add at least 1 additional ownership	itractor, Foreign, Nonresident Alien for t lype that is not from among that list.	the keyed Tax ID, ther	at least 1 of the follow	ing 5 owner typ	pes
III Owners List											^
Filter By		And Indicator		O Go					Bave Filte	rs 🔻 My Filte	ters▼
Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Per	centage owned		
	A.	<b>▲</b> ▼	<b>▲</b> ▼	<b>AV</b>	<b>₩</b> ₩	**	<b>▲</b> ▼	A.V			
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#### Add Owner

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vinbox > Enrollment Task List > Ner	v Enrollment > Atypical Agency Enrollment	\ General					HOLE Fau	CARTING CINKS	A my ruvonica ·		
	r Enrollinont y Frippical y gondy Enrollinon										
cation ID: 20200226110177			Nar	ne: Hawaii Atypical							
se 🖸 Actions 🔻 🥡											
Pe Add Owner an	ual										~
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VIDEI Owners Relationships	OL DISCLOSURES										
der E Owners Adverse Action	g home address, date of birth, and Socia	I Security Number, is required from pr	oviders and other disclosed ind	ividuals (e.g., owners, mai	aging employees, agent	s, etc.).					
UIRED DISCLUSURE INFORMATIO	ON										
der (including fiscal agents and mar	naged care entities) are required to disclo	ose the following information on owner	ship and control during enrollm	ent, revalidation and withir	35 days after any chang	je in ownership:					
The name and address of any personant of birth and Social Security Mu	on (individual or corporation) with owners	hip or control interest. The address for	corporate entities must include	, as applicable, primary bu	isiness address, every bu	usiness location and P.O. Box address.					
Other Tax Identification Number, in	the case of corporation, with an ownershi	ip or control interest or of any subcont	ractor in which the disclosing e	tity has a five percent or r	nore interest.						
Whether the person (individual or co	prporation) with an ownership or control in	nterest is related to another person wit	h 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 t	ne disclosing entity has	a five percent	r
tore interest is related to another period	erson with ownership or control interest a	is a spouse, parent, child or sibling.	an antity that is raimhursahla	w Medicaid and/or Medica	re						
The name, address, date of birth an	d Social Security Number of any managir	ng employee.	an enacy that is reinibursable	y weakan and of weak	16.						
JIRED OWNERS											
Anaging Employee is mandatory fo There must be at least one other ov	or all enrollment types. mershin type in addition to Managing Em	nlovee									
f any of the following 10 owner type	s are selected: Corporate-Charitable 501	[c]3, Corporate-Non Charitable, Corpo	prate-Publicly Traded, Corporat	e-Not Publicly Traded, Ho	ding Company, Indirect (	Owner, Limited Liability Company, Subcon	tractor, Foreign, Nonresident Alien fo	or the keyed Tax ID, the	n at least 1 of the follow	ng 5 owner typ	es
nust also be selected in addition: Br	oard of Directors, Chief Executive Officer	, Chief Financial Officer, Chief Informa	tion Officer, or Chief Operating	Officer.	15 1.05						
I you select any of the following owr For the Contractor/MCO Enrollment	nersnip types: Managing Employee, Boal Type, 3 ownership records must be adde	rd of Directors, Chief Executive Officer ed:	, Chief Information Officer, Chi	et Operating Officer, or Ch	et Financial Officer, you	must add at least 1 additional ownership t	ype that is not from among that list.				
(1) Agent	.,,										
(2) Board of Directors Chi	ef Executive Officer, Chief Financial Offic	cer, Chief Information Officer, or Chief	Operating Officer								
(2) 20010 01 21 2000, 010											
(3) Managing Employee											
(3) Managing Employee											^
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(a) Managing Employee Owners List Ier By		And Indicator		<b>O</b> Go					💾 Save Filter	s <b>y</b> My Filt	∧ rs▼
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(3) Managing Employee Owners List ter By Wher SSN/EIN/TIN V	Owner Information	And Indicator Owner Type	Address	© Go Start Date ▲♥	End Date ▲▼	Relationship Status ▲♥	Adverse Action	Pe	Save Filter	s <b>Y</b> My Filt	^ rs▼

### Add Ownership

🚔 Print 🛛 Help				
Application ID: 20200226110177	Name: H	awaii Atypical		
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 remaining address fields will be populat be returned.	equires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the ed and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will		
Address Line 1:	*	Address Line 2:		
Address Line 3:	(Enter Street Address of PO Box Only)	City/Town:	OTHER 💌 *	
State/Province:	OTHER V *	County:	OTHER	
Country:	UNITED STATES Y	Zip Code:	* - Validate Address	
			✓ OK OCar	ncel
Page ID: dlgEnrImntAddOwner(Provider)				

### Add Ownership

🚔 Print 🛛 Help					
Application ID: 20200226110177	Name: Hawaii Atypical				
III Provider Controlling Interest/Ownership					
Туре:	Managing Employee 💙 * 🜍	Percentage Owned:	50 *		^
SSN:	569696325 *	EIN/TIN:			
Legal Entity Name:		Entity Business Name:			
	(As shown on the Income Tax Return)		(Doing Business As)		
Owner NPI:					
First Name:	Joe *	Last Name:	Atypical	*	
Suffix:		DOB:	02/26/1980 *		
Phone Number:	(555) 555-5555 <b>* Extn:</b>	Email:		J	
Start Date:	*	End Date:			
	Please ensure you are providing the ho	ne 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 Address remaining address fields will be populated and validated	Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will			
	be returned.				
	Address valida	ion successful			
Address Line 1:	121 N Davis Blvd *	Address Line 2:			
	(Enter Street Address or PO Box Only)				
Address Line 3:		City/Town:	Bountiful	*	
State/Province:	UTAH • *	County:	Davis		
Country:	UNITED STATES *	Zip Code:	84010 * - 1806	Validate Address	
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r age ib. ageminino.udowner(r tovider)					

### Add Owners Relationship

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# > MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment > General									
Application ID: 20200226110177 Name: Hawaii Atypical									
H Pe Add Owner anual	^ ^								
Import Owner         Owners Relationships         Occurrence of the provider S           Provider B         Owners Adverse Action         Ang home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).									
by concerning of the second of									
(3) Managing Employee	•								
Filter By	Filters								
Owner SSN/EIN/TIN         Owner Information         Owner Type         Address         Start Date         End Date         Relationship Status         Adverse Action         Percentage owned									
AT         AT<									
Agent 121 N Davis Bivo 02/26/2020 12/31/2999 Not Completed Not Completed 50	~								
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## Add Owners Relationship

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Application ID: 20200226110177			Name: Hawaii Atypical		
III Add Relationship					^
Do any of the Owners have the followin	ng relationship (Daughter, Daughter-In Law, Fa	ther, Father-In Law, Mothe	er, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ? OYes ONo (Clic	k Save to update)	
Owner List					
Show Owners All	<b>⊙</b> Go				Save Filters Y My Filters
✓ Selected Owner:Atypical, Joe	SSN/EIN/TIN:569696325 Status:Not C	ompleted			
Assoc. Owner	SSN/EIN/TIN	Туре	Relation to Atypical, Joe	Relation to Assoc. Owner	
Atypical, Sally	565474858	Agent	Spouse	Spouse	
View Page: 1 O Go	Page Count SaveToXLS		Viewing Page: 1		K First Prev Next Dast
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### **Complete Adverse Actions**

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Application ID: 202002261101	77		Name: Hawaii	Atypical							
O Close ● Actions ▼ 🥡											
H Pe Add Owner	anual										^ ^
Import Owner											
Owners Relationsh	ding home address, date of birth, and So	cial Security Number, is required from provid	ers and other disclosed individuals (e.o	g., owners, managing employ	es, agents, etc.).						
REQUIRED DISCLUSURE INF	ction ອາຊ <sup>1</sup> າງ4TION										
Provider (including fiscal agents	and managed care entities) are required to di	sclose the following information on ownership	and control during enrollment, revalida	ation and within 35 days after	any change in ownership:						
<ul> <li>The name and address of</li> <li>Date of birth and Social Second</li> </ul>	any person (individual or corporation) with own curity Number (in the case of an individual)	ership or control interest. The address for cor	porate entities must include, as applica	ble, primary business addres	s, every business location	and P.O. Box address.					
Other Tax Identification Nu	mber, in the case of corporation, with an owne	rship or control interest or of any subcontract	or in which the disclosing entity has a fi	ve percent or more interest.							
Whether the person (indivi	dual or corporation) with an ownership or contr	ol interest is related to another person with ov	vnership or control interest as a spouse	e, parent, child or sibling; or w	hether the person (individ	ual or corporation) with an ownership o	or control interest of any	subcontractor in which t	he disclosing entity has	a five percent o	Nr -
The name of any other fisc	another person with ownership or control intere al agent or manage care entity in which an owr	st as a spouse, parent, child or sibling. 1er has an ownership or control interest in an	entity that is reimbursable by Medicaid	and/or Medicare.							
The name, address, date of	f birth and Social Security Number of any man	aging employee.									
REQUIRED OWNERS											
<ul> <li>Managing Employee is ma</li> </ul>	ndatory for all enrollment types.										
There must be at least one	other ownership type in addition to Managing	Employee.									
<ul> <li>If any of the following 10 or must also be selected in a</li> </ul>	wher types are selected: Corporate-Charitable Idition: Board of Directors. Chief Executive Offi	501[c]3, Corporate-Non Charitable, Corporate cer. Chief Financial Officer. Chief Information	e-Publicly Traded, Corporate-Not Public Officer or Chief Operating Officer	cly Traded, Holding Company	, Indirect Owner, Limited I	Liability Company, Subcontractor, Fore	ign, Nonresident Alien f	or the keyed Tax ID, the	n at least 1 of the follow	ng 5 owner typ	es
If you select any of the foll	owing ownership types: Managing Employee, B	oard of Directors, Chief Executive Officer, Ch	ief Information Officer, Chief Operating	g Officer, or Chief Financial O	ficer, you must add at lea	st 1 additional ownership type that is n	ot from among that list.				
For the Contractor/MCO E	nrollment Type, 3 ownership records must be a	dded:									
(1) Agent (2) Board of Dire	stors Chief Executive Officer Chief Financial (	Nificer Chief Information Officer or Chief One	arating Officer								
(3) Managing Em	ployee		inding officer								
III Owners List											^
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565474858	Atypical, Sally	Agent	121 N Davis Blvd	02/26/2020	12/31/2999	Completed	Not Comp	bleted	50		~
569696325	Atypical, Joe	Managing Employee	121 N Davis Blvd	02/26/2020	12/31/2999	Completed	Not Comp	oleted	50	_	
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#### **Disclose Adverse Actions**

		Name: Hawaii Atypica		
is an indirect ownership interest equal to five (5) per is a combination of direct and indirect ownership inte	cent or more in a disclosing entity; erests equal to five (5) percent or more in a discl	losing entity;		
vns an interest of five (5) percent or more in any mo an officer or director of a disclosing entity that is orga a partner in a disclosing entity that is organized as a	rtgage, deed of trust, note, or other obligation se anized as a corporation; or partnership?	scured by the disclosing entity if the interest equals at least $\ensuremath{\mathrm{fit}}$	e (5) percent of the value of the property or assets of the disclosing entity;	
ignificant business transaction" means any business	transaction or series of transactions that, during	g one fiscal year exceed the lesser of \$25,000 and five (5) pe	rcent of an offeror¿s total operating expenses.	
ubcontractor" means:				
individual, agency, or organization to which a discle individual, agency, or organization with which a fise	osing entity has contracted or delegated some of al agent has entered into a contract, agreement	f its management functions or responsibilities of providing me t, purchase order, or lease (or leases of real property) to obta	dical care to its patients; or n space, supplies, equipment, or services provided under the DHS agreement.	
upplier" means an individual, agency, or organization	n from which a provider purchases goods and se	ervices used in carrying out its responsibilities under its DHS	agreement (e.g. a commercial laundry firm, a manufacturer of hospital beds, or a pha	armaceutical firm).
holly owned subsidiary supplier," means a subsidiar	ry or supplier whose total ownership interest is h	neld by the Medicaid provider/applicant or by a person, person	is, or other entity with an ownership or controlling interest in the Medicaid provider/ap	oplicant.
nolly owned subsidiary supplier," means a subsidiar	ry or supplier whose total ownership interest is h	neld by the Medicaid provider/applicant or by a person, person	is, or other entity with an ownership or controlling interest in the Medicaid provider/a	pplicant.
olly owned subsidiary supplier," means a subsidiar AL ADVERSE LEGAL ACTION/CONVICTION AC any of the owners, under any current or former name	y or supplier whose total ownership interest is h TION HISTORY ne or business identity, ever had a final adverse	neld by the Medicaid provider/applicant or by a person, person elegal action listed above imposed against them? Please ans	is, or other entity with an ownership or controlling interest in the Medicaid provider/ap wer in the <b>'Owners with Adverse Action'</b> section below for each owner.	splicant.
olly owned subsidiary supplier," means a subsidiar AL ADVERSE LEGAL ACTION/CONVICTION AC any of the owners, under any current or former nan Owners with Adverse Action	ry or supplier whose total ownership interest is h TION HISTORY ne or business identity, ever had a final adverse	neld by the Medicaid provider/applicant or by a person, person legal action listed above imposed against them? Please ans	is, or other entity with an ownership or controlling interest in the Medicaid provider/an wer in the 'Owners with Adverse Action' section below for each owner.	splicant.
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### Step 9: Taxonomy Details

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### Add Taxonomy Details

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## Add Taxonomy

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### NUCC Taxonomy Code List

Ith Care Provider Taxonomy Code Set	
-	Health Care Provider Taxonomy Code Set
Introduction National Uniform Claim Committee Website Heip Individual or Groups (of Individuals) Group Multi-Specially Single Specially Single Specially Multi-Specially Single Specially Allergy & Immunology Allergy Clinical & Laboratory Immunology Clinical & Laboratory Immunology Clinical Autoration Medicine Pain Medicine Pain Medicine Pain Medicine Paintalogy Clinical & Laboratory Dematological Immunology Clinical & Laboratory Dematology Clinical & Laboratory D	Introduction           Name         Incoduction           Definition         The dust Care Drawshow Code as the an external, nonmedical data code set designed for use in an electronic environment, specification to the CX 1214 Health Care transactions. This includes the transactions mandated under HIPA.           Definition         The dust, Care Drawshow Code as the an external, nonmedical data code set designed for use in an electronic environment, specification of the CX 1214 Health Care transactions. This includes the transactions mandated under HIPA.           Definition         The dust, Care Drawshow Code as the anteractors in length. The code set is structured into three distinct "Levels" including Provider Corputing Care example. Hore care providers. For example: Allopathic & Osteopathic Physicians, Dental Providers, Including Provider Corputing Care example. The following boards will however, tave their gene or escription entiticates appear as Level III areas of specializations structured to the physicians based upon the General Specialization relevante by the appropriate national boards. The following boards will however, the whore on escriptication of the Code set of baseds that have multiple general contractions to the General Specialization structured to the duspin relevante of the code set of baseds that have multiple general contractions. Hole General Specialization will have or ording down to the provider fonces to provider fonces are estimated to the mere voider. The totoparty code set as a specialization. The ten otigit codes for each provider target and contrain no embedded logic. The codes are cogniticated on any one position with the code.           Devide Structured Hubble Codes for the code set of the provider for the tode set of the tode s
Aduit wedicine Geratric Medicine Hospice and Pallative Medicine Obesty Medicine Sleep Medicine Soorts Medicine	Medical Services (CMS) began work on identifying and coding an external provider code set that would be able to codity provider groups and provider area of specialization for all health care related providers. CMS' intent was to provide a single coding structure to support work on the N. Provider System, while X12N needed a single common code set for trading partner use. The two projects worked independently to some extent until, 1996 when the lists were coordinated and a single taxonomy code set. Nate' work resulted in a single taxonomy code set. That 'work resulted in a single taxonomy code set. That 'work resulted in a single taxonomy code set. That 'work resulted in a single taxonomy code set. That 'work resulted in a single taxonomy code set. That 'work resulted in a single taxonomy code set that both CMS ar members of X12N found meaningful, easy to use, and functional for electronic transactions.
General Practice Hospitalist	The sub-group initially started with the CMS draft taxonomy code set. This list incorporated all types of providers associated with health care in variou ways, e.g. technologists or technicians who support or repair equipment/machinery, contractors, physicians, dentists, suppliers. A number of the prov

### Step 10: Fee Payment

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> MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment									
Application ID: 20200226110177	Name: Hawaii Aty	pical							
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Enroll Provider - Atypical Agency									^
			Business	Process Wizard - Prov	ider Enrollment (Atvr	oical Agency), Click	on the Step # unde	r the Step (	Column.
Step	Required	Start Date	End Date	Status	Step Remark				
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete					
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete					
Step 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete					
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete					
Step 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete					
Step 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete					
Step 7: Add Additional Information	Optional	02/26/2020	02/26/2020	Complete					
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete					
Step 9: Add Taxonomy Details	Optional	02/26/2020	02/26/2020	Complete					
Step 10: Fee Payment	Optional			Complete					
Step 11: Employee Details -	Optional			Incomplete					
Step 12: Upload Documents	Required			Incomplete	Please upload re	quired documents.			
Step 13: Complete Enrollment Checklist	Required			Incomplete					
Step 14: Submit Enrollment Application for Approval	Required			Incomplete					
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### Step 10: 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 enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below. Upload your receipt or documentation of payment in the "Upload Documents" step. This is subject to federal and state approval.
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	x Payment Date:
	Payment Status	Confirmation Number:

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.

✓ Ok Scancel

Provider Fee Payment has been waived for the duration of the COVID-19 emergency. It may be reqired when the emergency passes.

#### innovation@work

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COVID-19 Waiver

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### Step 11: Upload Documents

MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment									
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Enroll Provider - Atypical Agency									
			Business	Process Wizard - Provi	der Enrollment (Atvr	ical Agency) Click	on the Sten # unde	r the Sten C	Colum
p	Required	Start Date	End Date	Status	Step Remark	nour Agenoy). Onour	on the otep # unde	i ine otep e	, orall
) 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete					
2: Add Locations	Required	02/26/2020	02/26/2020	Complete					
3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete					
4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete					
5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete					
6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete					
7: Add Additional Information	Optional	02/26/2020	02/26/2020	Complete					
8: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete					
9: Add Taxonomy Details	Optional	02/26/2020	02/26/2020	Complete					
10: Fee Payment	Optional	02/26/2020	02/26/2020	Complete					
11: Employee Details -	Optional			Incomplete					
12: Upload Documents	Required			Incomplete	Please upload re	quired documents.			
13: Complete Enrollment Checklist	Required			Incomplete					
5 14: Submit Enrollment Application for Approval	Required			Incomplete					
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### Step 11: Upload Documents

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

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

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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, Med-QUEST will send out a correspondence to providers that need to submit their FCBC Determination Letter. innovation@work

### **Upload Documents**

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Application ID: 20200226110177	Name: Hawa	waii Atypical
III Upload Document		^
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## **Upload Documents**

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### Step 12: Enrollment Checklist

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> MyInbox > Enrollment Task List > New Enrollment > Atypical Agency Enrollment							
pplication ID: 20200226110177	Name: Hawaii Atypical						
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Enroll Provider - Atypical Agency							
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Step	Required	Start Date	End Date	Status	Step Rema	rk	
Step 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete			
Step 2: Add Locations	Required	02/26/2020	02/26/2020	Complete			
tep 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete			
Step 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete			
tep 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete			
tep 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete			
Step 7: Add Additional Information	Optional	02/26/2020	02/26/2020	Complete			
Step 8: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete			
Step 9: Add Taxonomy Details	Optional	02/26/2020	02/26/2020	Complete			
Step 10: Fee Payment	Optional	02/26/2020	02/26/2020	Complete			
3 <del>tep 11: Employee Details</del>	Optional			Incomplete			
Step 12: Upload Documents	Required	02/26/2020	02/26/2020	Complete			
Step 13: Complete Enrollment Checklist	Required			Incomplete			
Step 14: Submit Enrollment Application for Approval	Required			Incomplete			
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#### \*Note – Step 11: Employee Details was removed from HOKU. Enrollment Checklist will be Step 12.

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### **Enrollment Checklist**

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Provider C	hecklist								~
uestion						Answer	Com	ments	
you need to reque	st a Retroactive or Future	Enrollment Date?	If Yes, enter the re-	sted date in the comment field to be considered.		Not Complete			
o you wish to end da	ate your enrollment? If yes	, enter date in com	ment field.			Not Complete			
re you currently excl	uded from any Hawaii or o	other state program	n? If yes, provide st	of exclusion and program in comment field.		Not Complete			
e you currently excl	uded from any federal pro	gram? If yes, provi	de the program an	te in comment field.		Not Complete	V L		
ave you ever had a	criminal or healthcare prog	gram-related convi	ction? If yes, provid	pe of conviction and date in comment field.		Not Complete			
we you ever had a j	udgment under any false	claims act? If yes,	list judgment and d	in comments field		Not Complete			
ave you been enrolle	ed by another State's Med	icaid Program. If y	es, provide each st	and effective date of enrollment in comments field.		Not Complete			
ve you ever had a	program exclusion/debarn	nent? If yes, provid	e program and dat	comments field.		Not Complete			
ave you ever had civ	vil monetary penalty? If ye	s, provide penalty	type and date. If ye	lease specify federal or state in comments field.		Not Complete			
re you trying to react	tivate a provider previousl	y active with Med-0	QUEST whose stat	ecame inactive or lapsed for any reason? If yes, please add the previous Me	d-QUEST ID in the comments field again.	Not Complete			
o you have 5% or m	ore ownership interest in o	other entities reimb	ursable by Medica	d/or Medicare? If Yes, provide details in "Add Ownership Details" step.		Not Complete			
ave you had any ma	lpractice settlement, judgi	ment, or agreemen	t? If yes, provide d	amount and dates in comments field.		Not Complete	L L		
his enrollment is for	a change of ownership (	CHOW) for an exist	ting provider with a	r name, NPI, or Tax ID, please add the previous information in the comment	box.	Not Complete	L L		
re you a Home Heal ate and date, also u	th Agency, DME provider, pload fingerprinting docun	home and commu nentation.	nity based provide	CBS) or nonemergency medical transportation provider? Have you had the re	equired fingerprinting completed? If yes, with	what Not Complete			
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### **Step 13: Submit Application**

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ep	Required	Start Date	End Date	Status	Step Remark		
ep 1: Provider Basic Information	Required	02/26/2020	02/26/2020	Complete			
ep 2: Add Locations	Required	02/26/2020	02/26/2020	Complete			
p 3: Add Correspondence Address	Required	02/26/2020	02/26/2020	Complete			
p 4: Add Provider Type/Specialties/Subspecialties	Required	02/26/2020	02/26/2020	Complete			
p 5: Associate Billing Provider/Other Associations	Optional	02/26/2020	02/26/2020	Complete			
p 6: Add License/Certification/Other	Optional	02/26/2020	02/26/2020	Complete			
p 7: Add Additional Information	Optional	02/26/2020	02/26/2020	Complete			
p 8: Add Provider Controlling Interest/Ownership Details	Required	02/26/2020	02/26/2020	Complete			
p 9: Add Taxonomy Details	Optional	02/26/2020	02/26/2020	Complete			
ep 10: Fee Payment	Optional	02/26/2020	02/26/2020	Complete			
ep 11: Employee Details	Optional			Incomplete			
ap 12: Upload Documents	Required	02/26/2020	02/26/2020	Complete			
ep 13: Complete Enrollment Checklist	Required	02/26/2020	02/26/2020	Complete			
ep 14: Submit Enrollment Application for Approval	Required			Incomplete			
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HOKU. Submit Application step will be Step 13.

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### **Submit Application**

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> New Enrollment > Atypi	ical Agency Enrollment						<u> </u>	
		Name: Hawaii A	typical					
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Application	1 ID: 2020022611017	7		EnrollmentT	ype: Atypical Agency	/ Provider		
		The information submitted for enrollment sh	all be verified and reviewed by the State	e.				
		During this time, any changes to the	nformation shall not be accepted.					
	l agree	e that the information submitted as a part of th	application is correct (Private and Con	nfidential).				
t Checklist								
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# **Review Provider Participation Agreement**

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A Sylnbox S Enrolment Task List S New Enrolment S Alypical Agency Enrolment				
Application ID: 20200226110177 Name: Hawaii Atypical				
O Close Submit Application After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.				
II PROVIDER AGREEMENT AND CONDITION OF PARTICIPATION (PART B)				^ ^
I/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:				
I/We agree to abide by the applicable provisions of the Hawaii State Medicaid Program set forth in the Hawaii Administrative Rules, Title 17, Subtitle 12, and applicable provisions set forth in the Code of Federal Regulations (C.F.R certification by the Hawaii State Medicaid Program, I/We also agree to abide by the policies and procedures contained in the Hawaii State Medicaid Manual. If I/We are a provider for the 1915 <sup>®</sup> waiver for participants with Developm I/We agree to abide by the policies and procedures contained in the Medicaid Manual.	.) related to the M nental Disabilities	edical Assistance F (DD) or Intellectual	Program. Up Disabilities	oon (ID),
I/We agree to comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352), Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112), and the Age Discrimination Act of 1975 (P.L. 94-135), and all the requirements issued purs promulgated by the regulations of the Department of Health and Human Services and hereby give assurance that I/We will immediately take any measures necessary to enact this agreement, to the effect that no person shall on the 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 ent Financial Assistance.	uant to the respect e grounds of the a tirety or in part dire	ctive title, section a pplicable categorie actly or indirectly by	nd/or act, as s such as ra r Federal	ace,
I/We agree to keep all such records necessary to disclose fully, upon request, the extent of care and/or services provided by me/we to eligible Medicaid beneficiaries and to furnish the Hawaii State Department of Human Services, Medicaid Investigations Division, such information from those records regarding any payments that have been claimed by me/we under the program as the Hawaii State Department of Human Services may, from time to time, requi	the Secretary of H ire as authorized t	lealth and Human y 42 C.F.R. §431.	Services, or 107(b)(2).	the
I/We agree to disclose full and complete information regarding ownership information as described in 42 C.F.R. §455 Subpart B. This includes but is not limited to disclosure of information on ownership and control (42 C.F.R. §455. 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 Hawaii State Department of Human Services, the Secretary of Health and Human Services, or the Medicaid Investigations Division in the Department of Attorney General.	.104), information nip of the disclosin	related to business g entity and at the	s transactior request of t	ns (42 he
I/We understand that the Hawaii State Medicaid Program may refuse to enter into or renew an agreement with me/we if any person, who has an ownership or control interest in the provider, or who is an agency or managing employ to that person's involvement in any program established under Medicaid Program (Title XIX) as stipulated in 42 C.F.R. §455.106.	yee, has been cor	victed of a crimina	l offense rel	ated
I/We agree to accept, as payment in full, the applicable amount or amounts established by the Hawaii State Medicaid Program in Chapter 1739, Hawaii Administrative Rules, plus any deductible, coinsurance, or copayment requiree the Medicaid recipient as stipulated in 42 C.F.R. §447.15. I/We am aware that it is violation of Federal law to accept or require additional payments over and beyond those established by the Hawaii State Department of Human Sen Medicaid Program. I/We understand the reimbursement rates shall be in accordance with payment methodologies pursuant to Chapter 1739, Hawaii Administrative Rules.	d by the Hawaii St vices for services	ate Medicaid Progr rendered under the	ram to be pa e Hawaii Sta	aid by ite
I/We understand that when changes in Hawaii State Department of Human Services and Hawaii State Medicaid Program policies and procedures become necessary due to changes in State or Federal laws or regulations, that such receipt of written notice from the Hawaii State Department of Human Services or the Hawaii State Medicaid Program to me/we.	h change will take	effect within thirty	(30) days of	:
I/We understand that (1) Any information provided by the Hawaii State Department of Human Services and the Hawaii State Medicaid Program to a provider and by a provider to the Department or Medicaid Program, shall be treate 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 conf 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 individu 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 HI 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 dis 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, Hawai	ed confidentially au fidential and shall ual, evaluations, a IV/AIDS shall be s sclosed in accorda ii Revised Statute	nd shall not be rele not be disclosed ex nd medical, psycho trictly confidential a ince with Chapter 3 s.	ased to othe ccept in blogical or and shall on 334-5, Hawa	er ly be iii
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#### innovation@work

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### **Review Provider Participation Agreement**

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Application ID: 20200226110177	1	Name: Hawaii Atypical							
Close Submit Application After reading the Terms and Conditions be sure to check the application	greement box located at the end of the docu	ument.							
IN THE CASE OF PROVIDERS WHICH ARE BUSINESSES, GROUPS, HOSP	ITALS, CORPORATIONS OR OTHER	R ENTITIES:							^
(1) I/We and each of us agree that all services for which our organization makes are submitted; (2) If any real property or structure thereon is provided or improve	a claim against the Hawaii State Med ed either directly or indirectly by Feder	dicaid Program (Title XIX) shall be o ral	only for services rendered by p	ersons who are properly lice	ensed and/or qu	ualified for the servic	e they provide for w	hich the clai	ms
Financial Assistance from the Department of Health and Human Services, this A Federal Financial Assistance is extended or for another purpose involving the pur 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 dire The service provider recognizes and agrees that such Federal Financial Assista the Assurance. This Assurance is binding on the service provider, its successory	Assurance shall obligate the service pr rovision of similar services and/or bene the period during which the Federal Fi cxtly or indirectly any or all Federal Fin nce will be extended in reliance on the s, transferees, and assignees, and to t	rovider, or in the case of any transfe efits. If any personal property is so innancial Assistance is extended to ancial Assistance that is extended : e representations and agreements i the person authorized to sign this A	er of such property, any transfe provided, this Assurance shall it either directly or indirectly by after the date hereof by the De made in this Assurance and th Assurance on behalf of the serv	eree, for the period during wh obligate the service provide (the Department of Health a epartment of Health and Hurr at the United States and/or the vice provider whose signature	hich the real pro- r for the period and Human Ser han Services, to the State of Har res appear belo	operty or structure is during which it retai vices; (3) This Assur hrough the Hawaii S waii shall have the ri w.	used for a purpose as ownership or pose ance is given by the ate Department of ght to seek judicial	e for which th ssession of th e service pro Human Servi enforcement	e he vider ices. t of
RETROACTIVE CERTIFICATION:									
I/We agree that retroactive provider certification shall be limited to no more than discretion of the Med-QUEST Division Administration. The month in which the a	twelve (12) months back to the date of pplication was received shall be count	on which the application was receiv ted as the first month.	ed in the Hawaii State Departm	nent of Human Services/Me	d-QUEST Divis	sion/Health Care Ser	vices Branch office	subject to th	e
ELECTRONIC SIGNATURE: This Acknowledgement is to let you know that by organization. For purposes of the acknowledgement, a digital mark is considered acknowledgment statement provided in the same area requiring the electronic s	submitting an electronic signature, you d a typed legal First and Last name (le ignature.	u are providing an electronic mark, egal name may include middle nam	that is held to the same standa ne, initial or suffix) followed by t	ard as a legally binding equiv the typed date. Any document	valent of a hand nt requiring an	dwritten signature pro electronic signature	ovided by you on be may contain a signa	ehalf of your ature	
AGREEMENT & ACKNOWLEDGEMENT: I agree that my electronic signature i future, repudiate the meaning of my electronic signature or claim that my electro acknowledgement that I am authorized to represent and bind the organization for being reproduced for future use. It is also acknowledged that this electronic sign	is the legally binding equivalent to my nic signature is not legally binding. Lik or which this documentation is submitte lature meets the standard identified for	handwritten signature. Whenever I kewise, I, on behalf of the organizat ed. An electronic record will be kep r uniqueness, verification, sole cont	execute an electronic signatur tion that I am authorized to rep ot of the documentation with wh trol, and record linkage.	re, it has the same validity ar resent, consent to do busine iich the electronic signature i	nd meaning as ess electronical is associated.	my handwritten sign lly. This electronic si This electronic record	ature. I will not, at a inature will function I will be retained ar	any time in th as nd capable of	e
The undersigned attest that they have entered into an agreement effective on th Med-QUEST Provider Enrollment.	e date indicated below. Both parties a	agree an authorized representative	of the enrolling entity has the a	authority to sign and submit t	this electronic a	agreement and to ma	intain enrollment in	formation thr	rough
□I/We have read all of the Provider Agr	eement and Condition of	Participation in the Ha	waii State Medicaid	Program and fully	understa	nd and agree	to its terms.		
	First Name:	Last Name:	Date:						
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### **Submission Complete**

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Your Applica	ation Numbe	er 202002261101	77 has been	successfully	itted for State review. Return with this application number to track the status of your application. $$ x					
Close										
III Enroll	I Provider -	Atypical Agend	cy							•
					Business Pro	ess Wizard - Provider	r Enrollment (Atypical Agency), Clic	k on the Step # und	r the Step (	Column.
Step					Required Start Date	End Date	Status	Step Remark		
Step 1: Provide	er Basic Informa	ation			Required 02/26/2020	02/26/2020	Complete			
Step 2: Add Lo	ocations				Required 02/26/2020	02/26/2020	Complete			
Step 3: Add Co	orrespondence	Address			Required 02/26/2020	02/26/2020	Complete			
Step 4: Add Pr	rovider Type/Sp	ecialties/Subspecialt	ties		Required 02/26/2020	02/26/2020	Complete			
Step 5: Associa	iate Billing Provi	ider/Other Associatio	ons		Optional 02/26/2020	02/26/2020	Complete			
Step 6: Add Lic	cense/Certificat	ion/Other			Optional 02/26/2020	02/26/2020	Complete			
Step 7: Add Ad	dditional Informa	ation			Optional 02/26/2020	02/26/2020	Complete			
Step 8: Add Pr	rovider Controlli	ng Interest/Ownershi	ip Details		Required 02/26/2020	02/26/2020	Complete			
Step 9: Add Ta	axonomy Details	5			Optional 02/26/2020	02/26/2020	Complete			
Step 10: Fee P	Payment				Optional 02/26/2020	02/26/2020	Complete			
Step 11: Emplo	oyee Details				Optional		Incomplete			
Step 12: Uploa	ad Documents				Required 02/26/2020	02/26/2020	Complete			
Step 13: Comp	plete Enrollment	t Checklist			Required 02/26/2020	02/26/2020	Complete			
Step 14: Subm	nit Enrollment A	pplication for Approv	ral		Required 02/26/2020	02/26/2020	Complete			
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### Contact Med-QUEST

https://medquest.hawaii.gov/HOKU

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# Thank You!

Persistence, Perseverance and Passion as always remains our credo.