Housing Stabilization Services (HSS) Provider Enrollment Guide

NORTH STAR POLICY CONSULTING

Ei-Consultants

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This guide is not a substitute for official guidance from the Minnesota Department of Human Services.

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Please contact the HSS TA Team at hss-tateam@mesh-mn.org with any questions or comments about this document.

INTRODUCTION

This document serves as a guide to the provider enrollment process for enrolling to provide Housing Stabilization Services (HSS) as a Minnesota Health Care Programs (MHCP) provider through the Minnesota Department of Human Services (MN DHS). This guide was created by the Housing Stabilization Services Technical Assistance Team (HSS-TA Team), which is a partnership between CSH, Ei-Consultants, Housing Matters, MESH, and North Star Policy Consulting. ***This guide is NOT a substitute for official guidance from DHS.*** Please reference the MN DHS Housing Stabilization Services Enrollment Criteria and Forms webpage for more information.

The HSS provider enrollment process is subject to change. Please check the MN DHS website for the most up-to-date information. The HSS-TA Team will work to keep this guide as current as possible.

This guide focuses on completing the enrollment forms. There are two ways to complete these forms:

(1) Online using the Minnesota Provider Screening and Enrollment (MPSE) Portal via the MN-ITS online system; or
(2) Faxing the forms to MHCP Provider Eligibility and Compliance at (651) 431-7493.

The most up-to-date forms are available at the DHS eDocs library. This guide provides examples of each required form with annotations clarifying how to complete them. The first section is a one-pager with information your agency can gather before completing the forms to help simplify the provider enrollment process. The following section is a walkthrough guide to using the MPSE Portal, and the last section is a guide to the fax option. The forms have been completed from the perspective of a fictional nonprofit. Modify the responses as appropriate for your agency/agency type.

As per the MN DHS website, in addition to completing the enrollment forms discussed in this guide, providers must also complete the following in order to become HSS providers:

- ❑ Complete the annual mandated reporter training, which includes training on vulnerable adult law. *(Applies to managers, supervisors, direct care staff, and staff who submit Housing Stabilization requests)*
- ❑ Pass a criminal background check. *(Applies to direct service HSS staff and managing employees; completed in NetStudy 2.0)*
- ❑ Be knowledgeable of local housing resources. *(Applies to all staff providing HSS)*
- ❑ Housing Consultation services providers must complete mandated Housing Consultation training on TrainLink. You will need a unique key to take this training. *(Applies to managers, supervisors, direct care staff, and staff who submit Housing Stabilization requests)*
- ❑ Housing Transition and Housing Sustaining services providers must complete mandated Housing Transition and Housing Sustaining training on TrainLink. You will need a unique key to take this training. *(Applies to managers, supervisors, direct care staff, and staff who submit Housing Stabilization requests)*

- ❑ All staff working directly with Housing Stabilization Services recipients must complete Housing Consultation, Housing Transition and Housing Sustaining training within 30 days of employment start date. *(Applies to all staff providing HSS)*
- ❑ Housing stabilization providers need to follow Home and community-based services requirements. Review the Home and community-based services providers webpage for additional information.

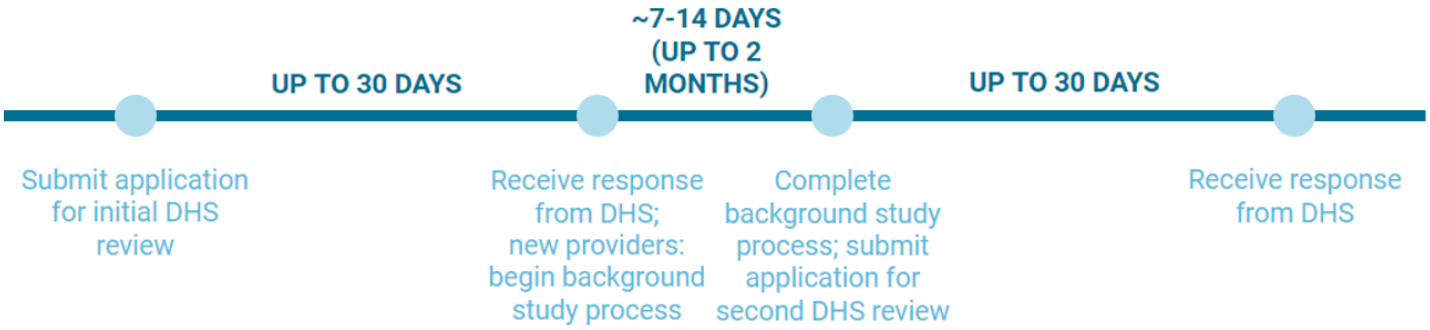
Timeline

Please allow for up to 30 days for DHS to process your application. Within 30 days of application submission, DHS will issue a MHCP Enrollment – Request for More Information letter via mail if you applied via fax, or via MPSE Portal if you applied online. **You will not be notified via email.**

This letter will include instructions for setting up your agency's HSS program in NETStudy 2.0 for completing background studies, and it will also inform you of any issues with your application so that you can correct them when resubmitting your application. Depending on how quickly you initiate the background study process in NETStudy 2.0, we anticipate that it could take around two weeks to complete the background study process. DHS allows up to two months to complete the background study process—your agency's deadline should be listed on your initial review response letter from DHS.

After completing the background study process and updating Form DHS-3891, upload the new Form DHS-3891 in the MPSE Portal under the "Notes" section, or fax it to DHS if you applied via fax. If DHS noted other needed revisions to your application in the letter, also make those changes when resubmitting your provider enrollment application. If you are using the MPSE Portal, your entire application will be reverted to a draft, but the only change that needs to be made before resubmission is updating Form DHS-3891, unless the letter from DHS indicates that you must make corrections to your application.

Please allow up to 30 days to hear back from DHS when you submit your provider enrollment application for the second review.



Important Notes

- Application fees must be paid prior to applying and are paid via the MHCP Provider Screening Fee Collections System.
    - When you pay the provider enrollment fee, be sure to keep a record of your payment. This could be a printout of the MHCP Provider Screening Fee Collections System website immediately after

paying (e.g., a screenshot of the website, the website printed to PDF, or a scan of a physical printout of the webpage), or a printout of the email confirmation of payment.
    - Please ensure that the address associated with the fee payment matches the physical practice address that you enter on your provider enrollment application.
- Housing Sustaining Services providers who own or control multiple locations (site-based housing) where services will be provided must pay an application fee for each location.
- Prior to submitting a HSS provider enrollment application, the mandated reporter training and the TrainLink Housing Stabilization Services trainings pertinent to the services your agency will be providing must be completed by the following staff, as noted on Forms DHS-7968 and DHS-7867: managers, supervisors, direct care staff, staff who submit Housing Stabilization requests. Please maintain a record of the completion of these trainings by each staff.
    - The HSS-TA Team has created a document with links to the trainings and explanations of how to access the TrainLink HSS trainings, available here.

NETStudy 2.0 Background Studies

Background studies are completed using the NETStudy 2.0 system. You will not be able to initiate background studies for HSS provider enrollment until DHS issues a Facility ID/Agency ID for your agency's HSS program following DHS's initial review of your HSS provider enrollment application. Regardless of whether your agency already has a NETStudy 2.0 account, you will need to resubmit your HSS provider enrollment application after DHS's initial review.

DHS's first review of your agency's HSS provider enrollment application can take up to 30 days, and the second review can take up to an additional 30 days. Depending on how quickly you set up your NETStudy 2.0 account, we anticipate that the background studies process could take up to 14 days to initiate. DHS allows up to two months to complete the background study process—your agency's deadline should be listed on your initial review response letter from DHS.

If you do not already have a NETStudy 2.0 account, set up your NETStudy 2.0 account by following the process indicated in the MHCP Enrollment – Request for More Information letter issued by DHS after they have reviewed your HSS provider enrollment application. This letter will assign your agency a Facility ID/Agency ID and provide instructions for NETStudy 2.0 system onboarding. Follow the directions in the letter to access the NETStudy 2.0 system and initiate background studies for managing staff/owners. Then, update Form DHS-3891 to include your staff's background study numbers, as well as the newly assigned Facility ID/Agency ID, and resubmit your application with the updated Form DHS-3891.

If you already have a NETStudy 2.0 account, you can add your agency's HSS program's Facility ID/Agency ID to your existing NETStudy 2.0 account. After DHS's initial review of your agency's HSS provider enrollment application, DHS will issue you a MHCP Enrollment – Request for More Information letter that includes a Facility ID/Agency ID to use in NETStudy 2.0 for your agency's HSS program. Email the point of contact for NETStudy 2.0 listed in the letter and request to add that Facility ID/Agency ID to your existing NETStudy 2.0 account.

If your staff already have background studies completed in NETStudy 2.0, you may be able to affiliate the existing background studies from an existing NETStudy 2.0 program roster to the new HSS roster, while still keeping the background studies on the original roster. This may be possible if the existing background study

had the same standards as the HSS background study. Information about this process is available at 2:47 in the Minnesota DHS Training - Roster part 2 YouTube video. We recommend you contact DHS's NETStudy 2.0 team for more information. This process would only be able to be completed once the new NETStudy 2.0 Facility ID/Agency ID for your agency's HSS program is issued following DHS's initial review of your agency's HSS provider enrollment application.

Who needs a background study?

- Once you have access to NETStudy 2.0 following DHS's initial review of your agency's HSS provider enrollment application, you will need to initiate background studies for the staff listed on DHS-3891.
- You will also need to run background studies in NETStudy 2.0 for all staff who will be providing Housing Stabilization Services (i.e., direct staff). You do not need to initiate these background studies for direct staff until your agency is approved to provide HSS. Your agency should provide oversight of each staff that will have direct contact with people served by the program until DHS issues a notice of the background study results.
- For nonprofits, members of the Board of Directors need to be listed on Form DHS-5259, but not on Form DHS-3891. They do not need to have background studies completed.

	Need a Background Study Completed	List on Form DHS-3891	List on Form DHS-5259
Managing employees and owners	✓	✓	✓
Board of Trustees members			✓
Direct service staff	✓		

You are able to appeal background study determinations for reconsideration if any staff's background study determination comes back as "disqualified." More information about the appeals process is available on NETStudy 2.0's Appeals webpage.

Before You Begin…

Consider registering for a National Provider Identification number.

- **The HSS-TA Team recommends using an NPI as opposed to an UMPI** as some providers have run into issues with billing using an UMPI. Please note that you can still choose to use an UMPI.
    - NPI numbers can be obtained via the NPPES Portal.
    - NPIs can generally be obtained within a day.
    - If your organization (or a different department within your organization) has obtained an NPI in the past, you may need to identify the NPI admin within your organization for assistance with applying for a new NPI for your HSS program.
    - This NPI Application guide from the California Department of Health Care Services goes through the step-by-step process of applying for an NPI in the NPPES Portal.
- NPI numbers can be obtained via the NPPES Portal.
- When signing up for an NPI, use the following taxonomy code: 251B00000X - Case Management.
- If your agency prefers to use a UMPI, please note that you cannot use an existing UMPI. DHS will assign your agency a new UMPI for HSS. Leave the NPI/UMPI field(s) blank on the forms for the initial submission, and then add the UMPI number to the forms once DHS assigns your agency a UMPI.
- More information about using NPI v. UMPI is available here.

Does your agency have an electronic funds transfer (EFT) vendor number, sometimes referred to as a SWIFT vendor number? This is a 10-digit vendor number followed by a 3-digit location number assigned from Minnesota Management & Budget (MMB) to receive electronic funds transfer.

- If your agency does have an EFT vendor number but you are unsure of the location code, the default location code is 001.
- If your agency does not have an EFT vendor number, please follow the guidance on the MMB website or request technical assistance. A guide to the registration process is available here.
    - Register here.
- The Minnesota Supplier Portal is available here.
- Be sure to sign up as a **New Supplier**.

Additional Resources

In addition to this guide, the HSS-TA Team offered a Provider Enrollment and Compliance Learning Session as part of their Housing Stabilization Services Learning Session series. The Powerpoint is available on the MESH website. The HSS-TA Team also offered a different Provider Enrollment webinar as part of the Medicaid Academy held in early 2021. The Powerpoint and recorded webinar are available on the MESH website. The HSS-TA Team may hold additional provider enrollment webinars in the future. Upcoming trainings are posted on the MESH website.

GETTING STARTED — GATHERING INFORMATION

Before your agency begins the Housing Stabilization Services (HSS) provider enrollment process, we recommend gathering the following information so that you are prepared to complete the forms more quickly and efficiently.

Item	Your Agency's Information
Federal Employer Identification Number (FEIN)	
MN Tax ID Number (if applicable)	
National Provider Identifier (NPI) *(do not need if your agency would like a new Unique Minnesota Provider Identifier (UMPI)* assigned by DHS)*	
MMB EFT SWIFT Vendor Number	
Authorized Officer name and title	
Authorized Officer email address	
Authorized Officer phone number	

**The HSS-TA Team recommends using an NPI as opposed to an UMPI as some providers have run into issues with billing using an UMPI, particularly when using certain EHRs. Please note that you can still choose to use an UMPI.*

We also recommend reaching out to your agency's **managing employees, owners, and/or board members** as early in the HSS provider enrollment process as possible to collect the following information. *Please note that this information is required for managing employees, owners, and board members, but only managing employees and owners need to have a background study completed. DHS requires this information to complete Form DHS-5259, or the Owners / Authorized Persons section of the MPSE Portal if applying via MPSE Portal.*

- Full legal name (first, middle, and last) — *must include full middle name, or indicate that the individual does not have a middle name*
- Social security number
- Date of birth
- Home address (street, city, state, zip code, county)
- Hire date
- Termination date (if applicable)
- Relationship to any other managing employees, owners, or board members (spouse, child, parent, sibling)
- Whether they have an ownership or control interest in any other Medicaid-disclosing entity

OPTION 1: ONLINE ENROLLMENT VIA THE MPSE PORTAL

The first option is to enroll online using the MPSE Portal. Unlike with the fax option, this option allows you to confirm that your application has been submitted and received.

Prior to completing the HSS provider enrollment process, your agency will need to decide whether you would prefer to use an NPI or UMPI. **The HSS-TA Team recommends using an NPI as opposed to an UMPI** as some providers have run into issues with billing using an UMPI, particularly when using certain EHRs. NPI numbers can be obtained via the NPPES Portal and are generally assigned the same day of application. If your organization (or a different department within your organization) has obtained an NPI in the past, you may need to identify the NPI admin within your organization for assistance with applying for a new NPI for your HSS program. This NPI Application guide from the California Department of Health Care Services goes through the step-by-step process of applying for an NPI in the NPPES Portal.

Required Paper Forms

For agencies enrolling via the MPSE Portal, please note that the following PDF forms must be completed and uploaded to the MPSE Portal:

- For the most up-to-date forms, visit the DHS eDocs library.
- DHS-4138 - MHCP Provider Agreement Form
- DHS-7618 - Home and Community-Based Settings Applicant Assurance Statement
- DHS-3891 - Request for Licensing Agency ID Number
- MHCP Fee Payment Confirmation
- If your agency plans to provide Housing Consultation Services: DHS-7968 - Housing Consultation Provider Assurance Statement
- If your agency plans to provide Housing Transition and Housing Sustaining Services: DHS-7967 - Housing Transition and Housing Sustaining Provider Assurance Statement

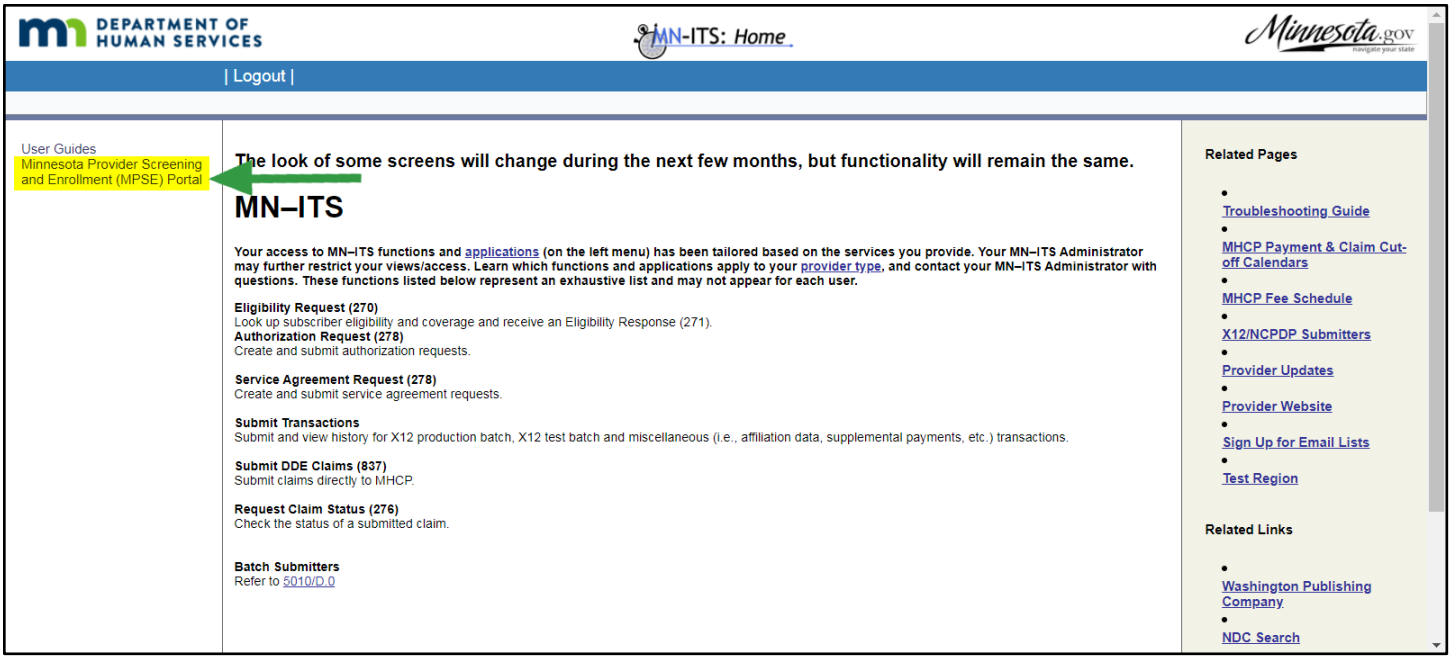
Completed and annotated examples of these forms are available later in this document under “Option 2: Enrollment via Fax.”

Accessing the MPSE Portal via MN-ITS

If you have never used the MN-ITS system before, follow the registration process for the MPSE Portal here. More information about the registration process is available here.

Existing providers who already have a MN-ITS account should already have access to the MPSE Portal within MN-ITS, highlighted in the screenshot on the following page. If you do not have an option to access the MPSE Portal once logged into MN-ITS, another staff at your agency needs to grant your account permission to access the MPSE Portal. If this is the case for you, please contact your agency’s MN-ITS administrator. The login page for the MN-ITS online system can be accessed here.

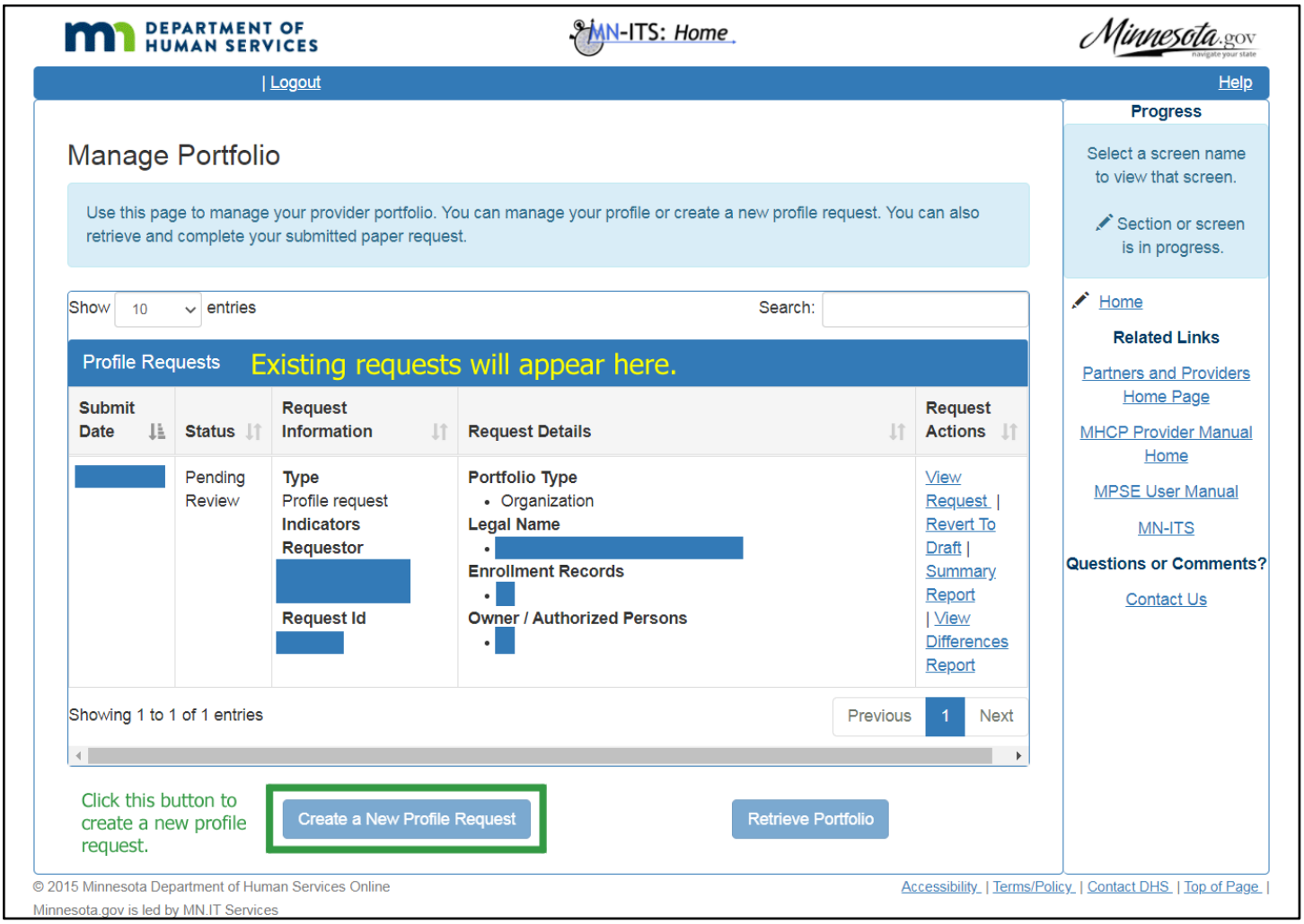
Once you are logged into MN-ITS, select “Minnesota Provider Screening and Enrollment (MPSE) Portal” in the left sidebar.



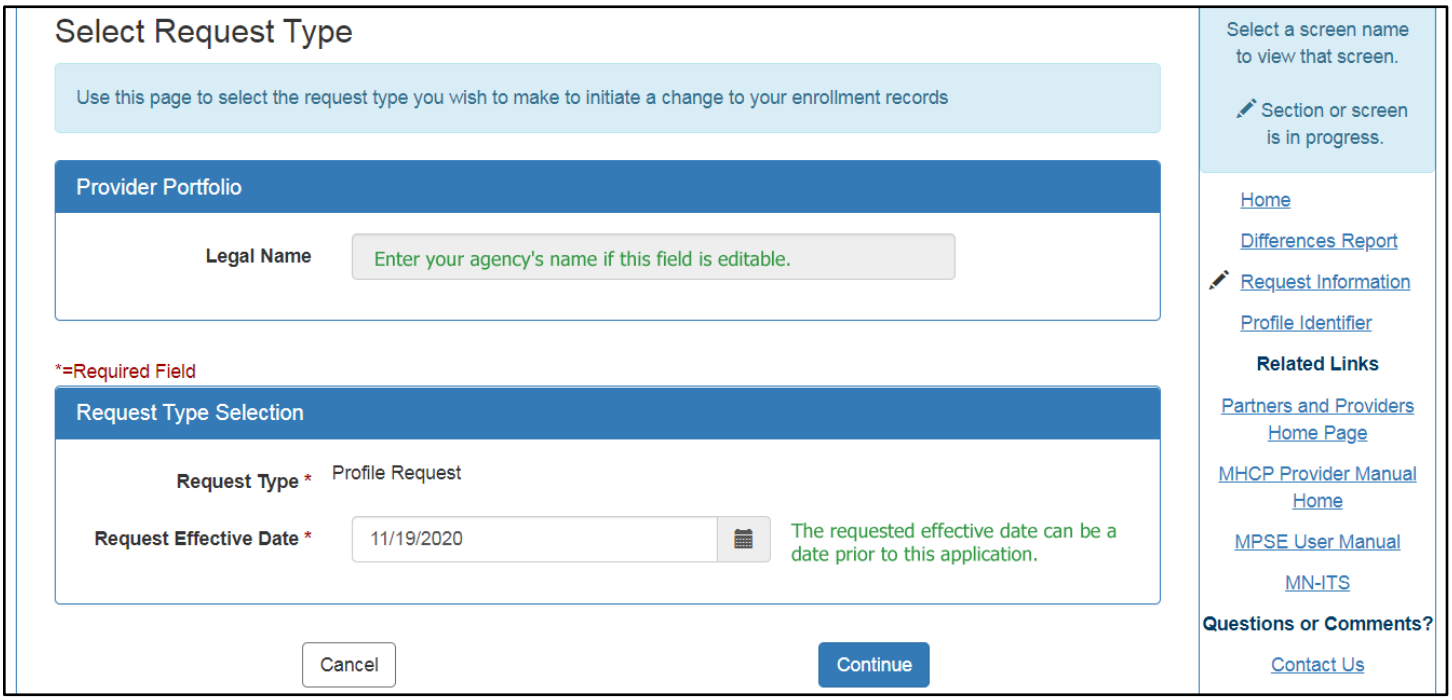
First Time MPSE Portal User: Getting Started: Creating a Profile Request

If your agency has already used the MPSE Portal in the past to create a profile request, skip this section and move onto the next section, "If You Have Used the MPSE Portal Before: Getting Started: Creating a New Enrollment Record Request." If this is your agency's first time using the MPSE Portal, follow the instructions below.

Once you have opened the MPSE Portal, you will see a screen similar to the one below. If you have never used the MPSE Portal before, click on "Create a New Profile Request" to begin the application to enroll as a HSS provider, as shown in the screenshot below.

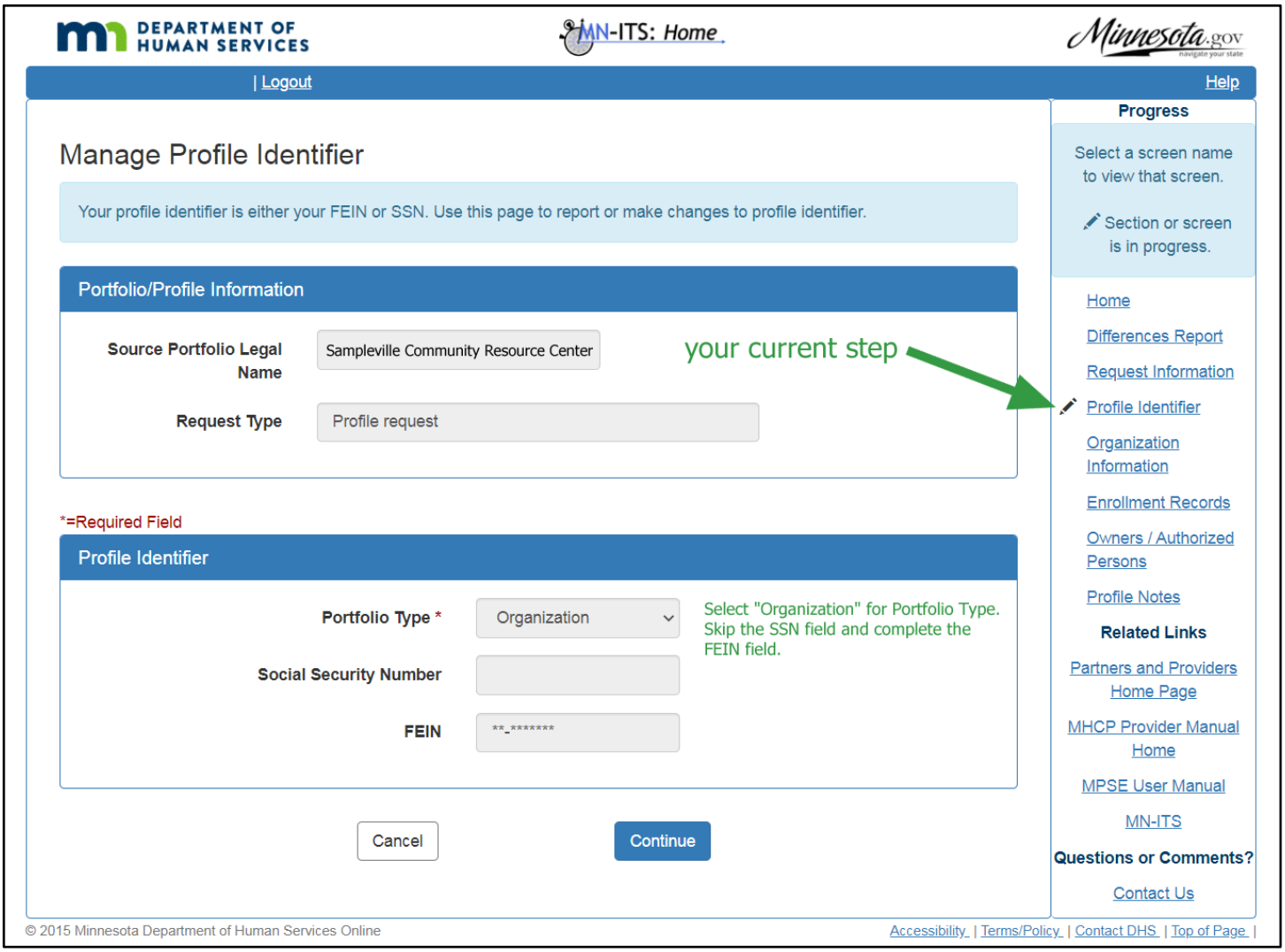


After selecting “Create a New Profile Request,” you will be taken to the “Select Request Type” page. If you have never used the MPSE Portal before, the portal will default to creating a Profile Request, where you will need to enter your agency’s legal name and FEIN, as shown in the following two screenshots. Please ensure that the request effective date that you select on this screen aligns with the request effective date indicated on your agency’s PDF HSS provider enrollment forms.

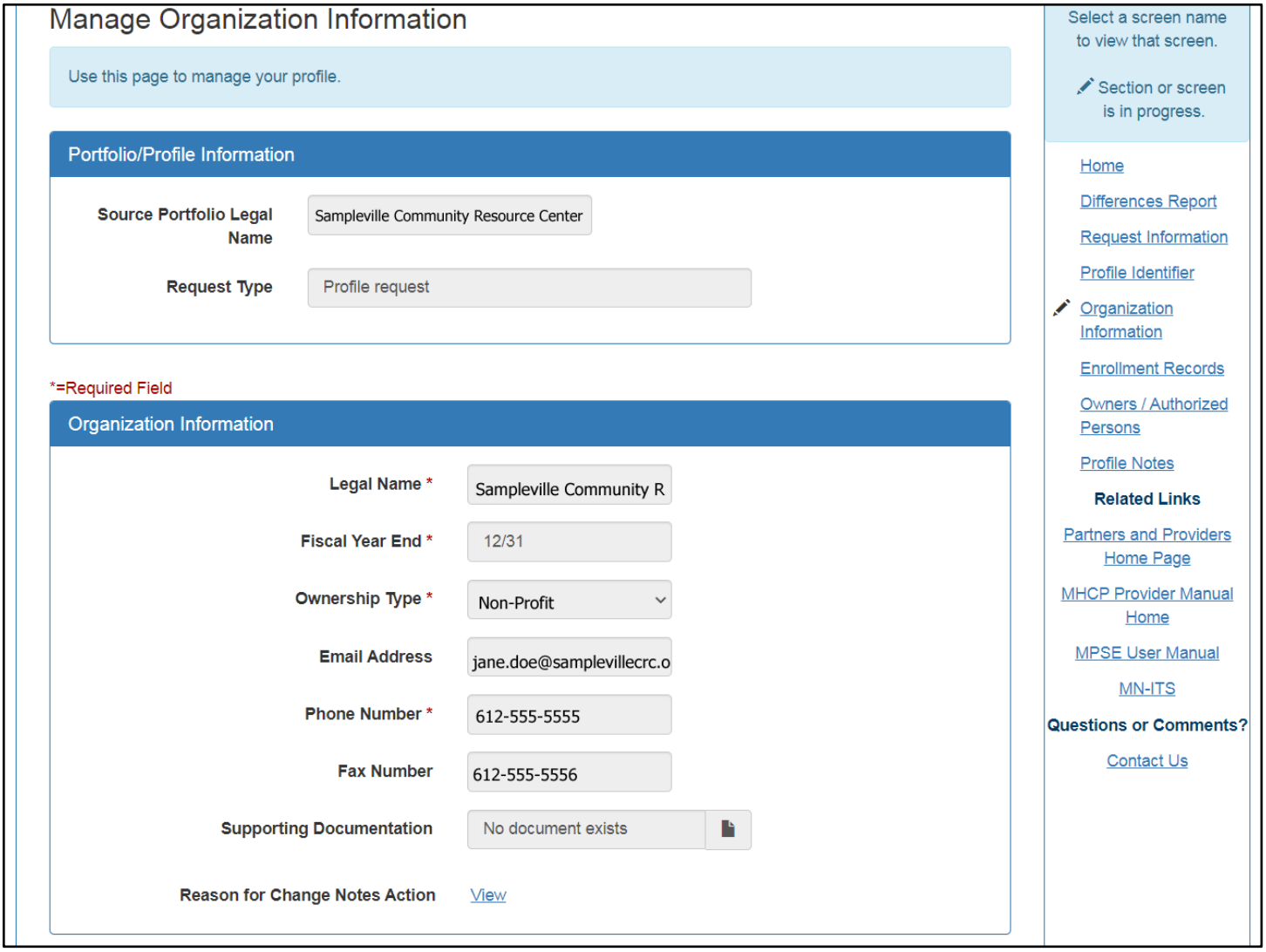


The next step is to complete the Profile Identifier section.

Note that once you are working on or viewing a profile request in the MPSE Portal, the right sidebar will display the various steps towards completing the request.

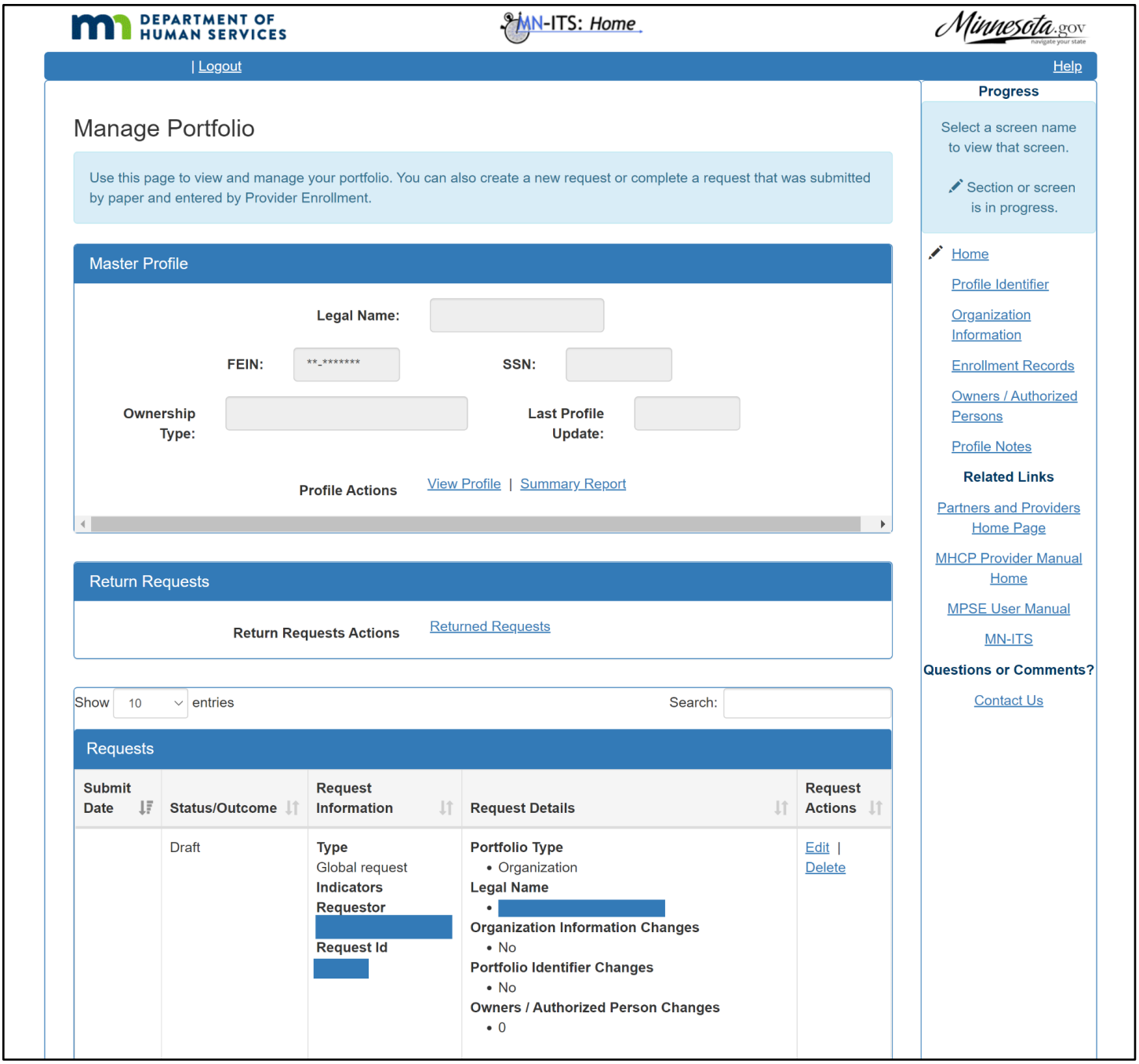


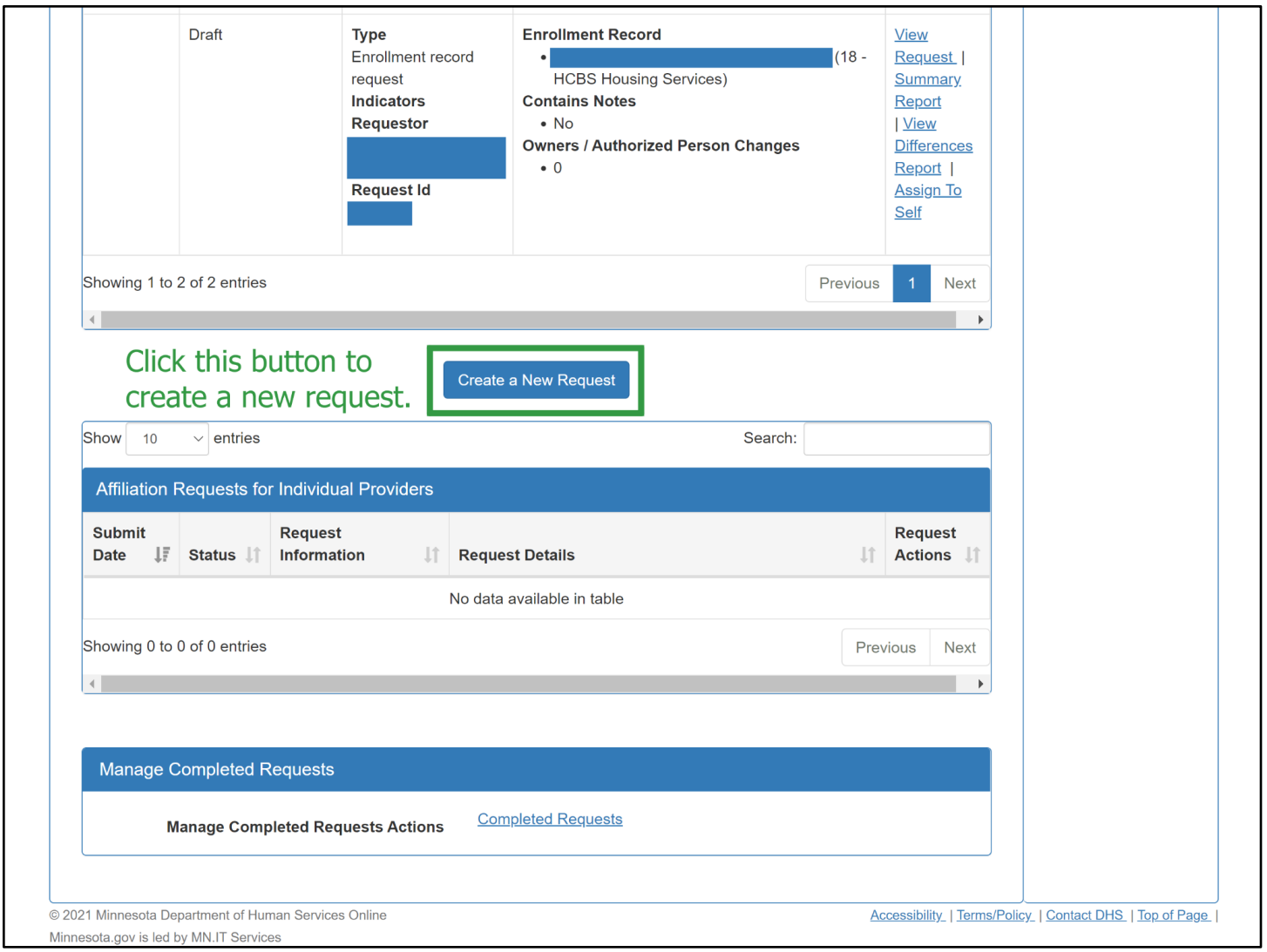
The next step is completing the Organization Information page. Fill out the fields as appropriate for your agency.



If You Have Used the MPSE Portal Before: Getting Started: Creating a New Enrollment Record Request

If you have used the MPSE Portal before, the home screen should look similar to the screenshot below. Select "Create a New Request" to get started with the HSS provider enrollment application.




Draft
Type
Enrollment record request
Indicators
Requestor
Request Id
Enrollment Record
(18 - HCBS Housing Services)
Contains Notes
No
Owners / Authorized Person Changes
0
View Request | Summary Report | View Differences Report | Assign To Self
Showing 1 to 2 of 2 entries
Previous
1
Next
Click this button to create a new request.
Create a New Request
Show 10 entries
Search:
Affiliation Requests for Individual Providers
Submit Date
Status
Request Information
Request Details
Request Actions
No data available in table
Showing 0 to 0 of 0 entries
Previous
Next
Manage Completed Requests
Manage Completed Requests Actions
Completed Requests
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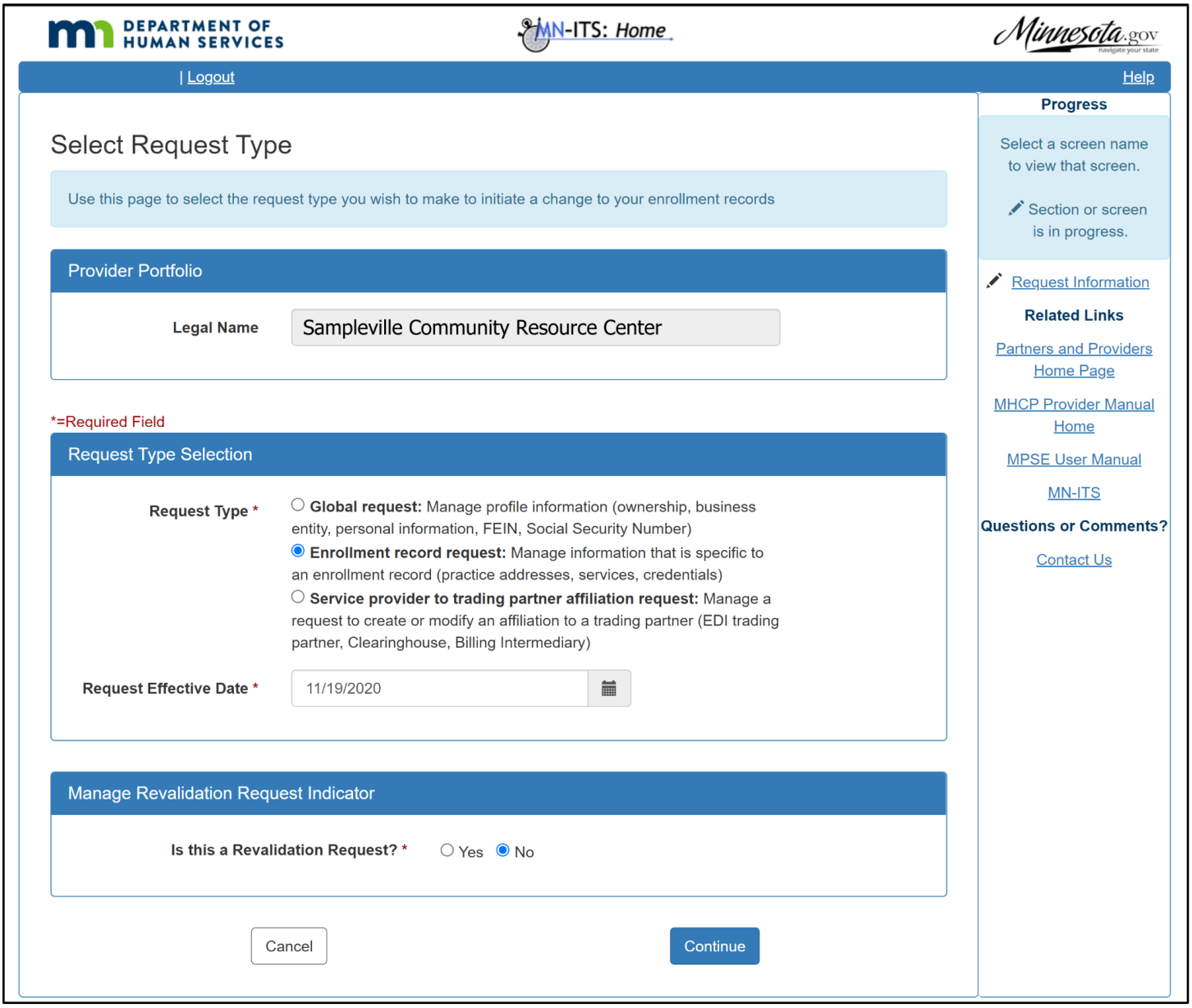
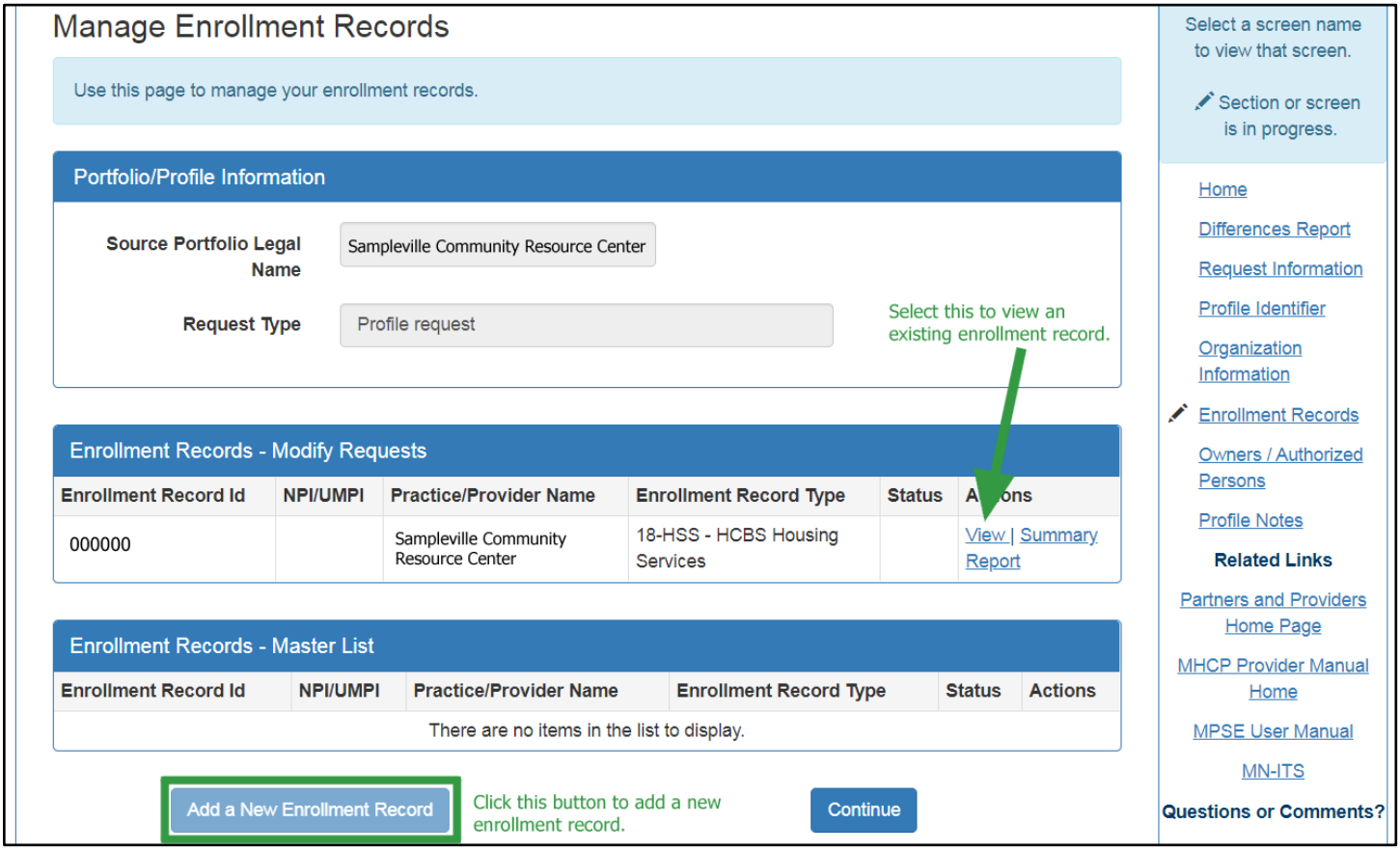
Once you select “Create a New Request,” select “Enrollment record request” for the request type. Please ensure that the request effective date that you select on this screen aligns with the request effective date indicated on your agency’s PDF HSS provider enrollment forms. For new HSS provider enrollment applications, select “No” for “Is this a Revalidation Request?”

As a side note, you can use the “Create a New Request” screen and select “Global request” if you ever need to update profile information about your agency, such as a change in agency ownership, business name, etc.

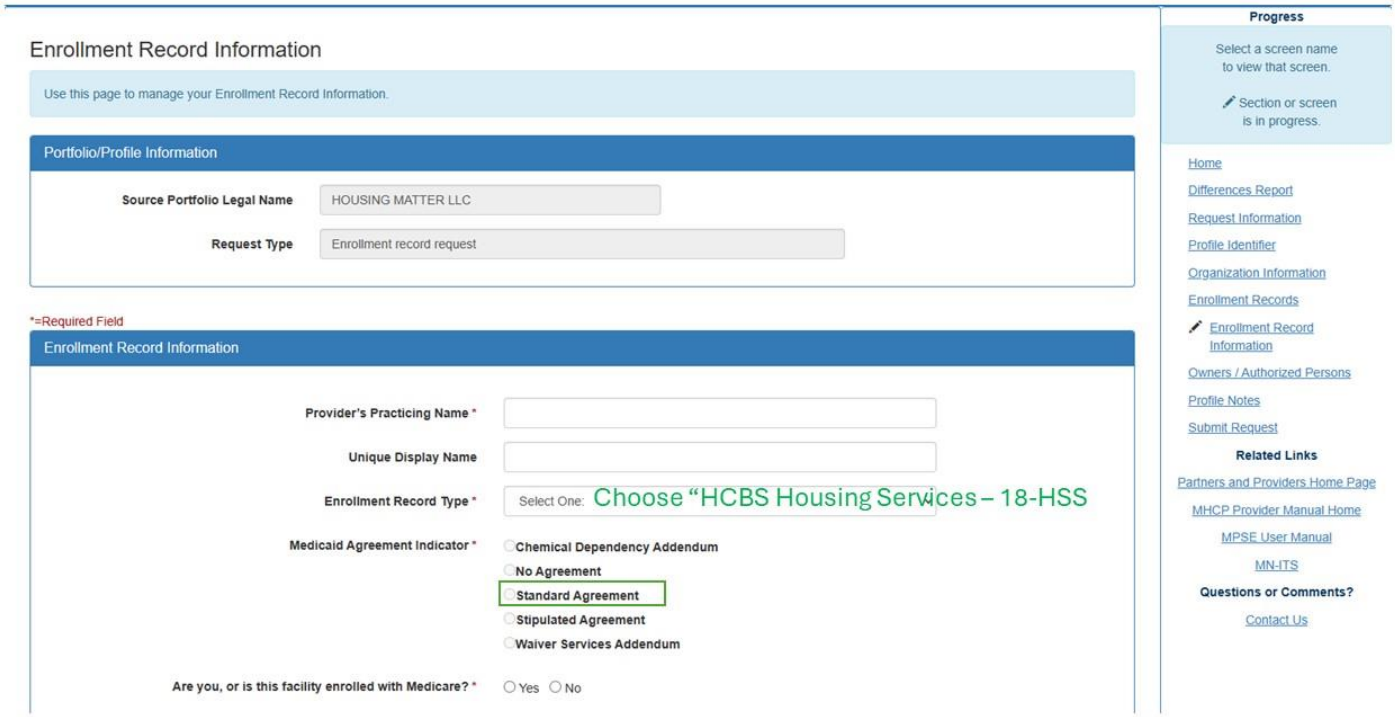


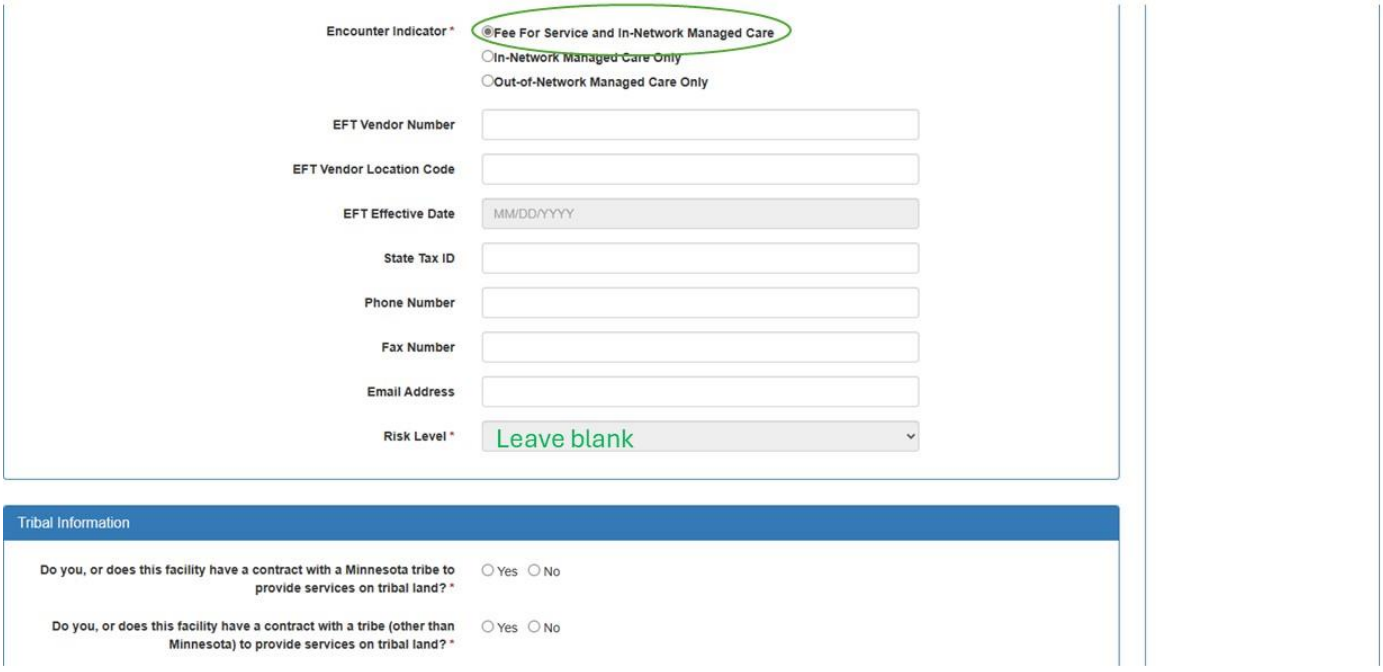
Enrollment Records

The next screen is the Manage Enrollment Records page, where you will see a list of existing enrollment records for your agency (if any). Select “Add a New Enrollment Record” at the bottom of the page. If you have already started to complete an enrollment record for HSS, select “View” or “Edit” in the “Actions” column for the corresponding enrollment record.

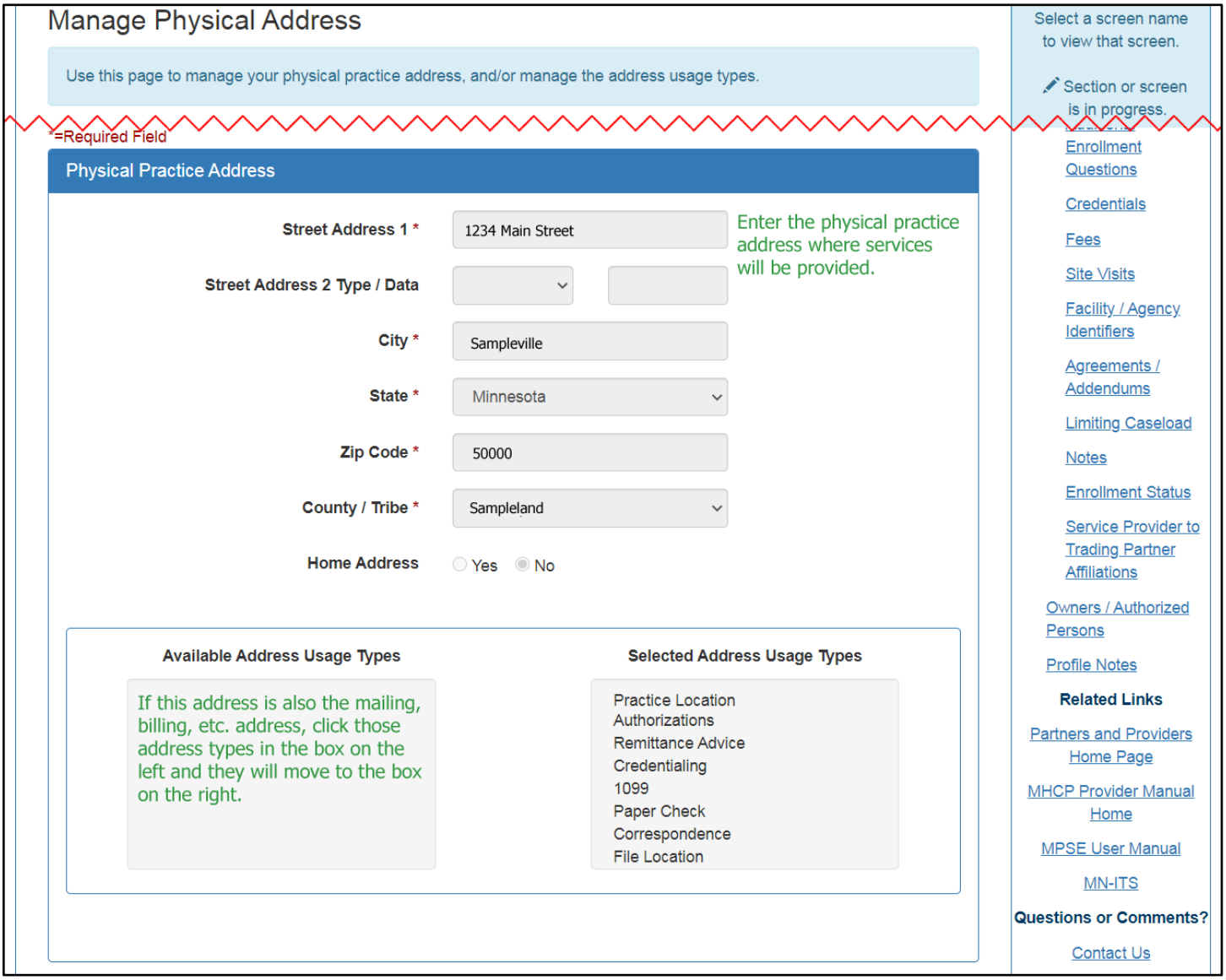


Next, complete the Enrollment Record Information page. Note that the right sidebar has now expanded to show the subsections of the Enrollment Records section.





The next subsection asks for the physical practice location of your agency.



* *The red zigzag line indicates where some content was cut from the screenshot.*

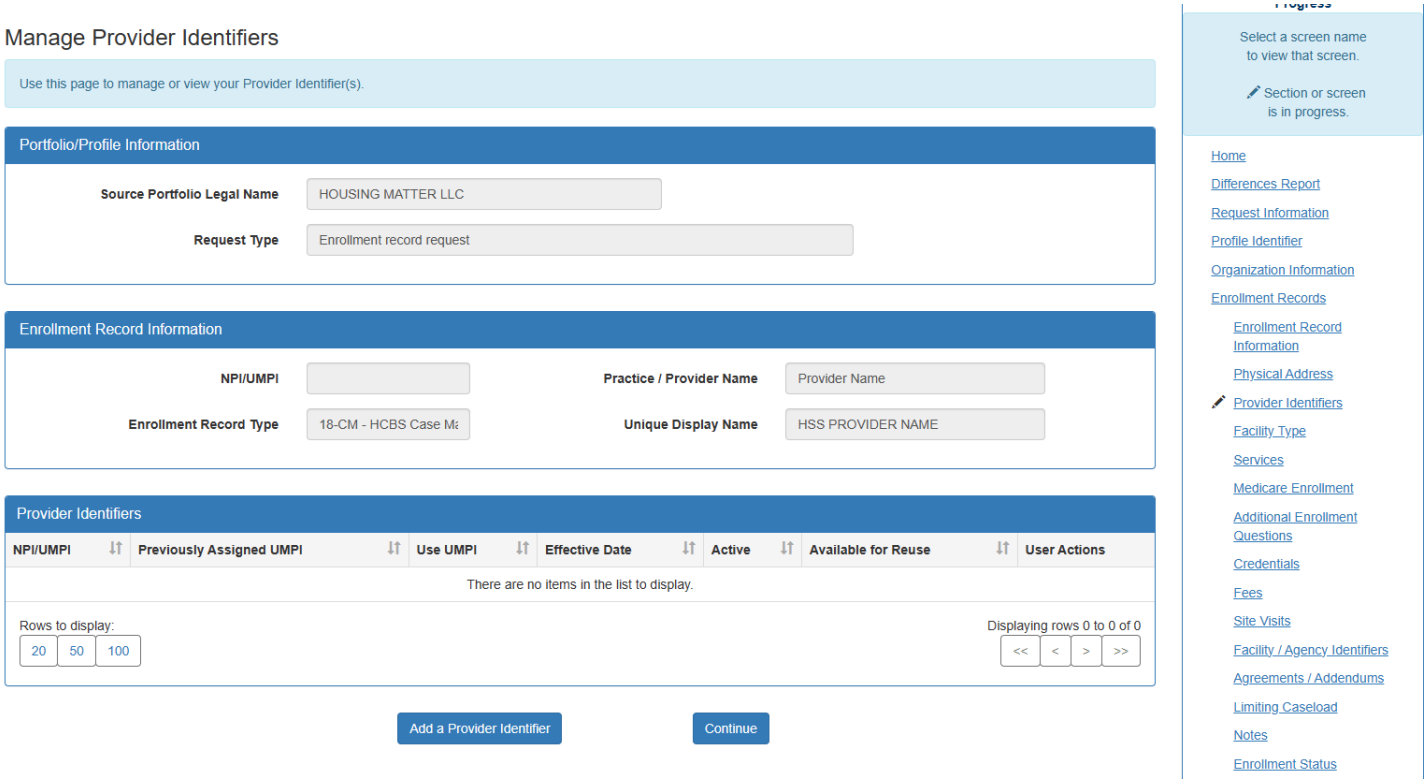
You can add different addresses on the next screen and select different address usage types as needed. For example, you can select to have your 1099s sent to one address and your paper checks to another.

The following subsection allows you to add Provider Identifiers.

If you plan to use a National Provider Identifier (NPI), select "No" to "Use UMPI," and enter the NPI in the "NPI/UMPI" text box.

If you plan to use a Unique Minnesota Provider Identifier (UMPI), select "Yes" for "Use UMPI" and leave the "NPI/UMPI" field blank, and DHS will assign your agency a UMPI for your HSS program. Please note that you cannot use an existing UMPI, but you can be assigned a new UMPI for your agency's HSS program.

Please select the effective date that you have been using throughout the application.



Manage Facility Type Information

This page shows this enrollment record's facility type information.

Portfolio/Profile Information

Source Portfolio Legal Name HOUSING MATTER LLC

Request Type Enrollment record request

Enrollment Record Information

NPI/UMPI

Practice / Provider Name Provider Name

Enrollment Record Type 18-CM - HCBS Case Ma

Unique Display Name HSS PROVIDER NAME

Facility Type Information

Facility Type	Start Date	End Date	User Actions
There are no items in the list to display.			

Rows to display: 20 50 100

Displaying rows 0 to 0 of 0 << < > >>

Add Facility Type Continue

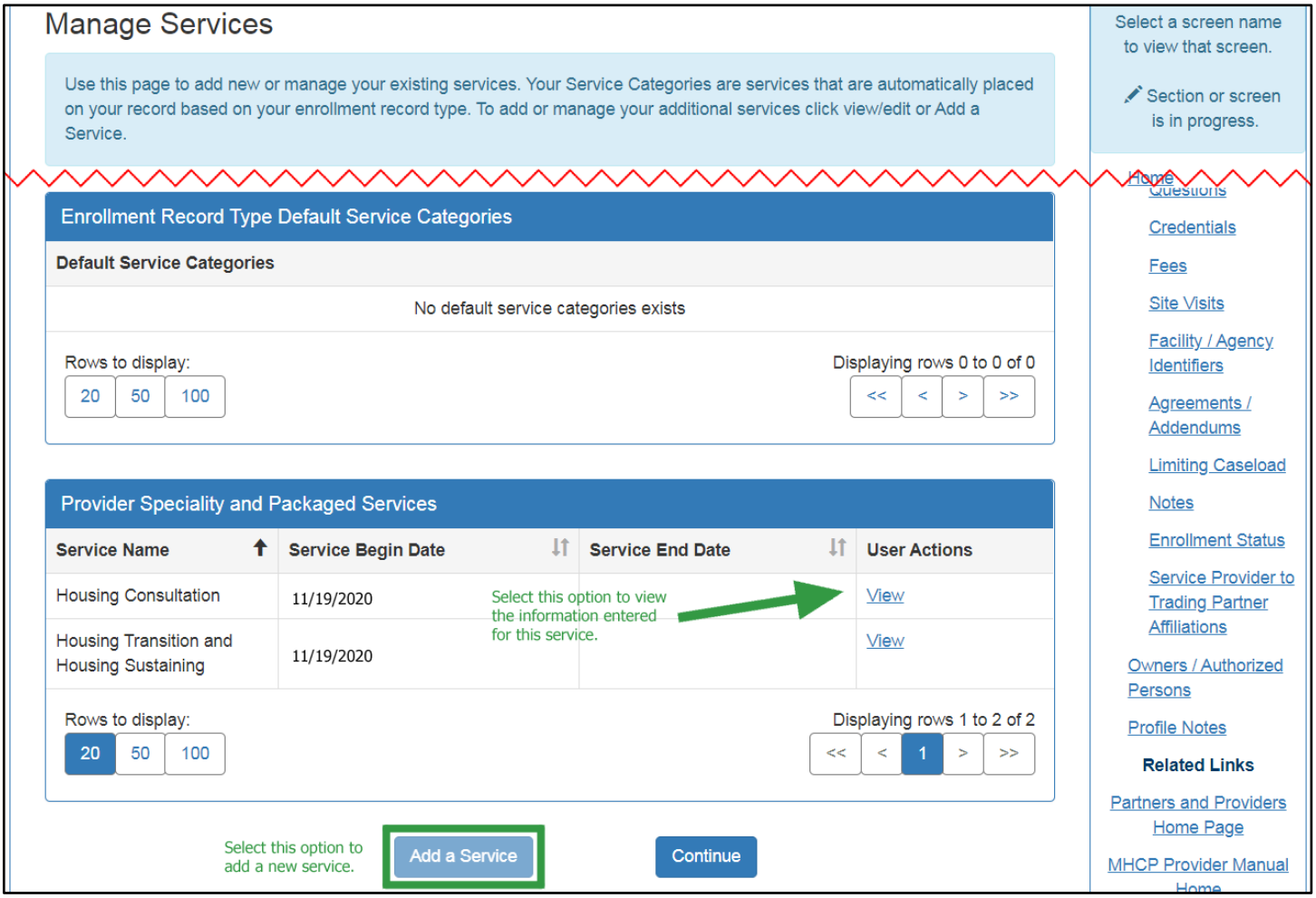
Progress

Select a screen name to view that screen.

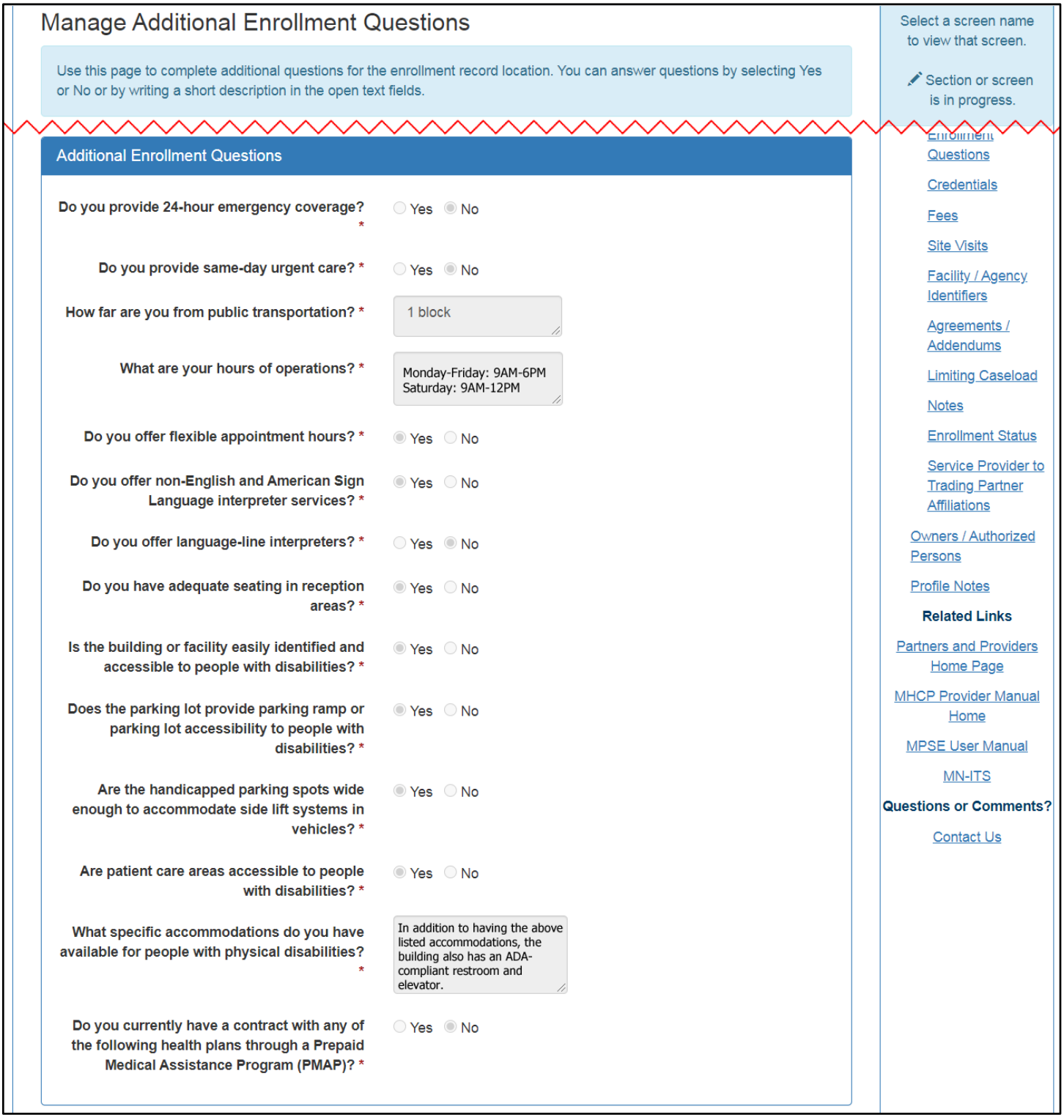
Section or screen is in progress.

- Home
- Differences Report
- Request Information
- Profile Identifier
- Organization Information
- Enrollment Records
  - Enrollment Record Information
  - Physical Address
  - Provider Identifiers
  - Facility Type
  - Services
  - Medicare Enrollment
  - Additional Enrollment Questions
  - Credentials
  - Fees
  - Site Visits
  - Facility / Agency Identifiers
  - Agreements / Addendums
  - Limiting Caseload
  - Notes
  - Enrollment Status

The next subsection, Manage Services, is where you indicate whether your agency will be providing Housing Consultation, Housing Transition and Housing Sustaining, or both categories of HSS services. Select “Add a Service” to add a new service (i.e., Housing Consultation and/or Housing Transition and Housing Sustaining), or select “View” next to the corresponding service in the Provider Speciality and Packaged Services table if you have already added the services and are making edits. When you add a new service, you need to select the service type and service begin date. Please select the effective date that you have been using throughout the application.



The next page asks additional enrollment questions. These questions do not affect whether DHS will approve or deny your agency's HSS provider enrollment application, but you must answer them. Please complete this section as appropriate for your agency.



Manage Additional Enrollment Questions

Use this page to complete additional questions for the enrollment record location. You can answer questions by selecting Yes or No or by writing a short description in the open text fields.

Additional Enrollment Questions

Do you provide 24-hour emergency coverage? *	○ Yes ◉ No
Do you provide same-day urgent care? *	○ Yes ◉ No
How far are you from public transportation? *	1 block
What are your hours of operations? *	Monday-Friday: 9AM-6PM Saturday: 9AM-12PM
Do you offer flexible appointment hours? *	◉ Yes ○ No
Do you offer non-English and American Sign Language interpreter services? *	◉ Yes ○ No
Do you offer language-line interpreters? *	○ Yes ◉ No
Do you have adequate seating in reception areas? *	◉ Yes ○ No
Is the building or facility easily identified and accessible to people with disabilities? *	◉ Yes ○ No
Does the parking lot provide parking ramp or parking lot accessibility to people with disabilities? *	◉ Yes ○ No
Are the handicapped parking spots wide enough to accommodate side lift systems in vehicles? *	◉ Yes ○ No
Are patient care areas accessible to people with disabilities? *	◉ Yes ○ No
What specific accommodations do you have available for people with physical disabilities? *	In addition to having the above listed accommodations, the building also has an ADA-compliant restroom and elevator.
Do you currently have a contract with any of the following health plans through a Prepaid Medical Assistance Program (PMAP)? *	○ Yes ◉ No

Select a screen name to view that screen.

Section or screen is in progress.

Enrollment Questions
Credentials
Fees
Site Visits
Facility / Agency Identifiers
Agreements / Addendums
Limiting Caseload
Notes
Enrollment Status
Service Provider to Trading Partner Affiliations
Owners / Authorized Persons
Profile Notes

Related Links

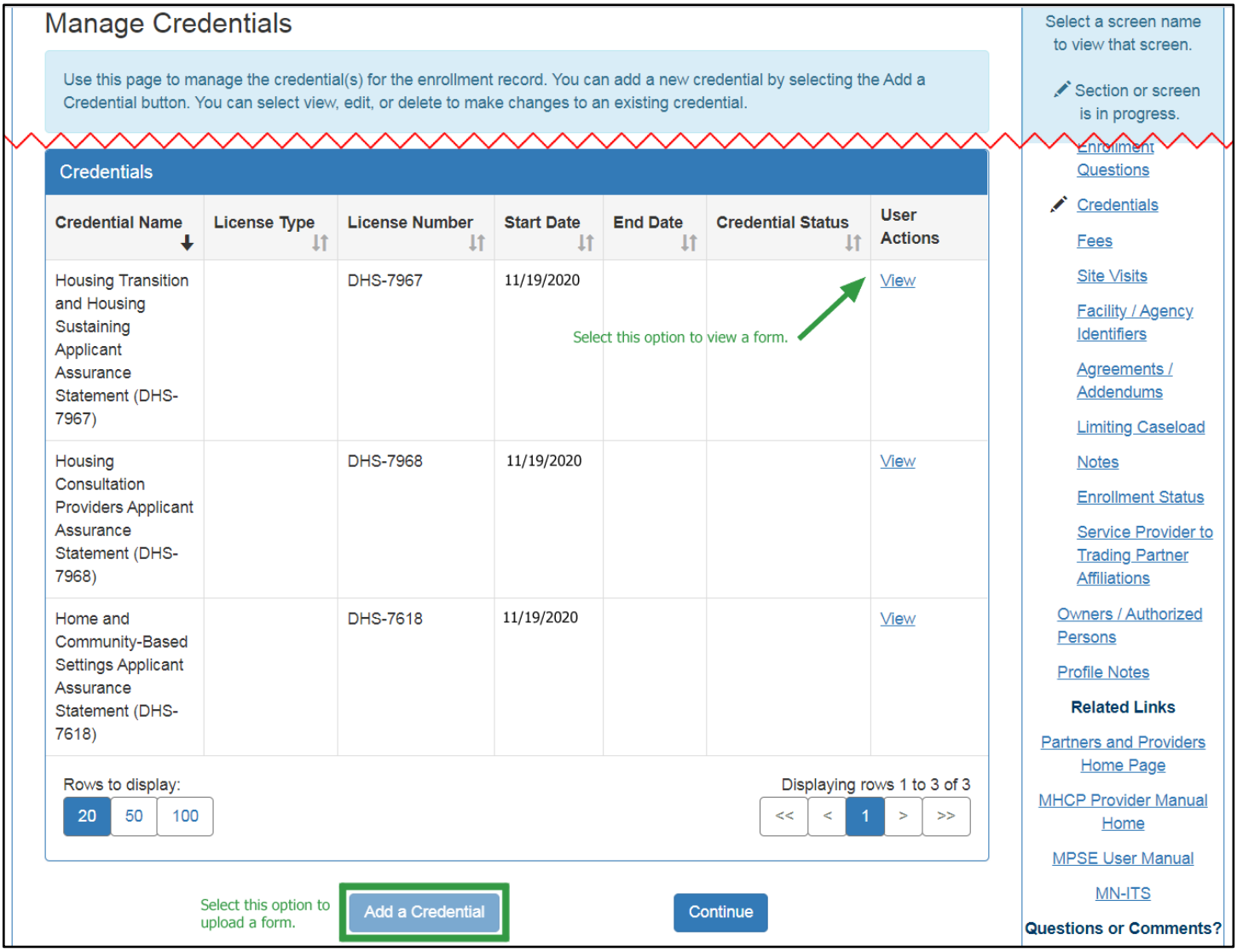
Partners and Providers Home Page
MHCP Provider Manual Home
MPSE User Manual
MN-ITS

Questions or Comments?

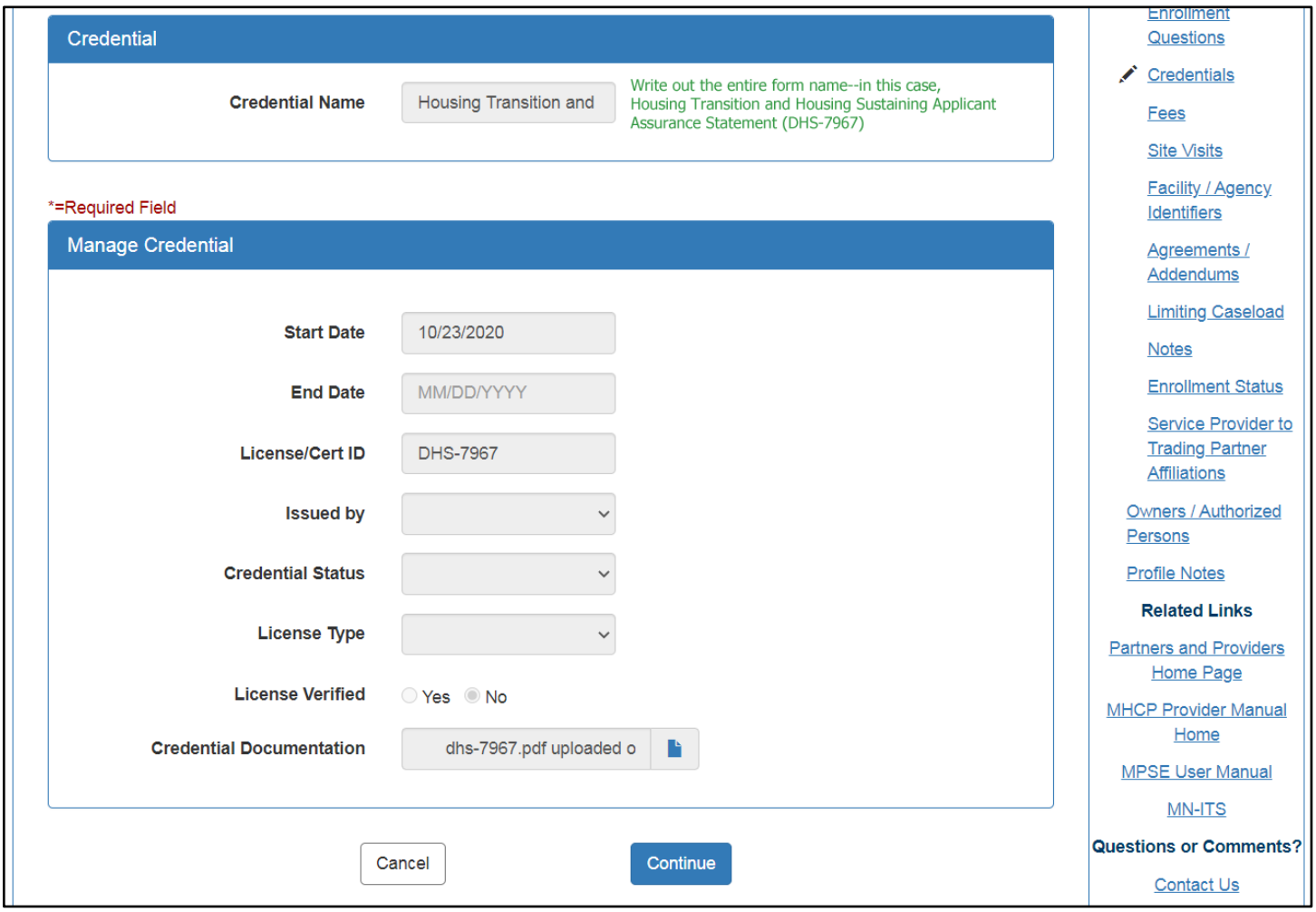
Contact Us

The next screen is the Manage Credentials page. In this subsection, you must upload Form DHS-7618 (Home and Community-Based Settings Applicant Assurance Statement). If you are providing Housing Transition and Housing Sustaining Services, upload Form DHS-7967. If you are providing Housing Consultation Services, upload Form DHS-7968. Completed and annotated examples of these three forms are available later in this document under "Option 2: Enrollment via Fax."

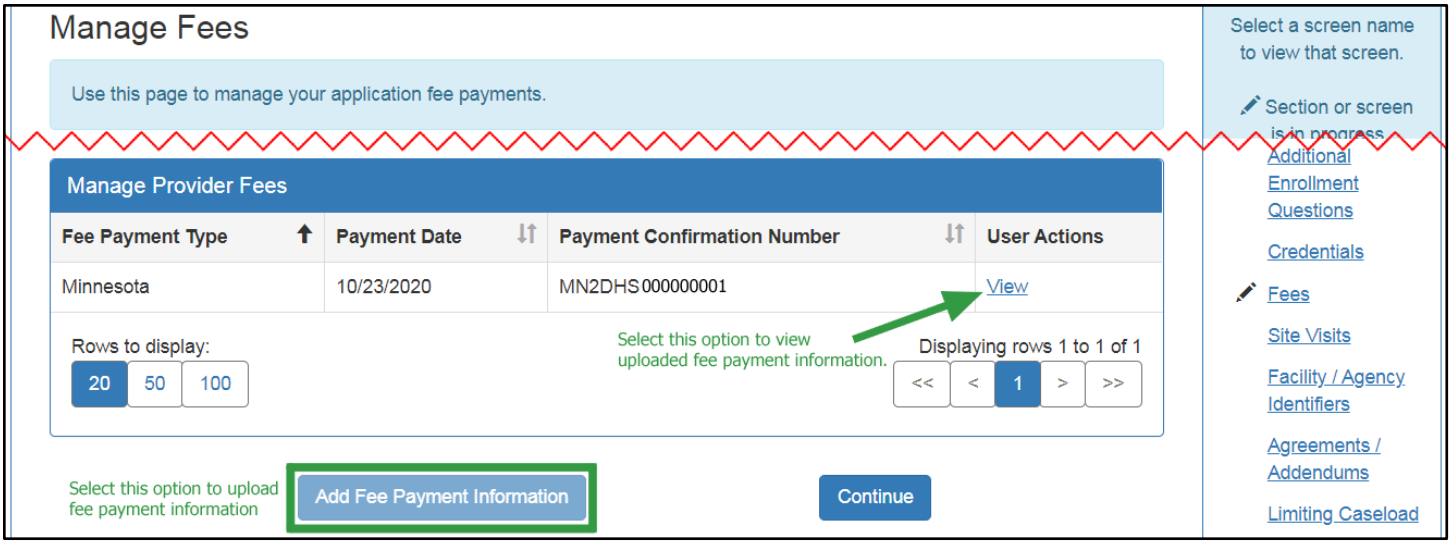
To add the forms, select "Add a Credential" and follow the prompts.



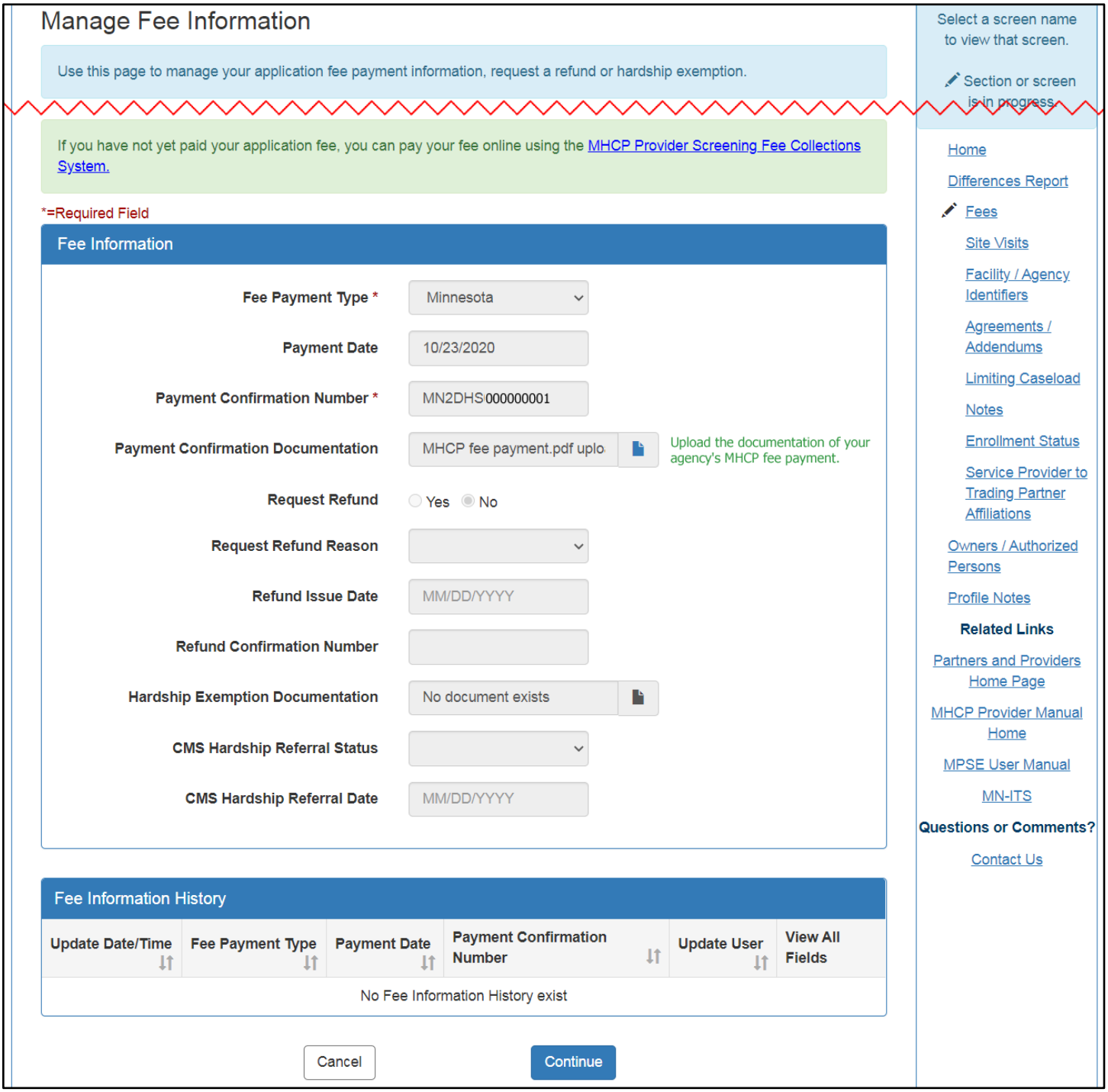
The following screenshot shows an example of the view mode for managing a credential.



The next screen displays fee payment information. To add fee payment information, select the button at the bottom of the page.

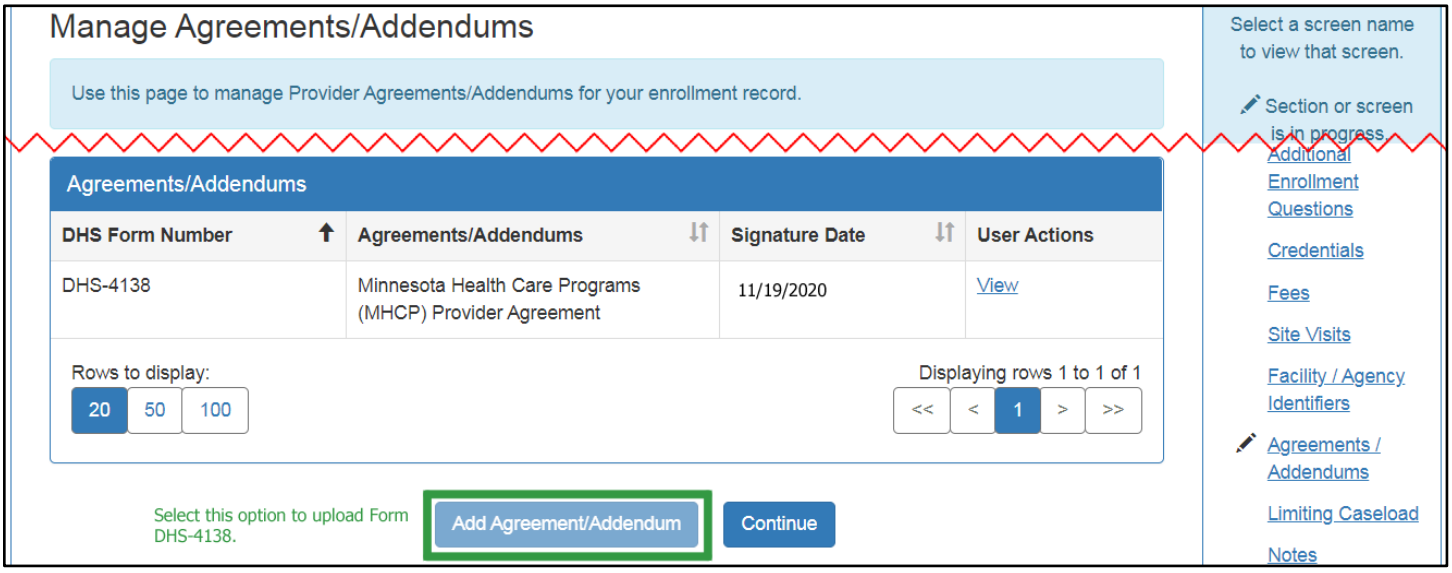


Upload documentation of your agency's MHCP fee payment and the payment confirmation number. Documentation would be a printout of payment confirmation, either from the MHCP Provider Screening Fee Collections System website immediately after paying, or an emailed receipt of payment.

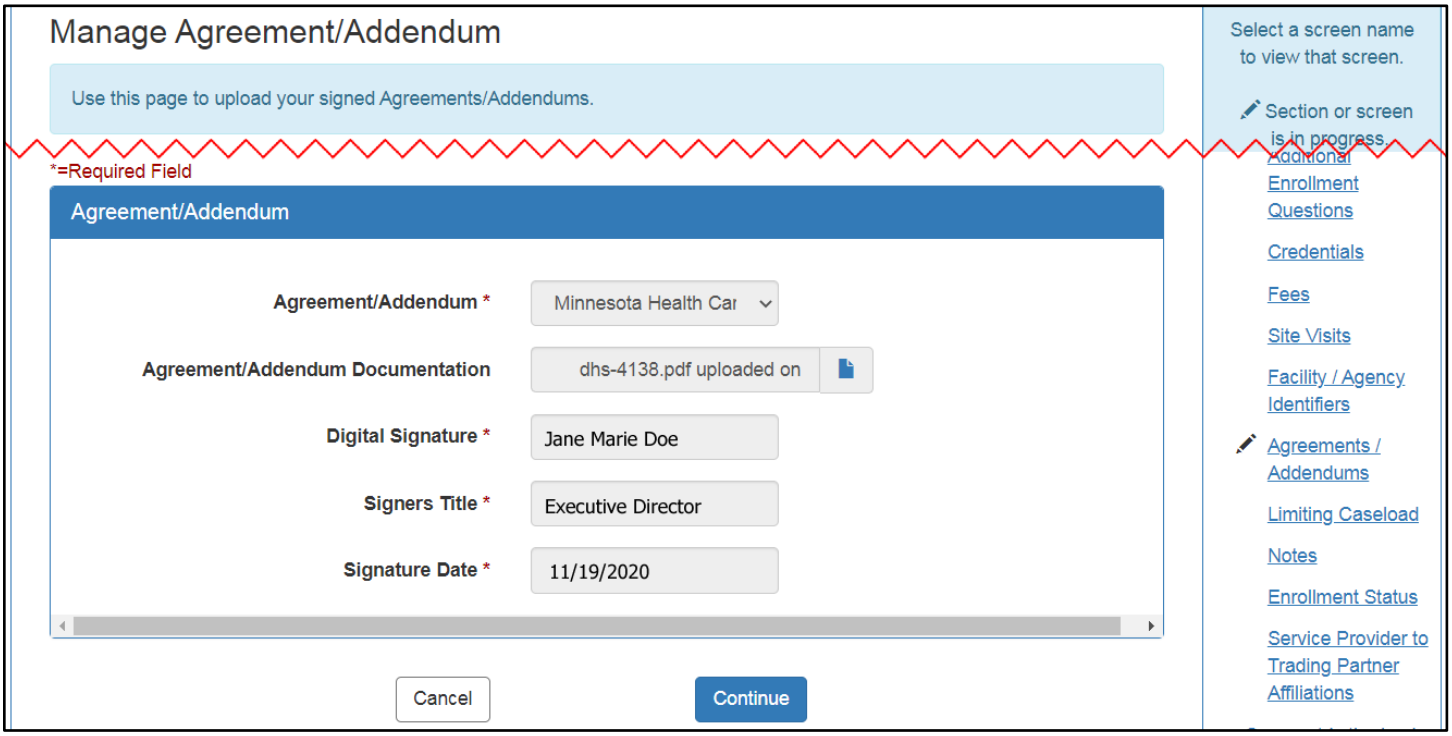


Skip the next two subsections, Site Visits and Facility / Agency Identifiers.

In the Agreements / Addendums subsection, upload Form DHS-4138, Minnesota Health Care Programs (MHCP) Provider Agreement. A completed and annotated example of this form is available later in this document under “Option 2: Enrollment via Fax.” Select “Add Agreement/Addendum” to upload the form.



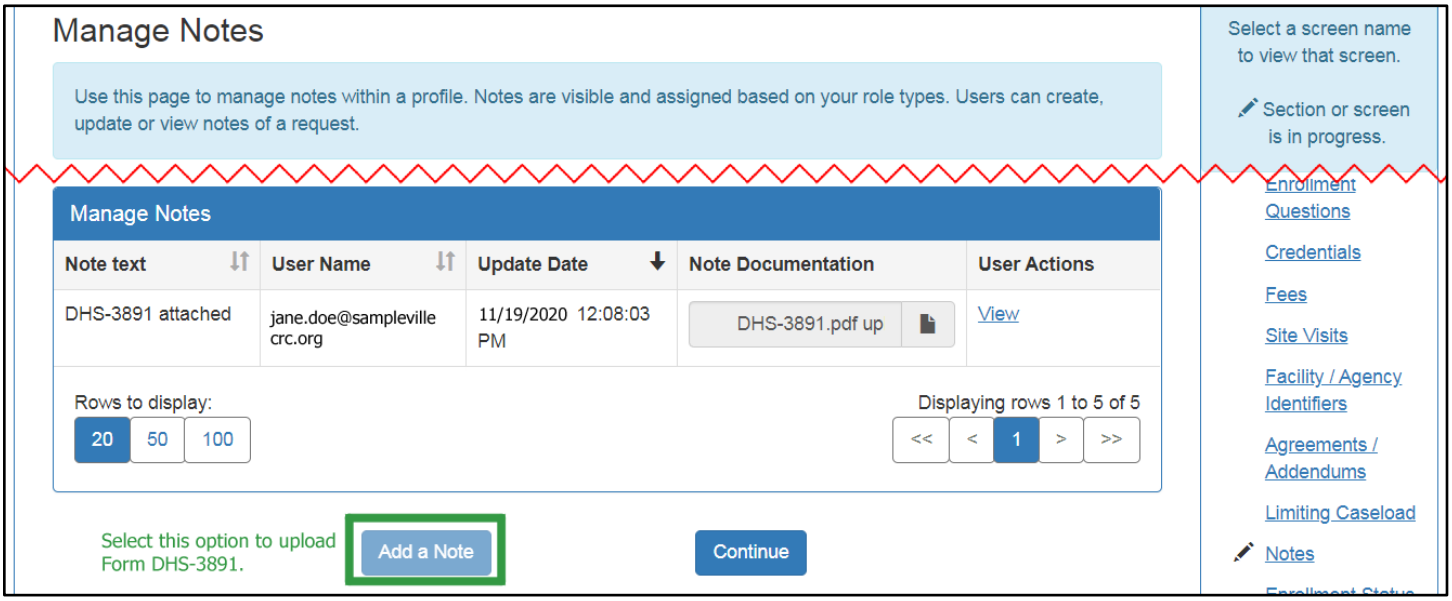
After clicking “Add Agreement/Addendum,” complete the next page. For the “Agreement/Addendum” field, select “Minnesota Health Care Programs (MHCP) Provider Agreement.” Upload Form DHS-4138 and complete the other fields.



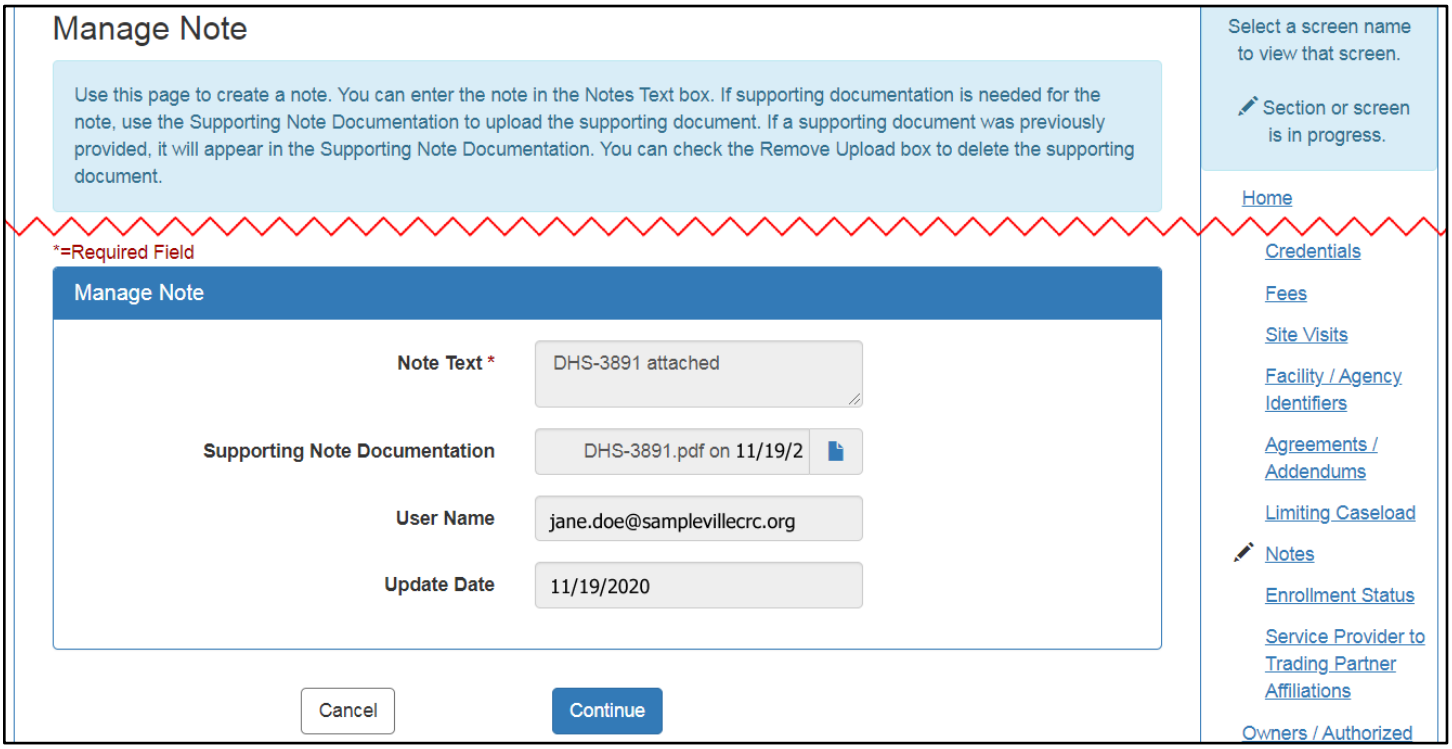
The next subsection is Limiting Caseload. Your agency does not need to complete this section.

The next subsection is Notes. In this section, upload Form DHS-3891 (Request for Licensing Agency ID Number). Select “Add a Note” to upload the documents. A completed and annotated example of this form is

available later in this document under “Option 2: Enrollment via Fax.” Please note that you will need to keep the owners / managers listed on this form up-to-date even after completing the provider enrollment process. Please update and resubmit this form in the MPSE Portal if the owners / managers of your agency change.



The next screenshot shows how to complete the form to upload the DHS forms in the Notes subsection.



Skip the next two subsections, Enrollment Status and Service Provider to Trading Partner Affiliations.

The sections you have completed thus far correspond to Form DHS-8018, Housing Stabilization Services Provider Enrollment Application. You do not need to complete the PDF version of this form if you are applying via MPSE Portal.

Owners / Authorized Persons

The next section is Owners / Authorized Persons, which corresponds to Form DHS-5259, Disclosure of Ownership and Control Interest of an Entity. You do not need to complete the PDF version of this form if you are applying via MPSE Portal.

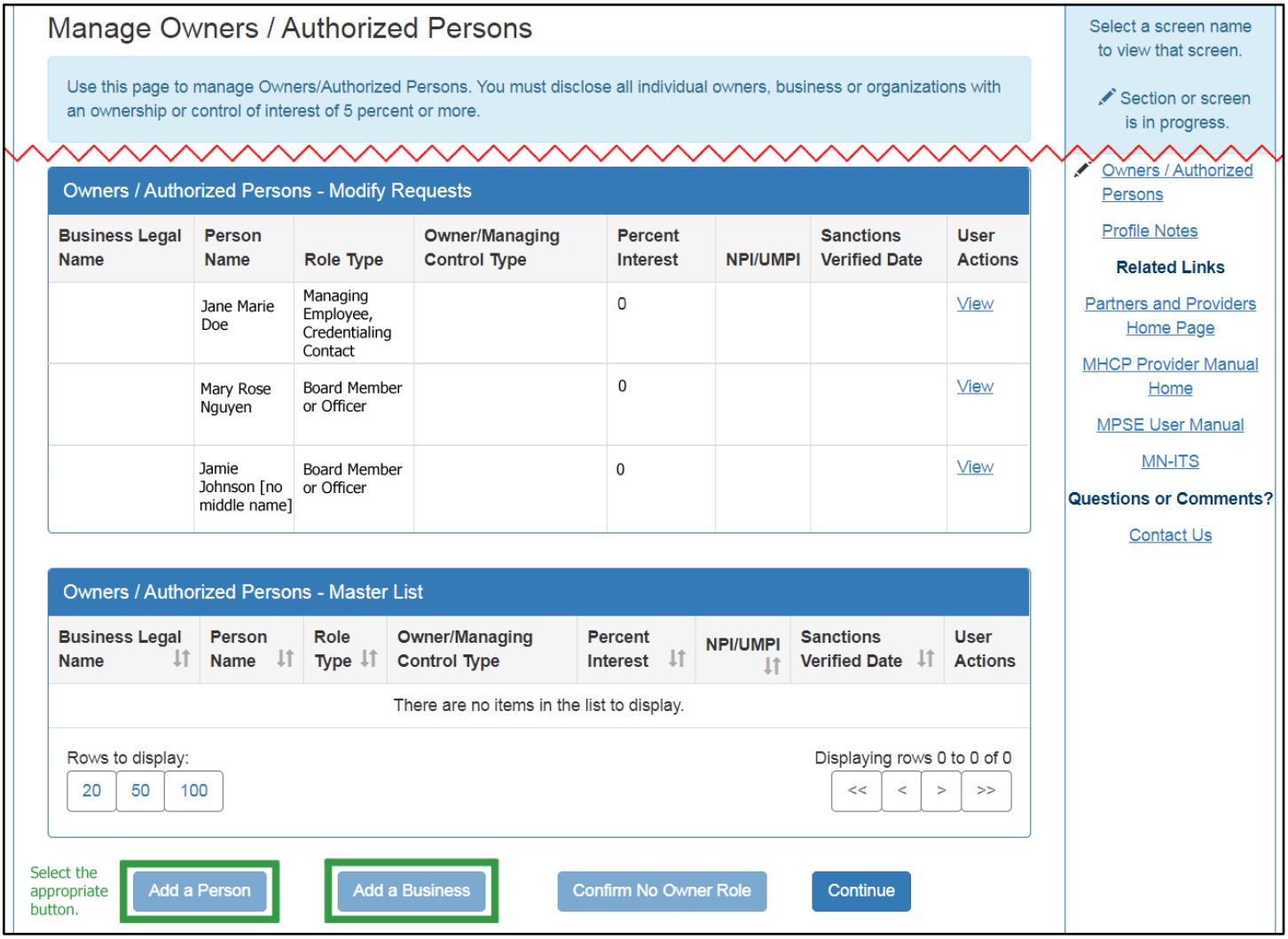
Each provider entity must complete the following sections for all people, businesses or organizations that meet any of the following criteria:

- Have an ownership or control interest of 5 percent or more in this disclosing entity
- Have an ownership or control interest in a subcontractor in which this disclosing entity has a direct or indirect ownership interest of 5 percent or more
- Are a managing employee (see definitions on page 5 of DHS-5259)

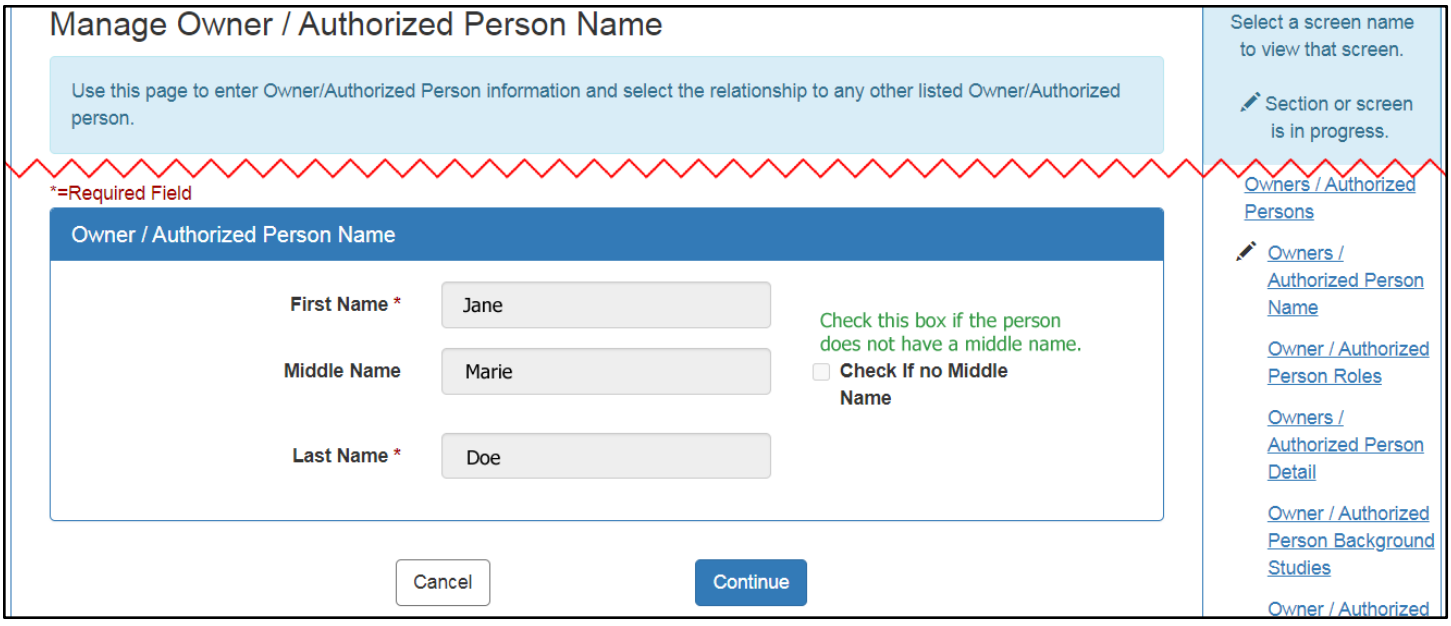
Please note that nonprofits should include board members and managing employees. If you have questions about who to include in this section, please contact DHS provider enrollment.

Please note that you will need to keep the owners / authorized persons listed in this section up-to-date, even after completing the provider enrollment process. If the owners / authorized persons for your agency change after you are an enrolled HSS provider, please update this section in the MPSE Portal.

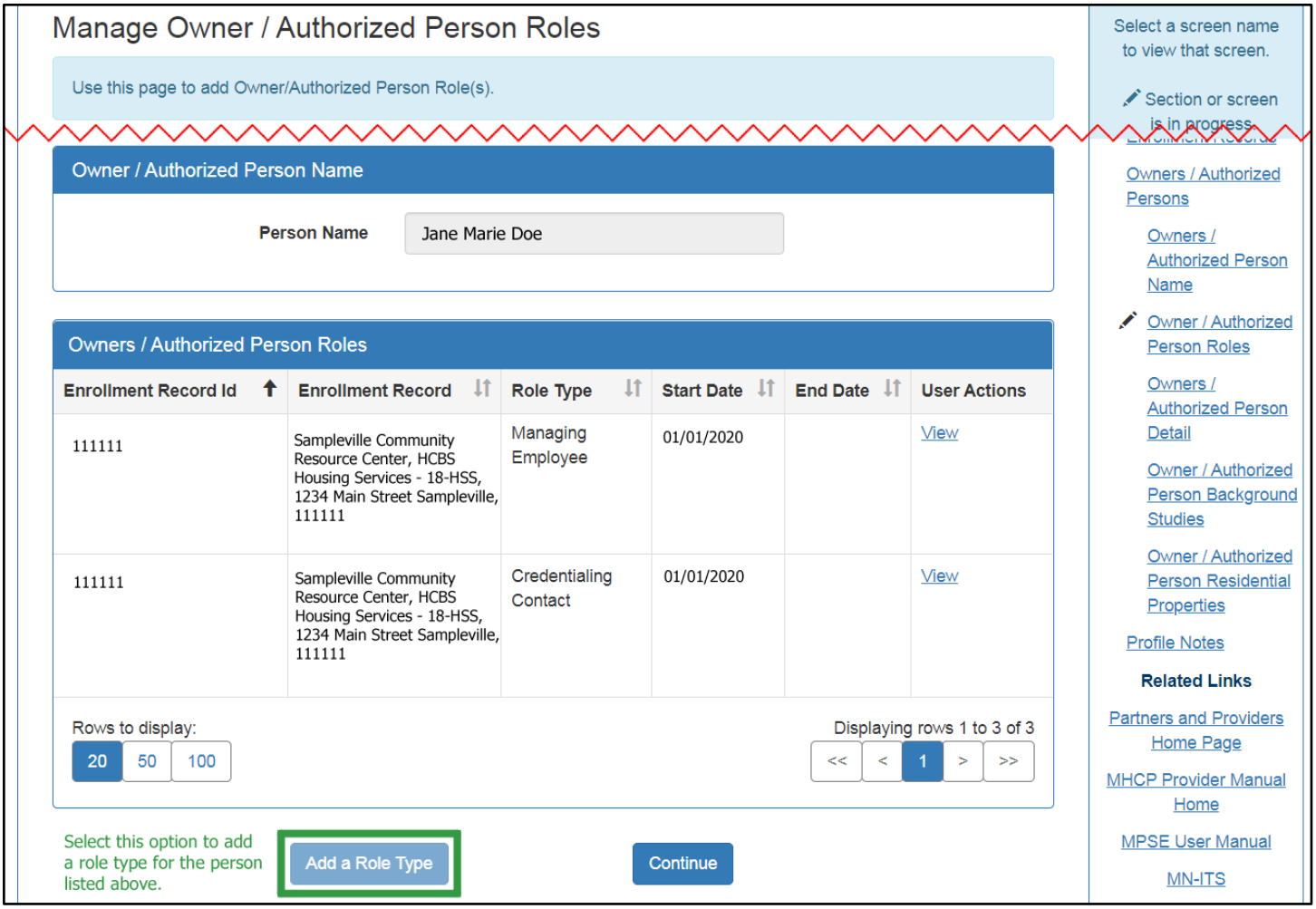
Select “Add a Person” (or “Add a Business” if applicable) to add entities as needed for your agency.



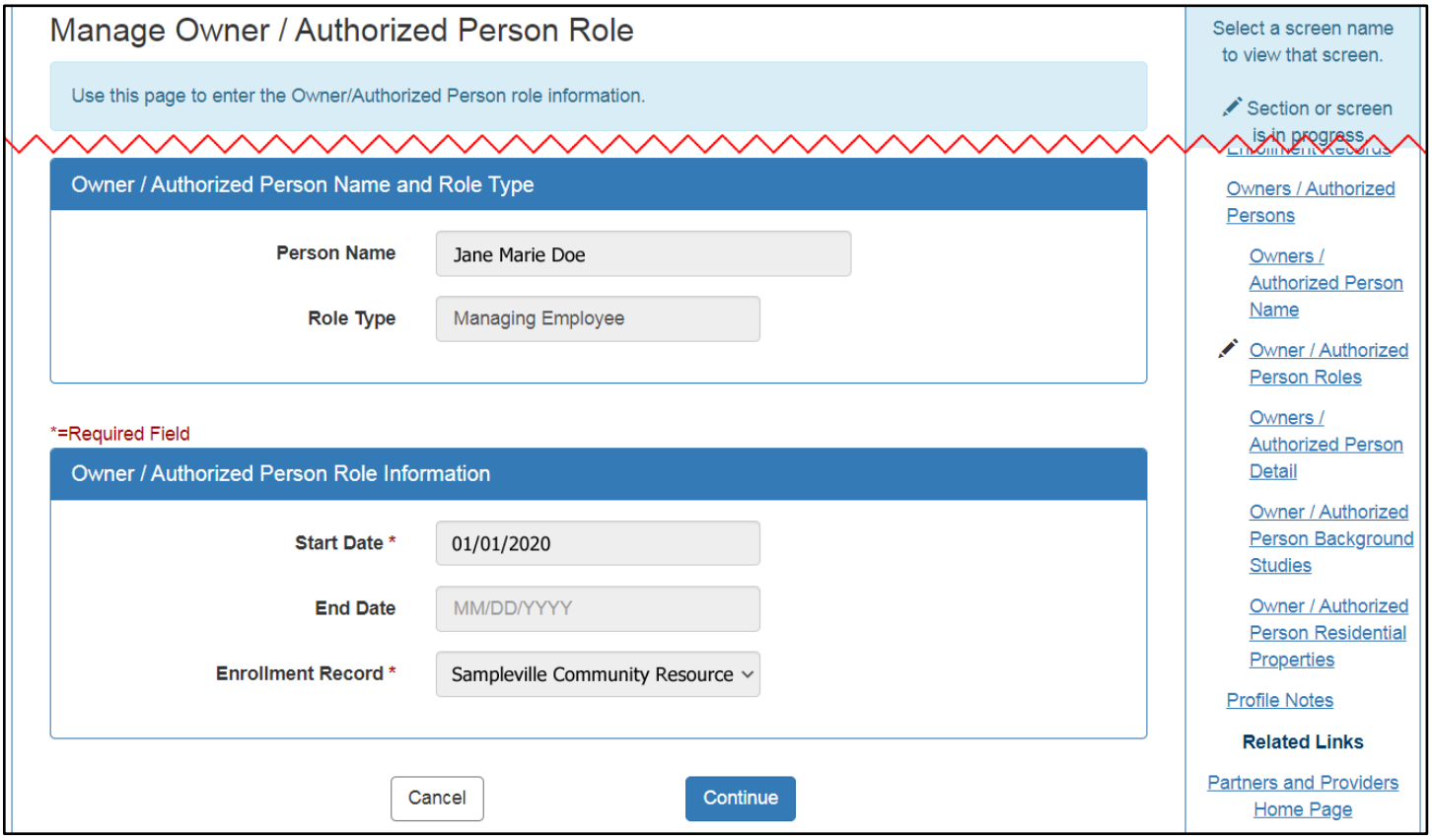
When you select “Add a Person,” the first page is for the Owner / Authorized Person’s name. You must include the person’s middle name if they have one. Please check the “Check if no middle name” box if the person does not have a middle name.



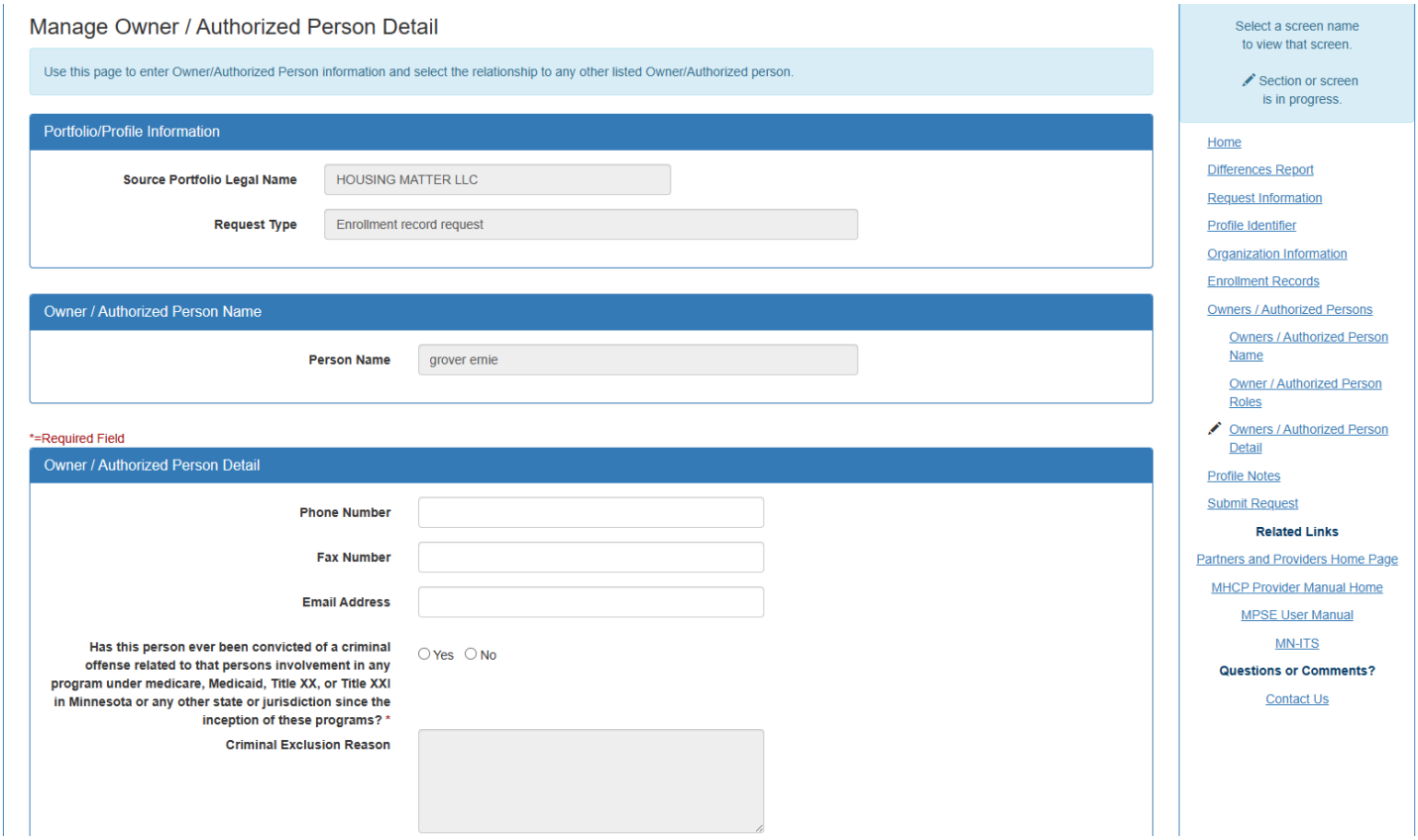
The next page allows you to add roles for that person. Select “Add a Role Type” to add a role. A person can be assigned multiple roles.

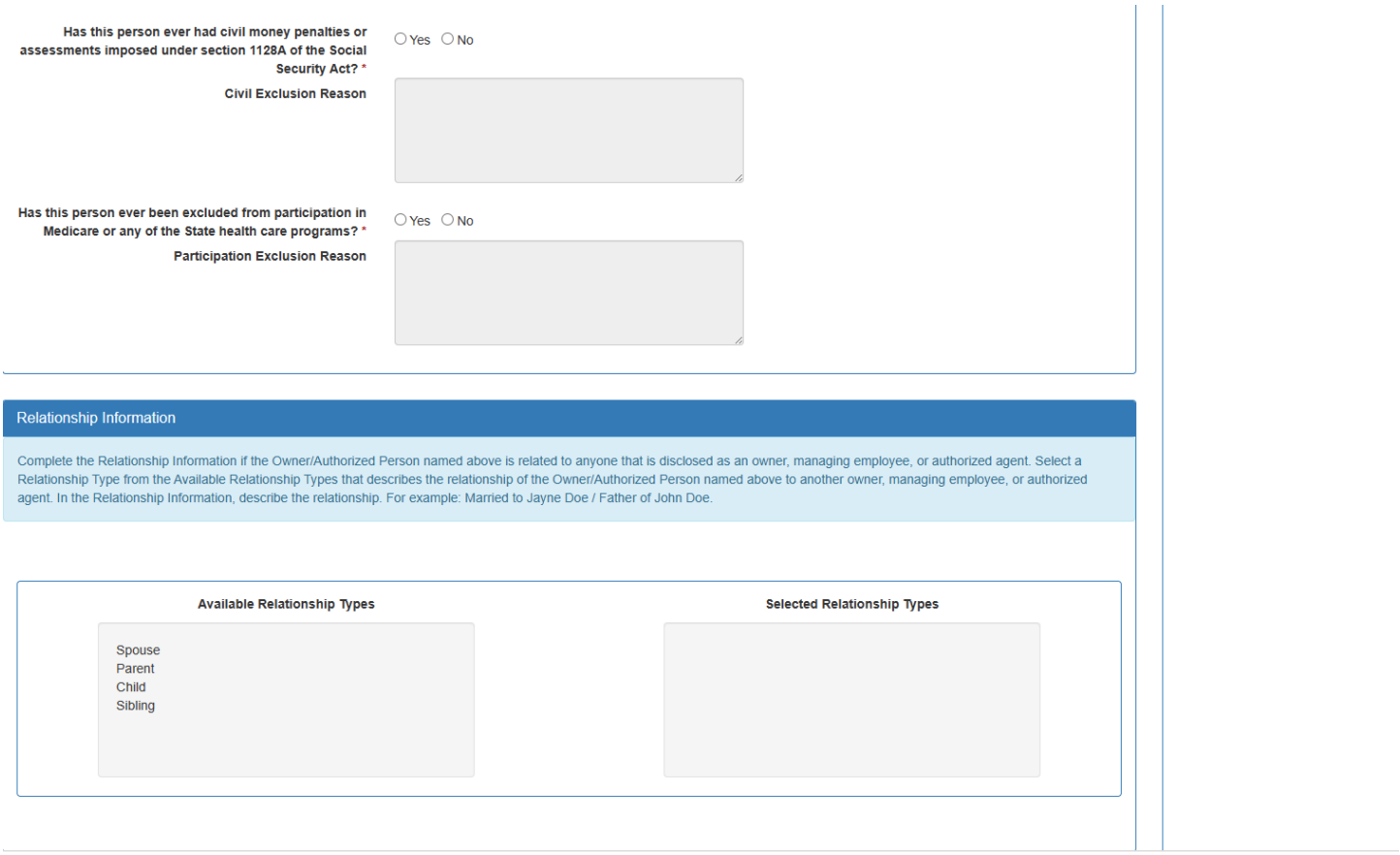


When adding a role, complete all required fields. Leave the end date field blank.



In the Owners / Authorized Person Detail subsection, fill out the required information for the individual. You will need to provide the person's date of birth, social security number, and home address. You will also need to answer the required questions in this section. If the person is related to another owner / authorized person as a spouse, parent, child, or sibling, you will need to indicate that in this section.





Skip the next subsection, Manage Owner / Authorized Person Background Studies.

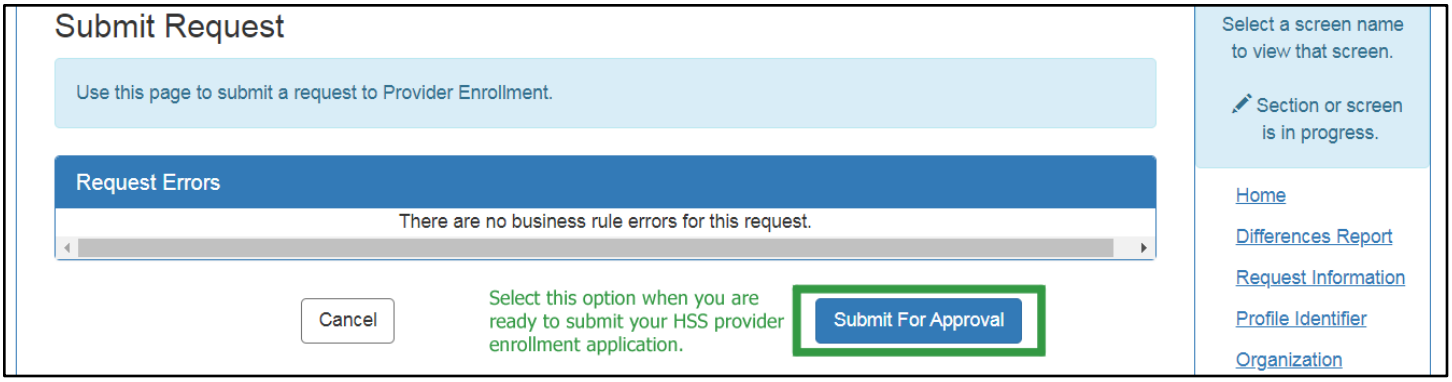
Only PCA providers need to complete the next subsection, Owner / Authorized Person Residential Properties.

Profile Notes

Skip the next section, Profile Notes.

Submit Request

The final section is Submit Request. Before submitting your request, make sure that there are no errors listed in the “Request Errors” box that need to be corrected. Once you are ready to submit your application, click “Submit For Approval” at the bottom of the Submit Request page.



After Initial DHS Review: Completing Background Studies and Resubmitting Your Application

After submitting your application, DHS will take up to 30 days to review it. After DHS has reviewed it, they will send your agency a MHCP Enrollment – Request for More Information letter with next steps, which will be uploaded to the MPSE Portal and sent via USPS mail. **You will not be notified via email.** This letter will assign a Facility ID/Agency ID for running background studies for your HSS program in NetStudy 2.0. Follow the directions in the letter to set up your agency's NETStudy 2.0 account. If your agency already has a NETStudy 2.0 account, you can request to add the newly assigned Facility ID/Agency ID for your agency's HSS program to your existing NETStudy 2.0 account.

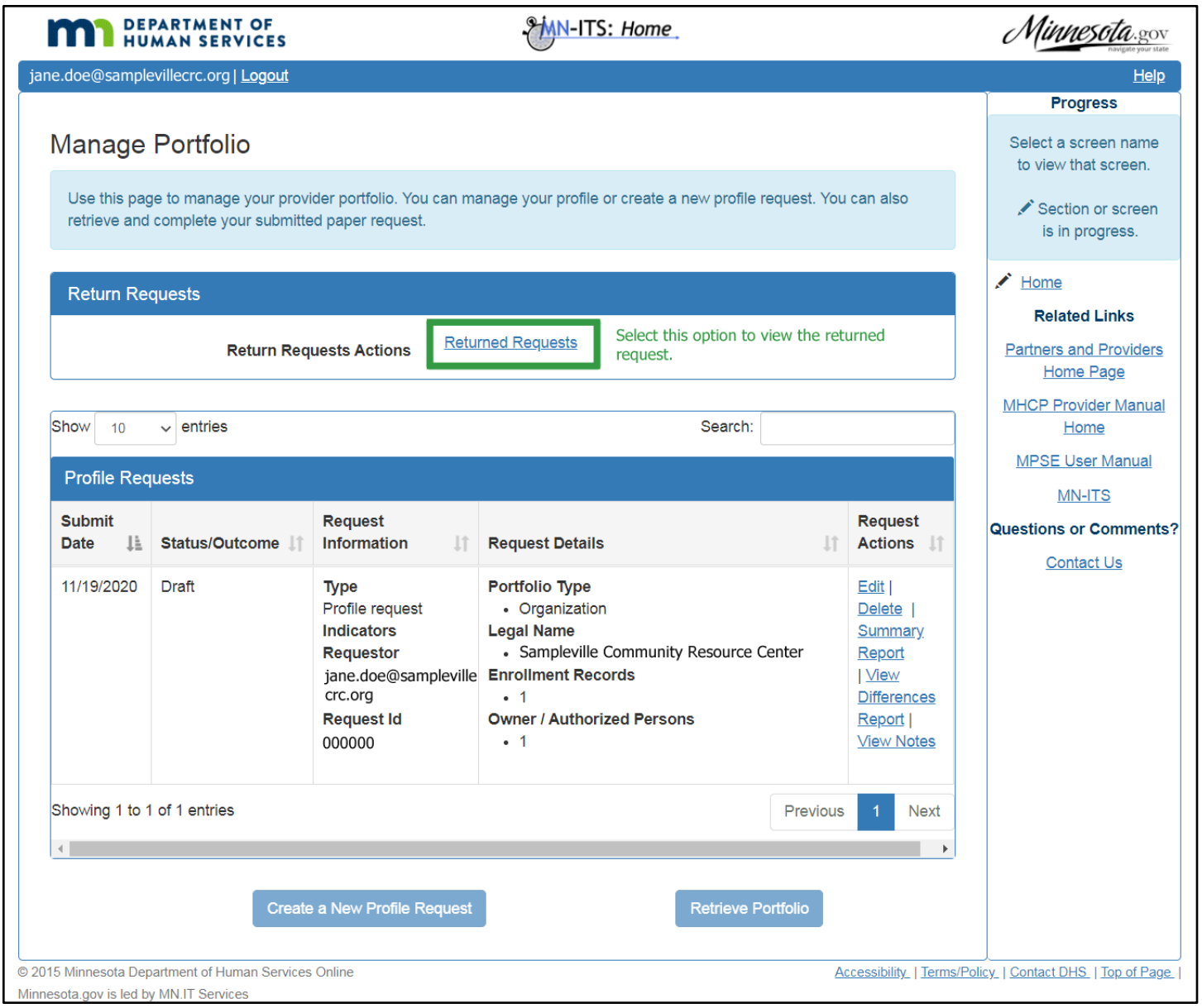
After setting up your NETStudy 2.0 account, initiate background studies for the individuals listed on Form DHS-3891 and update the form to include their BGS number and the newly assigned Facility ID/Agency ID, as per the instructions in your letter from DHS.

At this time, your application will be reverted back to being a draft, allowing you to make changes to your provider enrollment application.

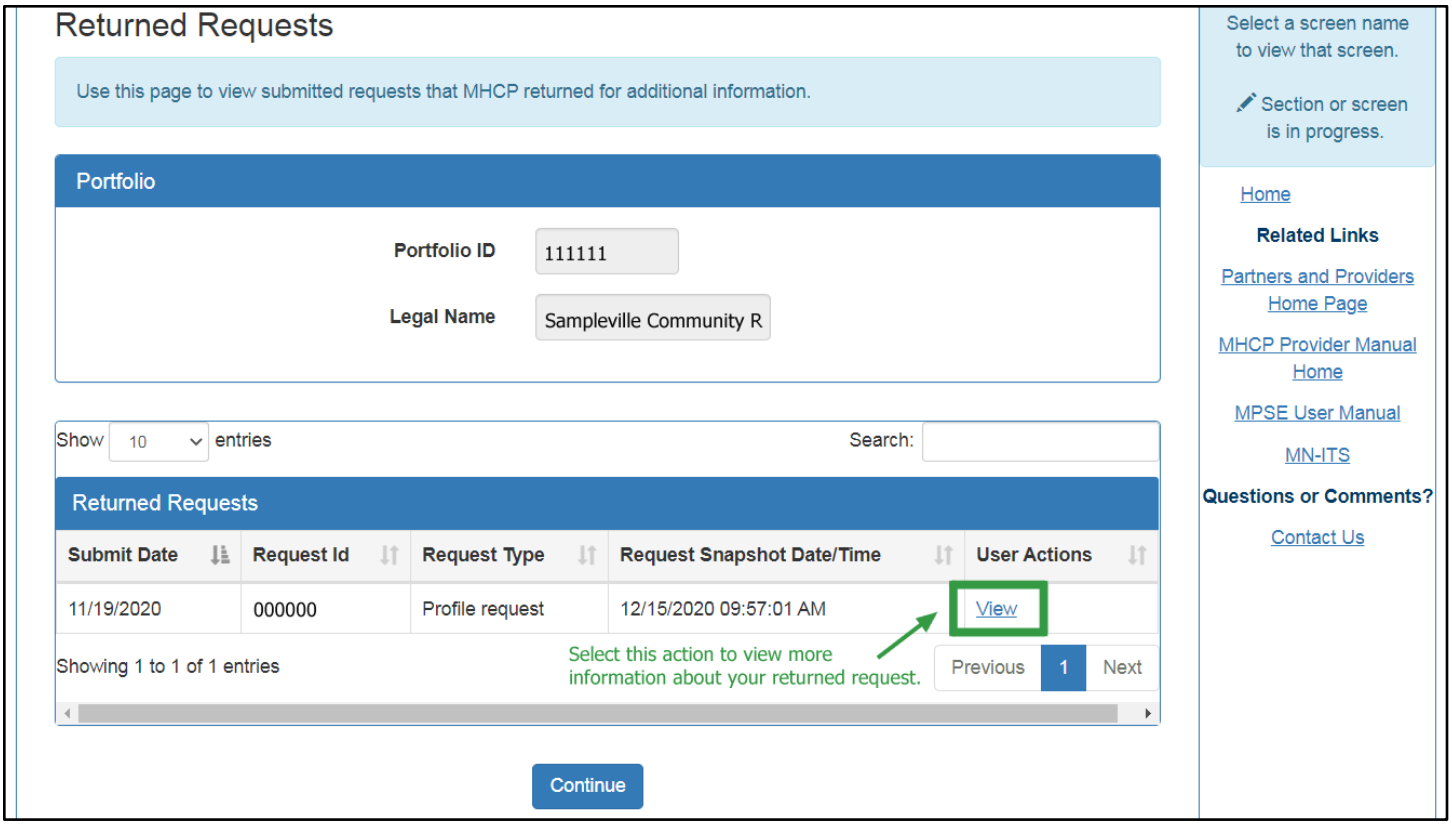
The initial review letter from DHS will also inform you of any other issues or errors with your application, and you will be able to make corrections when you resubmit your application. Please make these corrections.

If you have questions about anything included in the MHCP Enrollment – Request for More Information letter, please feel free to reach out to Skye Hart from the HSS-TA Team (not affiliated with DHS) to troubleshoot (skye@ei-consultants.com), or reach out directly to DHS's provider enrollment department.

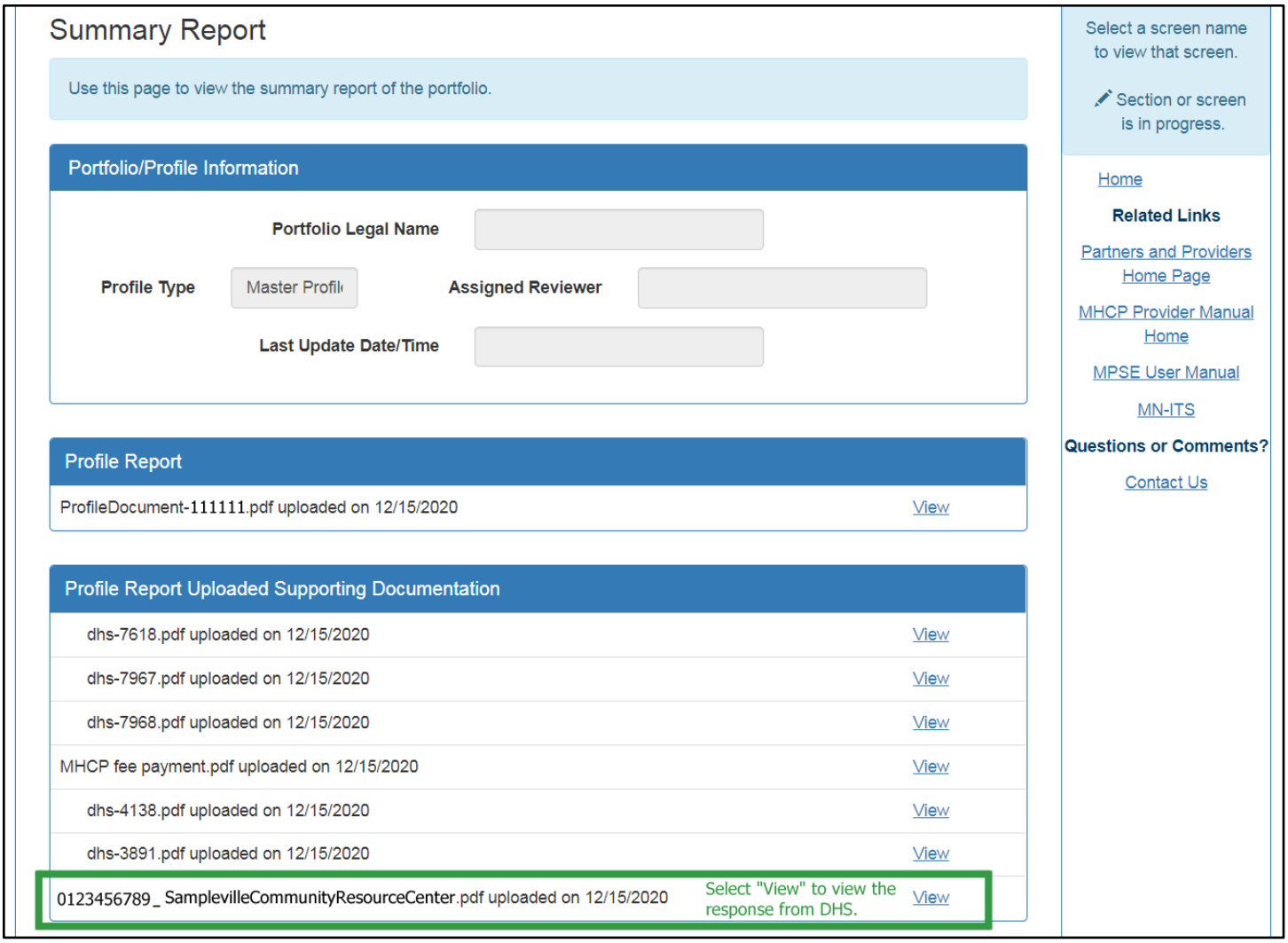
Once DHS has completed the initial review of your agency's HSS provider enrollment application, your MHCP Enrollment – Request for More Information letter will be available in the MPSE Portal under Returned Requests. This section will be available to your agency on the first page that appears after logging into the MPSE Portal (Manage Portfolio) once DHS has returned your application. Note that your profile request has been reverted back to a draft, allowing you to make revisions.


DEPARTMENT OF HUMAN SERVICES
MN-ITS: Home
Minnesota.gov
jane.doe@samplevillecrc.org | Logout
Help
Manage Portfolio
Use this page to manage your provider portfolio. You can manage your profile or create a new profile request. You can also retrieve and complete your submitted paper request.
Return Requests
Return Requests Actions
Returned Requests
Select this option to view the returned request.
Show 10 entries
Search:
Profile Requests
Submit Date
Status/Outcome
Request Information
Request Details
Request Actions
11/19/2020
Draft
Type
Profile request
Indicators
Requestor
jane.doe@samplevillecrc.org
Request Id
000000
Portfolio Type
Organization
Legal Name
Sampleville Community Resource Center
Enrollment Records
1
Owner / Authorized Persons
1
Edit | Delete | Summary Report | View Differences Report | View Notes
Showing 1 to 1 of 1 entries
Previous
1
Next
Create a New Profile Request
Retrieve Portfolio
Progress
Select a screen name to view that screen.
Section or screen is in progress.
Home
Related Links
Partners and Providers Home Page
MHCP Provider Manual Home
MPSE User Manual
MN-ITS
Questions or Comments?
Contact Us
© 2015 Minnesota Department of Human Services Online
Minnesota.gov is led by MN.IT Services
Accessibility | Terms/Policy | Contact DHS | Top of Page |

On the next screen, select “View” next to the appropriate returned request. If your agency has submitted multiple provider enrollment applications in the past, knowing the date you submitted the HSS provider enrollment application may be helpful for quickly identifying which of the returned requests is your HSS provider enrollment application.

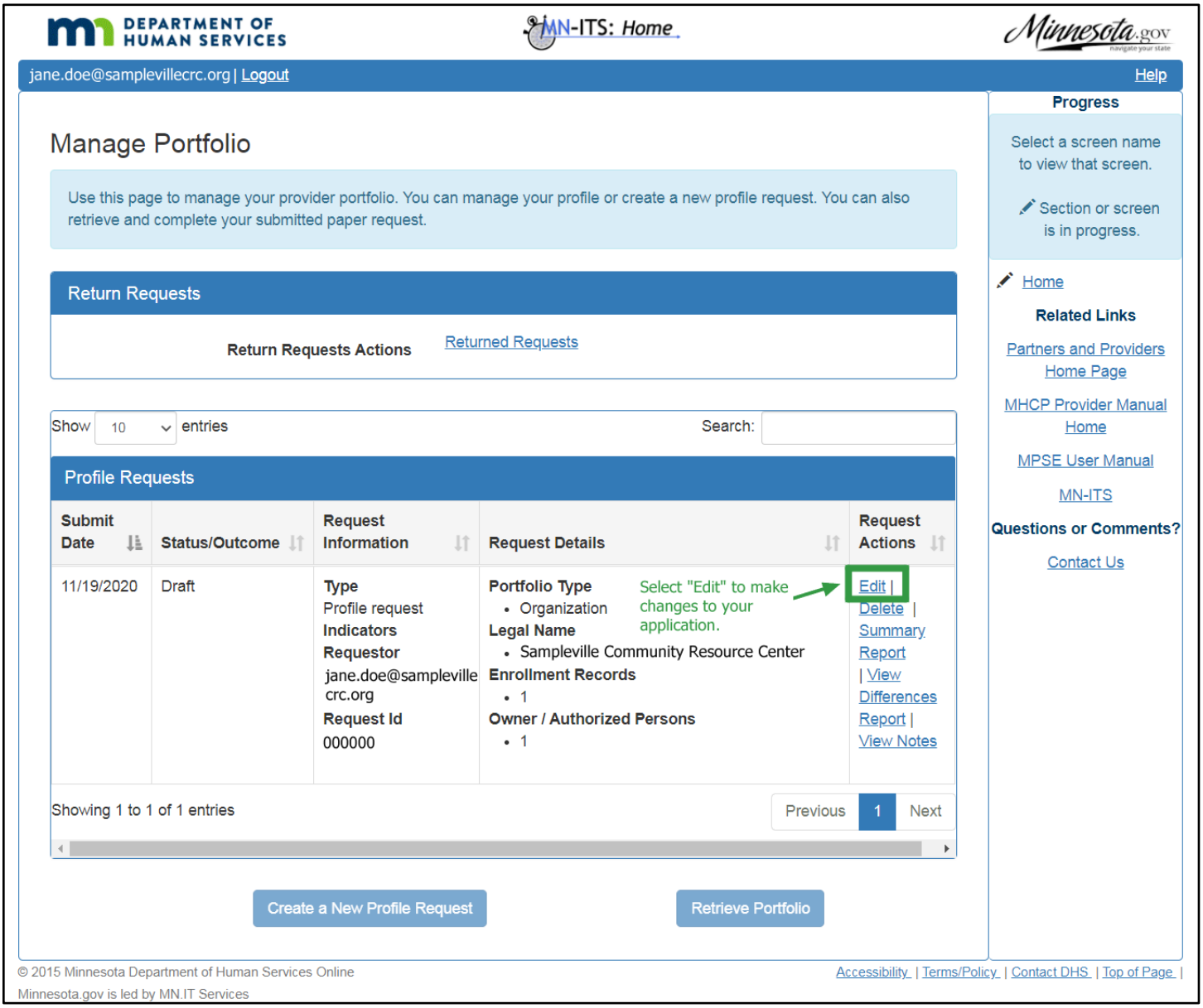


On the next screen, you should see all of the files you uploaded for your initial application, plus a new file containing your agency's name. This file is the response letter from DHS based on your initial application, and it contains instructions for setting up your agency's NETStudy 2.0 account. Select "View" next to this file to view the letter from DHS.

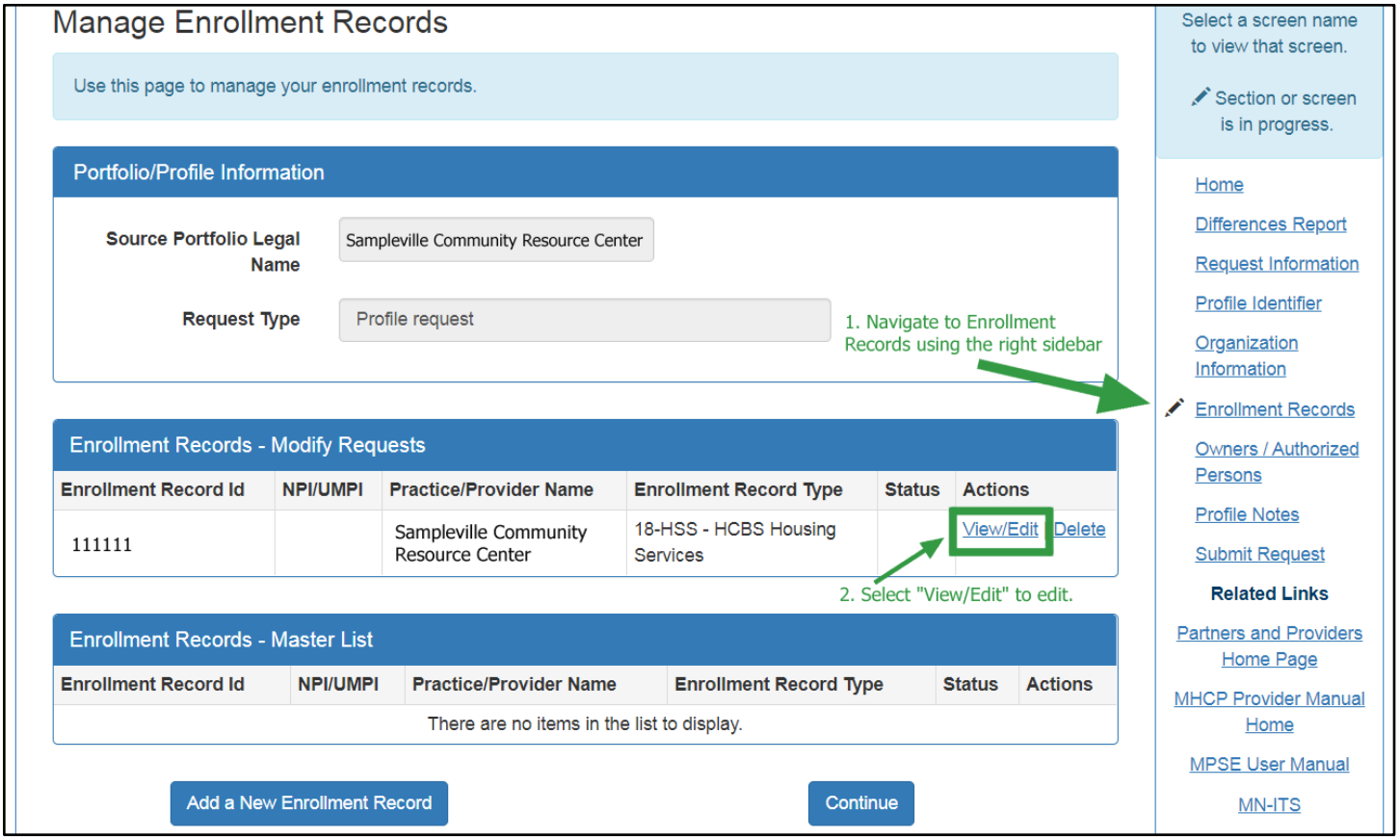


Please review the letter and if necessary, make changes to your application. Then, follow the directions in the letter to set up your agency's NETStudy 2.0 account and initiate background studies for staff and owners listed on Form DHS-3891. Next, add their BGS numbers and the newly assigned Facility ID/Agency ID to Form DHS-3891. You will now need to reupload Form DHS-3891.

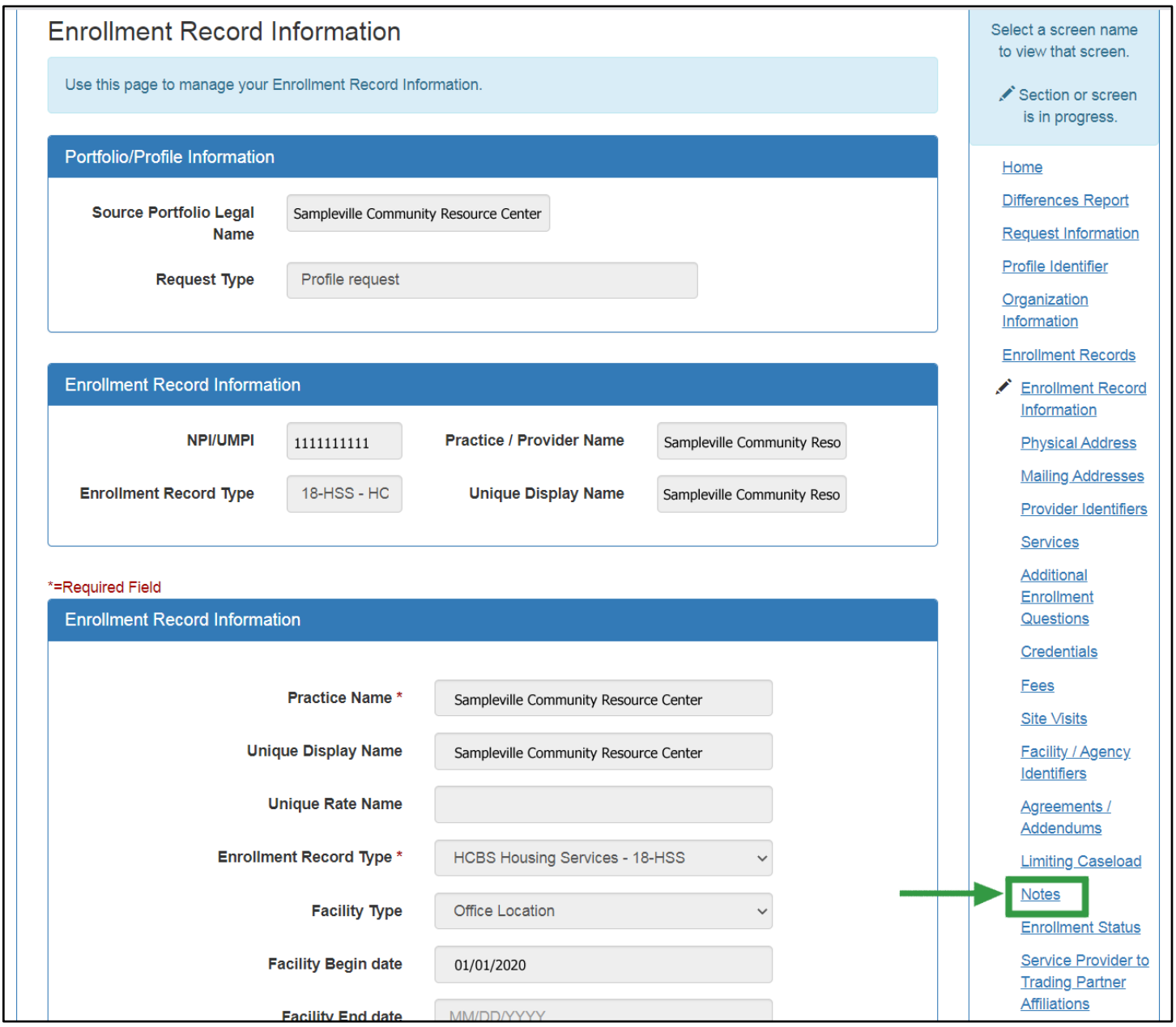
To upload your updated Form DHS-3891, you will need to navigate to Enrollment Records > Notes. From the first screen you see when logging into the MPSE Portal (Manage Portfolio), select “Edit” next to the appropriate profile request.



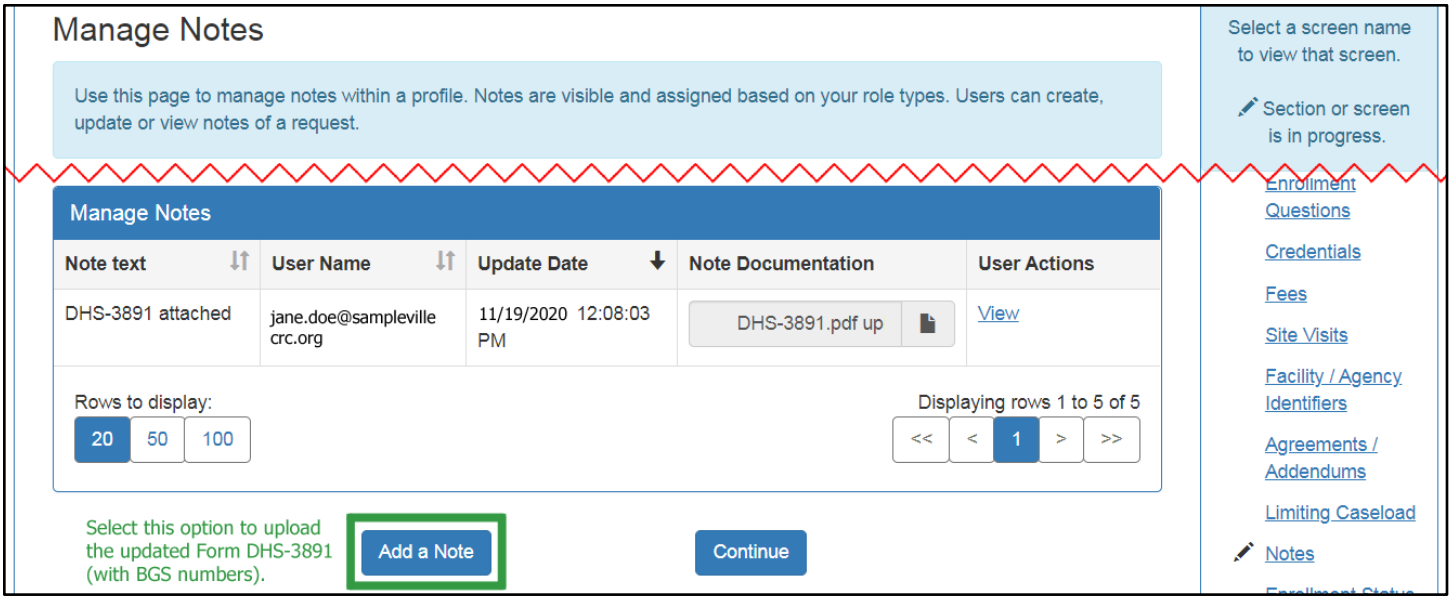
On the next page, select Enrollment Records in the right sidebar. On the Manage Enrollment Records Page, select “View/Edit.”



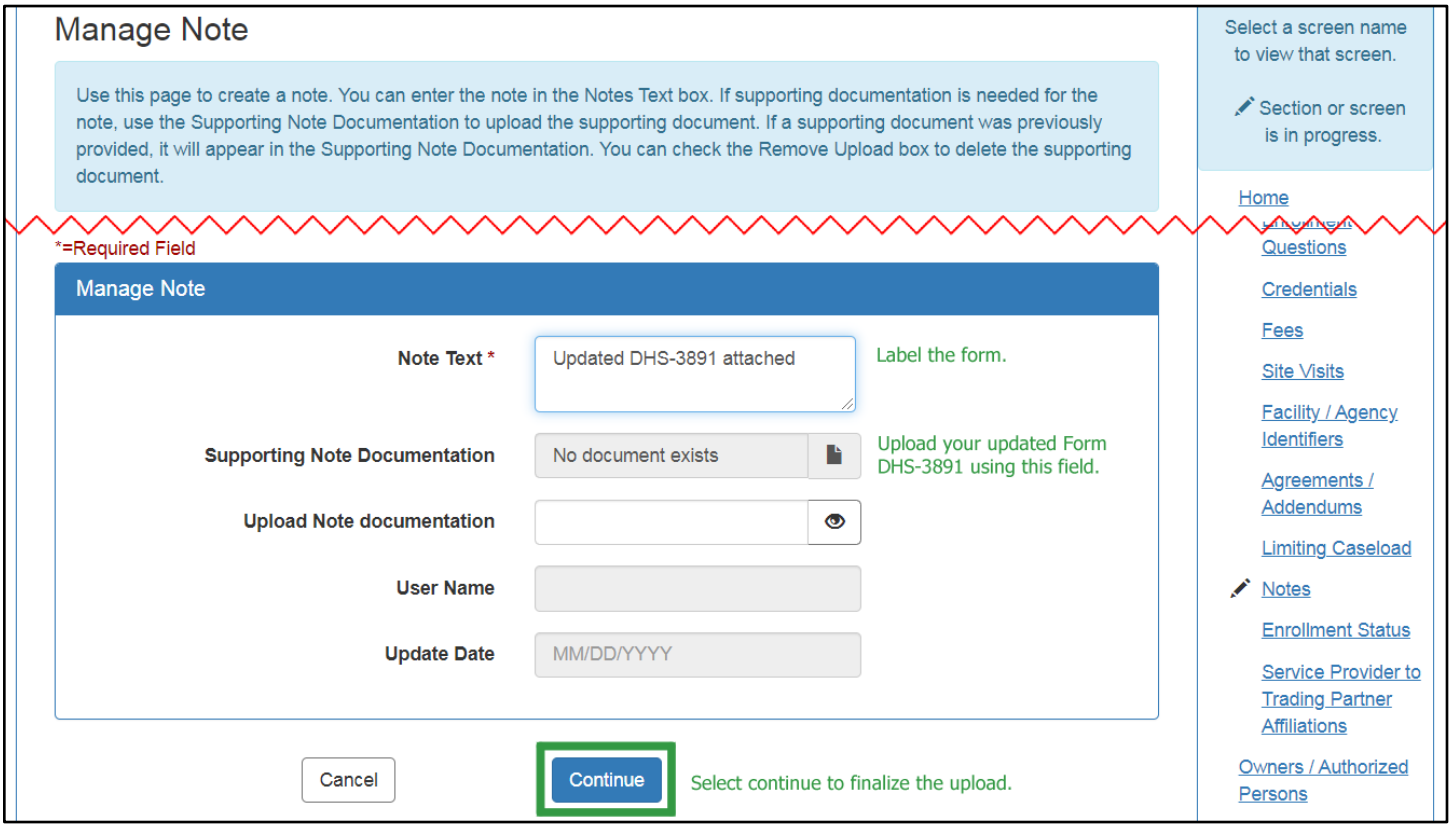
You will then need to navigate to the Notes subsection. Select Notes in the right sidebar.



In the Notes section, select “Add a Note” to upload your updated Form DHS-3891 (i.e., with BGS numbers for all staff and owners listed). Note that you cannot delete previous uploads.

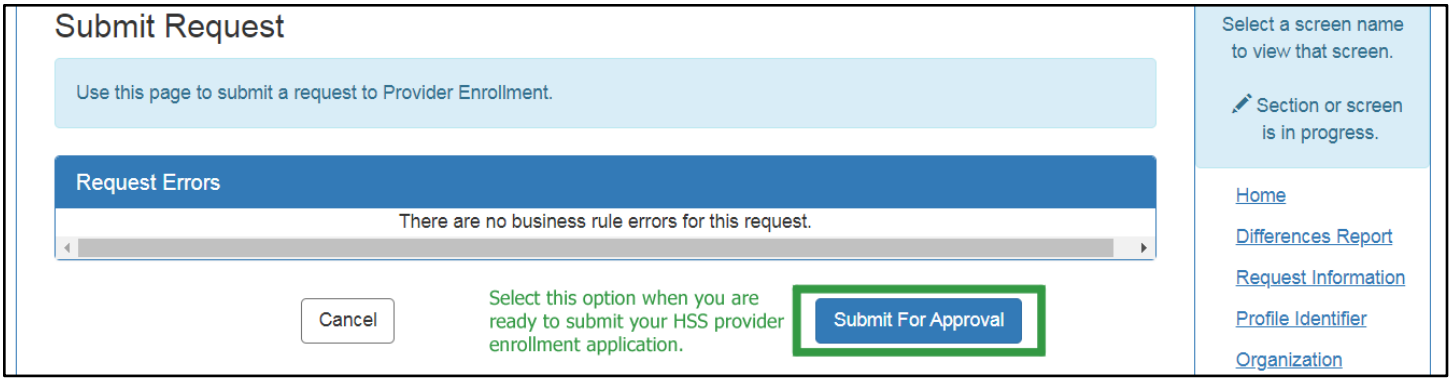


On the next screen, complete the “Note Text” field with a description of the upload, and upload the document to the “Supporting Note Documentation” field. Then, click continue.



Please be sure to make any other corrections requested by DHS in the MHCP Enrollment – Request for More Information letter that your agency was issued following the initial application review.

To resubmit your request, navigate to Submit Request using the right sidebar. Before submitting your request, make sure that there are no errors listed in the "Request Errors" box that need to be corrected. Once you are ready to submit your application, click "Submit For Approval" at the bottom of the Submit Request page.



After resubmitting your HSS provider enrollment application, DHS has up to 30 days to review your application. After they review your application, they can either approve it, or issue you another MHCP Enrollment – Request for More Information letter requesting additional changes to your application. If you are asked to make additional changes, please make those changes and resubmit your HSS provider enrollment application. If you have any questions about this process, please feel free to reach out to Skye Hart from the HSS-TA Team (not affiliated with DHS) to troubleshoot (skye@ei-consultants.com), or reach out directly to DHS's provider enrollment department.

OPTION 2: ENROLLMENT VIA FAX

When enrolling via fax, the following forms must be completed and faxed to MHCP Provider Eligibility and Compliance at (651) 431-7493:

- For the most up-to-date forms, visit the DHS eDocs library.
- DHS-8018 - Housing Stabilization Services Provider Enrollment Application
- DHS-4138 - MHCP Provider Agreement Form
- DHS-5259 - Disclosure of Ownership and Control Interest of an Entity
- DHS-7618 - Home and Community-Based Settings Applicant Assurance Statement
- DHS-3891 - Request for Licensing Agency ID Number
- DHS-3725 - EFT Vendor Number Notification
- MHCP Fee Payment Confirmation
- If your agency plans to provide Housing Consultation Services: DHS-7968 - Housing Consultation Provider Assurance Statement
- If your agency plans to provide Housing Transition and Housing Sustaining Services: DHS-7967 - Housing Transition and Housing Sustaining Provider Assurance Statement

For agencies enrolling via the MPSE Portal, please note that all forms except for DHS-8018, DHS-5259, and DHS-3725 must be completed and uploaded to the MPSE Portal. However, the equivalent information is entered directly into the portal.

Prior to completing the HSS provider enrollment process, your agency will need to decide whether you would prefer to use an NPI or UMPI. **The HSS-TA Team recommends using an NPI as opposed to an UMPI** as some providers have run into issues with billing using an UMPI, particularly when using certain EHRs. NPI numbers can be obtained via the NPPES Portal and are generally assigned the same day of application. If your organization (or a different department within your organization) has obtained an NPI in the past, you may need to identify the NPI admin within your organization for assistance with applying for a new NPI for your HSS program. This NPI Application guide from the California Department of Health Care Services goes through the step-by-step process of applying for an NPI in the NPPES Portal.

The remainder of this section includes annotated examples of all forms. Yellow highlighting indicates that the field must be completed. Cyan highlighting indicates that the field may need to be completed. Green text and arrows provide notes or indicate that some sections may need to be completed. Please note that the upper right corner of the PDF forms lists the form number and the month and year that the form was last updated (e.g., 11-21, indicating that the version of the form was last updated in November 2021). The example forms on the following pages may not be the latest versions of the forms available, but the information requested should be similar. Please use your best discretion when referencing the example forms on the following pages.

DEPARTMENT OF HUMAN SERVICES

DHS-8018-ENG 11-21

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Housing Stabilization Services – Provider Enrollment Application

To enroll to provide Housing Stabilization Services, complete your enrollment with MHCP in either one of the following ways:

1. **Complete your application electronically by using our online system, the Minnesota Provider Screening and Enrollment (MPSE) portal.**
   - New providers use MPSE Registration.
   - Existing MHCP-enrolled providers, log in to your MN–ITS account. If you never registered your MN–ITS account, your login information is on your original "Welcome" letter. If you do not have your letter, contact the MHCP Provider Call Center at 651-431-2700 or 800-366-5411 for assistance.
2. Type or neatly print the requested information as completely as possible. Do not skip required fields. An incomplete form will delay processing this application. Fax completed forms to MHCP Provider Eligibility and Compliance: 651-431-7493.

If you have questions about how MHCP may use and disclose private information about you, please see our Data Privacy Notice (DHS-6287) (PDF).

Application Fees

An application fee is required when enrolling with a Federal Employer Identification Number (FEIN). You must enroll each practice location separately. You must pay the fee for each enrollment application before you submit the application. MHCP will not refund the application fee for a denied enrollment application. Select one:

◉ Application fee was paid to Minnesota Health Care Programs

CONFIRMATION NUMBER: **MN2DHS 000000001**

◯ Application fee was paid to Medicare or another state's Medicaid program (attach proof of payment)

◯ Application fee is not required as I am applying with my SSN.

Organization Information (All information is required)

Please indicate your request by choosing one:

◉ New enrollment ◯ Reenrollment ◯ Revalidation ◯ Adding service

Provider Identifier Information

If you are enrolling with a National Provider Identifier (NPI), include the NPI in the box. If you do not have or are not using your NPI for this location, MHCP will assign the record a Unique Minnesota Provider Identifier (UMPI) for billing and record identification. If your organization does not have an NPI, or if you are opting to not use and have never been assigned an UMPI, leave this section blank. The effective date of the UMPI will align with the Requested Effective Enrollment Date.

Use UMPI ◯ Yes ◉ No If using NPI: Mark "No" If using UMPI: Mark "Yes"	EFFECTIVE DATE If using UMPI, fill this field with the requested effective date. If using NPI, leave blank.
NPI or UMPI 1111111111 If using NPI: Enter NPI. If using UMPI: Leave blank. DHS will assign a new UMPI.	NPI EFFECTIVE DATE 11/19/2020 If using NPI, fill this field with the requested effective date. If using UMPI, leave blank.

Either the Federal Employer Identification Number (FEIN) or Social Security Number (SSN) is required with the corresponding legal name. If you or the business have an FEIN, you must supply it. The legal name of the taxpayer and the Doing Business as (DBA) must be registered with the Minnesota State Secretary Office (MNSOS).

Page 1 of 6

REQUESTED EFFECTIVE ENROLLMENT DATE

11/19/2020 The effective date can be a date prior to this application. Ensure this date aligns across documents.

FEDERAL EMPLOYER ID (FEIN)	LEGAL NAME OF TAXPAYER, IF FEIN INDICATED
12-3456789	Sampleville Community Resource Center
SOCIAL SECURITY NUMBER (SSN)	LEGAL NAME OF PERSON (First, Middle and Last Name) IF SSN INDICATED
Leave blank.	Leave blank.
FISCAL YEAR END (default is 12/31)	EMAIL ADDRESS
12/31	jane.doe@samplevillecrc.org

Note that our example is a nonprofit.
Select the appropriate option for your agency.

DISCLOSING ENTITY STRUCTURE (Check the entity type that describes the enrolling provider.)

◯ Sole Proprietorship 2 ◯ Partnership 6 ◯ Corporation, LLC 7 ◉ Nonprofit 1
◯ Hospital Based Clinic 3 ◯ State 4 ◯ Public 5 ◯ Professional Association 9
◯ Other X (for example, LP, LLP, LLLP) SPECIFY TYPE: _____

OFFICE (MAIN) PHONE NUMBER (include area code)	OFFICE FAX NUMBER (include area code)
612-555-5555	612-555-5556

Select the appropriate Facility Type.

Notes:
Scattered site: select "Office Location" for Facility Type.

Providers should select residential if they are providing Housing Sustaining services at the practice address they own or control.

Enrollment Record Information

PRACTICE NAME (Doing Business As name)

Sampleville Community Resource Center

UNIQUE DISPLAY NAME (a unique name that you assign to identify each enrollment record)

Sampleville CRC HSS

Enrollment Record Type:
HCBS Housing Services - 18-HSS

Facility Type: ◉ Office Location ◯ Residential

FACILITY BEGIN DATE	STATE TAX ID
11/19/2020	0000000

Are you, or is this facility, enrolled with Medicare? ◯ Yes ◉ No

Encounter Indicator

HSS providers should select "Fee-for-Service and In-Network Managed Care."

Select an encounter indicator option that describes your enrollment record.

◉ **Fee-for-Service and In-Network Managed Care:** Fee-for-service (FFS) providers see MHCP members on Medical Assistance (MA) who are not enrolled with a managed care organization (MCO). In a FFS delivery system, providers bill MA directly and receive reimbursement for each covered service. MCO in-network managed care providers are providers who see MHCP members who are enrolled with an MCO and bill for those services through the MCO. By selecting this field, you are not required to be enrolled for MCO but are eligible.

◯ **In-Network Managed Care Only:** MCO in-network only is for providers who are enrolled with one or more MCOs and provide services to members who are enrolled with that MCO. Services provided to members through an MCO are billed through that MCO. NOTE: Choosing this option means I will not provide services to FFS members.

Remittance Sequence

Select one. This is the order that DHS will send remitted claims. Choose the option your agency would prefer.

Every two weeks, the Department of Human Services (DHS) will provide you with a report called a Remittance Advice (RA). This report will tell you the status of any claims you have submitted to DHS. This information will be listed on the RA alphabetically by member last name, unless you request a different order here. Check **only one** of the following:

◉ Alphabetically by member last name
◯ DHS transaction control number order
◯ Member MHCP ID number order
◯ Patient account or own reference number order

Tribal Information

Answer as appropriate for your agency.

Do you, or does this facility have a contract with a Minnesota tribe to provide services on tribal land? ◯ Yes ◉ No

Do you, or does this facility have a contract with a tribe (other than Minnesota) to provide services on tribal land? ◯ Yes ◉ No

TRIBAL SERVICE NOTE (if applicable)

Complete this section if applicable.

Physical Practice Address

Note: The physical practice address must be consistent with the address on Forms DHS-5259 and DHS-3725, as well as your agency's MHCP Fee Payment Confirmation.

Address 1

STREET ADDRESS 1 (This address cannot be a P.O. Box)			
1234 Main Street			
ADDRESS LINE 2 (Apt., Dept., Lot, Mailstop, Room, Suite, Trailer, Unit)			
CITY	STATE	ZIP CODE	COUNTY
Sampleville	MN	50000	Sampleland

Is your practice address also your home address? ◯ Yes ◉ No	If yes, do you want your home address listed in the MHCP provider directory? ◯ Yes ◉ No

Answer as appropriate for your agency.

Alternate Mailing Addresses

You can receive various types of information at one of three addresses. Your office location is Address 1 (in the Physical Practice Address section). If you want to receive information at an alternate address, list up to two more addresses here.

ADDRESS #2 Fill out if applicable.			
ATTENTION	ADDRESS LINE 1		
ADDRESS LINE 2 (Apt, Dept., Lockbox, Lot, Mailstop, P.O. Box, Room, Suite, Trailer, Tribal P.O. Box, Unit)			
CITY		STATE	ZIP CODE

ADDRESS #3 Fill out if applicable.			
ATTENTION	ADDRESS LINE 1		
ADDRESS LINE 2 (Apt, Dept., Lockbox, Lot, Mailstop, P.O. Box, Room, Suite, Trailer, Tribal P.O. Box, Unit)			
CITY		STATE	ZIP CODE

Available Address Usage Types	Select address 1, 2 or 3
• 1099	1
• Correspondence	1
• Credentialing	1
• Authorizations	1
• Paper Check	1
• Remittance Advice	1

Note: When you register your MN–ITS account, MHCP will upload all correspondence, remittance advices, prior authorizations and service agreements to your MN–ITS mailbox.

File Storage Location

Where are the organization's business files stored?

◉ Address 1 ◯ Address 2 ◯ Address 3 ◯ Other location (disclose location):

FILE STORAGE LOCATION Fill out if applicable.			
STREET ADDRESS	CITY	STATE	ZIP CODE

Service Request and Credentials

◉ Housing Consultation
◉ Housing Transition and Sustaining

The PDF will only let you select one option. However, you may apply for both options. The second option was bubbled in using pen on the printed document.

Attach a copy of applicant assurance statements required for each service with your application request.

Additional Enrollment Questions

Answer these questions as appropriate for your agency.
These questions do not affect whether DHS willl approve or deny your agency's HSS provider enrollment application, but you must answer them.

You must answer all fourteen (14) questions or the form will be rejected.

1. Do you provide 24-hour emergency coverage? ◯ Yes ◉ No
2. Do you provide same-day urgent care? ◯ Yes ◉ No
3. How far are you from public transportation? 1 block
4. What are your hours of operation?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open	9:00 am	9:00 am	9:00 am	9:00 am	9:00 am	9:00 am	closed
Close	6:00 pm	6:00 pm	6:00 pm	6:00 pm	6:00 pm	12:00 pm	closed

5. Do you offer flexible appointment hours? ◉ Yes ◯ No
6. Do you offer both non-English and American Sign Language interpreter services? ◉ Yes ◯ No
7. Do you offer language-line interpreters? ◯ Yes ◉ No
8. Do you have adequate seating in reception areas? ◉ Yes ◯ No
9. Is this building or facility easily identified and accessible to people with disabilities? ◉ Yes ◯ No
10. Does the parking lot provide parking ramp or parking lot accessibility to people with disabilities? ◉ Yes ◯ No
11. Are the handicapped parking spots wide enough to accommodate side lift systems in vehicles? ◉ Yes ◯ No
12. Are patient care areas accessible to people with disabilities? ◉ Yes ◯ No
13. What specific accommodations do you have available for people with physical disabilities?

In addition to having the above listed accommodations, the building also has an ADA-compliant restroom and elevator.

14. Do you currently have a contract with any of the following health plans through a Managed Care Organization (MCO)? ◯ Yes ◉ No

If yes, then you must select one or more of the following:

- ☐ Blue Plus
- ☐ HealthPartners
- ☐ Hennepin Health
- ☐ Itasca Medical Care (IMCare)
- ☐ Medica
- ☐ PrimeWest Health
- ☐ South Country Health Alliance (SCHA)
- ☐ UCare

Provider Statement

An officer, administrator, manager, director or person with similar authority must sign this provider application for an organization or business.

I certify that the information provided on this form is true and correct. I will notify MHCP Provider Eligibility and Compliance of any additions or changes to the information.

I acknowledge that any misrepresentations in the information submitted to MHCP, including false claims, statements, documents or concealment of a material fact, may be cause for denial or termination of participation as a Medicaid provider.

Check if signing electronically: Check this box if signing electronically.

☒ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

PROVIDER NAME (type or print clearly)	TITLE	
Jane Doe	Executive Director	
PROVIDER SIGNATURE (required)		DATE (mm/dd/yyyy)
Jane Doe		11/19/2020
CONTACT PERSON	PHONE NUMBER	EMAIL ADDRESS
Jane Doe The contact person does not have to be the same as the signer.	612-555-5555	jane.doe@samplevillecrc.org

All MHCP applications must also include:

☒ Minnesota Health Care Programs (MHCP) Provider Agreement (DHS-4138) (PDF)

☒ There may be additional forms to complete. Please refer to Housing Stabilization Services Enrollment Forms and Criteria webpage

If you have any questions about enrollment, contact us at 651-431-2700 or 800-366-5411, or at the TTY/TDD number 651-215-0086 or 800-366-8930. See the Enrollment with Minnesota Health Care Programs (MHCP) webpage for more information.

Please read, date and sign all forms that are listed and fax them with this enrollment application to MHCP Provider Eligibility and Compliance at 651-431-7493 or complete your enrollment using the MPSE portal. Keep copies for your records.

DEPARTMENT OF HUMAN SERVICES

DHS-4138-ENG 11-21

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Provider Agreement

As a participating provider in Minnesota Health Care Programs (MHCP) administered by the Minnesota Department of Human Services (DHS), the provider agrees to:

1. Furnish DHS, the Secretary of the U.S. Department of Health and Human Services (DHHS), or the Minnesota Medicaid Fraud Control Unit (MFCU) with such information as it may request regarding payments claimed for services provided under these programs.
2. Comply with all federal and state statutes and rules relating to the delivery of services to individuals and to the submission of claims for such services.
3. Provide to DHS its National Provider Identifier (NPI) and include its NPI on all claims, if the provider is eligible for an NPI.
4. Comply with all provisions of Minnesota Statutes, 62J.536, which requires electronic transmission of claims, eligibility and other transactions, using DHS' secure, HIPAA-compliant, automated transaction tool MN–ITS.
5. Accept as payment in full, amounts paid in accordance with schedules established by DHS, except where payment by the member has been authorized by DHS.
6. Enroll in electronic funds transfer (EFT) if the provider is a pay-to provider and if that is requested by DHS.
7. Ensure, when required by law, that a health service program administered by DHS is the payer of last resort by ascertaining the legal and financial liabilities of third parties to pay for covered services, and pursuing such third party payments.
8. Assume full responsibility for the accuracy of claims submitted to DHS in accordance with the certification requirements of the Code of Federal Regulations, title 42, section 455.18 and Minnesota Statutes, 256B.27, subdivision 2.
9. Submit claims at no more than the provider's usual and customary fee to the general public and only after the medical care or service has been provided, in accordance with Minnesota Rules, 9505.0450, subpart 1.
10. Except for claims for services under a waiver program, submit claims only for services, supplies, and equipment that are medically necessary as defined at Minnesota Rules, 9505.0175, subpart 25, and that meet professionally recognized standards of health care that the provider knows or has reason to know are properly reimbursable under federal and state statutes and rules.
11. Make full disclosure of ownership and control information as required by the Code of Federal Regulations, title 42, sections 455.100 - 455.106, and upon request, full disclosure of business transactions, as is required by the Code of Federal Regulations, title 42, section 455.105.
12. Make full disclosure of persons convicted of program crimes as required by the Code of Federal Regulations, title 42, section 455.106.
13. Ensure that the provider, all of its owners, managers, employees and contractors are not excluded from participation in Medicare, Medicaid or other federal health care programs, by searching the Office of Inspector General List of Excluded Individuals and Entities (LEIE). You must conduct this search at the time of enrollment, before hiring new employees or entering into a contract with a contractor, and monthly to see changes since the last search. The provider must immediately report any exclusion information discovered to DHS.
14. Verify member eligibility before rendering services.

Leave blank if your agency would like to be assigned a UMPI.

Electronic initials accepted.

AUTHORIZED INITIALS
JD

PROVIDER NAME	NPI or UMPI	PROVIDER TYPE
Sampleville Community Resource Center	1111111111	18 HSS

15. Comply with all federal statutes, implementing regulations and guidance prohibiting discrimination on the basis of race, color, national origin, sex, age, religion and disability in any program or activity receiving federal financial assistance from DHHS.
16. Provide member services of the same scope and quality as would be provided to the general public, within MHCP guidelines, in accordance with section 1902(a)(10)(B) – (E) of the Social Security Act.
17. Comply with the provisions of any fully executed addendum required by DHS, which is incorporated with the Provider Agreement (that is, the addendum becomes part of the original Provider Agreement).
18. Ensure that its employees and contractors comply with all MHCP requirements, including any requirements added post-enrollment.
19. Comply with the advance directive requirements if the provider is a hospital, nursing facility, a provider of home health care, personal care assistance services, hospice, or managed care organization (MCO), as required by the Code of Federal Regulations, title 42, sections 489.102 and 417.436.
20. Maintain records that fully disclose the extent of services provided to MHCP members for a period of five years after the initial date of billing DHS, in accordance with Minnesota Rules, 9505.2160 – 9505.2245, or for the duration of contested case proceedings, whichever is longer.
21. Ensure proper handling and safeguarding by the provider's employees, contractors, and authorized agents of protected information collected, created, used, maintained, or disclosed on behalf of DHS. For the purposes of this agreement, "protected information" means data subject to any of the laws described in 21.A. This responsibility includes:

    A. Ensuring that employees and agents of the provider comply with and are properly trained about:

    (1) The Minnesota Government Data Practices Act (MGDPA), Minnesota Statutes Chapter 13, in particular 13.46 Welfare Data;

    (2) The Minnesota Medical Records Act, Minnesota Statutes, 144.291 – 144.298;

    (3) The federal Health Insurance Portability and Accountability Act (HIPAA), including but not limited to the requirements of the Privacy Rule and Security Regulations, the Code of Federal Regulations, title 45, sections 160 and 164;

    (4) Federal law and regulations that govern the use and disclosure of substance abuse treatment records, United States Code, title 42, 290dd-2 and the Code of Federal Regulations, title 42, sections 2.1 – 2.67; and

    (5) Any other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information.

    B. Ensuring, consistent with the laws stated in 21.A, that the provider's employees, contractors, and authorized agents:

    (1) Do not use or further disclose protected information created, collected, received, stored, used, maintained or disseminated in the course or performance of this agreement other than as necessary to perform their obligations under this agreement, or as required by law, either during the period of this agreement or after (respectively, the Code of Federal Regulations, title 45, sections 164.502(b) and 164.514(d), and Minnesota Statutes, 13.05, subdivision 3).

    (2) Use appropriate administrative, physical, and technical safeguards to prevent use or disclosure of the protected information other than as provided for by this agreement and to ensure the confidentiality, integrity, and availability of any protected health information that it creates, receives, maintains, or transmits on behalf of DHS.

Leave blank if your agency would like to be assigned a UMPI.

Electronic initials accepted.

AUTHORIZED INITIALS
JD

PROVIDER NAME	NPI or UMPI	PROVIDER TYPE
Sampleville Community Resource Center	1111111111	18 HSS

(3) Do not transmit protected health information (PHI) over the internet or any other unsecure or open communication channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent than those described in the Code of Federal Regulations, title 45, section 164.312. If the provider stores or maintains PHI in encrypted form, the provider shall, at DHS' request, promptly provide DHS with the key or keys to decrypt such information. The provider shall not forward previously encrypted data to any other party, unless otherwise required by this agreement.

(4) Mitigate, to the extent practicable, any harmful effects known to the provider of a use, disclosure, or breach of security with respect to protected information by the provider in violation of this agreement.

(5) Make the required notifications upon discovery of a breach, as defined in the Code of Federal Regulations, title 45, section 164.402, of unsecured PHI to DHS, to each individual whose unsecured PHI has been breached, and, when the breach involves the unsecured PHI of more than 500 people, to the media of a state or jurisdiction. See the Code of Federal Regulations, title 45, sections 164.400 – 164.414.

22. Accept and be bound by the terms and conditions of DHS' Electronic Data Interchange (EDI) Trading Partner Addendum to Provider Agreement when billing electronically. The provider acknowledges that any organization or individual that submits claims on its behalf will abide by the EDI Trading Partner Agreement as an agent of the provider. The provider authorizes the agent to bind the provider to the terms of the EDI Trading Partner Agreement. The provider will give each EDI trading partner an individual login ID and password.
23. For provider entities receiving or making Medicaid payments totaling at least $5 million annually, establish written policies and procedures for the education of all employees, contractors and agents, that includes information about the False Claims Act and other provisions named in section 1902(a)(68)(A) of the Social Security Act.
24. Determine the applicability to the provider of any other state or federal laws and ensure compliance with those laws.
25. Cooperate with DHS audit procedures.
26. Execute any required Assurance Statements and provide certification or licensure information if required by DHS for a particular provider type. The provider also agrees to notify DHS of any changes to its certification or licensure status.
27. Comply with Minnesota Statutes, 256B.0644 as a requirement of participation in other state health care programs. The provider agrees to provide active caseload data upon DHS' request and at least 10 days before limiting acceptance of new MHCP members.
28. Refund any overpayments made to the provider by DHS, including those resulting from payments made by Medicare, third party payers, billing errors, fraudulent billing, and from increased interim payments made pursuant to DHS' plan for continuity of operations during times of pandemic and crisis.

Leave blank if your agency would like to be assigned a UMPI.

Electronic initials accepted.

AUTHORIZED INITIALS
JD

PROVIDER NAME	NPI or UMPI	PROVIDER TYPE
Sampleville Community Resource Center	1111111111	18 HSS

29. Notify DHS no later than 30 days before the effective date of a sale, merger, or transfer of an enrolled entity, in accordance with Minnesota Rules, 9505.0195, subpart 8. Failure to notify DHS may result in the sale or transfer not becoming effective with DHS for any purpose, including claims processing, payment of claims and claims adjustments. The provider also agrees to notify DHS whether it intends to transfer its NPI or its Federal Employer Identification Number (FEIN) to the new owner and to complete any documentation or addenda DHS requires, including a Provider Entity Sale or Transfer Addendum (DHS-5550) (PDF). The provider acknowledges that upon sale, merger or transfer of the enrolled entity, DHS will recognize the effective date of the sale or transfer as the date from which all claims payments or adjustments will be assigned to the new owner, without regard to date of service, date of submission to DHS, or adjudication date, including those resulting from a later audit or reprocessed claims. Any intent on the part of the provider or purchaser to the contrary must be addressed in the purchase agreement and transfer documents and is the responsibility of the provider and purchaser to enforce. DHS retains the right to pursue monetary recovery, or civil or criminal actions against the seller or transferor. Nothing in this agreement negates the obligation of the new owner to contact DHS by the effective date of sale, merger or transfer.
30. Accept that this agreement may be immediately terminated for either of the following:
    A. At the discretion of DHS if it determines that the provider has violated a material term of the agreement, including but not limited to:
        (1) Noncompliance by the provider with the HIPAA Privacy Rule and Security Standards. If termination is not feasible, DHS shall report the breach to the secretary of DHHS.
        (2) Failure of the provider to sign a new agreement within 30 days of a request from DHS, in accordance with Minnesota Rules, 9505.0195, subpart 5.
    B. Upon sale or transfer of the enrolled provider.
31. Ensure that upon termination of this agreement, the provider shall continue to:
    A. Extend all of the protections of this agreement to all of the protected information DHS provides to the provider, or created or received by the provider on behalf of DHS, that the provider still maintains in any form, including information that is in the hands of the contractors and agents of the provider, and limit its further use and disclosure.
    B. Maintain all other records of claims submitted for a minimum of five years, consistent with paragraph 20 of this agreement.
32. Accept that any ambiguity in this agreement will be resolved to permit DHS to comply with HIPAA, MDGPA, and other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information and other state and federals laws and regulations.

Signature requirements for this Provider Agreement

- **All individual and organizational providers**: Type your provider name, the national provider identifier (NPI) or unique Minnesota provider identifier (UMPI), and the provider type on the first page of this agreement. When you type this information, it will automatically populate to pages 2 and 3.
- **Individual providers**: Initial each page of this Provider Agreement. Write the name and title of the person signing and sign the last page of this agreement.
- **Organizational providers**: An administrator, manager, director or other person authorized to sign must initial each page, write the name and title of the person signing, and sign the last page of this agreement. This person must also be disclosed on the Disclosure of Ownership and Control Interest of an Entity (DHS-5259) (PDF).

Leave blank if your agency would like to be assigned a UMPI.

Electronic initials accepted.

AUTHORIZED INITIALS
JD

PROVIDER NAME	NPI or UMPI	PROVIDER TYPE
Sampleville Community Resource Center	1111111111	18 HSS

Check if signing electronically: Check this box if signing electronically.

☒ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

NAME OF PERSON SIGNING (TYPE OR PRINT)	TITLE	
Jane Doe	Executive Director	
SIGNATURE		DATE
Jane Doe		11/19/2020

Keep a copy of the Provider Agreement for your files and upload the original form, along with all other required documentation, using the online **Minnesota Provider Screening and Enrollment (MPSE) portal**, **or** fax to the appropriate number as follows:

- Personal care provider organizations, fax to 651-431-7465.
- Home and community-based waiver providers, fax to 651-431-7493.
- All other provider types, fax to 651-431-7462.

DEPARTMENT OF HUMAN SERVICES

DHS-5259-ENG 1-22

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Disclosure of Ownership and Control Interest of an Entity

This form is an addendum to your MHCP Provider Agreement. MHCP requires you to submit this form as part of your enrollment with us. We are required by federal law to collect this information. See MHCP Provider Requirements (Get a Provider Identification Number, Register for MN–ITS, Screen Employees and Contractors). **Also see Definitions on the last page of this form.**

Complete this form:

- As a condition of MHCP participation
- When the provider entity first enrolls with MHCP
- Whenever any information on your Disclosure of Ownership and Control Interest form changes
- Upon reenrollment (MHCP will notify you 30 days before your renewal is due)

Disclosing Entity Identifying Information and Structure

ENTITY'S LEGAL NAME ACCORDING TO IRS	ENTITY'S DOING BUSINESS AS NAME (DBA)		
Sampleville Community Resource Center	Sampleville Community Resource Center		
PROVIDER TYPE: 18 HSS (Leave blank if your agency would like to be assigned a UMPI. →)	NPI OR UMPI: 1111111111	OFFICE PHONE NUMBER: 612-555-5555	
FACILITY ADDRESS: 1234 Main Street	CITY: Sampleville	STATE: MN	ZIP CODE: 50000
FEDERAL EMPLOYER ID (FEIN): 12-3456789	MINNESOTA TAX ID NUMBER: 0000000		

CHECK THE ENTITY TYPE THAT DESCRIBES THE ENROLLING PROVIDER: Select the appropriate option for your agency.

◯ Sole proprietorship 2	◯ Partnership 6	◯ Corporation, LLC 7	◉ Nonprofit 1
◯ Hospital based clinic 3	◯ State 4	◯ Public 5	◯ Professional association 9
◯ Other X (i.e., LP, LLP, LLLP) SPECIFY TYPE: _____			

Each provider entity must complete the following sections for all people, businesses or organizations that meet any of the following criteria:

- Have an ownership or control interest of 5 percent or more in this disclosing entity
- Have an ownership or control interest in a subcontractor in which this disclosing entity has a direct or indirect ownership interest of 5 percent or more
- Are a managing employee (see Definitions on the last page)

For a person: If you list a person, you must include that person's SSN and residential (home) address.

For a business: If you list a business, you must include the business' federal tax ID (FEIN) and primary business address for every business location (including street address) and every post office box address.

See page 6 of this form for more information about who to list. Nonprofits must list managing employees and board members. People listed on this form (such as board members) do not necessarily require background studies.

Individual Person Ownership or Control Interest

List all individual owners, managing employees, and people with control interest. See instructions on the last page for more information about completing this section.

ARE YOU A(N) (check all that apply):

◯ Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor)

◉ Managing employee (not CEO, CFO, COO, CTO) ◯ Owner - List percent of ownership interest if 5 percent or more: _____

◯ Indirect owner - List percent of ownership interest if 5 percent or more: _____ Entity name: _____

◯ Board member, officer, or business and finance controller - CEO, CFO, COO, CTO

◯ Trustee ◯ Authorized agent ◯ Other: _____

FULL LEGAL NAME (LAST)	FIRST	MIDDLE (If no middle name, write in "N/A")	SOCIAL SECURITY NUMBER	DATE OF BIRTH
Doe	Jane	Marie	000000000	01/01/1965

ADDRESS	CITY	STATE	ZIP CODE	COUNTY OR INDIAN RESERVATION
100 1st Street	Sampleville	MN	50000	Sampleland

◉ Hire date 01/01/2020 (m/d/yyyy)
◯ Termination date _____ (m/d/yyyy)

RELATIONSHIP TO ANY OTHER LISTED PERSON: ◯ Spouse ◯ Child ◯ Parent ◯ Sibling

BACKGROUND STUDY NUMBER OR REQUEST ID (always required for NEMT): Leave blank.

ARE YOU A(N) (check all that apply):

◯ Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor)

◯ Managing employee (not CEO, CFO, COO, CTO) ◯ Owner - List percent of ownership interest if 5 percent or more: _____

◯ Indirect owner - List percent of ownership interest if 5 percent or more: _____ Entity name: _____

◉ Board member, officer, or business and finance controller - CEO, CFO, COO, CTO

◯ Trustee ◯ Authorized agent ◯ Other: _____

FULL LEGAL NAME (LAST)	FIRST	MIDDLE (If no middle name, write in "N/A")	SOCIAL SECURITY NUMBER	DATE OF BIRTH
Nguyen	Mary	Rose	000000001	01/01/1964

ADDRESS	CITY	STATE	ZIP CODE	COUNTY OR INDIAN RESERVATION
101 1st Street	Sampleville	MN	50000	Sampleland

◉ Hire date 01/01/2020 (m/d/yyyy)
◯ Termination date _____ (m/d/yyyy)

RELATIONSHIP TO ANY OTHER LISTED PERSON: ◯ Spouse ◯ Child ◯ Parent ◯ Sibling

BACKGROUND STUDY NUMBER OR REQUEST ID (always required for NEMT): Leave blank.

ARE YOU A(N) (check all that apply):

◯ Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor)

◯ Managing employee (not CEO, CFO, COO, CTO) ◯ Owner - List percent of ownership interest if 5 percent or more: _____

◯ Indirect owner - List percent of ownership interest if 5 percent or more: _____ Entity name: _____

◉ Board member, officer, or business and finance controller - CEO, CFO, COO, CTO

◯ Trustee ◯ Authorized agent ◯ Other: _____

FULL LEGAL NAME (LAST)	FIRST	MIDDLE (If no middle name, write in "N/A")	SOCIAL SECURITY NUMBER	DATE OF BIRTH
Johnson	Jamie	N/A	000000002	01/01/1963

ADDRESS	CITY	STATE	ZIP CODE	COUNTY OR INDIAN RESERVATION
102 1st Street	Sampleville	MN	50000	Sampleland

◉ Hire date 01/01/2020 (m/d/yyyy)
◯ Termination date _____ (m/d/yyyy)

RELATIONSHIP TO ANY OTHER LISTED PERSON: ◯ Spouse ◯ Child ◯ Parent ◯ Sibling

BACKGROUND STUDY NUMBER OR REQUEST ID (always required for NEMT): Leave blank.

Copy this page as needed to enter more individual owners.

☐ Check this box if you are submitting multiple pages with more people listed.

Business Ownership or Control Interest

Is your business owned by or does another entity have a control interest in your business?

◯ Yes – list other other entities ◉ No – skip to the next page Only complete the rest of the page if it is relevant to your agency.

ARE YOU A(N) (check all that apply):

◯ Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor) ______

◯ Owner - List percent of ownership interest if 5 percent or more: ______

◯ Indirect owner - List percent of ownership interest if 5 percent or more: ______ Entity name: ______

◯ Trustee

◯ Other: ______

FULL LEGAL NAME (taxpayer name of FEIN or on W-9 from IRS)		FEDERAL EMPLOYER ID (FEIN)	
ADDRESS	CITY	STATE	ZIP CODE
COUNTY OR INDIAN RESERVATION	OWNERSHIP OR CONTROL INTEREST ◯ Begin date ______ (m/d/yyyy) ◯ End date ______ (m/d/yyyy)		

ARE YOU A(N) (check all that apply):

◯ Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor) ______

◯ Owner - List percent of ownership interest if 5 percent or more: ______

◯ Indirect owner - List percent of ownership interest if 5 percent or more: ______ Entity name: ______

◯ Trustee

◯ Other: ______

FULL LEGAL NAME (taxpayer name of FEIN or on W-9 from IRS)		FEDERAL EMPLOYER ID (FEIN)	
ADDRESS	CITY	STATE	ZIP CODE
COUNTY OR INDIAN RESERVATION	OWNERSHIP OR CONTROL INTEREST ◯ Begin date ______ (m/d/yyyy) ◯ End date ______ (m/d/yyyy)		

ARE YOU A(N) (check all that apply):

◯ Subcontractor (If person or entity is listed because of ownership or control interest in a subcontractor, name the subcontractor) ______

◯ Owner - List percent of ownership interest if 5 percent or more: ______

◯ Indirect owner - List percent of ownership interest if 5 percent or more: ______ Entity name: ______

◯ Trustee

◯ Other: ______

FULL LEGAL NAME (taxpayer name of FEIN or on W-9 from IRS)		FEDERAL EMPLOYER ID (FEIN)	
ADDRESS	CITY	STATE	ZIP CODE
COUNTY OR INDIAN RESERVATION	OWNERSHIP OR CONTROL INTEREST ◯ Begin date ______ (m/d/yyyy) ◯ End date ______ (m/d/yyyy)		

Copy this page and complete it for any additional people, businesses or organizations.

☐ Check this box if you are submitting any more pages with information about people, businesses or organizations who own or have a control interest in your business.

Does any person, business or organization you listed have an ownership or control interest in any other Medicaid disclosing entity or any entity that does not participate in Medicaid, but is required to disclose ownership and control interest because of participation in any Title V, XVIII, or XX programs?

◯ Yes – complete the following for each person, business or organization ◉ No

FULL LEGAL NAME (Person: Last, first, middle; Business or Organization: taxpayer name of FEIN or on W-9 from IRS) Complete if applicable.				% OF OWNERSHIP INTEREST
FULL LEGAL NAME OF OTHER PROVIDER (Taxpayer name of FEIN or on W-9 from IRS)			COUNTY OR INDIAN RESERVATION	
ADDRESS OF OTHER PROVIDER	CITY		STATE	ZIP CODE

Check the appropriate Yes or No box for each of the following questions.

A. Has any person having an ownership or control interest ever:
- Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the start of these programs? ◯ Yes ◉ No
- Had civil money penalties or assessments imposed under section 1128A of the Social Security Act? ◯ Yes ◉ No
- Been excluded from participation in Medicare or any of the state health care programs? ◯ Yes ◉ No

B. Has any managing employee or agent ever:
- Been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the start of these programs? ◯ Yes ◉ No
- Had civil money penalties or assessments imposed under section 1128A of the Social Security Act? ◯ Yes ◉ No
- Been excluded from participation in Medicare or any of the state health care programs? ◯ Yes ◉ No

Complete the following for any Yes answer. Complete if applicable.

FULL LEGAL NAME (Last, first, middle)	SOCIAL SECURITY NUMBER
REASON FOR ANSWERING YES (for example, conviction, money penalties, exclusion from Medicare or state health care programs)	

PCA providers only: Complete the following information for all residential properties you own, lease or manage that could be or are used for providing home care services. Complete if applicable.

FULL LEGAL NAME OF RESIDENCE OR PROVIDER (Taxpayer name of FEIN or on W-9 from IRS)				DO YOU OWN, LEASE OR MANAGE THE PROPERTY? ◯ Own ◯ Lease ◯ Manage
ADDRESS OF PROPERTY	CITY	STATE	ZIP CODE	COUNTY OR INDIAN RESERVATION

Signature

By signing below, I, an authorized officer (CEO, president) with authority to bind the entity, certify that:

- The information on this form is true and correct
- I will notify MHCP Provider Eligibility and Compliance of any changes to this information

Check if signing electronically: Check this box if signing electronically.

☑ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

NAME (PRINT)	TITLE	PHONE NUMBER
Jane Doe	Executive Director	612-555-5555
SIGNATURE		DATE
Jane Doe		11/19/2020

Upload this form via the Minnesota Provider Screening and Enrollment (MPSE) portal or fax all pages of this form to DHS at 651-431-7462.

Definitions

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

Managing employee
Managing employee (not CEO, CFO, COO, CTO) means a person who exercises operational or managerial control over, or who directly or indirectly conducts or manages the day-to-day operations of an institution, organization, agency or school, such as a general manager, business manager, administrator, director.

Ownership or control interest
Ownership or control interest means any person, business or organization to which any one or more of the following apply:

- Direct ownership of 5 percent or more in the disclosing entity
- Indirect ownership interest equal to 5 percent or more in a disclosing entity (meaning ownership in another entity that has an ownership interest in the disclosing entity)
- Determine the amount of indirect ownership interest by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equals an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation that owns 5 percent of the stock of the disclosing entity, B's interest equals a 4 percent indirect ownership interest in the disclosing entity and need not be reported
- A combination of direct and indirect ownership interest equal to 5 percent or more in the disclosing entity
- Owns an interest of 5 percent or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity Determine the percentage of ownership, mortgage, deed of trust, note, or other obligation by multiplying the percentage of interest owned in the obligation by the percentage of the disclosing entity's assets used to secure the obligation. For example: If A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equals 6 percent and must be reported. If B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equals 4 percent and need not be reported
- Is an officer or director of a disclosing entity that is organized as a corporation (for profit or non-profit)
- Is a partner in a disclosing entity that is organized as a partnership.

Subcontractor
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.

Title V
Maternal and Child Health Services Block Grant

Title XVIII
Health Insurance for the Aged and Disabled (Medicare)

Title XX
Block Grants to States for Social Services and Elder Justice

Title XXI
State Children's Health Insurance Program

Instructions for completing Individual Person Ownership or Control Interest

IMPORTANT
If you are not able to complete this form online, click Print Blank Form at the top of the first page to print the form and complete it by hand.

"Are you a(n)..."
If a person holds multiple positions within the entity, company, or organization, you must select all roles that apply.

Full legal name (last, first, middle)
You must disclose full legal name, including a full middle name. If a person does not have a middle name, enter "N/A".

Social Security number
The person's Social Security number is required.

Date of birth
The person's date of birth is required.

Home residence address, city, county or Indian reservation, state, zip code
Do not use the enrolling business address. Use the address of where the person lives.

Hire date or termination date
- If a person is being added to an existing record, or if this is being reported as a new enrollment requirement, select "Hire date" and provide the date of hire.
- If a person has left the agency or company, select "Termination date" and provide the date of termination

Relationship to any other listed person
Disclose any of the following, if applicable: spouse, child, parent, sibling.

Background study number or request ID
The following providers must complete this section:

- PCA agencies
- Transportation providers (excludes ambulance transportation)
- Anyone with 5 percent or more ownership interest or control when the entity has been assigned as high risk
- Home and community-based services (HCBS) providers providing the following services:
  - Homemaker basic cleaning
  - Caregiver living expenses
  - Housing access coordination (HAC)
  - Independent living skills (ILS) therapy services

DEPARTMENT OF HUMAN SERVICES

DHS-7618-ENG 8-21

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Home and Community-Based Settings Provider Assurance Statement

PROVIDER NAME		NPI or UMPI
Sampleville Community Resource Center	Leave blank if your agency would like to be assigned a UMPI. →	1111111111
ADDRESS		
1234 Main Street		
CITY	STATE	ZIP CODE
Sampleville	MN	50000

This assurance statement is an addendum to the provider's Minnesota Health Care Programs (MHCP) Provider Agreement.

Definition of Home and Community-Based Settings

The federal Centers for Medicare & Medicaid Services (CMS) changed the definition of home and community-based settings found in Title XIX of the Social Security Act, sections 1915(c) and 1915(i) for Medicaid Home and Community-Based Services. The rule raises expectations around what is possible for older adults and people with disabilities. It requires that all people:

- Have information and experiences with which to make informed decisions
- Are treated with respect and are empowered to make decisions about how, when and where to receive services
- Have opportunities to be involved in the community, including living and working in integrated settings

Refer to Covered and Noncovered Services in the Home and Community-Based Waiver Services (HCBS) section of the MHCP Provider manual to review the policy information and definitions for the services listed on this page.

I provide the following service(s) (check all that apply):

- ☐ Adult Foster Care
- ☐ Adult day services or adult day services bath
- ☐ Adult day services, family adult day services (FADS)
- ☐ Community Residential Services (Adult)
- ☐ Community Residential Services (Child)
- ☐ Customized living
- ☐ Day Support Services
- ☐ Family Residential Services (Adult)
- ☐ Family Residential Services (Child)
- ☐ Integrated Community Supports
- ☐ Prevocational services

Providing these services is not necessary when enrolling as a Housing Stabilization Services provider.

For Housing Stabilization Services, refer to the Housing Stabilization Services section of the MHCP Provider manual to review the policy information and definitions for the services listed on this page.

I provide the following service(s) (check all that apply): Check the services your agency will be providing (check at least one). Your agency can provide one or both of these services.

- ☒ Housing Consultation
- ☒ Housing Transition and Housing Sustaining

Provider Assurance Statement

By initialing the following statements (electronic initials accepted), I, the provider listed on this form, assure that the initialed statements are correct for the services my organization provides (as checked in the previous section).

For all Services Provided

Initial all in this section.

JD My agency or organization complies with all home and community-based services (HCBS) setting requirements identified by CMS in the Code of Federal Regulations, title 42, sections 441.530, 441.710, or 441.725:

JD The setting is integrated in and supports full access of people receiving Medicaid HCBS to the greater community, including:

- opportunities to seek employment and work in competitive integrated settings
- the ability to engage in community life
- control personal resources
- receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS

JD The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

JD The setting optimizes, but does not regiment, individual initiative, autonomy and independence to make life choices, including, but not limited to, daily activities, physical environment and with whom to interact.

JD The setting facilitates individual choice about services and supports, and who provides them.

For Residential Services Only

Initial all in this section if your agency provides Housing Stabilization-Sustaining in a provider-owned or controlled residential setting.

_____ My agency or organization understands in a provider-owned or controlled residential setting (foster care, customized living, community residential services, family residential services, housing stabilization-sustaining, integrated community supports), in addition to the requirements specified in the previous section, we must meet the following additional conditions:

_____ The unit or dwelling (for example, single-family home or apartment) is a specific physical place that the person receiving services can own, rent or occupy under a legally enforceable agreement. Also, the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord-tenant law of the state, county, city or other designated entity. For settings in which landlord-tenant laws do not apply, a residency agreement or other form of written agreement will be in place for each person receiving services, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord-tenant law.

_____ People receiving services have privacy in their sleeping area or living unit.

_____ People receiving services can lock entrance doors to units or bedrooms, with only appropriate staff having keys to doors.

_____ People receiving services that share units or bedrooms have a choice of roommates in that setting.

_____ People receiving services have the freedom to furnish and decorate their bedroom or living units according to the lease or other agreement.

_____ People receiving services have the freedom and support to control their own schedules and activities, and have access to food at any time.

_____ People receiving services are able to have visitors of their choosing at any time.

_____ The setting is physically accessible to the person receiving services.

_____ The additional conditions for residential settings will only be modified for a person receiving services if the modifications meet **all** the following:

This field is a continuation of the previous page.

- Are agreed to and documented in the person's service plan
- Will not result in a setting having the qualities of an institution
- Are not imposed upon others in the same residence
- Are the least restrictive alternative, imposed for the shortest possible time, to meet the person's needs.

For Elderly Waiver or Alternative Care Only

Skip this section. Do not initial this section.

_____ I will provide adult day services, adult foster care, customized living or family adult day services under the Elderly Waiver or Alternative Care program in the following location (initial one):

_____ In a hospital, nursing facility, intermediate care facility with developmental disability (ICF/DD), or institution for mental disease (IMD). For example, the waiver service setting and the facility location share the same address or share a common wall.
Name of institution or facility: _____

_____ Adjacent to a public* hospital, nursing facility, intermediate care facility with developmental disability (ICF/DD), or institution for mental disease (IMD). For example, the waiver service setting's location is touching the institutional facility or its property with no intervening parcel of land between the two settings.
*Definition of public: A public institution is an inpatient facility that is financed and operated by a county, state, municipality, or other unit of government. A privately owned nursing facility is not a public institution.
Name of institution or facility: _____

_____ Initial here if neither apply.

For Disability Waivers Only

Skip this section. Do not initial this section.

_____ I assure that people receiving customized living (Brain Injury [BI] or Community Access for Disability Inclusion [CADI]), community residential services (BI, Community Alternative Care [CAC], CADI, or Developmental Disabilities [DD]), family residential services (BI, CAC, CADI or DD) or integrated community supports (BI, CAC, CADI or DD) are not authorized to receive these services in the following settings:

- Adjoined to or on the same property as an institution (nursing facility, hospital, ICF/DD)
- Institution for mental disease (IMD)
- Other institution that has any financial interest in the living setting

_____ For settings established on or after July 1, 2019, I assure that people receiving adult day services (BI, CAC, CADI or DD), family adult day services (BI, CAC, CADI or DD), day support services (BI, CAC, CADI or DD), or prevocational services (BI, CAC, CADI or DD) are not authorized to receive them in the following settings:

- Adjoined to or on the same property as an institution (nursing facility, hospital, ICF/DD)
- Institution for mental disease (IMD)
- Other institution that has any financial interest in the living setting.

This requirement only applies to new adult day, family adult day, day support, or prevocational settings established on or after July 1, 2019.

More Information about the HCBS Settings Requirements

Providers can find A Provider's Guide to Putting the HCBS Rule into Practice (PDF) in addition to other resources, on the HCBS settings transition plan webpage.

An officer with authority to bind the entity (CEO, president) must sign this assurance statement. Retain a signed copy of this form in your files.

Check if signing electronically: Check this box if signing electronically.

☒ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

AUTHORIZED OFFICER NAME	TITLE	
Jane Doe	Executive Director	
SIGNATURE		DATE
Jane Doe		11/19/2020
CONTACT NAME	The contact person does not have to be the same as the signer.	PHONE NUMBER
Jane Doe		612-555-5555

Upload this signed Provider Assurance Statement with required documents through the online Minnesota Provider Screening and Enrollment (MPSE) portal or fax to **651-431-7493**.

DEPARTMENT OF HUMAN SERVICES

DHS-3891-ENG 4-17

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Request for Licensing Agency ID Number

Division of Licensing

Minnesota law (256B.4912, subd. 1(c)) requires the Department of Human Services to conduct background studies (BGS) for the owners and managerial officials of non-licensed entities that enroll to provide services through the Home and Community Based Services (HCBS) waiver or Alternative Care (AC) programs.

Complete the information below and fax this document with your enrollment request to 651-431-7493. MHCP will use this information to assign a facility ID for your agency and request the Background Studies division to create your NETStudy 2.0 account.

Owners and managing employees are required to be listed on this form if the business structure is sole proprietorship, partnership, and/or corporation. Nonprofits do not need to list board members on this form.

Entity Information

Type or clearly print the required information.

ENTITY NAME (Enrolling Provider or Provider Agency) Sampleville Community Resource Center			
ADDRESS 1234 Main Street	CITY Sampleville	STATE MN	ZIP CODE 50000
CONTACT PERSON (OWNER) Jane Doe			PHONE NUMBER 612-555-5555
BACKGROUND STUDY MAILING ADDRESS (If different than address above)	CITY	STATE	ZIP CODE
CONTACT PERSON FOR ALL BACKGROUND STUDY CORRESPONDENCE Jane Doe — This person will be the person who will be managing the NETStudy 2.0 account for HSS background studies.			PHONE NUMBER 612-555-5555
EMAIL ADDRESS (please print) jane.doe@samplevillecrc.org			FAX NUMBER 612-555-5556
ASSIGNED AGENCY ID NUMBER (for office use only) Leave this field blank for the initial submission. Write in the assigned agency ID for the re-submission once DHS assigns a Facility ID/Agency ID following the initial submission.		Leave blank if your agency would like to be assigned a UMPI. →	NPI or UMPI 1111111111

Entity Owners and Managing Employees

Complete information about each owner, managing employee or anyone else with five percent, or more controlling interest in the entity. (Attach additional sheets if necessary.) Each person listed must clear a background study before MHCP will enroll the entity as a provider.

Owner or Managerial Official (full legal name(s) and position title)		SSN	Date of birth	Percent of ownership	BGS (for office use only)
Jane Doe, Executive Director	○ Owner ◉ Manager	000000000	01/01/1965		Leave this field blank for the initial submission. Write in the NETStudy 2.0 background study number for the re-submission.
Complete as many rows as necessary for your agency.	○ Owner ○ Manager				
	○ Owner ○ Manager				
	○ Owner ○ Manager				

Page 1 of 2

Complete this page if necessary.

Owner or Managerial Official (full legal name(s) and position title)		SSN	Date of birth	Percent of ownership	BGS (for office use only)
	◯ Owner ◯ Manager				
	◯ Owner ◯ Manager				
	◯ Owner ◯ Manager				
	◯ Owner ◯ Manager				
	◯ Owner ◯ Manager				
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	◯ Owner ◯ Manager				
	◯ Owner ◯ Manager				
	◯ Owner ◯ Manager				

DEPARTMENT OF HUMAN SERVICES

DHS-3725-ENG 1-22

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

EFT Supplier ID Notification

MHCP providers must have an active 10-digit supplier ID and a 3-digit supplier location code assigned from Minnesota Management & Budget (MMB) upon registering as a supplier in order to receive electronic funds transfers (EFT). MHCP uses the MMB supplier ID to pay providers for services rendered to MHCP members. Use this form to notify MHCP of your supplier ID and supplier location code.

To obtain the 10-digit supplier ID needed to complete this form, you **must have completed the following**:

- Go to Minnesota Supplier Portal website and select "Register for an Account" and register as a "New Supplier" to get a supplier ID and supplier location code.
- To update or add banking information to an existing Supplier ID via the Supplier Portal, refer to Update Supplier Profile or you can submit the MMB EFT Bank Change Request (PDF). If you have questions whether your supplier ID is active for direct deposit, call MMB at 651-201-8106.

It will take 10 business days after adding your banking information before your supplier ID becomes active. After that, notify MHCP of your supplier ID for electronic funds transfers (EFTs) in the following ways:

1. Complete it electronically by using our online Minnesota Provider Screening and Enrollment (MPSE) portal.
   - New providers register for MPSE.
   - Existing MHCP enrolled providers, log in to your MN–ITS account. If you never registered your MN-ITS account, your login information is on your original "Welcome" Letter.
2. Use this form to type or neatly print the requested information as completely as possible. Complete all fields. An incomplete form will delay processing this application. Fax this form to MHCP Provider Eligibility and Compliance: 651-431-7462.

If you have questions about how MHCP may use and disclose private information about you, please see our Data Privacy Notice (DHS-6287) (PDF).

Provider Information

PROVIDER NAME	National Provider Identifier (NPI) or Unique Minnesota Provider Identifier (UMPI)		
Sampleville Community Resource Center	1111111111 Leave blank if your agency would like to be assigned a UMPI.		
PROVIDER STREET ADDRESS	CITY	STATE	ZIP CODE
1234 Main Street	Sampleville	MN	50000
10-DIGIT SUPPLIER ID PLUS 3-DIGIT SUPPLIER LOCATION CODE	9-DIGIT FEDERAL TAX ID/SOCIAL SECURITY NUMBER ASSOCIATED WITH VENDOR		
0000000000 - 001 Refer to instructions above on the form.	123456789		

- I understand if this supplier ID is not active for EFT, there will be delays in my MHCP payments until the supplier ID is associated to an active bank account.
- I authorize MHCP to deposit payments for services rendered, by electronic funds transfer to the bank account associated to the supplier ID listed.

Contact Information

Check if signing electronically: Check this box if signing electronically.

☒ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

CONTACT NAME		PHONE NUMBER
Jane Doe		612-555-5555
FAX NUMBER	EMAIL ADDRESS	
612-555-5556	jane.doe@samplevillecrc.org	
SIGNATURE		DATE
Jane Doe		11/19/2020

Fax this form to MHCP Provider Eligibility and Compliance: 651-431-7462

DHS-7968 - Housing Consultation Provider Assurance Statement

Clear Form

DEPARTMENT OF HUMAN SERVICES

ONLY FILL OUT DHS-7968 IF YOU ARE APPLYING TO PROVIDE HOUSING CONSULTATION SERVICES.

DHS-7968-ENG 2-22

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Housing Consultation Provider Assurance Statement

PROVIDER NAME	EFFECTIVE DATE	NPI OR UMPI
Sampleville Community Resource Center	11/19/2020	1111111111

Leave blank if your agency would like to be assigned a UMPI.

This assurance statement is an addendum to the provider's MHCP Provider Agreement.

Definition of Housing Consultation

Refer to the Housing Stabilization Services section in the MHCP Provider Manual to review the policy information and definition for this service. See Minnesota Statutes 256B.051 for statutory legal reference.

Provider Assurance Statement

By initialing each requirement (electronic initials are accepted) and signing this form, I, the named provider, assure I or staff in my employ:

JD Have knowledge of local housing resources.

JD Pass the online Housing Consultation services training available on TrainLink. I have kept records of completion in our files, which can be reviewed for auditing purposes. I assure the following people have completed the training:

Please note that by initialing and signing this form, you are assuring that the following staff have completed the listed trainings at the time of provider enrollment.

- Manager
- Supervisor
- Direct care staff
- Staff who submit Housing Stabilization requests

JD Complete Mandated Reporter training annually, which includes training on vulnerable adult law.

By initialing each requirement and signing this form, I, the named provider, assure that my organization will complete the following:

JD Submit successfully completed background studies required of all owners and managerial officials of the program before initial enrollment, reenrollment and revalidation. Owners or managerial officials oversee the management or policies of services that provide direct contact.

JD Initiate a background study for each staff person that will have direct contact with people served by the program.

JD Provide oversight of each staff that will have direct contact with people served by the program until the Minnesota Department of Human Services (DHS) issues a notice of the background study results.

JD Take any action ordered in notice of employee's background study results.

JD Meet and maintain compliance with the requirements of Minnesota Statute 245C as a licensed or unlicensed direct contact service provider.

Page 1 of 2

This assurance statement must be signed by an officer with authority to bind the entity (CEO, president). A signed copy of this form must be retained in your files.

Check if signing electronically: Check this box if signing electronically.

☒ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

AUTHORIZED OFFICER NAME	TITLE	
Jane Doe	Executive Director	
SIGNATURE		DATE
Jane Doe		11/19/2020
CONTACT NAME	The contact person does not have to be the same as the signer.	PHONE NUMBER
Jane Doe		612-555-5555

Upload this signed Provider Assurance Statement with required MHCP Home and Community-Based Services Programs Provider Enrollment documents through the online Minnesota Provider Screening and Enrollment (MPSE) portal or fax to MHCP Provider Eligibility and Compliance at 651-431-7493.

DHS-7967 - Housing Transition and Housing Sustaining Provider Assurance Statement

Clear Form

DEPARTMENT OF HUMAN SERVICES

ONLY FILL OUT DHS-7967 IF YOU ARE APPLYING TO PROVIDE HOUSING TRANSITION & SUSTAINING SERVICES.

DHS-7967-ENG 2-22

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Housing Transition and Housing Sustaining Provider Assurance Statement

PROVIDER NAME	EFFECTIVE DATE	NPI OR UMPI
Sampleville Community Resource Center	11/19/2020	1111111111

Leave blank if your agency would like to be assigned a UMPI.

This assurance statement is an addendum to the provider's MHCP Provider Agreement.

Definition of Housing Transition and Housing Sustaining

Refer to the Housing Stabilization Services section in the MHCP Provider Manual to review the policy information and definition for this service. See Minnesota Statutes 256B.051 for statutory legal reference.

Provider Assurance Statement

By initialing each requirement (electronic initials are accepted) and signing this form, I, the named provider, assure I or staff in my employ:

JD Have knowledge of local housing resources.

JD Pass the online Housing Transition and Housing Sustaining services training available on TrainLink. I have kept records of completion in our files, which can be reviewed for auditing purposes. I assure the following people have completed the training:

- Manager
- Supervisor
- Direct care staff
- Staff who submit Housing Stabilization requests

Please note that by initialing and signing this form, you are assuring that the following staff have completed the listed trainings at the time of provider enrollment.

JD Complete Mandated Reporter training annually, which includes training on vulnerable adult law.

JD Ensure services and settings meet Home and Community-Based Services (HCBS) requirements.

By initialing each requirement and signing this form, I, the named provider, assure that my organization will complete the following:

JD Submit successfully completed background studies required of all owners and managerial officials of the program before initial enrollment, reenrollment, revalidation or for new providers before enrollment.

JD Initiate a background study for each staff person that will have direct contact with people served by the program.

JD Provide supervision of each staff that will have direct contact with people served by the program until the Minnesota Department of Human Services (DHS) issues a passing notice of the background study results.

JD Take any action ordered in notice of employee's background study results.

JD Meet and maintain compliance with the requirements of Minnesota Statute 245C as a licensed or unlicensed direct contact service provider.

Page 1 of 2

This assurance statement must be signed by an officer with authority to bind the entity (CEO, president). A signed copy of this form must be retained in your files.

Check if signing electronically: Check this box if signing electronically.

☒ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

AUTHORIZED OFFICER NAME	TITLE	
Jane Doe	Executive Director	
SIGNATURE		DATE
Jane Doe		11/19/2020
CONTACT NAME	The contact person does not have to be the same as the signer.	PHONE NUMBER
Jane Doe		612-555-5555

Upload this signed Provider Assurance Statement with required MHCP Home and Community-Based Services Programs Provider Enrollment documents through the online Minnesota Provider Screening and Enrollment (MPSE) portal or fax to MHCP Provider Eligibility and Compliance at 651-431-7493.