# Housing Stabilization Services (HSS) Provider Enrollment Guide



**Last Revised: February 28, 2023** *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 <u>hss-tateam@mesh-mn.org</u> 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 <u>CSH</u>, <u>Ei-Consultants</u>, <u>Housing</u> <u>Matters</u>, <u>MESH</u>, and <u>North Star Policy Consulting</u>. *This guide is NOT a substitute for official guidance from DHS*. Please reference the <u>MN DHS Housing Stabilization Services Enrollment Criteria and Forms webpage</u> for more information.

The HSS provider enrollment process is subject to change. Please check the MN DHS website for the most upto-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:

- Online using the Minnesota Provider Screening and Enrollment (MPSE) Portal via the <u>MN-ITS</u> 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 <u>DHS eDocs library</u>. 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 <u>MN DHS website</u>, 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 <u>mandated reporter training</u>, 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 <u>Housing Consultation</u> training on TrainLink. You will need a <u>unique key</u> 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 <u>Housing</u> <u>Transition and Housing Sustaining</u> training on TrainLink. You will need a <u>unique key</u> 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 <u>Home and community-based services providers</u> 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 <u>MHCP Provider Screening Fee</u> <u>Collections System</u>.

• 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 <u>mandated reporter training</u> and the <u>TrainLink Housing Stabilization Services trainings</u> 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 <u>here.</u>

#### 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 HSS Provider Enrollment Guide - HSS-TA Team 4 Last revised: March 2024 had the same standards as the HSS background study. Information about this process is available at 2:47 in the <u>Minnesota DHS Training - Roster part 2 YouTube video</u>. We recommend you <u>contact DHS's NETStudy 2.0</u> 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	$\checkmark$	$\checkmark$	$\checkmark$
Board of Trustees members			$\checkmark$
Direct service staff	$\checkmark$		

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 <u>NETStudy 2.0's Appeals webpage</u>.

## 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 <u>NPPES Portal</u>.
  - 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.
  - <u>This NPI Application guide</u> from the California Department of Health Care Services goes through the step-by-step process of applying for an NPI in the <u>NPPES Portal</u>.
- NPI numbers can be obtained via the <u>NPPES Portal</u>.
- 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 <u>MMB website</u> or request technical assistance. A guide to the registration process is available <u>here</u>.
   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 <u>Powerpoint</u> is available on the <u>MESH</u> <u>website</u>. The HSS-TA Team also offered a different Provider Enrollment webinar as part of the Medicaid Academy held in early 2021. The <u>Powerpoint</u> and <u>recorded webinar</u> are available on the <u>MESH website</u>. The HSS-TA Team may hold additional provider enrollment webinars in the future. Upcoming trainings are posted on the <u>MESH website</u>.

## **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) <i>(do not need if your agency would like a new Unique Minnesota Provider Identifier (UMPI)* assigned by DHS)</i>	
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 <u>NPPES Portal</u> 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. <u>This NPI Application guide</u> from the California Department of Health Care Services goes through the step-by-step process of applying for an NPI in the <u>NPPES Portal</u>.

### **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 <u>DHS eDocs library</u>.
- <u>DHS-4138</u> MHCP Provider Agreement Form
- <u>DHS-7618</u> Home and Community-Based Settings Applicant Assurance Statement
- DHS-3891 Request for Licensing Agency ID Number
- <u>MHCP Fee Payment</u> Confirmation
- If your agency plans to provide Housing Consultation Services: <u>DHS-7968</u> Housing Consultation Provider Assurance Statement
- If your agency plans to provide Housing Transition and Housing Sustaining Services: <u>DHS-7967</u> 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 <u>MN-ITS</u> system before, follow the registration process for the MPSE Portal <u>here</u>. More information about the registration process is available <u>here</u>.

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 <u>here</u>.

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

DEPARTMENT HUMAN SERV	OF ICES	Minnesota.gov
	Logout	
User Guides Minnesota Provider Screening and Enrollment (MPSE) Portal	The look of some screens will change during the next few months, but functionality will remain the same.  INN-ITS  Your access to MN-ITS functions and applications (on the left menu) has been tailored based on the services you provide. Your MN-ITS Administrator may further restrict your views/access. Learn which functions and applications apply to your <i>provide</i> (type, and contact your MN-ITS Administrator with questions. These functions listed below represent an exhaustive list and may not appear for each user.  Eligibity Request (270) Look up subscriber eligibility and coverage and receive an Eligibility Response (271). Authorization Request (278) Create and submit authorization requests.  Submit and view history for X12 production batch, X12 test batch and miscellaneous (i.e., affiliation data, supplemental payments, etc.) transactions.  Submit DDE Claims (827) Submit claims directly to MHCP.  Request Claim Status (276) Check the status of a submitted claim.  Batch Submitters Refer to \$0100.0	Related Pages  Troubleshooting Guide  MHCP Payment & Claim Cut- off Calendars  MHCP Fee Schedule  X12/NCPDP Submitters  Provider Updates  Provider Website  Sign Up for Email Lists  Test Region  Related Links  Washington Publishing Company.
		NDC Search

#### 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.

Manage I	Portfolic	)				Select a screen nam to view that screen.
Use this page retrieve and o	e to manage complete you	your provider portfolio. Yo Ir submitted paper reques	ou can manage your profile or create a st.	new profile request. You	can also	Section or scree is in progress.
Show 10	✓ entries			Search:		Mome Related Links
Profile Requ Submit Date	status ↓†	Request Information	s will appear here. Request Details	tt.	Request Actions ↓↑	Partners and Provide Home Page MHCP Provider Manu Home
	Pending Review	Type Profile request Indicators Requestor	Portfolio Type Organization Legal Name Enrollment Records		View Request   Revert To Draft   Summary Report	MPSE User Manua MN-ITS Questions or Commen Contact Us
		Request Id	Owner / Authorized Persons		<u>View</u> Differences Report	
Showing 1 to 1	of 1 entries			Previous	1 Next	

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.

Select Request Type	Select a screen name to view that screen.
Use this page to select the request type you wish to make to initiate a change to your enrollment records	Section or screen is in progress.
Provider Portfolio	Home
Legal Name         Enter your agency's name if this field is editable.	Differences Report  Request Information  Profile Identifier
*=Required Field	Related Links
Request Type Selection	Partners and Providers Home Page
Request Type * Profile Request	<u>MHCP Provider Manual</u> <u>Home</u>
Request Effective Date *       11/19/2020       Image: The requested effective date can be a date prior to this application.	MPSE User Manual
	Questions or Comments?
Cancel	Contact Us

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.

DEPARTMENT OF HUMAN SERVICES	MN-ITS: Home	Minnesota.gov
<u>Logou</u>		Help
Manage Profile Iden Your profile identifier is either yo	tifier ur FEIN or SSN. Use this page to report or make changes to profile identifier.	Progress Select a screen name to view that screen. Section or screen is in progress.
Portfolio/Profile Information		Home
Source Portfolio Legal Name	Sampleville Community Resource Center YOUr current step	Differences Report Request Information
Request Type	Profile request	Organization Information
*=Demuired Field		Enrollment Records
Profile Identifier		Owners / Authorized
Social	Portfolio Type *       Organization       Select "Organization" for Portfolio Skip the SSN field and complete FEIN field.         Security Number       FEIN field.	olio Type. te the Profile Notes Related Links Partners and Providers Home Page
	FEIN **_******	MHCP Provider Manua Home
		MPSE User Manual
	Cancel	<u>MN-ITS</u> Questions or Comment
		Contact Us
015 Minnesota Department of Human Serv	ices Online Acces	

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

Manage Organization Informatio	n	Select a screen name to view that screen.
Use this page to manage your profile.		Section or screen is in progress.
Portfolio/Profile Information		Home
Source Portfolio Legal Sampleville Commun	ity Resource Center	Differences Report
Name		Request Information
Request Type Profile request		Profile Identifier
		Organization     Information
*-Demoired Field		Enrollment Records
Organization Information		<u>Owners / Authorized</u> <u>Persons</u>
		Profile Notes
Legal Name *	Sampleville Community R	Related Links
Fiscal Year End *	12/31	Partners and Providers Home Page
Ownership Type *	Non-Profit ~	MHCP Provider Manual Home
Email Address	jane.doe@samplevillecrc.o	MPSE User Manual
		MN-ITS
Phone Number *	612-555-5555	Questions or Comments?
Fax Number	612-555-5556	<u>Contact Us</u>
Supporting Documentation	No document exists	
Reason for Change Notes Action	View	

## 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.

	PARTMENT OF		MN-ITS: Home	l.	Minnesota.gov
	<u>Logout</u>				<u>Help</u>
Manage	Portfolio				Progress Select a screen name to view that screen.
Use this pag by paper an	ge to view and manag id entered by Provider	e your portfolio. You ca Enrollment.	an also create a new request or complete a request that v	was submitted	Section or screen is in progress.
Master Pro	ofile				• <u>Home</u>
		Legal Name:			Profile Identifier Organization Information
	FEIN:	**_*****	SSN:		Enrollment Records
Owne	rship		Last Profile		<u>Owners / Authorized</u> <u>Persons</u>
	Туре:		Update:		Profile Notes
		Profile Actions	iew Profile   Summary Report		Related Links
4				▶	Partners and Providers Home Page
				1	MHCP Provider Manual
Return Re	quests				<u>Home</u>
	Return Re	equests Actions	Returned Requests		MPSE User Manual
		•			uestions or Comments
Show 10	<ul> <li>✓ entries</li> </ul>		Search:		Contact Us
Requests					
Submit Date ↓	Status/Outcome 🔱	Request Information	↓↑ Request Details	Request Actions	
	Draft	Type Global request Indicators Requestor Request Id	Portfolio Type  • Organization Legal Name • Organization Information Changes • No Portfolio Identifier Changes	Edit   Delete	

	• 0	Differen Report Assign Self	nces   <u>To</u>
;	Pre	evious 1	Next
outton to ew request.	a New Request		
	Search:		
r Individual Providers			
Request Information 11 Reques	st Details	Reques	st s ↓1
No data a	available in table		
\$		Previous	Next
			•
Requests	<u>pleted Requests</u>		
man Services Online		Accessibility	Terms/Policy   Contact DHS   Top of Par
	s Dutton to ew request. Create or Individual Providers Request information If Request No data s Requests pleted Requests Actions Com uman Services Online	s Pr  putton to create a New Request Search: Search: Pr  r Individual Providers Request Information Request No data available in table s  Requests Pr  request	s Previous 1

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.

DEPARTMENT OF HUMAN SERVICES	S SMN-IT	S: Home	Minnesota.gov
<u>Logout</u>			<u>Help</u>
			Progress
Select Request Type	9		Select a screen name to view that screen.
Use this page to select the requ	lest type you wish to make to initiate a change	e to your enrollment records	Section or screen is in progress.
Provider Portfolio			Request Information
l egal Name	Sampleville Community Resource	e Center	Related Links
Legan Hame	Sampleville community resource		Partners and Providers <u>Home Page</u>
*=Required Field			MHCP Provider Manual Home
Request Type Selection			MPSE User Manual
Request Type *	<ul> <li>Global request: Manage profile informate entity, personal information, FEIN, Social Se</li> <li>Enrollment record request: Manage information an enrollment record (practice addresses, s</li> <li>Service provider to trading partner affir request to create or modify an affiliation to a</li> </ul>	ion (ownership, business acurity Number) ormation that is specific to ervices, credentials) i <b>liation request:</b> Manage a u trading partner (EDI trading	<u>MN-ITS</u> Questions or Comments? <u>Contact Us</u>
Request Effective Date *	partner, Clearinghouse, Billing Intermediary		
Manage Revalidation Requ	est Indicator dation Request? *   〇 Yes		
Cá	ancel	Continue	

### **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.

Manage Enrolln	nent Red	cords				Select a screen name to view that screen.
Use this page to manag	e your enrollm	ent records.				Section or screen is in progress.
Portfolio/Profile Inform	mation					Home
Source Portfolio L N Request 1	egal Sam ame	pleville Community Resource Cent	er	Select 1	this to view an	Differences Report Request Information Profile Identifier
				existing	) enroiment record.	Organization Information ✓ Enrollment Records
Enrollment Records -	Modify Requ	uests				Owners / Authorized Persons
000000	NPI/UMPI	Sampleville Community Resource Center	18-HSS - HCBS Housing Services	Status	View   Summary Report	Profile Notes Related Links
Enrollmont Popordo	Master List					Partners and Providers Home Page
Enrollment Record Id	NPI/UMPI	Practice/Provider Name	Enrollment Record T	ype :	Status Actions	MHCP Provider Manua Home
		There are no items in the	e list to display.			MPSE User Manual

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

			Progress
Enrollment Record Information	ı		Select a screen name to view that screen.
Use this page to manage your Enrollment Record	d Information.		Section or screen is in progress.
Portfolio/Profile Information			Home
Source Bartfolia Lagel Name		110	Differences Report
Source Portfolio Legai Name	HOUSING MATTER		Request Information
Request Type	Enrollment record re	quest	Profile Identifier
			Organization Information
			Enrollment Records
Required Field Enrollment Record Information			Enrollment Record Information
			Owners / Authorized Persons
	rouider's Practicing N	300 a 1	Profile Notes
	Towner's Fracticing N		Submit Request
	Unique Display I	Name	Related Links
		Choose "HCBS Housing Services 19 HSS	Partners and Providers Home Page
	Enrollment Record 1	ype - selectione: CHOUSE HODS HOUSINg SELACES - 18-HSS	MHCP Provider Manual Home
Med	icaid Agreement Indic	ator * Chemical Dependency Addendum	MPSE User Manual
		CNo Agreement	MN-ITS
		Standard Agreement	Questions or Comments?
		Stipulated Agreement	Contact Us
		Waiver Services Addendum	
Are you, or is this facilit	y enrolled with Medica	are?* O Yes O No	
E	ncounter Indicator *	Fee For Service and In-Network Managed Care     In-Network Managed Care Only     Out of Network Managed Care Only	
	ET Vandor Number	Courtor-Network managed Care Only	
	ndor Loostics Cort-		
EFTVe	EET Effective Print	- HALIDDANAY	
	Crit Ellective Date		
	Phone Number		
	Filone Number		
	Fax Number		
	Email Address	Lesser March	
	RISK Level *	Leave blank *	
nformation			
you, or does this facility have a contract with a provide service	a Minnesota tribe to ces on tribal land?*	○ Yes ○ No	
o you, or does this facility have a contract with	h a tribe (other than	○ Yes ○ No	
minnesota) to provide service			

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

Manage Physical Address		. ,	Select a screen name to view that screen.
Use this page to manage your physical practice addr	Section or screen		
=Required Field	~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	Enrollment
Physical Practice Address			Questions
Street Address 1 *	1234 Main Street	Enter the physical practice	Ecos
		will be provided.	Site Visits
Street Address 2 Type / Data	~		Facility / Agency
City *	Sampleville		Identifiers
State *	Minnosota		<u>Agreements /</u> <u>Addendums</u>
State	Winnesota V		Limiting Caseload
Zip Code *	50000		Notes
County / Tribe *	Sampleland ~		Enrollment Status
Home Address			<u>Service Provider to</u> <u>Trading Partner</u> <u>Affiliations</u>
			Owners / Authorized
Available Address Usage Types	Selected Add	dress Usage Types	Profile Notes
If this address is also the mailing,	Practice Locatio	n	Related Links
billing, etc. address, click those	Authorizations Remittance Advice		Partners and Providers
left and they will move to the box	Credentialing		Home Page
on the right.	Paper Check		Home
	Correspondence File Location	e	MPSE User Manual
			<u>MN-ITS</u>
			Questions or Comments?
			<u>Contact Us</u>

\* 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 Provider Identifiers	Select a screen name
Use this page to manage or view your Provider Identifier(s).	Section or screen is in progress.
Portfolio/Profile Information	Home
Source Portfolio Legal Name HOUSING MATTER LLC	Differences Report
Request Type Enrollment record request	Request Information Profile Identifier
	Organization Information
	Enrollment Records
Enrollment Record Information	Enrollment Record Information
NPI/UMPI         Practice / Provider Name         Provider Name	Physical Address
	Provider Identifiers
Enrollment Record Type 18-CM - HCBS Case Ma Unique Display Name HSS PROVIDER NAME	Facility Type
	Services
	Medicare Enrollment
	Additional Enrollment Questions
NPI/UMPI 11 Previously Assigned UMPI 11 Use UMPI 11 Effective Date 11 Active 11 Available for Reuse 11 User Actions	Credentials
There are no items in the list to display.	Fees
Rows to display: Displaying rows 0 to 0 of 0	Site Visits
	Facility / Agency Identifiers
	Agreements / Addendums
Add a Provider Identifier Continue	Limiting Caseload
	INULES

i iogress

#### Manag

Facility

lanage Facility Type Informa		Select a screen name to view that screen			
This page shows this enrollment record's facility	type information.				Section or screen is in progress.
Portfolio/Profile Information					Home
Source Portfolio Legal Name	HOUSING MATTER LLC				Differences Report Request Information
Request Type	Enrollment record request				Profile Identifier Organization Information
					Enrollment Records
Enrollment Record Information					Enrollment Record Information
NPI/UMPI		Practice / Provider Name	Provider Name		Physical Address
Enrollment Record Type	18-CM - HCBS Case Ma	Unique Display Name	HSS PROVIDER NAME		<u>Facility Type</u>
					Services Medicare Enrollment
Facility Type Information	1 Start Date	↓↑ End Date	↓↑ User Actions		Additional Enrollment Questions
	There are	no items in the list to display			Credentials
		no tema in the list to display.			Fees
Rows to display:           20         50         100				Displaying rows 0 to 0 of 0	Site Visits <u>Facility / Agency Identifiers</u> Agreements / Addendums
	Add Facility	Туре	Continue		Limiting Caseload

Progress

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.

Manage Services	;				Select a screen name
Use this page to add new of on your record based on your Service.	Section or screen is in progress.				
~~~~~	~~~~~	~~~~~~	~~~~~	~~~~	
Enrollment Record Type	Default Service Categori	es			Credentials
Default Service Categories	5				Fees
	No default	service categories exists			Site Visits
Rows to display:			Displaying row	rs 0 to 0 of 0	<u>Facility / Agency</u> Identifiers
20 50 100			<< <	> >>	<u>Agreements /</u> <u>Addendums</u>
					Limiting Caseload
Provider Speciality and	Packaged Services				Notes
Service Name	Service Begin Date	Service End Date	↓î User Acti	ons	Enrollment Status
Housing Consultation	11/19/2020	Select this option to view	View		Service Provider to Trading Partner
Housing Transition and		for this service.	View		Affiliations
Housing Sustaining	11/19/2020				Owners / Authorized Persons
Rows to display:	Profile Notes				
20 50 100	Related Links				
	Partners and Providers				
Select	this option to	ice Continue			<u>Home Page</u>
add a	new service.	Continue			MHCP Provider Manual Home

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 G	Questions	Select a screen name to view that screen.
Use this page to complete additional questions for the or No or by writing a short description in the open te	ne enrollment record location. You can answer questions by selecting Yes xt fields.	Section or screen is in progress.
Additional Enrollment Questions	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	
		<u>Credentials</u>
bo you provide 24-nour emergency coverage ?	○ Yes ◎ No	<u>Fees</u>
Do vou provide same-dav urgent care? *	Ves No	<u>Site Visits</u>
		<u>Facility / Agency</u> Identifiers
How far are you from public transportation? *	1 block	<u>Agreements /</u>
What are your hours of operations?*	Monday-Eriday: QAM-6PM	Addendums
	Saturday: 9AM-12PM	Limiting Caseload
Do you offer flexible appointment hours? *		Enrollment Status
,		Service Provider to
Do you offer non-English and American Sign Language interpreter services? *	Yes ○ No     No	<u>Trading Partner</u> <u>Affiliations</u>
Do you offer language-line interpreters? *	○ Yes  ◎ No	<u>Owners / Authorized</u> <u>Persons</u>
Do you have adequate seating in reception		Profile Notes
areas? ^		Related Links
Is the building or facility easily identified and accessible to people with disabilities? *	Yes ○ No     No	Partners and Providers Home Page
Does the parking lot provide parking ramp or		MHCP Provider Manual Home
parking lot accessibility to people with disabilities? *		MPSE User Manual
		MN-ITS
Are the handicapped parking spots wide enough to accommodate side lift systems in	● Yes ○ No	Questions or Comments?
vehicles? *		Contact Us
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	

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.

I	Manage Cree	dentials	al(a) for the enrollment	record Veu ee		-		Select a screen name to view that screen.
	Credential button. Y	Section or screen						
$\sim$	~~~~~	~~~~~	~~~~~	~~~~	$\sim$	~~~~~	~~~~	
	Credentials							Questions
	Credential Name	Lisense Tree	Licence Number	Stort Data	End Date	Oredential Status	User	Credentials
		License type	License Number	Start Date	End Date		Actions	Fees
	Housing Transition		DHS-7967	11/19/2020		-	View	Site Visits
	and Housing Sustaining Applicant			Selec	ct this option to	view a form.		<u>Facility / Agency</u> Identifiers
	Assurance Statement (DHS-							<u>Agreements /</u> <u>Addendums</u>
_	7967)							Limiting Caseload
	Housing		DHS-7968	11/19/2020			<u>View</u>	<u>Notes</u>
	Providers Applicant							Enrollment Status
	Assurance Statement (DHS- 7968)							<u>Service Provider to</u> <u>Trading Partner</u> Affiliations
	Home and Community-Based		DHS-7618	11/19/2020			<u>View</u>	<u>Owners / Authorized</u> <u>Persons</u>
	Settings Applicant							Profile Notes
	Statement (DHS-							Related Links
	7618)							Partners and Providers
	Rows to display:	Home Page						
								Home
								MPSE User Manual
		MN-ITS						
	upload a form.							Questions or Comments?

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

*	•			
Credential				<u>Enrollment</u> Questions
Credential Name	Housing Transition and	Write out the entire form namein this case, Housing Transition and Housing Sustaining Applicant Assurance Statement (DHS-7967)		<u>Credentials</u> <u>Fees</u>
				Site Visits
*=Required Field				<u>Facility / Agency</u> Identifiers
Manage Credential				<u>Agreements /</u>
				Limiting Caseload
Start Date	10/23/2020			Notes
End Date				Enrollment Status
End Bute				Service Provider to
License/Cert ID	DHS-7967			<u>Trading Partner</u> Affiliations
Issued by	~		<u>o</u>	wners / Authorized
Crodential Status				<u>ersons</u>
Gredential Status				Related Links
License Type	~		Part	mers and Providers
Licopos Verified				Home Page
License vernied	O Yes ● No		MHC	<u>SP Provider Manual</u>
Credential Documentation	dhs-7967.pdf uploaded	do 📘	M	<u>nome</u> DSE Liser Manual
				MNLITS
			Quest	tions or Comments
c	Cancel	Continue	quoot	Contact Us

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

	Manage Fees								
~	Use this page to manage your	Section or screen							
	Manage Provider Fees				Enrollment				
	Fee Payment Type	Payment Date	Payment Confirmation Number	1 User Actions	Credentials				
	Minnesota	10/23/2020	MN2DHS00000001	View	Fees				
	Rows to display:	<u>Site Visits</u> <u>Facility / Agency</u> Identifiers							
	Select this option to upload fee payment information	\dd Fee Payment Informati	on	•	Agreements / Addendums Limiting Caseload				

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.

Manage Fee Information		Select a screen name to view that screen.
Use this page to manage your application fee payme	nt information, request a refund or hardship exemption.	Section or screen
If you have not yet paid your application fee, you can <u>System.</u>	pay your fee online using the MHCP Provider Screening Fee Collections	<u>Home</u> Differences Report
*=Required Field		Fees
Fee Information		Site Visits
Fee Payment Type *	Minnesota ~	<u>Facility / Agency</u> Identifiers
Payment Date	10/23/2020	<u>Agreements /</u> <u>Addendums</u>
Deumourt Confirmation Number		Limiting Caseload
Payment Commation Number *		<u>Notes</u>
Payment Confirmation Documentation	MHCP fee payment.pdf uplo	Enrollment Status
Request Refund	⊖ Yes ⊚ No	<u>Service Provider to</u> <u>Trading Partner</u> <u>Affiliations</u>
Request Refund Reason	~	<u>Owners / Authorized</u> <u>Persons</u>
Refund Issue Date	MM/DD/YYYY	Profile Notes
Refund Confirmation Number		Related Links
Hardship Exemption Documentation	No document exists	Partners and Providers Home Page
		MHCP Provider Manual Home
CMS Hardship Referral Status	~	MPSE User Manual
CMS Hardship Referral Date	MM/DD/YYYY	MN-ITS
		Questions or Comments?
L		Contact Us
Fee Information History		
Update Date/Time Fee Payment Type Payment	Date Payment Confirmation ↓↑ Update User View All Fields	
No Fe	ee Information History exist	
L		
Cancel	Continue	

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.

	Manage Agreements		Sel to	lect a screen name		
	Use this page to manage Provid		Section or screen			
	Agreements/Addendums	Ť	Additional Enrollment Questions			
	DHS Form Number	Agreements/Addendums	Signature Date	User Actions		Credentials
	DHS-4138	Minnesota Health Care Programs (MHCP) Provider Agreement	11/19/2020	View		Fees
Rows to display:         Displaying rows 1 to 1 of 1           20         50         100				, whi	<u>Site Visits</u> <u>Facility / Agency</u> Identifiers <u>Agreements /</u> Addendums	
Select this option to upload Form Add Agreement/Addendum Continue						Limiting Caseload

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.

	Manage Agreement/Addendum							
	Use this page to upload your signed Agreements/Ad	Section or screen						
$\sim$	*=Required Field							
	Agreement/Addendum		Questions					
			<u>Credentials</u>					
	Agreement/Addendum *	Minnesota Health Car 🗸	<u>Fees</u>					
	Agreement/Addendum Documentation	dhs-4138.pdf uploaded on	<u>Site Visits</u> <u>Facility / Agency</u> Identifiers					
	Digital Signature *	Jane Marie Doe	Agreements / Addendums					
	Signers Title *	Executive Director	Limiting Caseload					
	Signature Date *	11/19/2020	<u>Notes</u> Enrollment Status					
	•	•	Service Provider to					
	Cancel	Continue	<u>Affiliations</u>					

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.

	Manage Notes	Select a screen name to view that screen.							
	Use this page to man update or view notes	Use this page to manage notes within a profile. Notes are visible and assigned based on your role types. Users can create, update or view notes of a request.							
$\succ$		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~							
	Note text	User Name 11	Update Date	Note Documentation	User Actions	Credentials			
	DHS-3891 attached	jane.doe@sampleville crc.org	11/19/2020 12:08:03 PM	DHS-3891.pdf up	View	<u>Fees</u> <u>Site Visits</u>			
	Rows to display:2050100	<u>Facility / Agency</u> Identifiers Agreements / Addendums							
	Select this option Form DHS-3891.		Limiting Caseload						

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

Manage Note		Select a screen name to view that screen.
Use this page to create a note. You can enter the note in the Notes Text box. If supporting documentation is needed for the note, use the Supporting Note Documentation to upload the supporting document. If a supporting document was previously provided, it will appear in the Supporting Note Documentation. You can check the Remove Upload box to delete the supporting document		Section or screen is in progress.
*=Required Field	$\sim$	Home Credentials
Manage Note		Fees
Note Text * DHS-3891 attached		<u>Site Visits</u> Facility / Agency Identifiers
Supporting Note Documentation DHS-3891.pdf on 11/19/2		<u>Agreements /</u> <u>Addendums</u>
User Name jane.doe@samplevillecrc.org		Limiting Caseload
		Notes
Update Date 11/19/2020		Enrollment Status
		Service Provider to
		Trading Partner
Cancel		<u>Aminations</u> Owners / Authorized

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.

Manage Owners / Authorized Persons								Select a screen name to view that screen.
Use this page to an ownership or	Section or screen is in progress.							
Owners / Authorized Persons - Modify Requests								Owners / Authorized     Persons
Business Legal Name	Person Name	Role Type	Owner/Managing Control Type	Percent Interest	NPI/UMPI	Sanctions Verified Date	User Actions	Profile Notes Related Links
	Jane Marie Doe	Managing Employee, Credentialing Contact		0			<u>View</u>	Partners and Provider Home Page
	Mary Rose Nguyen	Board Member or Officer		0			<u>View</u>	MHCP Provider Manu Home MPSE User Manual
	Jamie Johnson [no middle name]	Board Member or Officer		0			<u>View</u>	<u>MN-ITS</u> Questions or Commer
Owners / Autho								<u>Contact Us</u>
Business Legal Name I	Person Name 1	Role O Type If C	wner/Managing ontrol Type	Percent Interest ↓1	NPI/UMPI ↓↑	Sanctions Verified Date ↓1	User Actions	
There are no items in the list to display.								
Rows to display:         Displaying rows 0 to 0 of 0           20         50         100								
lect the propriate Add a tton.	a Person	Add a E	Business	confirm No Own	er Role	Continue		

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.

Manage Owner / Authorized Person Name	Select a screen name to view that screen.
Use this page to enter Owner/Authorized Person information and select the relationship to any other listed Owner/Authorized person.	Section or screen is in progress.
*=Required Field	Owners / Authorized
Owner / Authorized Person Name	Persons
First Name * Jane Check this box if the person	Authorized Person Name
Middle Name Marie does not have a middle name. Check If no Middle Name	<u>Owner / Authorized</u> Person Roles
Last Name * Doe	<u>Owners /</u> Authorized Person Detail
	Owner / Authorized
Cancel	<u>Person Background</u> Studies
	Owner / Authorized

## 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.

Manage Owner / A	Manage Owner / Authorized Person Roles							
Use this page to add Owner	Section or screen							
Owner / Authorized Pers	Owner / Authorized Person Name       Person Name       Jane Marie Doe							
Owners / Authorized Pers	Owners / Authorized Person Roles							
Enrollment Record Id 1	Enrollment Record	Role Type	Start Date 1	End Date 1	User Actions	<u>Owners /</u> Authorized Person		
111111	Sampleville Community Resource Center, HCBS Housing Services - 18-HSS, 1234 Main Street Sampleville, 111111	Managing Employee	01/01/2020		View	Detail Owner / Authorized Person Background Studies		
111111	Sampleville Community Resource Center, HCBS Housing Services - 18-HSS, 1234 Main Street Sampleville, 111111	Credentialing Contact	01/01/2020		View	Owner / Authorized Person Residential Properties Profile Notes Pelated Links		
Rows to display: 20 50 100 Select this option to add	Rows to display:     Displaying rows 1 to 3 of 3       20     50     100       Select this option to add       a role bree for the percent							
a role type for the person listed above.	MN-ITS							

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

	Manage Owner / Authorize	ed Person Role	Select a screen name to view that screen.
	Use this page to enter the Owner/Authorize	Section or screen	
$\sim$	~~~~~~	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	
	Owner / Authorized Person Name and	l Role Type	Owners / Authorized
			Persons
	Person Name	Jane Marie Doe	Owners / Authorized Bereen
	Role Type	Managing Employee	Name
			Owner / Authorized     Person Roles
	*=Required Field		<u>Owners /</u> Authorized Person
	Owner / Authorized Person Role Infor	<u>Detail</u>	
	Start Date *	01/01/2020	<u>Owner / Authorized</u> Person Background <u>Studies</u>
	End Date	MM/DD/YYYY	Owner / Authorized
	Enrollment Record *	Sampleville Community Resource ~	Person Residential Properties
		Profile Notes	
			Related Links
	Ca	Continue	Partners and Providers Home Page

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.

Manage Owner / Authorized Person Detail	Select a screen name
Use this page to enter Owner/Authorized Person information and select the relationship to any other listed Owner/Authorized person.	Section or screen is in progress.
Portfolio/Profile Information         Source Portfolio Legal Name       HOUSING MATTER LLC         Request Type       Enrollment record request         Owner / Authorized Person Name       grover emie	Home Differences Report Request Information Profile Identifier Organization Information Enrollment Records Owners / Authorized Person Name Owner / Authorized Person Roles Courses (Authorized Person Cou
-Required Field Owner / Authorized Person Detail	Detail Profile Notes
Phone Number         Fax Number         Fax Number         Email Address         Has this person ever been convicted of a criminal offense related to that persons involvement in any program under medicare, Medicaid, Title XX, or Title XXI in Minnesota or any other state or jurisdiction since the inception of these programs?*         Oriminal Exclusion Reason	Submit Reguest Related Links Partners and Providers Home Page MHCP Provider Manual Home MPSE User Manual MN-ITS Questions or Comments? Contact Us

Relationship Information         Complete the Relationship Information if the Owner/Authorized Person named above is related to anyone that is disclosed as an owner, managing employee, or authorized agent. Select a Relationship Type from the Available Relationship Types that describes the relationship of the Owner/Authorized Person named above to another owner, managing employee, or authorized agent. Select a agent. In the Relationship Information, describe the relationship. For example: Married to Jayne Doe / Father of John Doe.         Selected Relationship Types         Selected Relationship Types	Has this person ever had civil money penalties or assessments imposed under section 1128A of the Social Security Act? * Civil Exclusion Reason Has this person ever been excluded from participation in Medicare or any of the State health care programs? * Participation Exclusion Reason	<ul> <li>Yes ○ No</li> <li>Yes ○ No</li> </ul>
Complete the Relationship Information if the Owner/Authorized Person named above is related to anyone that is disclosed as an owner, managing employee, or authorized agent. Select a Relationship Type from the Available Relationship Types that describes the relationship of the Owner/Authorized Person named above to another owner, managing employee, or authorized agent. Select a gent. In the Relationship Information, describe the relationship. For example: Married to Jayne Doe / Father of John Doe.           Available Relationship Types         Selected Relationship Types           Spouse         Parent           Child         Sibling	Relationship Information	
Available Relationship Types     Selected Relationship Types       Spouse     Parent       Child     Sibling	Complete the Relationship Information if the Owner/Authorized R Relationship Type from the Available Relationship Types that des agent. In the Relationship Information, describe the relationship.	rson named above is related to anyone that is disclosed as an owner, managing employee, or authorized agent. Select a ribes the relationship of the Owner/Authorized Person named above to another owner, managing employee, or authorized for example. Married to Jayne Doe / Father of John Doe.
Available Relationship Types     Selected Relationship Types       Spouse     Parent       Child     Sibling		
Spouse Parent Child Sibling	Available Relationship Types	Selected Relationship Types
	Spouse Parent Child Sibling	

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.

Submit Request	Se	elect a screen name
Use this page to submit a request to Provider Enrollment.		Section or screen is in progress.
Request Errors There are no business rule errors for this request.	•	<u>Home</u> Differences Report
Cancel Select this option when you are ready to submit your HSS provider enrollment application.		Request Information Profile Identifier Organization

## 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 (<u>skye@ei-consultants.com</u>), 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.
	PARTMENT OF		MN-ITS: Home		Minnesota.gov
e.doe@sample	villecrc.org   <u>Logout</u>				<u>Help</u>
Manage Use this pag retrieve and	Portfolio e to manage your provi complete your submitte	der portfolio. You can ma d paper request.	anage your profile or create a new profile request. Y	′ou can also	Progress Select a screen name to view that screen. Section or screen is in progress
Return Red	quests Return Requ	uests Actions	The d Requests Select this option to view the request.	returned	Home     Related Links     Partners and Providers     Home Page
Show 10	<ul> <li>✓ entries</li> </ul>		Search:		MHCP Provider Manual Home MPSE User Manual
Profile Req	uests				MN-ITS
Submit Date 斗	Status/Outcome 1	Request Information 1	Request Details	Request	Questions or Comments
11/19/2020	Draft	Type Profile request Indicators Requestor jane.doe@sampleville crc.org Request Id 000000	Portfolio Type • Organization Legal Name • Sampleville Community Resource Center Enrollment Records • 1 Owner / Authorized Persons • 1	Edit   Delete   Summary Report   <u>View</u> Differences Report   <u>View Notes</u>	<u>Contact Us</u>
Showing 1 to 1	of 1 entries		Previo	us 1 Next	
	Create	a New Profile Request	Retrieve Portfolio		
5 Minnesota Dep	artment of Human Services	Online		Accessibility   Terms/Po	licy   Contact DHS   Top of Pag

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.

Returned Re	Select a screen name to view that screen.				
Use this page to vi	Section or screen is in progress.				
Portfolio				Home	
	Portfolio ID 111111 Legal Name Sampleville Community R				
Show 10 v er	ntries		Search:	MPSE User Manual MN-ITS Questions or Comments?	
Submit Date	Request Id 🗍	Request Type	Request Snapshot Date/Time	Contact Us	
11/19/2020	000000	Profile request	12/15/2020 09:57:01 AM		
Showing 1 to 1 of 1 e					

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.

Summary Report	Select a screen name to view that screen.
Use this page to view the summary report of the portfolio.	Section or screen is in progress.
Portfolio/Profile Information	Home
Portfolio Legal Name	Related Links
Profile Type Master Profile Assigned Reviewer	Partners and Providers Home Page
Last Update Date/Time	MHCP Provider Manual Home
	MPSE User Manual
	MN-ITS
Profile Report	Questions or Comments?
ProfileDocument-111111 pdf uploaded on 12/15/2020	Contact Us
Profile Report Uploaded Supporting Documentation	
dhs-7618.pdf uploaded on 12/15/2020 View	
dhs-7967.pdf uploaded on 12/15/2020 View	
dhs-7968.pdf uploaded on 12/15/2020 View	
MHCP fee payment.pdf uploaded on 12/15/2020	
dhs-4138.pdf uploaded on 12/15/2020 View	
dhs-3891.pdf uploaded on 12/15/2020	
0123456789_SamplevilleCommunityResourceCenter.pdf uploaded on 12/15/2020 Select "View" to view the vesponse 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.

	PARTMENT OF MAN SERVICES		MN-ITS: Home		Minnesota.gov
e.doe@sample	evillecrc.org   <u>Logout</u>				<u>Help</u>
					Progress
Manage	Portfolio				Select a screen name to view that screen.
Use this pag retrieve and	je to manage your provi complete your submitte	der portfolio. You can ma d paper request.	anage your profile or create a new profile request. `	∕ou can also	Section or screen is in progress.
Return Red	quests				✓ <u>Home</u>
	•				Related Links
	Return Req	uests Actions	ned Requests		Partners and Providers Home Page
Show 10	✓ entries		Search:		MHCP Provider Manual Home
Profile Reg	uests				MPSE User Manual
					MN-ITS
Submit Date 1	Status/Outcome 1	Request Information	Request Details	Request	Questions or Comments
11/19/2020	Draft	Type Profile request Indicators Requestor jane.doe@sampleville crc.org Request Id 000000	Portfolio Type       Select "Edit" to make         • Organization       changes to your         Legal Name       application.         • Sampleville Community Resource Center         EnrolIment Records         • 1         Owner / Authorized Persons         • 1	Edit   Delete   Summary Report   <u>View</u> Differences Report   <u>View Notes</u>	<u>Contact Us</u>
Showing 1 to 1	of 1 entries		Previo	ous 1 Next	
	Create	a New Profile Request	Retrieve Portfolio		
5 Minnesota Dep	partment of Human Services	Online		Accessibility   Terms/Pol	J icy_   Contact DHS_   Top of Pag

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

Manage Enrolln	nent Red	cords							Select a screen name to view that screen.
Use this page to manage your enrollment records.						Section or screen is in progress.			
Portfolio/Profile Inforr	nation								Home
Source Portfolio Legal Sampleville Community Resource Center					Differences Report Request Information				
Request T	Request Type       Profile request         1. Navigate to Enrollment         Records using the right sidebar					Profile Identifier Organization Information			
									Enrollment Records
Enrollment Records -	Modify Requ	Jests			4-4	A			<u>Owners / Authorized</u> <u>Persons</u>
Enrollment Record Id	NPI/UMPI	Practice/Provider Name	Enrollment Record Typ	be S	tatus	Action	IS		Profile Notes
111111		Sampleville Community Resource Center	18-HSS - HCBS Housin Services	g		View/E	dit Delete		Submit Request
				2. Selec	ct "Viev	v/Edit"	to edit.		Related Links
Enrollment Records -	Master List								Partners and Providers <u>Home Page</u>
Enrollment Record Id	NPI/UMPI	Practice/Provider Name	Enrollment Recor	d Type	S	tatus	Actions		MHCP Provider Manual
		There are no items in the	e list to display.						Home
			_						MPSE User Manual
Add a Nev	v Enrollment F	Record		Continue					MN-ITS

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

Enrollment Record Information			Select a screen name to view that screen.
Use this page to manage your Enrollment Record Informat	on.		Section or screen is in progress.
Portfolio/Profile Information			Home
Source Portfolio Logal	autras Castar		Differences Report
Name	source center		Request Information
Request Type Profile request			Profile Identifier
			Organization Information
			Enrollment Records
Enrollment Record Information			Enrollment Record Information
NPI/UMPI 111111111 Pr	actice / Provider Name Samp	oleville Community Reso	Physical Address
Enrollment Record Type 18-HSS - HC		aleville Community Pero	Mailing Addresses
	Samp	leville continuity Reso	Provider Identifiers
			Services
*=Required Field			Additional Enrollment
Enrollment Record Information			Questions
			Credentials
Practice Name *	ampleville Community Resource Cente	er -	Fees
			<u>Site Visits</u>
Unique Display Name	ampleville Community Resource Cente	er	<u>Facility / Agency</u> Identifiers
Unique Rate Name			<u>Agreements /</u> <u>Addendums</u>
Enrollment Record Type *	ICBS Housing Services - 18-HSS	~	Limiting Caseload
Facility Type	Office Location	~	Notes Enrollment Status
Facility Begin date	1/01/2020		Service Provider to Trading Partner
Facility End date	M/DD/YYYY		Amiliations

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.

	Manage Note	Select a screen name to view that screen.				
	Use this page to man update or view notes	Section or screen is in progress.				
$\sim$	~~~~~	~~~~~	~~~~~	~~~~~	~~~~~~	
	Manage Notes					Questions
	Note text 41	User Name	Update Date	Note Documentation	User Actions	Credentials
	DHS-3891 attached	jane.doe@sampleville crc.org	11/19/2020 12:08:03 PM	DHS-3891.pdf up	View	<u>Fees</u> <u>Site Visits</u>
	Rows to display:2050100	<u>Facility / Agency</u> Identifiers Agreements / Addendums				
	Select this option t the updated Form (with BGS number	Limiting Caseload				

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.

	Manage Note			Select a screen name to view that screen.
	Use this page to create a note. You can enter the note note, use the Supporting Note Documentation to uploa provided, it will appear in the Supporting Note Docume	Section or screen is in progress.		
$\sim$	*=Required Field	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	~~~~~~	Home Questions
	Manage Note			Credentials
				Fees
	Note Text *	Updated DHS-3891 attached	Label the form.	Site Visits
				Facility / Agency
	Supporting Note Documentation	No document exists	Upload your updated Form	Identifiers
				<u>Agreements /</u>
	Upload Note documentation	۲		<u>Addendums</u>
				Limiting Caseload
	User Name			Notes
	Update Date	MM/DD/YYYY		Enrollment Status
				Service Provider to
				Affiliations
	Cancel	Continue Select continue to f	inalize the upload.	Owners / Authorized Persons

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.

Submit Request	Select a screen name to view that screen.
Use this page to submit a request to Provider Enrollment.	Section or screen is in progress.
Request Errors There are no business rule errors for this request.	Home Differences Report
<ul> <li>Select this option when you are ready to submit your HSS provider enrollment application.</li> </ul>	Request Information Profile Identifier Organization

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 (<u>skye@ei-consultants.com</u>), 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 <u>DHS eDocs library</u>.
- DHS-8018 Housing Stabilization Services Provider Enrollment Application
- <u>DHS-4138</u> MHCP Provider Agreement Form
- DHS-5259 Disclosure of Ownership and Control Interest of an Entity
- <u>DHS-7618</u> Home and Community-Based Settings Applicant Assurance Statement
- <u>DHS-3891</u> Request for Licensing Agency ID Number
- <u>DHS-3725</u> EFT Vendor Number Notification
- <u>MHCP Fee Payment</u> Confirmation
- If your agency plans to provide Housing Consultation Services: <u>DHS-7968</u> Housing Consultation Provider Assurance Statement
- If your agency plans to provide Housing Transition and Housing Sustaining Services: <u>DHS-7967</u> 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 <u>NPPES Portal</u> 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. <u>This NPI Application guide</u> from the California Department of Health Care Services goes through the step-by-step process of applying for an NPI in the <u>NPPES Portal</u>.

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.

DHS-8018 - Housing Stabilization Services Provider Enrollment Application

DEPARTMENT OF HUMAN SERVICES



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 <u>Minnesota Provider Screening</u> <u>and Enrollment (MPSE) portal</u>.
  - New providers use MPSE Registration.
  - Existing MHCP-enrolled providers, log in to your <u>MN–ITS</u> 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 <u>Data</u> <u>Privacy Notice (DHS-6287) (PDF)</u>.

# **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 00000001

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

 $\bigcirc$  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 If using NPI: Enter NPI.			NPI EFFECTIVE DA	TE If using NPI fill this field with the requested
11111111	If using UMPI a new UMPI.	If using UMPI: Leave blank. DHS will assign a new UMPI.		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 EFFECTIV	E ENROLLMEN	T DATE						
11/19/2020	1/19/2020 The effective date can be a date prior to this application. Ensure this date aligns across documents.							
FEDERAL EMPLOYER II	FEDERAL EMPLOYER ID (FEIN) LEGAL NAME OF TAXPAYER, IF FEIN INDICATED							
12-3456789		Sampleville Community	Resourc	e Center				
SOCIAL SECURITY NUM	SOCIAL SECURITY NUMBER (SSN) LEGAL NAME OF PERSON (First, Middle and Last Name) IF SSN INDICATED							
Leave blank	Leave blank							
ELECAL YEAR FND (def	ault is 12/31)	EMAIL ADDRESS		NI-L-L				
12/31		iane.doe@sampleville	ecrc.org	Note the Select t	lat our example is a nonprofit.	dency		
	TRUCTURE (Ch	eck the entity type that describes	the enrolli	ng provider )		geneyi		
	rshin 2	$\bigcirc$ Partnershin 6			Nonprofit 1			
Hospital Based	d Clinic 3	$\bigcirc$ State 4		iblic 5	Professional Association 9			
Other X (for ex	ample, LP,	LLP, LLLP) SPECIFY TYPE:	Ú la		Ŭ,			
OFFICE (MAIN) PHON	E NUMBER (inc	lude area code)		OFFICE FAX NUMBER (i	nclude area code)			
612-555-5555				612-555-5556	Select the appropriate Facility Type.			
Enrollment	Enrollment Record Information				Notes: Scattered site: select "Office Loc for Facility Type.	cation"		
PRACTICE NAME (Doing Business As name) Sampleville Community Resource Center the				Providers should select residential if they are providing Housing Sustaining				
UNIQUE DISPLAY NAME (a unique name that you assign to identify each enrollment record) services at the practice address th own or control.				they				
Enrollment Record Type: HCBS Housing Services - 18-HSS				Facility Type:	• Office Location OResident	tial		
FACILITY BEGIN DATE		STATE TAX ID		Are you, or is this	s facility, enrolled 💦 🗌 Yes	No		
11/19/2020		0000000 with Medicare?						

#### 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
- OHS transaction control number order
- O Member MHCP ID number order
- OPatient account or own reference number order

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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.			

# Address 1

**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.

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	<mark>50000</mark>	Sampleland		
Is your practice address also Yes No If yes, do you want your home address Yes No your home address?					

Answer as appropriate for your agency.

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# **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
 The PDF will only let you select one option. However, you may apply for both options.
 Housing Transition and Sustaining
 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.

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#### Answer these questions as appropriate for your agency.

# 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.

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

- 1. Do you provide 24-hour emergency coverage?
- 2. Do you provide same-day urgent care?
- 3. How far are you from public transportation? 1 block
- 4. What are your hours of operation?

		Monday	Tuesday	Wednesday	Thursday	Friday	s	aturday	Sunday	,
0	pen	9:00 am	9:00 am	9:00 am	9:00 am	9:00 am	9:00	am	closed	
c	lose	6:00 pm	6:00 pm	6:00 pm	6:00 pm	6:00 pm	12:0	0 pm	closed	
5.	Dog	you offer flexible	e appointment l	nours?				• Yes	<mark>) No</mark>	
6.	Doy	you offer both n	on-English and	American Sign l	_anguage interp	reter services?		• Yes	<mark>🔿 No</mark>	
7.	Do	you offer langua	ige-line interpre	eters?				O Yes	🖲 No	
8.	Do	you have adequ	ate seating in re	eception areas?				• Yes	<mark>🔾 No</mark>	
9.	ls th	nis building or fa	cility easily ider	ntified and acces	sible to people v	with disabilities	?	• Yes	<mark>🔾 No</mark>	
10.	Doe disa	es the parking lo abilities?	t provide parkir	ng ramp or parki	ng lot accessibil	ity to people wi	th	• Yes		
11.	Are veh	the handicappe icles?	ed parking spots	s wide enough to	o accommodate	side lift systems	s in	• Yes		
12.	Are	patient care are	as accessible to	people with dis	abilities?			• Yes	<mark>🔾 No</mark>	
13	. Wha	at specific accon	nmodations do	you have availat	ole for people w	ith physical disa	bilitie	es?		
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)? If yes, then you must select one or more of the following:							,			
		Blue Plus   HealthPartners   Hennepin Hea   Itasca Medical	; lth Care (IMCare)	Medica Prime South UCare	a West Health Country Health ,	Alliance (SCHA)				

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⊖ Yes	• No
⊖ Yes	• No

# **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)					
Jun Da				11/19/2020	
CONTACT PERSON	PHONE	NUMBER	EMAIL ADDRESS	-	
Jane Doe The contact person does not have the same as the signer.	to be 612-5	55-5555	jane.doe@samplevillecrc.or	g	

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 <u>Housing Stabilization Services Enrollment Forms and</u> <u>Criteria</u> 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 <u>MPSE portal</u>. Keep copies for your records.

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DHS-4138 - MHCP Provider Agreement Form

# DEPARTMENT OF HUMAN SERVICES



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 <u>Minnesota Statutes</u>, <u>62J.536</u>, 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 <u>Code of Federal Regulations, title 42, section 455.18</u> and <u>Minnesota Statutes, 256B.27</u>, 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 <u>Minnesota Rules</u>, 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 <u>Minnesota Rules</u>, <u>9505.0175</u>, 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 <u>Code of Federal Regulations, title</u> <u>42, sections 455.100 - 455.106</u>, and upon request, full disclosure of business transactions, as is required by the <u>Code of Federal Regulations, title 42, section 455.105</u>.
- 12. Make full disclosure of persons convicted of program crimes as required by the <u>Code of Federal Regulations, title</u> <u>42, section 455.106</u>.
- 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 <u>Office of Inspector</u> <u>General List of Excluded Individuals and Entities (LEIE)</u>. 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 you agency would like to be assigned <b>Ele</b> a UMPI.	AUTHORIZED INI	ITIALS	
PROVIDER NAME	NPI or UMPI	PROVIDER TYPE		
Sampleville Community Resource Center	1111111111	18 HSS		

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- 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 <u>Code of Federal Regulations, title 42, sections 489.102</u> and <u>417.436</u>.
- 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 <u>Minnesota Rules</u>, <u>9505.2160 9505.2245</u>, 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 <u>Code of Federal Regulations, title 45</u>, <u>sections 160</u> and <u>164</u>;
    - (4) Federal law and regulations that govern the use and disclosure of substance abuse treatment records, <u>United States Code, title 42, 290dd-2</u> and the <u>Code of Federal Regulations, title 42, sections 2.1 – 2.67</u>; 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 <u>Code of Federal Regulations, title 45, sections 164.502(b) and 164.514(d)</u>, and <u>Minnesota Statutes, 13.05</u>, 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 you agency would like to be assigned <b>Ele</b> a UMPI.	Leave blank if your agency would like to be assigned Electronic initials accepted. a UMPI.		ITIALS
PROVIDER NAME	NPI or UMPI	PROVIDER TYPE		
Sampleville Community Resource Center	1111111111	18 HSS		

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- (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 <u>Code of Federal Regulations, title 45, section</u> <u>164.312</u>. 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 <u>Code of Federal Regulations</u>, <u>title 45, section 164.402</u>, 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 <u>Code of Federal Regulations</u>, <u>title 45, sections 164.400 164.414</u>.
- 22. Accept and be bound by the terms and conditions of DHS' <u>Electronic Data Interchange (EDI) Trading Partner</u> <u>Addendum to Provider Agreement</u> 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 <u>section 1902(a)(68)(A) of the Social Security Act</u>.
- 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 <u>Minnesota Statutes</u>, <u>256B.0644</u> 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.

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PROVIDER NAME	NPI or UMPI	PROVIDER TY	/PE		
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- 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 <u>Minnesota Rules</u>, <u>9505.0195</u>, 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 <u>Provider Entity Sale or Transfer Addendum (DHS-5550) (PDF)</u>. 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 <u>Minnesota Rules</u>, 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 <u>Disclosure of Ownership and Control Interest of an Entity (DHS-5259) (PDF)</u>.

	Leave blank if you agency would like to be assigned Ele- a UMPI.	r ctronic initials accepted.	AUTHORIZED INITIALS
PROVIDER NAME	NPI or UMPI	PROVIDER TYPE	
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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		1		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 <u>Minnesota Provider Screening and Enrollment (MPSE) portal</u>, 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.

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DHS-5259 - Disclosure of Ownership and Control Interest of an Entity

DEPARTMENT OF HUMAN SERVICES



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 <u>MHCP Provider Requirements</u> (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	ENTITY'S DOING BUSINESS AS NAME (DBA)							
Sampleville Commur	Sampleville Co	mmunity Re	esourc	e Center				
PROVIDER TYPE	Leave blank if your agency wou	d NPI OR UMPI		OFFICE PH	IONE NUMBER			
18 HSS	like to be assigned a UMPI. —	<mark>1111111111111111111111111111111111111</mark>		612-555-5555				
FACILITY ADDRESS		CITY		STATE	ZIP CODE			
1234 Main Street		Sampleville		MN	50000			
FEDERAL EMPLOYER ID (FEIN)		MINNESOTA TAX ID NUMBE	R					
12-3456789		0000000						
CHECK THE ENTITY TYPE THAT DESCRI	CHECK THE ENTITY TYPE THAT DESCRIBES THE ENROLLING PROVIDER: Select the appropriate option for your agency.							
○ Sole proprietorship 2	O Partnership 6	Corporation, LLC 7	Nonpro	ofit 1				
O Hospital based clinic 3	O State 4	Public 5	O Profess	ional asso	ociation 9			
Other X (i.e., LP, LLP, LLLP)								

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.

# Individual Person Ownership or Control Interest this form (such as board members) do not

necessarily require background studies. 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	y):								
Subcontractor (If perso	n or entity is listed b	ecause of owne	ership	or contr	rol interest	in a subc	ontractor	, name the sub	contractor)
Managing employee (n	not CEO, CFO, COO, C	TO)	00	wner - L	ist percen	t of owner	ship inte	rest if 5 percen	it or more:
O Indirect owner - List pe	rcent of ownership in	nterest if 5 perc	cent or	r more :		Entity r	name:		
O Board member, officer,	or business and fina	nce controller -	- CEO,	CFO, CC	00, СТО	-			
Trustee	O Authorized agen	t	$\bigcirc 0$	)ther:					
FULL LEGAL NAME (LAST)	FIRST		1	MIDDLE	If no mide	lle name,	SOCIAL SE	CURITY NUMBER	DATE OF BIRTH
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ADDRESS		CITY			STATE	ZIP CODE		COUNTY OR IND	IAN RESERVATION
100 1st Street		Samplevill	е		MN	50000		Samplelar	nd
Hire date 01/01/2020	(m/d/vvvv)	RELATIONSHIP TO	O ANY O	THER LIST	ED PERSON			BACKGROUND S	TUDY NUMBER OR REQUEST ID
Termination date	(m/d/yyyy)	○ Spouse	$\bigcirc c$	Thild	○ Parent	🔿 Sib	ling	(always required	for NEMT)
									<b>N</b> .
ARE YOU A(N) (check all that apply	y):								
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O Managing employee (n	not CEO, CFO, COO, C	TO)	$\bigcirc 0$	<mark>)wner - L</mark>	list percen	t of ownei	ship inte	rest if 5 percen	it or more:
OIndirect owner - List pe	rcent of ownership ir	nterest if 5 perc	ent or	r more :		_ Entity r	name:		
Board member, officer,	or business and fina	nce controller -	- CEO,	CFO, CC	ю, сто				
	Authorized agon	t	$\bigcirc 0$	ther ·					
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FULL LEGAL NAME (LAST)	FIRST	·		MIDDLE	If no mide	lle name,	SOCIAL SE	CURITY NUMBER	DATE OF BIRTH
FULL LEGAL NAME (LAST)	FIRST Mary			MIDDLE	If no mido write in "N	lle name, I/A"	SOCIAL SE	CURITY NUMBER	DATE OF BIRTH
FULL LEGAL NAME (LAST) Nguyen Address	First Mary	СІТҮ		MIDDLE	If no mide write in "N STATE	lle name, I/A" ZIP CODE	SOCIAL SE	CURITY NUMBER	DATE OF BIRTH 01/01/1964 IAN RESERVATION
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FULL LEGAL NAME (LAST)         Nguyen         ADDRESS         101 1st Street <ul> <li>Hire date 01/01/2020</li> <li>Termination date</li> <li>ARE YOU A(N) (check all that apply</li> <li>Subcontractor (If perso</li> <li>Managing employee (n</li> <li>Indirect owner - List pe</li> <li>Board member, officer,</li> <li>Trustee</li> </ul> FULL LEGAL NAME (LAST)             Johnson         ADDRESS           102 1st Street <ul> <li>Hire date 01/01/2020</li> <li>Termination date</li> </ul>	O (m/d/yyyy)	CITY Samplevill RELATIONSHIP TC CITY CITY CITY RELATIONSHIP TC CITY Samplevil RELATIONSHIP TC Spouse	e o o o c c c c c c c c c c c c c	MIDDLE  MIDDLE  Rose  THER LIST  Child  or contr  or contr  Child  N/A  THER LIST  Child	If no midd write in "N STATE MN ED PERSON O Parent col interest ist percen DO, CTO If no midd write in "N STATE MN ED PERSON O Parent	Ile name, J/A" ZIP CODE 50000 Sib in a subco t of owner Entity r Ile name, J/A" ZIP CODE 50000 Sib	SOCIAL SE OOOOOC Ing Dontractor Ship inter SOCIAL SE SOCIAL SE OOOOOO	CURITY NUMBER COUNTY OR IND CO	DATE OF BIRTH O1/01/1964 IAN RESERVATION TUDY NUMBER OR REQUEST ID for NEMT) k. DOCONTRACTOR DATE OF BIRTH O1/01/1963 IAN RESERVATION IND IND IND IND IND IND IND IND IND IN

Copy this page as needed to enter more individual owners.

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

Page 2 of 6

# **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):				
O Subcontractor (If person or entity is listed because of own	nership or control interest	in a subcontractor, na	ame the sub	contractor)
Owner - List percent of ownership interest if 5 percent or	more:			
OIndirect owner - List percent of ownership interest if 5 per	rcent or more :	Entity name:		
Trustee				
Other:				
FULL LEGAL NAME (taxpayer name of FEIN or on W-9 from IRS)			FEDERAL E	MPLOYER ID (FEIN)
	CITY		CTATE	710 CODE
ADDRESS			STATE	ZIPCODE
COUNTY OR INDIAN RESERVATION	OWNERSHIP OR CONTROL INT	TEREST		
	O Begin date	(m/d/yyyy)	End date _	(m/d/yyyy)
ARE VOLLA(N) (check all that apply):				
	analaina an ao mtual internat	in a culturation stars as		
	lership of control interest	. In a subcontractor, no	ane the sub	contractor)
Owner - List percent of ownership interest if 5 percent or	more:			
O Indirect owner - List percent of ownership interest if 5 per	rcent or more :	_ Entity name:		
○ Trustee				
Other:				
FULL LEGAL NAME (taxpayer name of FEIN or on W-9 from IRS)			FEDERAL E	MPLOYER ID (FEIN)
ADDRESS	CITY		STATE	ZIP CODE
		TEDECT		
		(m/d/aaaa)	) Food alasta	(m/d/una)
	O Begin date	(11/0/уууу)	End date _	(11/0/уууу)
ARE YOU A(N) (check all that apply):				
Subcontractor (If person or entity is listed because of own	nership or control interest	in a subcontractor, na	ame the sub	contractor)
		· ·		
Owner - List percent of ownership interest if 5 percent or	more:			
Indirect owner - List percent of ownership interest if 5 percent of	reent or more:	Entity name:		
Other				
FULL LEGAL NAME (taxpayer name of FEIN or on W-9 from IKS)			FEDERALE	MPLOYER ID (FEIN)
ADDRESS	CITY		STATE	ZIP CODE
COUNTY OR INDIAN RESERVATION	OWNERSHIP OR CONTROL INT			

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.

Page 3 of 6

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	% OF OWNERSHIP INTEREST				
Complete if applicable.					
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? Ores ONO
  - Had civil money penalties or assessments imposed under section 1128A of the Social Security Act?
  - Been excluded from participation in Medicare or any of the state health care programs? OYes ONo
- 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? OYes ONo

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?				
					0	Own	⊖ Lease	⊖ Manage	2
ADDRESS OF PROPERTY	CITY		STATE	ZIP CODE		COUNT	Y OR INDIAN R	ESERVATION	

Page 4 of 6

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

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

Page 5 of 6

# 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 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

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# <u>DHS-7618</u> - Home and Community-Based Settings Applicant Assurance Statement





MINNESOTA HEALTH CARE PROGRAMS (MHCP)

# Home and Community-Based Settings Provider Assurance Statement

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

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 <u>Covered and Noncovered Services</u> 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 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 <u>Housing Stabilization Services</u> 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

K Housing Transition and Housing Sustaining

Page 1 of 4

# **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.

- 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:
  - <u>JD</u> 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.

Page 2 of 4

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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 <sup>S</sup> 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.

Page 3 of 4

# More Information about the HCBS Settings Requirements

Providers can find <u>A Provider's Guide to Putting the HCBS Rule into Practice (PDF)</u> in addition to other resources, on the <u>HCBS settings transition plan</u> 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			<mark>11/19/2020</mark>
CONTACT NAME	The contact person does not have	e to be	PHONE NUMBER
Jane Doe	the same as the signer.		612-555-5555

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

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DHS-3891 - Request for Licensing Agency ID Number

DEPARTMENT OF HUMAN SERVICES



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	CITY	STATE	ZIP CODE				
1234 Main Street	Sampleville	MN	50000				
CONTACT PERSON (OWNER)	·		PHONE NUMBER				
Jane Doe			<mark>612-555-5555</mark>				
BACKGROUND STUDY MAILING ADDRESS (If different than address above)	CITY	STATE	ZIP CODE				
CONTACT PERSON FOR ALL BACKGROUND STUDY CORRESPONDENCE			PHONE NUMBER				
Jane Doe This person will be the person who will be managing	the NETStudy 2.0 account for HSS background	d studies.	<mark>612-555-5555</mark>				
EMAIL ADDRESS (please print)			FAX NUMBER				
jane.doe@samplevillecrc.org	<mark>612-555-5556</mark>						
ASSIGNED AGENCY ID NUMBER (for office use only)	cy would	NPI or UMPI					
re-submission once DHS assigns a Facility ID/Agency ID following the init	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 Offi (full legal name(s) and position	<b>cial</b> title)	SSN	Date of birth	Percent of ownership	<b>BGS</b> (for office use only)
Jane Doe, Executive Director	Owner Manager	00000000	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.

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

DHS-3725 - EFT Vendor Number Notification

### DEPARTMENT OF HUMAN SERVICES



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 <u>Update Supplier</u> <u>Profile</u> or you can submit the <u>MMB EFT Bank Change Request (PDF)</u>. 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:

- 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 <u>Data</u> <u>Privacy Notice (DHS-6287) (PDF)</u>.

PROVIDER NAME		National Provider Identifier (NPI) or Unique Minnesota Provider Identifier (UMPI)			
Sampleville Community Reso	urce Center	Leave blank if your agency would like to be assigned a UMPI.			uld
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			
000000000 - 001	Refer to instructions above on the form.	<mark>123456789</mark>			

#### **Provider Information**

- 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.

Page 1 of 2

### **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		<mark>612-555-5555</mark>
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

Page 2 of 2

#### **DHS-7968** - Housing Consultation Provider Assurance Statement **Clear Form ONLY FILL OUT**

DEPARTMENT OF DHS-7968 IF YOU ARE

HUMAN SERVICES APPLYING TO PROVIDE DHS-7968-ENG

MINNESOTA HEALTH CARE PROGRAMS (MHCP) HOUSING CONSULTATION SERVICES.

# Housing Consultation Provider Assurance Statement

PROVIDER NAME	EFFECTIVE DATE	NPI OR UMPI
Sampleville Community Resource Center	11/19/2020	111111111

This assurance statement is an addendum to the provider's MHCP Provider Agreement. Leave blank if your agency would like to be assigned a UMPI.

### 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		PHONE NUMBER	
Jane Doe	the same as the signer.		612-555-5555	

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

Page 2 of 2
## DHS-7967 - Housing Transition and Housing Sustaining Provider Assurance Statement

Clear Form

ONLY FILL OUT



JD

HUMAN SERVICES APPLYING TO PROVIDE DHS-

MINNESOTA HEALTH CARE PROGRAMS (MHCP) HOUSING TRANSITION & SUSTAINING SERVICES.

## **Housing Transition and Housing Sustaining Provider** Assurance Statement

PROVIDER NAME	EFFECTIVE DATE	NPI OR UMPI	
Sampleville Community Resource Center	11/19/2020	111111111	

This assurance statement is an addendum to the provider's MHCP Provider Agreement. Leave blank if your agency would like to be assigned a UMPI.

## 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.
  - 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:
    - Please note that by initialing and signing this form, you are assuring that the following Manager •
    - staff have completed the listed trainings at the time of provider enrollment. Supervisor •
    - Direct care staff
    - Staff who submit Housing Stabilization requests

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.

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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		<mark>11/19/2020</mark>		
CONTACT NAME	The contact person does not have to be		PHONE NUMBER	
Jane Doe	the same as the signer.		<mark>612-555-5555</mark>	

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

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