



Provider Participation Request Application

Please select the Program you are interested in contracting:

- Elant Choice, Inc. d/b/a EverCare Choice; Managed Long Term Care Plan [MLTCP]
- EverCare Social Adult Day Care Program
- Elant Choice, Inc. d/b/a EverCare at Home; Certified Home Health Agency [CHHA]

This Provider Participation Request Application is to be completed by organizations that seek contract consideration for services you intend to provide.

Please complete form and fax to 845-569-1887, Attention: Ilana Charette, Contracts Coordinator.
Please note: The completion of this form does not in any way create an agreement.

Company Name: _____

Services you would like to provide as a Contracted Vendor to be listed in our Provider Network or Clinical Care Team [please check all that apply]:

- | | |
|--|---|
| <input type="checkbox"/> Homecare Services Licensed Agency | <input type="checkbox"/> Homecare Services Certified Agency |
| <input type="checkbox"/> Homecare Services Therapies [PT, OT, SLP] | <input type="checkbox"/> Homecare Services Nutrition |
| <input type="checkbox"/> Homecare Services Social Work | <input type="checkbox"/> Skilled Nursing Facility [SNF] No. of Beds: ____ |
| <input type="checkbox"/> Adult Day Health Services | <input type="checkbox"/> Social Day Care |
| <input type="checkbox"/> DME Supplies | <input type="checkbox"/> Meals |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Social & Environmental |
| <input type="checkbox"/> Consulting | <input type="checkbox"/> Fiscal Intermediary CDPAS |
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Dentistry <input type="checkbox"/> Oral Surgery |
| <input type="checkbox"/> Optometry | <input type="checkbox"/> Podiatry |
| <input type="checkbox"/> Other: _____ | |

Thank you for your interest in partnering with EverCare!

I. APPLICATION

A. ORGANIZATIONAL INFORMATION

Date: ____ / ____ / ____

Organization's Legal Name: _____

Known As or d/b/a Name: _____

Corporate Office Street Address 1: _____

Corporate Office Street Address 2: _____

City, State, Zip: _____, _____

Tel: (_____) _____ Fax: (_____) _____

Website: _____

Not-For-Profit Small Business Minority Business Woman-Owned Business

NPI #: _____ MMIS #: _____

PFI #: _____ Tax ID #: _____

Medicaid Certified: Yes No Number _____

Does your comprehensive and/or professional/malpractice insurance coverage meet or exceed the Plan’s requirement of \$1 million per incident | \$3 million per aggregate? Yes No

In what counties are you licensed to operate/do you serve?

Orange Rockland Dutchess

What are your hours of operation?

Monday Tuesday Wednesday Thursday Friday

Hours: _____ : _____ am to _____ : _____ pm

Saturday Sunday

Hours: _____ : _____ am to _____ : _____ pm

B. CONTACT INFORMATION

Branch Office Street Address 1: _____

Branch Office Street Address 2: _____

City, State, Zip: _____, _____

Tel: (_____) _____ Fax: (_____) _____

Office Building is Wheelchair Accessible: Yes No

Services are Wheelchair Accessible [e.g. dental chair]: Yes No

C. LEADERSHIP INFORMATION

President|CEO|Owner Name: _____

Corporate Office Street Address 1: _____

City, State, Zip: _____ , _____ _____

Tel: (_____) _____ Fax: (_____) _____

Cell: (_____) _____ Email: _____

Contract Manager Name: _____

Tel: (_____) _____ Fax: (_____) _____

Cell: (_____) _____ Email: _____

Please Note:

It is a vital component to our comprehensive compliance program that we build a Provider Network and Clinical Care Team of contracted vendors ensuring that within the past 5 years, the organization, any affiliate [including a wholly or partially owned subsidiary] any predecessor company or entity, any owner of 5.0% or more of the firm’s shares, any director, officer, partner or proprietor or any employee alleged to have been acting on the part of the organization has **not** been the subject of any of the following: Medicare or Medicaid Sanctions or denial, restriction and/or suspension; Civil or criminal investigation of the New York State Ethics Commission involving violation[s] of Section 73 and Section 74 or other Sections of the Public Office Law; Criminal investigation, indictment, or judgement of conviction for any business-related conduct constituting a crime under state or federal law; Federal or state suspension, denial, restriction, suspension, reduction, revocation and/or debarment of a license/certification; State Labor Law violation deemed willful; nor, Any other federal or state citations, notices, violations orders, pending administrative hearings or proceedings, or determinations of a violation of any regulation.

It is a vital component to our comprehensive compliance program that we build a Provider Network and Clinical Care Team of contracted vendors ensuring all staff who are providing services at all times meet regulatory requirements, including valid licensure/certification, and are trained and fully competent to perform contracted duties. EverCare will review all applications to ensure steps are in place to ensure qualifications, compliance, thoroughly vetted, and sanction-screened staff.

Should a contractual agreement be signed, any information provided in this application, which subsequently is found to be false, may lead to adverse action[s], including but not limited to, denial of payments, the termination of the contract, and/or reporting to governing/regulatory bodies.