SANDHILLS CENTER
Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org Victoria Whitt, CEO

Hospital Based Inpatient Psychiatric Services Re-Credentialing Application To the Sandhills Center Network

For IPRS (State Funds) and Medicaid Services

Please submit application to:

Sandhills Center for MH, I/DD & SAS
Network Operations Dept.
Credentialing Specialist
P.O. Box 9
West End, NC 27376

INSTRUCTIONS

Hospitals must be enrolled as a provider with Sandhills Center to qualify for reimbursement for Hospital services under the 1915 b/c Medicaid Waiver. Hospitals must also have a signed contract with Sandhills Center to qualify for reimbursement of Hospital services with State (North Carolina) funds.

Re-Credentialing includes the following steps:

1. A provider's Re-Credentialing packet is considered to be invalid and must be returned to the provider for corrections and/or for additional information if:
   a) The version date on any of the documents that comprise the provider's Re-Credentialing packet is prior to October 2017. Older versions are not accepted.
   b) All spaces in the application have not been completed. Please indicate "N/A" or "None" if the question is not applicable.
   c) The Contact person's Name, Title and email address in not completed.
   d) The Signatures are not original & are not an authorized agent for the group entity.
   e) The text has been altered, highlighted, struck through, or obstructed through the use of correction fluids.
   f) The responses are illegible.
   g) The National Provider Identifier is not a valid number.
   h) Any of the documents or pages that complete the provider Re-Credentialing packet are missing.
   i) Any of the requested information in any of the documents that comprise the provider Re-Credentialing packet is missing, with the exception of the fax number and email address.
   j) Any of the required accreditation documentation is missing, including license, permit, certification, endorsement, National Plan & Provider Enumeration System (NPPES) letter etc.
   k) The provider name entered on the Medicaid Participation Agreement (for Out-of-State) does not match the required accreditation documentation and the NPPES letter (where required).

Group Applicant (Required Document Attachments)

Sandhills Center Hospital Based Inpatient and Outpatient Psychiatric Services Re-Credentialing Application.

- ☐ A copy of Accreditation Verification Letter.
- ☐ A copy of the current approval letter from CMS to participate in the Medicaid Program.
- ☐ A copy of your National Plan & Provider Enumeration System (NPPES) Letter.
- ☐ A copy of your most current Rate Notification for DRG, Rehabilitation, Psychiatric, Inpatient DRG Specific RCC Letter from the North Carolina Department of Health & Human Services Division of Medical Assistance.
- ☐ A copy of current Certified Articles of Incorporation or Articles of Organization.
- ☐ Documentation required for "Yes" answers under Disciplinary Actions.
- ☐ An original signed & dated Sandhills Center Attestation Statement.
- ☐ An original signed & dated Letter of Attestation for False Claims Act.
- ☐ A copy of your current license from the N.C. Division of Health Services Regulation.
- ☐ If an Out-of-State/Border-area Provider – A copy of a current approval letter to participate in your State's Medicaid Program.
- ☐ An original signed & dated Trading Partner Agreement (TPA)
- ☐ A copy of current Certificate of Insurance for Commercial, General, Professional & Worker's Compensation Liability indicating by provider's name coverage amounts, effective dates, expiration dates and policy numbers. (Coverage Minimum Amounts: $1,000,000 / $3,000,000 aggregate) *(SHC does not accept Notice of Intent as proof of insurance).*
- ☐ A copy of current valid DEA Certificate.
- ☐ A copy of current valid W9.
- ☐ Current Valid Enrollment with NCTracks to include all of the service site addresses

IMPORTANT POINTS TO REMEMBER

1. If services are being provided at multiple sites, you are required to list each site in this application.
2. Copies of the applicable accreditation documentation must accompany the application. If these documents are missing, the application will be returned to the provider.
3. Retain a copy of your completed Re-Credentialing application packet and all documentation submitted with the Re-Credentialing application packet for your records.
4. SHC will notify the provider within ten (10) business days of receipt of the completed application or if materials are missing.
5. Billing information and clinical coverage policies are available on Sandhills Center website at www.sandhillscenter.org.
6. Providers are requested to include on their application the name, email address, phone and fax numbers of the individual contact person at their site who is responsible for receiving Sandhills Center Network information.
7. Please review your Re-Credentialing Application packet BEFORE submitting to Sandhills Center for completeness, accuracy, and that you have signed and dated all pages requiring signature within the application. Any illegible or missing items will cause a delay in Re-Credentialing your application.
8. If you have any questions regarding the Re-Credentialing process, please contact your Credentialing Specialist.
9. Cultural Competency Training is required.
10. Each provider facility must be accommodating for members with physical disabilities. If facility is not accommodating, please provide an explanation of how those members with physical disabilities would be accommodated.

Date of Application:	For Office Use Only
Provider Name:	Prior MD Approval Date:
	SHC ID#:

Section 1: Hospital Information

1. Organization Name:
(Your organization's name must match the organization name on you current accreditation documentation & your current letter of approval from the Centers for Medicare and Medicaid Services)

2. Legal Name of Organization:
(as used for tax reporting purposes if different from Organization Name)

3. Doing Business As (DBA): *(if applicable)*

4. Federal Tax ID #:

5. Federal Tax Status ◯ **For Profit** ◯ **Non-Profit**

6. Taxonomy #(s): *(Please provide a list of Taxonomy #s for each site you are applying for on this application.)*

7. National Provider Identifier #:
(Please provide a copy of the NPI Certification Letter with this application. Please provide a list of NPI #s for each site you are applying for on this application.)

8. Is this hospital enrolled in NCTracks? ◯ **Yes** ◯ **No (If "No", provide Enrollment Registration # and Submission Date)**

Registration #: **Submission Date:**

9. Is your Hospital/Program an approved North Carolina Medicaid Service Provider? ◯ **Yes** ◯ **No**
If yes, please attach the most recent copy of your "Rate Notification for DR, Rehabilitation, Psychiatric, In-patient DRG Specific RCC Letter" from the North Carolina Division of Medical Assistance.

10. Organization Address:
Street **City** **State** **Zip+4** (Required)
(Must be a physical address – P.O. Box is not acceptable)

11. Check (√)County of Address :

☐ Anson	☐ Guilford	☐ Harnett
☐ Hoke	☐ Lee	☐ Montgomery
☐ Moore	☐ Randolph	☐ Richmond
☐ Other:		

12. Accepting new patients? ◯ **Yes** ◯ **No**

12. Website Address:

13. Number of years doing business under this name:

14. Has this Organization ever been in business under a different name? ◯ **Yes** ◯ **No**

If yes, what name:

15. PRIMARY CONTACT INFORMATION

Primary Contact Name:

Primary Contact Title:

Primary Contact E-mail Address:

16. DIRECTORS' INFORMATION

Director's Name	Director's Phone & Email Address
Executive Director / CEO:	
Financial Director/CFO:	
Assistant Director:	
Clinical/Medical Director:	
Behavioral Health Director:	
Emergency Dept. Director:	
Chairman of the Board:	

17. PERSONS AUTHORIZED TO SIGN CONTRACTS & OTHER LEGAL DOCUMENTS

Name:	**Title:**
Name:	**Title:**
Name:	**Title:**

Section 1: Hospital Information continued

18. Is the Organization incorporated? ◯ Yes ◯ No
(If yes, please attach a copy of the Certified Articles of Incorporation and any subsequent changes to the Articles of Incorporation)

19. Is the Organization State owned? ◯ Yes ◯ No

20. Has your organization ever had a contract cancelled by another LME-MCO / Area Authority / County Program in North Carolina or similar entity in another state? ◯ Yes ◯ No
(If yes, please attach explanation)

21. Identify other providers, if any, which are owned or operated by the applicant under the same owner name.
Name of Provider: _____
Address w/ Zip+4: _____
Relationship (Nursing Home, Home Health Agency, Community Based Residential Facility Hospital)

22. Is the applicant a subsidiary company, either wholly or partially owned by another organization or business?
◯ Yes ◯ No *(If yes, please provide the following information)*
Legal Business Name – Parent Company: _____
Type of Ownership: _____

23. Admission/Discharge Criteria for Inpatient Psychiatric Services, PRTF, IOP, PH, or Outpatient Services:
(May attach facility policy)

FINANCIAL & BILLING INFORMATION (The following capacity will be needed)

a) An operational computer system to include Digital Subscriber Line (DSL) or higher speed connection to the internet and hardware and/or software fire wall.

Is this currently available? ◯ Yes ◯ No

b) Current Anti-virus Protection on all devices that will store or display member identifiable information.

Is this currently available? ◯ Yes ◯ No

c) Please provide the name, number and email address of your facility's billing staff:
Name: _____
Phone: _____
Email Address: _____

d) Please indicate the method you will use to perform electronic billing:

◯ Sandhills Center Provider Direct System (web based system that you will access through high speed internet.)

◯ HIPAA Compliant Transaction Sets (837P and/or 8371 electronic files)

If you plan to use HIPAA Compliant Transaction Sets (837P and/or 8371), please list the name of your software & software vendor.

e) Do you currently have members insured by third party payers? ◯ Yes ◯ No

f) Are you contracted with any third party payer? ◯ Yes ◯ No

g) Are you interested in electronic funds transfer of payments from Sandhills Center? ◯ Yes ◯ No

If yes, you must complete an Authorization Agreement for Automatic Deposits.

24. QUALITY MANAGEMENT

a) Please indicate your hospital's contact name, phone number & email address for follow-up on incident reports or investigations:

Name:	
Phone Number:	Email Address:

b) Do you have a Clients' Rights Committee? ◯ Yes ◯ No

Clients' Rights Contact Name:	
Phone Number:	Email Address:

c) Quality Management Contact:

Phone Number:	Email Address:

Section 2: Facility Programs Information		
Facility/Program Name:		
Address w/ Zip+4:		
NPI #:	Rate Billing Code:	
Number of Beds:	Child/Adolescent or Adult:	
Is this facility/site staffed and equipped to serve members with physical disabilities? ◯ Yes ◯ No		
If no, please explain how you plan to accommodate those members with physical disabilities.		
Supporting Psychiatrist(s) Name & Address:		
Hospital Employee or Other Practice?	If Hospital Employee please list their NPI #:	
Accreditation:		
Date of last JCAHO Review:	Years Accredited	Expiration Date
Licensure:		
DHSR License #:	Expiration Date:	

Section 2: Facility Programs Information		
Facility/Program Name:		
Address w/ Zip+4:		
NPI #:	Rate Billing Code:	
Number of Beds:	Child/Adolescent or Adult:	
Is this facility/site staffed and equipped to serve members with physical disabilities? ◯ Yes ◯ No		
If no, please explain how you plan to accommodate those members with physical disabilities.		
Supporting Psychiatrist(s) Name & Address:		
Hospital Employee or Other Practice?	If Hospital Employee please list their NPI #:	
Accreditation:		
Date of last JCAHO Review:	Years Accredited	Expiration Date
Licensure:		
DHSR License #:	Expiration Date:	

Section 2: Facility Programs Information		
Facility/Program Name:		
Address w/ Zip+4:		
NPI #:	Rate Billing Code:	
Number of Beds:	Child/Adolescent or Adult:	
Is this facility/site staffed and equipped to serve members with physical disabilities? ◯ Yes ◯ No		
If no, please explain how you plan to accommodate those members with physical disabilities.		
Supporting Psychiatrist(s) Name & Address:		
Hospital Employee or Other Practice?	If Hospital Employee please list their NPI #:	
Accreditation:		
Date of last JCAHO Review:	Years Accredited	Expiration Date
Licensure:		
DHSR License #:	Expiration Date:	

Section 3: DISCIPLINARY ACTIONS

You must answer all questions in this section.

	Yes	No
1. Have you, any of the individuals or entities listed in sections above or any individual employed in a clinical role ever:	○	○
a) Been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony or enter into a pre-trial agreement for a felony?		
If yes, list the name(s) of the individual(s) and you must attach a complete copy of the criminal complaint and final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.	○	○
b) Had any disciplinary action taken against any business or professional license held in this or any other state?	○	○
c) Had your license to practice restricted, reduced or revoked in this or any other state?	○	○
d) Been previously found by a licensing, certifying or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided?	○	○
e) Entered into a Consent Order issued by a licensing, certifying or professional standards board or agency?	○	○
If any of the questions above were answered "Yes", please provide the following information:		
Against Whom?		
Action Taken?		
Who Took Action?		
Date of Action?		
If yes, you must attach a complete copy of the Consent Order and/or Final Disposition. You must also attach documentation from the proper authorities approving the re-instatement of the license.		
f) Had any action or investigation against you or any owner or qualified professional in your organization relating to:		
License:	○	○
Certification:	○	○
Registration:	○	○
Privileges:	○	○
Billing Organizations:	○	○
Sanctions:	○	○
g) Have any adverse actions been filed against you by : (If yes, please attach an explanation)	○	○
Medicaid:	○	○
Medicare:	○	○
Other Insurance:	○	○
h) Been denied enrollment, suspended, excluded, terminated or involuntarily withdrawn from Medicare, Medicaid or any other government or private health care or health insurance program in any state, or been employed by a corporation, business, or professional association that has ever been suspended, excluded, terminated or involuntarily withdrawn from Medicare, Medicaid or any other government or private health care or health insurance program in any state?	○	○
If yes, you must list the name(s) & provider number(s) of the individual(s) or entity(ies) & attach a complete copy of the applicable documentation.		

Name	Provider Number

i) Has your organization been excluded from participation in Federal Health Care Programs under either Sections 1128 or 1128A of the Social Security Act?	○	○

Section 3: DISCIPLINARY ACTIONS continued

	Yes	No
j) Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that ever had suspended payments from Medicare or Medicaid in any state? If yes, you must list the name(s) and provider number(s) of the individual(s) or entity(ies) & attach a complete copy of the applicable documents.	○	○

Name	Provider Number

k) Had any civil monetary penalties levied against this organization / entity or any individuals or entities listed above in h), i), j) or k) above by Medicare, Medicaid or other State or Federal Agency Program, including the Division of Health Service Regulation (DHSR), even if the fine(s) have been paid in full? If yes, you must attach an explanation & supporting documentation from the agency or program which levied the penalties as to the reason.	○	○
l) Owe money to Medicare or Medicaid that has not been paid?	○	○
m) Been convicted under Federal or State Law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services? If yes, list the name(s) of the individual(s) & you must attach a complete copy of the criminal complaint & final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.	○	○

Name(s)

n) Been convicted under Federal or State Law of a criminal offense related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance? If yes, list the name(s) of the individual(s) & you must attach a complete copy of the criminal complaint & final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.	○	○
o) Been convicted of any criminal offense related to fraud, theft, embezzlement, breach of fiduciary responsibility, financial misconduct or moral turpitude? If yes, list the name(s) of the individual(s) & you must attach a complete copy of the criminal complaint & final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.	○	○
p) Been found to have violated Federal or State Laws, rules or regulations governing North Carolina's Medicaid Program or any other State Medicaid Program or any other publicly funded Federal or State Health Care or Health Insurance Program and been sanctioned accordingly? If yes, you must list the name(s) and provider number(s) of the individual(s) or entity(ies) & attach a complete copy of the applicable documentation.	○	○

Name(s)	Provider Number(s)

Section 3: DISCIPLINARY ACTIONS continued		
	Yes	No
q) Been convicted of an offense against the law other than a minor traffic violation? If yes, list the name(s) of the individual(s) & you must attach a complete copy of the criminal complaint & final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.	○	○
r) Has anyone in your company who has an ownership, managerial or clinical role ever been sanctioned by any professional organization or government organization for violation of ethics, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country? If yes, list the name(s) of the individual(s) & you must attach a complete copy of the criminal complaint & final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.	○	○
s) Are you aware of any circumstances that may result in such an action? If yes, attach explanation.	○	○

Section 4: SIGNAUTRE AUTHORIZATION & RELATED INFORMATION REQUIRED
*****ALL INFORMATION MUST BE ENTERED FOR THE APPLICATION TO BE PROCESSED*****
I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a PCHP Medicaid Provider.
Name of Authorized Agent:
Title:
Authorized Agent's Signature Above this line
Date:

SANDHILLS CENTER

Hospital Specifics

Cultural, Racial, Ethnic, Gender and Linguistic Data Form

(This information will reside within Sandhills Center's Provider Directory and the online Provider Search. This section is self-reported information and requires no backup documentation.)

By providing the information below, you will be assisting Sandhills Center with member/provider matching as well as providing information necessary for analyzing our network and its ability to meet our Members' cultural, racial, ethnic and linguistic needs.

Hospital Name:		
Counties Served:		
☐ Anson	☐ Guilford	☐ Harnett
☐ Hoke	☐ Lee	☐ Montgomery
☐ Moore	☐ Randolph	☐ Richmond
☐ Other(s):		
Ages Served:		
☐ All Ages	☐ Adults (22+)	☐ Child/Adolescent (5-21)
☐ Early Childhood (0-4)	☐ Geriatrics (55+)	
Populations:		
☐ All Populations	☐ Female	☐ Gay & Lesbian
☐ Gender Identity Issues	☐ Hearing Impaired	☐ HIV/Aids
☐ IDD-Adult	☐ IDD-Child	☐ Male
☐ MH-Adult	☐ MH-Child	☐ SA-Adult
☐ SA-Child	☐ Sexually Reactive/Aggressive Youth	☐ Visually Impaired
Race/Ethnicities:		
☐ All Races/Ethnicities	☐ American Indian & Alaska Native	☐ Asian, Pacific Islander
☐ Black or African American	☐ Hispanic or Latino	☐ White
Languages Spoken Fluently:		
☐ American Sign Language	☐ Chinese/Korean	
☐ English	☐ French	
☐ German	☐ Hmong	
☐ Spanish	☐ Other:	
○ Yes ○ No - Completed Cultural Competency Training.		

Sandhills Center

Hospital Specialties

By providing the information below, you will be assisting Sandhills Center with member/provider matching as well as providing information necessary for analyzing our network and its ability to meet our members' needs.

Please check all that apply.

☐	Abuse-Physical, Sexual, and/or Emotional	☐	Therapeutic Foster Care
☐	Addiction Psychiatry	☐	Trauma Focused Services
☐	Addiction Treatment	☐	Dialectical Behavior Therapy
☐	Anger Management	☐	Eye Movement Desensitization and Reprocessing Therapy
☐	Assessment Evaluation	☐	Matrix Model (SA)
☐	Career/Vocational Counseling	☐	Motivational Interviewing
☐	Child Psychiatry	☐	MST (Multi Systemic Therapy)
☐	Co-Location with/Primary Care Physician	☐	Seven Challenges (SA)
☐	Cognitive / IQ	☐	Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
☐	Cognitive Behavioral Therapy	☐	Wellness Recovery Action Plan
☐	Community-Based Services	☐	Amnestic Disorder
☐	Crisis Services	☐	Anxiety/Phobias
☐	Crisis/Solution focused Brief Therapy	☐	Attention Deficit Hyperactivity Disorder
☐	Detoxification Services	☐	Autism - Asperger
☐	Developmental limited/extended	☐	Behavior Plans
☐	Faith Based Counseling/Services	☐	Bipolar Disorder (Manic - Depressive Illness)
☐	Forensic Psychology/Psychiatry	☐	Chemical Dependency / Substance Abuse
☐	Forensic Screening/Evaluation	☐	Co-Occurring / Dual DX-Mental Illness, Mental Health, Substance Abuse
☐	General Psychiatry	☐	Conduct Disorders
☐	General Psychology	☐	Dementia Disorder
☐	Gero Psychiatry	☐	Depression
☐	Grief and Loss Therapy	☐	Eating Disorders
☐	Health Psychology-Chronic Medical Conditions	☐	Factitious Disorders
☐	Inpatient Services	☐	Impulse Control
☐	Intensive In-Home Therapy	☐	Mental Health
☐	Maltreatment	☐	Intellectual /Developmental Disabilities
☐	Marriage and Family Counseling	☐	Obsessive-Compulsive Disorder
☐	Neglect	☐	Personality Disorders
☐	Neuro Psych	☐	Post-Traumatic Stress Disorder (PTSD)
☐	Outpatient Therapy	☐	Schizophrenia and other Psychotic Disorders
☐	Personality	☐	Sex Offender Treatment
☐	Play Therapy, Filial Relaxation / Meditation-Hypnotherapy	☐	Sexual & Gender Identity Issues Illness, Mental Health / Substance Abuse
☐	Psychiatry	☐	Sleep Disorders
☐	Psychological Testing	☐	Somatoform Disorders
☐	Rape	☐	Traumatic Brain Injury
☐	Residential Services	☐	Abuse and Neglect
☐	Self-Direction	☐	Dual Disability
☐	Telemedicine		

Please List Independent Practitioners:

If the Hospital has LIPs (including provisional) that are billing for services under the Hospital's Tax ID #, then please list all LIPs with their credentials, license type, NPI # and Taxonomy # for those who are currently serving SHC members.

(You may make copies of this page if more space is needed/ please print)

	LIP Name	License Type	NPI	Taxonomy
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SANDHILLS CENTER

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org Victoria Whitt, CEO

Attestation Statement

No Stamps or Copies Please (Original Only)

This Application is to be signed by the individual who has authorization to submit an application on behalf of this hospital.

I certify that I am authorized to sign this application and the information I have provided is complete and accurate to my knowledge. I understand that any misstatement in this application may constitute grounds for denial of the application or termination of a resulting participating agreement.

In making this application for membership or reappointment in the Sandhills Center Provider Network, I acknowledge that I have read and agree to comply with the Sandhills Center contract requirements, Trading Partner Agreement, and credentialing criteria and I am familiar with the standards and ethics of the national, state, and local associations that apply to and govern the hospital and the clinical professions within. I agree to be bound by the terms thereof if the hospital is granted provider status, and I further agree to be bound by the terms thereof in all matters relating to the consideration of this application for membership in the provider network.

By application for membership or reappointment in the Sandhills Center Provider Network, I signify my willingness to appear for an interview in regard to my application. I authorize Sandhills Center to consult with administrators and members of the agencies, corporations or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application.

Upon request, I will obtain and provide to Sandhills Center materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary actions, suspensions, or actions to curtail my clinical practice, I further authorize Sandhills Center to collect any information necessary to verify the information in the credentialing application.

I understand and agree that I, as representative of this Hospital, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications.

I release from liability all representatives of Sandhills Center for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications. I also hereby release from liability any and all individuals and organizations that provide information to Sandhills Center or its staff in good faith and without malicious intent concerning my competence, ethics, character, and other qualifications for membership in the Provider Network, and I hereby consent to the release of such information.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Sandhills Center may report the rejection to the appropriate state licensing board.

In the event that I am accepted for participation in the Sandhills Center provider network, I consent to Sandhills Center for inspection of member records relating to Sandhills Center members as necessary for its peer and utilization review purposes as permitted by state or federal laws and regulations. I further agree to notify Sandhills Center in a timely manner **(not to exceed 30 days)** of any changes to the information requested on the application.

_____

Name of Hospital above

_____

Name of Authorized Representative (please print above)

_____

Signature of Authorized Representative above ***Date***

North Carolina Department of Health & Human Services

MEDICAID LETTER OF ATTESTATION

The Deficit Reduction Act (DRA) of 2005, which went into effect January 1, 2007, required specific changes to states' Medicaid programs. One of the changes is the requirement for employee education about false claims recovery. Section 6032 of the DRA amended the Social Security Act, Title 42, United States Code, Section 1396(a) by inserting an additional relevant paragraph (68). This paragraph is cited below; in summary it requires any entities that receive or make annual payment under the Medicaid State Plan of at least five million dollars to have detailed, specific written policies established about the Federal and State False Claims Act for their employees, agents and contractors.

Specifically, 1396(a) (68) of the Social Security Act requires that any entity that receives or makes annual payments under the State plan of at least $5,000,000 as a condition of receiving such payments, shall –

(A) Establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under section 3729 through 3733 of title 31, United States Code [31 USCS 3729-3733], administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code [31 USCS 3801 et. seq.], an State laws pertaining to civil penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste and abuse in Federal health care programs (as defined in section1128B(f)[42 USCS 1320-7b(f)];

(B) Include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste and abuse; and

(C) Include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of the employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste and abuse;

Effective January 1, 2007, all providers who meet the above conditions are required to certify that they are in compliance with 1396(a)(68) of the Social Security Act as a condition of enrollment in the North Carolina Medicaid Program.

As a North Carolina Medicaid provider, or the owner / operator / manager of a North Carolina Medicaid provider entity, I certify that our entity has read and understands the above requirements. I also certify that if our entity receives or makes annual payments under the State plan of at least $5,000,000 we have complied with and established written policies and procedures that provide detailed information concerning the Federal False Claims Act, 31 USC 3729 et. seq., administrative remedies for false claims and statements established under 31USCS 3801 et. seq., and any North Carolina State Laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste and abuse in Federal health care programs.

I further certify, when the above conditions apply, that our entity's written policies include detailed provisions regarding our policies and procedures for detecting and preventing fraud, waste and abuse; and that our employee handbook contains a specific discussion of the Federal and State False Claims Act, the rights of the employees to be protected as whistleblowers, and our policies and procedures for detecting, preventing fraud, waste and abuse.

Copies of any and all training manuals, written policies and procedures for detecting and preventing fraud, waste, and abuse, and employee handbooks will be maintained on site for a minimum of five (5) years for inspection and auditing by the Division of Medical Assistance.

*Medicaid Provider Name (must match name on Medicaid Participation Agreement or Provider Administrative Participation Agreement)
*Street Address (Physical Site – not P.O. Box)
*City, State and Zip + 4 (required)
I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual applications must have the provider's original signature. Authorized agents can only sign for a group application.
*Signature of Applicant or Authorized Agent above Date
*Printed Name and Title above

Required fields are marked with an asterisk (*).

SANDHILLS CENTER

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org Victoria Whitt, CEO

Trading Partner Agreement

TRADING PARTNER AGREEMENT– Electronic Data Interchange (EDI)

This document constitutes an agreement to the following provisions for exchanging Electronic Data Interchange (EDI) between the Trading Partner and Sandhills Center (SHC).

The Trading Partner agrees:

1. To conform to the requirements for *Administrative Simplifications* as defined in the provisions of the *Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-91),* and regulations promulgated there under and to take no action which adversely affects SHC's HIPAA compliance.

2. That it will promptly notify SHC of any and all unlawful or unauthorized disclosures of confidential information or protected health information (PHI) that comes to its attention and will cooperate with SHC in the event any litigation arises concerning the unauthorized use, transfer, or disclosure of either confidential or protected health information.

3. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all participant-specific data from improper access.

4. That it will ensure that all files transmitted comply with the appropriate national *Electronic Data Interchange (EDI) Transaction Set Implementation Guide, in effect on the date of transmission, as provided by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.*

5. That it will establish and maintain procedures and controls so that information concerning SHC health plan participants or any information obtained from SHC, shall not be used by agents, officers, or employees of the trading partner other than for its sole intended purpose.

6. That the information stated in any EDI Trading Partner Profile(s) submitted with this Agreement, or subsequently is correct and complete.

7. That it will allow SHC 30 days after receipt of written notice from the Trading Partner if there is any change in the trading partner representative or location where electronic transactions are sent.

8. That it is bound by this written agreement to comply with state and federal law, if the trading partner is an intermediary for the billing provider.

SHC agrees:

1. To conform to the requirements for *Administrative Simplifications* as defined in the provisions of the *Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-91),* and regulations promulgated there under and to take no action which adversely affects the trading partner's HIPAA compliance.

2. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all participant-specific data from improper access.

3. That it will ensure that all files transmitted comply with the appropriate national *Electronic Data Interchange (EDI) Transaction Set Implementation Guide, in effect on the date of transmission, as provided by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.*

Both parties agree:

1. That documents will not be considered as received and no responsibility assigned until accessible at the receiving party's computer.

2. That upon receiving any documents, to prepare and transmit a timely response or an acknowledgement of transaction receipt. If acceptance of a document is required, a document is not considered received until an acceptance acknowledgement is returned.

3. To notify the other party within a reasonable time frame if any transmitted data are received in an unintelligible or garbled form.

4. That each party will provide and maintain the equipment, software, services, and testing necessary to transmit and receive documents.

5. To conduct business and perform as required by this agreement and any applicable rules or regulations.

6. That this agreement will remain in effect until terminated by either party with at least 30 days prior written notice. The notice will specify the effective date of termination, but will not affect the obligations or rights of either party prior to the effective date of termination. This agreement is automatically terminated in the event the trading partner is disqualified through a federal administrative action or state action. That any document transmitted according to this agreement will be considered an original and signed when received.

Effect of Termination

1. Except as provided in paragraph (2) of this section or in the contract or by other applicable law or agreements, upon termination of this agreement and services provided by the Trading Partner, for any reason, the Trading Partner shall return or destroy all Protected Health Information received from SHC, or created or received by Trading Partner on behalf of SHC. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of the Trading Partner. Trading Partner shall retain no copies of the Protected Health Information.

2. In the event that Trading Partner determines that returning or destroying the electronic protected health information is not feasible, Trading Partner shall provide to SHC notification of the conditions that make return or destruction not feasible. Trading Partner shall extend the protections of this agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Trading Partner maintains such Protected Health Information.

_____

Trading Partner Name

_____

Street Address Line 1 (Site/Physical Address, not a P.O. Box)

_____

Street Address Line 2

_____

City, State, Zip Code

_____

Contact Information (Phone Number, email address)

_____

Signature of Applicant or Authorized Individual Date

_____

Printed Name and Title

For Sandhills Center for MH, DD & SAS use only

Trading Partner's EDI Submitter ID: _____

Sandhills Center for MH, DD & SAS Receiver ID: SHC303

Please return completed form to:
Sandhills Center for MH, DD & SAS
P.O. Box 9
West End, NC 27376
Attn: EDI Coordinator, Information Technology Department

SANDHILLS CENTER
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WAIVER REGARDING
AUTO AND WORKERS' COMP INSURANCE COVERAGE

Dear Provider:

Sandhills Center is now requiring that all agency applicants provide proof of auto and worker's comp insurance coverage or sign a waiver stating that the auto and worker's comp insurance is not required. If your agency does not have the aforementioned insurance coverage, we ask that you please complete, sign and date the waiver below as part of your agency's Sandhills Center application.

I, _____, attest to the following regarding Auto and Workers' Comp Liability coverage for
Please Print Name

_____:
Please Print Agency Name

- ◯ Agency **does** have Auto Liability coverage, and I have attached proof of auto insurance coverage.
- ◯ Agency **does not** have Auto Liability coverage, and I have attached an explanation on agency letterhead as to why not. I hereby acknowledge that by checking this option and providing the aforementioned explanation, Sandhills Center is reasonably relying upon these representations in making a decision on my credentialing application.
- ◯ Agency **does** have Worker's Comp Liability coverage, and I have attached proof of Workers' Comp insurance coverage.
- ◯ Agency **does not** have Worker's Comp Liability coverage, and I have attached an explanation on agency letterhead as to why not. I hereby acknowledge that by checking this option and providing the aforementioned explanation, Sandhills Center is reasonably relying upon these representations in making a decision on my credentialing application.

_____
Provider Signature

_____
Date

Indemnification Agreement: By signing this waiver, I hereby agree to indemnify and hold harmless Sandhills Center from all losses, costs, damages, claims, liabilities and expenses (including attorneys' fees and court costs) whatsoever, which may arise or be claimed against Sandhills Center, for any loss, injuries or damages, consequent upon or arising from any acts, omissions, neglect or fault in connection with Sandhills Center's reliance upon this waiver.

P.O. Box 9, West End, NC 27376
24-Hour Access to Care Line: 800-256-2452
TTY: 1-866-518-6778 or 711
Serving Anson, Guilford, Harnett, Hoke, Lee, Montgomery,
Moore, Randolph & Richmond Counties