



Medicaid Information  
Technology System

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# **Provider Medicaid Portal User Manual**

## **Volume 3B**

### **Enrollment - Organizations**

T4D027\_Provider\_Medicaid\_Portal\_UM\_03B\_Enrollment.doc

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# 1 PROVIDER ENROLLMENT - ORGANIZATIONS

Instructions for enrollment presented in this volume of the Provider Medicaid Portal User Manual address new enrollment for organizations who wish to provide comprehensive medical care to Ohio Medicaid recipients.

Organizations who have not previously worked with the Ohio Department of Jobs and Family Services (ODJFS) under a Medicaid provider agreement can easily enroll via the Provider Medicaid Portal. Access to the Provider Medicaid Portal's external Internet pages is necessary to begin the enrollment process.

## General Information

If assistance is needed while working through the enrollment panels for MITS, providers can contact ODJFS. Phone numbers are posted for assistance on the right side of the Welcome to Ohio Medicaid Banner:



**Providers should call 1-800-686-1516.** This is a toll-free number for Ohio Medicaid Information Systems and connects the caller to an interactive voice response system.

## Special Features

When working in the Provider Medicaid Portal application, special features are available. These features include icons and special characters that the system displays to assist with performing tasks. A brief description of each feature is shown next.

Icon	Meaning
	The value entered or selected in the field is in error. When this icon appears, a message that identifies the error appears at the top of the page.
	View more detailed information about a record in a list. <b>Note:</b> dependent on site setting selected from Account > Site Settings.
	Access online Help information for a panel. Located in the upper right corner of a panel, when this feature is available for that panel.
	Select or deselect a row of information for processing.

Special Character	Meaning
*	An asterisk next to a field name indicates that information is required in that field. Some fields will be required based on selections or values made in other fields; in these cases, an asterisk may not appear next to the field.

Special Character	Meaning
?	A bold question mark appears when the cursor hovers over a field label. The question mark indicates that online help is available for that field. When the question mark is visible, click on the field name to view its definition.

## Accessing the Provider Medicaid Portal

To provide and be reimbursed for Ohio Medicaid services, new enrollees must access the Ohio MITS online Provider Medicaid Portal system to manage and perform tasks using an individual provider account. The Ohio Provider Medicaid Portal is accessed from the ODJFS web site. To access the Ohio Provider Medicaid Portal, a provider must have:

- A computer with public Internet access via an Internet Service Provider (ISP).
- Microsoft Internet Explorer version 6.5 – 8.0 or Firefox 1.5 – 3.5 loaded as the browser on the computer that will be used to perform MITS tasks.

The steps below explain how to access the ODJFS Ohio Medicaid Welcome page.

1. Double-click the **Internet Explorer** icon  on the computer's desktop, or the **Firefox** icon  if using Firefox as an internet browser. The browser application opens and displays the provider's personal Internet home page.
2. **Copy**, then **paste** the URL address below it in the **Address** field at the top of the browser. Press **Enter** on the keyboard.

<http://jfs.ohio.gov/OHP/index.stm>

3. The internet **ODJFS Medicaid Welcome Page** displays.

### ODJFS Medicaid Welcome Page

The Ohio Department of Job and Family Services Medicaid Welcome page is the gateway to the Provider Medicaid Portal.

Ohio.gov | Department of Job and Family Services

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About JFS | Our Services | Info Center | News & Events

Job & Family Services Ohio Medicaid

Medicaid Home  
MITS  
Consumer Info  
**Provider Info**  
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Latest News

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**Welcome to Ohio Medicaid**  
Ohio's public health care program

**Need help?**  
Consumers: 1-800-324-8680  
Providers: 1-800-686-1516  
[Locate a county office](#)

**Important MITS Information:** If you have questions about MITS or recently filed claims, please call 1-800-686-1516 between the hours of 8:00 a.m. - 4:30 p.m. Monday through Friday.

For other contact information please [click here](#)

If you have already contacted the Provider Call Center for user ID and password issues, please be patient while your issue is being researched. We will respond as soon as possible. Please do not resubmit requests.

**Welcome to Ohio Medicaid**

MITS

**MITS IS LIVE!**  
[CLICK HERE](#)  
[Important MITS Information](#)

**Consumers**

- Get coverage
- Already enrolled?
- Programs
- Other Resources

**Providers**

- Billing
- Enrollment & Support
- Provider Types
- Other Resources

**Resources**

- Publications
- Workgroups & Committees
- Helpful Links

News

[Coming January 1, 2012 federal mandated HIPAA 5010 Implementation](#)

[Medicaid Managed Care Quarterly News Letter](#)

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Note that there are several links on the left side of the page, and boxes in the center of the page. These links and boxes provide quick access to additional Ohio Medicaid information.

To **begin** the **enrollment** process:

1. Click on the **Provider Info** link on the left side of the page, OR
2. Click in the **Providers** box in the center of the page.
3. The **Welcome Providers** page displays.

### Welcome Providers Page

The Welcome Providers page contains links to information for billing, enrollment, news, provider types, and other resources. On the left side, it also contains links to the Ohio Medicaid Home page, general information, and ODJFS contact information.



## Job &amp; Family Services Ohio Medicaid

Medicaid Home

MITS

Consumer Info

Provider Info

Resources

About Us

Latest News

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Acronyms

ADA Compliance

External Link Disclaimer

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Feedback/  
Case-Specific Concerns

Help/FAQs

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Site Index

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## Welcome Providers

Resources for Ohio Medicaid Providers

Are you a provider in need of technical assistance?  
Call the IVR: 1-800-686-1516

Billing

Enrollment & Support

News

- [Direct Deposit](#)
- [Billing Instructions](#)
- [EDI, HIPAA & Code Sets](#)
- [Trading Partners & EDI Claims](#)
- Updated [How to Refund Overpayments to The State](#)
- [Remittance Advice - \(Pre MITS ONLY\)](#)
- New! [Answer Keys: Problems while submitting claims in MITS](#)

- New! [Provider Enrollment](#)
- [Provider Assistance](#)
- [Sanctioned/Terminated Providers](#)
- [Federal Requirement for Revalidation/Re-enrollment](#)

New! [COB & TPL Training Handouts and FAQs](#)

[Log on to MITS](#)

[MITS Provider Training begins 9/15 and ends 10/30. Register Now!](#)

[More MITS Info](#)

[Ohio Medicaid Provider Incentive Program for Electronic Health Records \(MPIP\)](#)

Provider Types

- [Clinic \(FQHC, RHC, OHF\)](#)
- [HME/DME](#)
- [Home Care](#)
- [Hospital](#)
- [Long-Term Care](#)
- [Managed Care](#)
- [Pharmacy](#)
- [Home Health Services](#)

Other Resources

- [Benefit Recovery & Coordination](#)
- [Fee Schedules/Rates](#)
- [Forms](#)
  - [MITS EDMS Cover Page](#)
- [Healthcheck Screening Forms](#)
- [e-Manuals](#)
- [Helpful Links](#)
- [Get an NPI](#)
- [Transmittal Letter Notification](#)

**Basic Billing Training Notice:**

Due to MITS Go-Live the Ombudsman area will not be able to conduct basic billing training until further notice. Information will be available on the provider web page when these classes resume. If you feel you are in need of training, please contact an Ombudsman at 614-644-1399 to schedule a consultation.

**To proceed with enrollment:**

1. Click the **Provider Enrollment** link in the center of the page in the Enrollment & Support area.
2. The **Provider Enrollment** page displays.

**Provider Enrollment Page**

The Provider Enrollment page is the portal to the enrollment process.



Ohio.gov | Department of Job and Family Services

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### Job & Family Services Ohio Medicaid

<p>Medicaid Home</p> <p>MITS</p> <p>Consumer Info</p> <p>Provider Info</p> <p>Resources</p> <p>About Us</p> <p>Latest News</p>	<p style="text-align: center;"><b>Provider Enrollment</b></p> <p><b>Important Enrollment Updates:</b> <a href="#">CLICK HERE TO ENROLL</a></p> <p>Effective 8/2/2011: The Ohio Department of Job and Family Services (ODJFS) has implemented the new Medicaid Information Technology System (MITS). Please <a href="#">click here</a> to enroll as a new Medicaid Provider, <a href="#">click here</a> to check enrollment status or <a href="#">click here</a> to login to the secure MITS portal to update demographic information as an existing provider.</p> <p>NOTE: All paper enrollment documents received by ODJFS after June 28 have, or will be returned. All provider files in the old system have been transferred to MITS.</p> <p><u>For additional information please contact us:</u></p> <p>Provider Enrollment Unit P.O. Box 1461 Columbus, Ohio 43216-1461</p> <p><b>Please listen to the entire message before making your selection</b> <b>Telephone: 1-800-686-1516, select option 3, then option 1, then option 1 again, then option 4</b></p> <p>Monday through Friday, 8:00 a.m. to 4:30 p.m</p> <p><b>Background Checks Required for Ohio Home Care Providers:</b> Non-agency Ohio Home Care waiver providers (personal care aides, home care attendants, nurses and other waiver service providers) are required to have a criminal background check conducted by the Bureau of Criminal Identification and Investigation (BCI&amp;I). If you have lived in Ohio for at least five years, you are required to have only an Ohio criminal background check. If you have lived in Ohio for fewer than five years, or if you were convicted of a crime in another state, you must request both an Ohio background check and a FBI background check.</p> <p>The results of your background check must be submitted <b>DIRECTLY</b> to ODJFS from BCI&amp;I to the address below. Background checks submitted to us by the Webcheck vendor, local law enforcement agencies, the applicant, or any entity other than BCI&amp;I can not be accepted. You must provide the address below to the Webcheck vendor when you have your background check completed.</p> <p>ODJFS Attn: BCI&amp;I PO Box 183017 Columbus, Ohio 43218-3017</p> <p>To obtain a background check, you must go to a location that performs electronic WebCheck background checks for submission to BCI&amp;I. A listing of WebCheck agencies can be found on the Ohio Attorney General's website at the following link: <a href="#">WebCheck Community Listing</a>. You may also contact BCI&amp;I by telephone at (877) 224-0043.</p> <p>Direct Deposit</p> <p>To receive payments via direct deposit please complete the <a href="#">Direct Deposit Authorization Agreement</a>.</p>	<p>MITS</p> <p><b>Enroll as a New Provider</b></p> <p><b>Check Provider Enrollment Status</b></p> <p><b>Update Demographic Information</b></p> <p><b>Contact Enrollment</b> Please listen to the entire message before making your selection</p> <p>1-800-686-1516, select option 3, then option 1, then option 1 again, then option 4</p> <p><b>Documents:</b></p> <p><a href="#">Group Information Form</a></p> <p><a href="#">CSTO-Other Equivalent Training Option-Forms</a></p> <p><a href="#">IRS - W-9</a></p> <p><a href="#">Executive Order #2007 - 01S</a></p> <p><a href="#">Confirmation from Consumer - JFS 0624</a></p> <p><a href="#">Documentation of Training if not STNA or recently completed nurse aide training - JFS 0622</a></p> <p><a href="#">Home Care Attendant Addendum M - JFS 02391</a></p> <p><a href="#">Home Care Attendant Skilled Task Authorization - JFS 02390</a></p> <p><a href="#">Home Care Attendant Medication Authorization - JFS 2389</a></p>
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To **enter** the public MITS portal and **enroll**:

1. Click the red rectangle at the top of the page with the link **CLICK HERE TO ENROLL**.
2. The **Instructions** panel displays, as detailed in Section 2 of this document.



## 2 ENROLLMENT TASKS

Tasks for enrollment presented in this volume of the Provider Medicaid Portal User Manual include a general overview of enrollment for organizations.

### General Enrollment Instructions

The **Instructions** panel is the first enrollment panel that displays, and provides important detailed information regarding how to proceed with the enrollment process. From this panel, the remaining panels for the enrollment process are accessed. The basic steps necessary for completing the enrollment application are as follows:

1. Work through each panel by entering the required information.
2. Proceed to the next panel by selecting the **Next** button at the bottom of each panel.
3. To review information in a prior panel select the **Previous** button at the bottom of each panel.
4. Complete all required information in each panel before proceeding to the next one.
5. To exit the Provider Enrollment application and return to the **Instructions** panel, select the **exit** button.

### Instructions Panel

The Instructions panel displays instructions for the provider enrollment process.

**Instructions** ?

Welcome to the online Provider Enrollment process.

Please complete each of the steps in the enrollment process. When you have completed all the steps, please click on the 'submit' button to submit the application for processing. If you fail to complete the application, it will be purged at midnight.

Please click the [Checklist](#) link prior to starting the enrollment application in order to select the checklist for your provider type.

For instructions on completing the enrollment application please click on the question mark (?) in the title bar.

Please click the 'new application' button to start a new Provider Enrollment application or click the 'continue application' button to continue with an existing application.

If you are a provider currently rendering Medicaid services to consumers and wish to make changes to your name, address, email, etc., please click the 'exit' button and login to select the Demographic Maintenance Tab.

Please click the [ODJFS Forms Central](#) link to access a comprehensive listing of ODFJS forms and publications. To view documents regarding the administration and compliance of ODJFS programs and services, please click the [ODJFS eManuals](#) link.

[FAQ for Provider Enrollment](#)

[FAQ for Provider Re-enrollment](#)

**IMPORTANT** - An Application Tracking Number (ATN) will be assigned to you. This number is necessary for accessing the status of submitted applications and for continuing an application that was not finished. Please write the number down and keep it for your records PRIOR TO EXITING.

Your application will be saved until 12:00 EST Midnight in 3 days. At 12:00 EST Midnight in 3 days, your application will be deleted from the system if your application has not been submitted.

exit new application continue application

### Tasks for this panel

To **access** enrollment instructions and begin the enrollment process:

1. Click the **Checklist** hyperlink to access and select the correct provider type for enrollment.
2. Click the ? icon in the upper right corner of the panel to view instructions for completing the enrollment online application.
3. Click the **ODJFS Forms Central** link to view forms and publications.
4. Click the **ODJFS eManuals** link to review information regarding the administration of, and compliance with, ODJFS Medicaid programs and services.
5. Click the **FAQ for Provider Enrollment** or **FAQ for Provider Re-enrollment** link to find answers to frequently asked questions about provider enrollment and re-enrollment.
6. To proceed with a new enrollment, select the **new application** button.
7. To continue with an existing enrollment, select the **continue application** button.
8. To exit the application, select the **exit** button.

### Field Descriptions – Instructions

Field	Description	Field Type	Data Type	Length
continue application	After the applicant has entered the Application Tracking Number and the Business or Last Name from the existing application, the application is displayed.	Button	N/A	0
exit	Exit the current panel and go back to the provider enrollment landing page.	Button	N/A	0
new application	Advance to the first page in the provider enrollment process to begin a new application.	Button	N/A	0
Checklist	Link to display checklists associated with different provider types.	Hyperlink	N/A	0
FAQ for Provider Enrollment	Link to an ODJFS pdf that lists frequently asked questions about the provider enrollment process.	Hyperlink	N/A	0
FAQ for Provider Re-enrollment	Link to an ODJFS pdf that lists frequently asked questions about the re-enrollment process.	Hyperlink	N/A	0
ODJFS Forms Central	Links to the ODJFS Provider Forms Central website ( <a href="http://www.odjfs.state.oh.us/forms/inter.asp">http://www.odjfs.state.oh.us/forms/inter.asp</a> ).	Hyperlink	N/A	0
ODJFS eManuals	Links to the ODJFS Provider eManuals website ( <a href="http://emanuals.odjfs.state.oh.us/emanuals/">http://emanuals.odjfs.state.oh.us/emanuals/</a> ).	Hyperlink	N/A	0
Instructions	Instructions for the online provider enrollment wizard.	Label	N/A	0

### Field Edits – Instructions

None.

## Continue Application Panel

The Continue Application panel is used by an applicant to search for existing applications by entering the Application Tracking Number (ATN) and business or last name on the application. The provider is then able to continue entry of an existing application by selecting a search result row.

Search					
*ATN	401832				
*Business OR Last Name	PECKOWITZ			search	clear
Search Results					
ATN	Name	Document	Date Received	Status	
401832	PECKOWITZ	ONLINE ENROLLMENT APPLICATION	03/05/2010	NOT SUBMITTED	
			previous	next	exit

### Tasks for this Panel

To **continue** an enrollment application:

1. Enter valid values in the **ATN** and **Business OR Last Name** fields.
2. Select the **search** button to search for a record matching the entered search criteria.
3. Select the **clear** button to reset the search criteria.
4. Select the **previous** button to return to the previous panel.
5. Select the **next** button to proceed to the next enrollment panel.
6. To exit the application, select the **exit** button.

### Field Descriptions – Continue Application – Organization

Field	Description	Field Type	Data Type	Length
clear	Clears all the search criteria.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
search	Displays the Search Results based on the criteria entered on the search panel.	Button	N/A	0
ATN	Unique code assigned to	Field	Number	9

Field	Description	Field Type	Data Type	Length
	the application for identification purposes.			
ATN (List)	Unique code assigned to the application for identification purposes.	Field	Number	9
Business OR Last Name	Business name or the last name if an individual.	Field	Character	50
Date Received	Date application received.	Listview	Date (MM/DD/CCYY)	10
Document	Name of the application.	Listview	Character	0
Name (List)	Business name or the last name if an individual.	Listview	Character	50
Status	Current status of the application.	Listview	Character	0

### Field Edits – Continue Application

Field	Field Type	Error Code	Error Message	To Correct
ATN	Field	0	Application Tracking Number (ATN) is required	This field must be completed.
Business OR Last Name	Field	0	Name of Business or Individual Last Name is required.	This field must be completed.

## Enrollment Tracking Search Panel

The Enrollment Tracking Search panel is used by a provider to check the status of an enrollment application, or upload additional documentation for, an enrollment application.

### Tasks for this Panel

To **check** the status of an enrollment:

1. Enter valid values in the **ATN** and **Business OR Last Name** fields.
2. Select the **search** button.
3. Select the **clear** button to reset the search criteria.

## Field Descriptions – Enrollment Tracking Search

Field	Description	Field Type	Data Type	Length
Clear	Clears all the search criteria.	Button	N/A	0
Search	Displays the Search Results based on the criteria entered on the search panel.	Button	N/A	0
ATN	Application Tracking Number (ATN). The system-assigned key that uniquely identifies a provider application. Is required.	Field	Number	9
Business OR Last Name	Business or last name on the enrollment application. Is required.	Field	Character	50

## Field Edits – Enrollment Tracking Search

Field	Field Type	Error Code	Error Message	To Correct
ATN	Field	0	ATN is required.	Enter a valid ATN.
Business OR Last Name	Field	0	Business or Last Name is required.	Enter a value for Business or Last Name.

## Enrollment Tracking Search Results Panel

The Enrollment Tracking Search Results panel displays a list of enrollment applications matching the search criteria entered on the Enrollment Tracking Search panel.

**Note:** Any attachment not uploaded during enrollment can be uploaded from this panel if the application has a status of Submitted.

Search Results				
ATN	Name	Document	Date Received	Status
400091	HOSPITAL	ENROLLMENT APPLICATION	08/14/2007	NOT SUBMITTED

### Tasks for this Panel

There are no tasks to perform in this panel.

## Field Descriptions – Request Type

Field	Description	Field Type	Data Type	Length
ATN	Application tracking number that uniquely identifies a provider application.	Field	Number	9
Date Received	Date the enrollment was received.	Field	Date (MM/DD/CCYY)	10

Field	Description	Field Type	Data Type	Length
Document	List of required documents.	Field	Character	25
Name	Name of enrolling provider.	Field	Character	50
Status	Status of the provider's enrollment.	Field	Character	24

### Field Edits – Request Type

None

## Enrollment Request Type Panel

The **Enrollment Type** selected by the enrolling provider may determine the information required to complete the enrollment, as well as the available possible actions the enroller can request. Actions that may be requested based on enrollment type are as follows:

- Initial Enrollment
- Change of Operator/Provider (CHOP)
- Facility New to Ohio Medicaid
- Facility Re-entering Medicaid Program
- Out of State Provider
- Replacement Facility

The Provider Enrollment-Request Type panel is used by a provider applicant to select the type of enrollment and provider type for the application.



The screenshot shows a web form titled "Request Type". It contains three dropdown menus: "\*Enrollment Type" set to "INDIVIDUAL PRACTITIONER", "\*Action Request" set to "INITIAL ENROLLMENT", and "\*Provider Type" which is currently empty. Below these is a question "\*Are you a provider new to Ohio Medicaid?" with "Yes" and "No" radio buttons. At the bottom, there are three buttons: "previous", "next", and "exit".

### Tasks for this Panel

To specify **enrollment** and **provider** types:

1. Select the appropriate description for the enrolling provider from the **Enrollment Type** drop down list box.
2. Select a value from the **Action Request** drop down list box.
  - a. If the enrolling provider is an individual practitioner, a group practice, an organization, a hospital, or a managed care provider, select **INITIAL ENROLLMENT**.

- b. If the enrolling provider is a long term care facility or an intermediate care facility for the mentally retarded, select **FACILITY NEW TO OHIO MEDICAID**.
3. Select the appropriate provider type for the enrolling provider from the **Provider Type** drop down list box.
4. Select **Yes** for the question **Are you a provider new to Ohio Medicaid?**
5. Select the **next** button to proceed to the next enrollment panel.
6. To exit the application, select the **exit** button.

### Field Descriptions – Request Type

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Action Request	Requested action to be taken with application. Valid values: Initial Enrollment, Re-enrollment, and Change of Ownership.	Field	Drop Down List Box	0
Are you a provider new to Ohio Medicaid?	Indicates if the provider has been previously registered with Ohio Medicaid.	Field	Radio Button	0
Enrollment Type	Indicates the type of enrollment application. Example valid value: Individual Practitioner.	Field	Drop Down List Box	0
Provider Type	Provider type of the applicant. Valid values: Clinic, Physician, Pharmacy, Dentist, Hospital, and Other.	Field	Drop Down List Box	0

### Field Edits – Request Type

Field	Message
Provider Type	A valid Provider Type is required.

To continue the enrollment application process, detailed information about the type of enrollment for which the application is being made must be entered in the Identifying Information panel that is appropriate for the enrolling provider. This panel displays in several different views that request different information, depending on the provider type that was selected in the **Request Type** panel. The provider types available for selection are grouped into the following enrollment categories by the system:

- Individual Practitioner
- Group Practice
- Organization
- Long Term Care Nursing Facility or Intermediate Care Facility for the Mentally Retarded
- Managed Care Provider Reporting Number
- Hospital

A different Identifying Information panel displays for each provider type. This section of the Provider Medicaid Portal User Manual addresses enrollment for these providers:

- Organizations

Providers who practice under a legal entity that is an organization use a provider type of **Organization** to enroll to use the Provider Medicaid Portal.

## Identifying Information Panel – Organization

This version of the Identifying Information panel allows an organization applicant to enter identifying information, including provider numbers, certification and license information, and federal identification numbers

The screenshot shows a web form titled "Identifying Information" with a question mark icon in the top right corner. The form contains the following fields and controls:

- \*Organization Legal Name: Text input field
- Medicare Type: Dropdown menu
- Medicare Provider Number: Text input field
- Previous Medicaid Provider Number: Text input field
- Certification Number: Text input field
- \*Ownership Type: Dropdown menu
- Doing Business As Name: Text input field
- \*Type: Dropdown menu
- \*SSN/FEIN: Text input field
- NPI: Text input field
- CLIA Number: Text input field
- License or Accreditation: Dropdown menu
- \*License Number: Text input field
- \*License Issue Date: Text input field
- \*License Expiration Date: Text input field

At the bottom of the form, there are three buttons: "previous", "next", and "exit".

### Tasks for this panel

To enter identifying information:

1. Enter valid values in the **Organization Legal Name**, **SSN/FEIN**, **License Number**, **License Issue Date**, and **License Expiration Date** fields.
2. Select values from the **Ownership Type** and **Type** drop down list boxes.

3. Enter values in the **Medicare Provider Number, Previous Medicaid Provider Number, Certification Number, Doing Business As Name, NPI,** and **CLIA Number** fields, if applicable.
4. Select values from the **Medicare Type** and **License or Accreditation** drop down list boxes, if applicable.
5. Select the **previous** button to review information entered in previous panels, if desired.
6. Select the **next** button to proceed to the next enrollment request.
7. To exit the application, select the **exit** button.

**Note:** When required fields are completed and the **next** button is selected, a Microsoft Internet Explorer pop-up opens with the ATN number. This ATN number should be noted for future reference.

### Field Descriptions – Identifying Information – Organization

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Saves the updated information on the panel and navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
CLIA Number	Clinical Laboratory Improvement Act (CLIA) number assigned to the organization.	Field	Number	10
Certification Number	Certification Number of the organization.	Field	Number	7
Doing Business As Name	Name for organization doing business under a trade or company name.	Field	Character	50
License Expiration Date	Expiration Date of License of the organization.	Field	Date (MM/DD/CCYY)	8
License Issue Date	Issue Date of the License of the organization.	Field	Date (MM/DD/CCYY)	8
License Number	License number of the organization.	Field	Character	10
License or Accreditation	Type of license or accreditation held by organization.	Field	Drop Down List Box	0
Medicare Provider Number	Medicare Provider Number of the organization.	Field	Number	10
Medicare Type	Medicare type PTAN/CCN.	Field	Drop Down List Box	4
NPI	National Provider Identifier number of the organization. If an individual, enter NPI associated with SSN.	Field	Number	10

Field	Description	Field Type	Data Type	Length
Organization Legal Name	Legal name of the organization.	Field	Character	50
Ownership Type	Type of ownership.	Field	Drop Down List Box	1
Previous Medicaid Provider Number	Previous Medicaid Provider Number of the organization.	Field	Number	10
SSN/FEIN	SSN Number or Federal Employer Identification Number of the organization.	Field	Number	9
Type	Type of tax ID. Valid values: SSN or FEIN.	Field	Drop Down List Box	4

### Field Edits – Identifying Information – Organization

Field	Field Type	Error Code	Error Message	To Correct
CLIA Number	Field	1	CLIA Number is required.	This field must be completed when provider type is Independent Laboratory.
Doing Business As Name	Field	0	Doing Business As (D/B/A) is required.	This field must be completed.
License Expiration Date	Field	1	License Expiration Date is required.	This field must be completed.
License Issue Date	Field	1	License Issue Date is required.	This field must be completed.
	Field	2	License Issue Date[1/1/2010 12:00:00 AM] must be less than or equal to License Expiration Date[10/10/2009 12:00:00 AM]	Enter a date less than or equal to the Expiration Date
License Number	Field	1	License Number is required.	This field must be completed.
Medicare Provider Number	Field	1	When Medicare Type is selected Medicare Provider Number is required.	Enter Medicare Provider Number.
Medicare Type	Field	1	When Medicare Provider Number is selected Medicare Type is required.	Enter Medicare Type.
NPI	Field	1	NPI is required.	This field must be completed.

Field	Field Type	Error Code	Error Message	To Correct
SSN/ FEIN	Field	1	SSN/FEIN is required.	This field must be completed.
Type	Field	1	Type is required	This field must be completed.
NPI Associated with SSN	TBD	TBD	TBD	TBD

## Tax ID – Organization

Organization providers enter their tax information in this panel.

### Tasks for this panel

To **enter** tax information:

1. Select valid values from the **IRS Tax Type**, **TaxIDExempt**, **W9 Form**, **Form 147**, and **State** drop down list boxes.
2. Enter valid values in the **IRS Tax ID**, **Name**, **Address 1**, **City**, **Zip**, and **IRS Effective Date** fields.
3. Enter values in the **Address 2**, 4-digit **ZIP** extension, **IRS End Date**, **Phone**, and **Phone** extension fields, if applicable.
4. Select the **previous** button to review information entered in previous panels, if desired.
5. Select the **next** button to proceed to the next enrollment panel.
6. To exit the application select the **exit** button.

### Field Descriptions – Tax ID – Organization

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
State	Provider's state.	Combo Box	Character	2
Address 1	Provider's street address 1.	Field	Character	60

Field	Description	Field Type	Data Type	Length
Address 2	Provider's street address 2. (Optional)	Field	Alphanumeric	60
City	Provider's city.	Field	Character	15
Ext	Provider's phone number extension.	Field	Number	4
Form 147	Indicates whether the provider has submitted Form 147, stating name and tax identification number.	Field	Drop Down List Box	1
IRS Effective Date	Effective date of IRS tax ID.	Field	Date (MM/DD/CCYY)	8
IRS End Date	End date of IRS tax ID.	Field	Date (MM/DD/CCYY)	8
IRS Tax ID	Provider's tax ID.	Field	Number	9
IRS Tax Type	Identifies the identification number as either Social Security Number or Federal Employee/Employer Identification Number	Field	Character	1
Name	Provider's name.	Field	Character	50
Phone	Provider's phone number.	Field	Number	10
Tax ID Exempt	Indicates whether the provider is exempt from receiving a 1099 statement.	Field	Drop Down List Box	1
W9 Form	Indicates whether the provider provided a W-9 form.	Field	Drop Down List Box	1
Zip	Provider zip code.	Field	Number	5
Zip+4	Provider 4-character zip code extension.	Field	Number	4

### Field Edits – Tax ID – Organization

Field	Field Type	Error Code	Error Message	To Correct
State	Combo Box	1	A valid State is required.	Select a State.
Address 1	Field	1	Address 1 is required.	Enter an Address 1.
City	Field	1	City is required.	Enter a City.
Form 147	Field	1	Form 147 is required.	Select Yes or No.
Form 147	Field	2	You must answer 'YES' to one of the following fields: TaxIDExempt, W9	Select 'YES' for TaxIDExempt, W9 Form, or

Field	Field Type	Error Code	Error Message	To Correct
			Form, or Form 147.	Form 147 fields.
IRS Effective Date	Field	1	IRS Effective Date is required.	Enter an IRS Effective Date.
IRS Effective Date	Field	2	IRS Effective Date must be less than or equal to IRS End Date.	IRS Effective Date must be less than or equal to IRS End Date.
IRS End Date	Field	1	IRS End Date is required.	Enter an IRS End Date.
IRS End Date	Field	2	IRS Effective Date must be less than or equal to IRS End Date.	IRS Effective Date must be less than or equal to IRS End Date.
IRS Tax ID	Field	1	IRS Tax ID is required.	Enter a valid Tax ID.
IRS Tax ID	Field	2	Tax ID must be 9 digits.	Enter a valid Tax ID.
IRS Tax Type	Field	4	IRS Tax Type is required.	Select a Tax ID Type.
Phone	Field	1	Phone must be 10 digits in length.	Enter phone with 10 digits.
Tax ID Exempt	Field	1	Tax ID Exempt is required.	Select Yes or No.
Tax ID Exempt	Field	2	You must answer 'YES' to one of the following fields: TaxIDExempt, W9 Form, or Form 147.	Select 'YES' for TaxIDExempt, W9 Form, or Form 147 fields.
W9 Form	Field	1	W9 Form is required.	Select Yes or No.
W9 Form	Field	2	You must answer 'YES' to one of the following fields: TaxIDExempt, W9 Form, or Form 147.	Select 'YES' for TaxIDExempt, W9 Form, or Form 147 fields.
Zip	Field	1	Zip is required.	Enter a 5 digit zip.
Zip	Field	2	Zip must be 5 digits in length.	Enter a 5 digit zip.
Zip+4	Field	1	Zip must be 4 digits in length.	Enter 4 digit zip code extension.

## Optional Services – Organization

The Optional Services panel displays for all enrolling Organization providers using the Hospital Wizard.

Page 8 of 27. Please make note of your MITS ID. 10/10/11

### Optional Services ?

*Instructions: Check the services the hospital will bill for under its Ohio Medicaid Provider Agreement and enter the required information for each service. If you provide Pharmacy, DME and/or Ambulance/Wheelchair Van services you must also complete the Pharmacy/DME and Transportation sections of this application.*

\*Pharmacy  Yes  No

Pharmacy License Type

Pharmacy License Number

Pharmacy License Issue Date

Pharmacy License Expiration Date

Pharmacy DEA Registration Number

Primary Pharmacist Name

Pharmacist License Number

\*Orthotics and Prosthetics  Yes  No

Orthotics/Prosthetics License Number

Orthotics/Prosthetics License Issue Date

Orthotics/Prosthetics License Expiration Date

\*Respiratory Care  Yes  No

Respiratory Care Board License Number

Respiratory Care Board License Issue Date

Respiratory Care Board License Expiration Date

\*Audiology  Yes  No

Audiologist License Number

Audiologist License Issue Date

Audiologist License Expiration Date

\*Hearing Aid  Yes  No

Hearing Aid Dispenser License Number

Hearing Aid Dispenser License Issue Date

Hearing Aid Dispenser License Expiration Date

\*Air Fixed Wing  Yes  No

\*Air Rotary  Yes  No

\*Water Transport  Yes  No

\*Wheelchair Van  Yes  No

\*Outpatient Services  Yes  No

\*ORCB Licensed DME Supplier  Yes  No

\*Physician  Yes  No

\*DME Supplier  Yes  No

\*Land Ambulance  Yes  No

### Tasks for this panel

To **enter** information on optional services:

1. Select **Yes** or **No** for **Pharmacy** service.
  - a. If **Yes** is selected, enter valid values in the **Pharmacy License Type, Pharmacy License Number, Pharmacy License Issue Date, Pharmacy License**

**Expiration Date, Pharmacy DEA Registration Number, Primary Pharmacist Name, and Pharmacist License Number** fields.

2. Select **Yes** or **No** for **Orthotics and Prosthetics** service.
  - a. If **Yes** is selected, enter valid values in the **Orthotics/Prosthetics License Number, Orthotics/Prosthetics License Issue Date, and Orthotics/Prosthetics License Expiration Date** fields.
3. Select **Yes** or **No** for **Respiratory Care** service.
  - a. If **Yes** is selected, enter valid values in the **Respiratory Care Board License Number, Respiratory Care Board License Issue Date, and Respiratory Care Board License Expiration Date** fields.
4. Select **Yes** or **No** for **Audiology** service.
  - a. If **Yes** is selected, enter valid values in the **Audiologist License Number, Audiologist License Issue Date, and Audiologist License Expiration Date** fields.
5. Select **Yes** or **No** for **Hearing Aid** service.
  - a. If **Yes** is selected, enter valid values in the **Hearing Aid Dispenser License Number, Hearing Aid Dispenser License Issue Date, and Hearing Aid Dispenser License Expiration Date** fields.
6. Select **Yes** or **No** for the following services: **Air Fixed Wing, Air Rotary, Water Transport, Wheelchair Van, Outpatient Services, ORCB Licensed DME Supplier, Physician, DME Supplier, and Land Ambulance.**
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.
9. To exit the application, select the **exit** button.

### Field Descriptions – Optional Services – Organization

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Air Fixed Wing	Question stating if it is for Air Fixed Wing.	Field	Radio Button	1
Air Rotary	Question stating if it is for Air Rotary.	Field	Radio Button	1
Audiologist License	The date for which the	Field	Date	8

Field	Description	Field Type	Data Type	Length
Expiration Date	license will expire.		(MM/DD/CCYY)	
Audiologist License Issue Date	The date for which the license begins.	Field	Date (MM/DD/CCYY)	8
Audiologist License Number	The license number assigned.	Field	Alphanumeric	11
Audiology	Question stating if is for Audiology. Other fields are required if 'Yes' is selected.	Field	Radio Button	1
DME Supplier	Question stating if it is for DME Supplier.	Field	Radio Button	1
Hearing Aid Dispenser	Question stating if is for Hearing Aid Dispenser. Other fields are required if 'Yes' is selected.	Field	Radio Button	1
Hearing Aid Dispenser License Expiration Date	The date for which the license will expire.	Field	Date (MM/DD/CCYY)	8
Hearing Aid Dispenser License Issue Date	The date for which the license begins.	Field	Date (MM/DD/CCYY)	8
Hearing Aid Dispenser License Number	The license number assigned.	Field	Alphanumeric	11
Land Ambulance	Question stating if it is for Land Ambulance.	Field	Radio Button	1
ORCB Licensed DME Supplier	Question stating if it is for ORCB Licensed DME Supplier.	Field	Radio Button	1
Orthotics and Prosthetics	Question stating if is for Orthotics and Prosthetics. Other fields are required if 'Yes' is selected.	Field	Radio Button	1
Orthotics/Prosthetics License Expiration Date	The date for which the license will expire.	Field	Date (MM/DD/CCYY)	8
Orthotics/Prosthetics License Issue Date	The date for which the license begins.	Field	Date (MM/DD/CCYY)	8
Orthotics/Prosthetics License Number	The license number assigned.	Field	Alphanumeric	11
Outpatient Services	Question stating if it is for Outpatient Services.	Field	Radio Button	1
Pharmacist License Number	The license number assigned to the Primary	Field	Alphanumeric	11

Field	Description	Field Type	Data Type	Length
	Pharmacist.			
Pharmacy	Question stating if is for Pharmacy. Other fields are required if 'Yes' is selected.	Field	Radio Button	1
Pharmacy DEA Registration Number	The assigned DEA number.	Field	Alphanumeric	11
Pharmacy License Expiration Date	The date for which the license will expire.	Field	Date (MM/DD/CCYY)	8
Pharmacy License Issue Date	The date for which the license was issued.	Field	Date (MM/DD/CCYY)	8
Pharmacy License Number	The license number assigned.	Field	Number	11
Pharmacy License Type	Dropdown containing a list of possible Pharmacy license type to choose from.	Field	Drop Down List Box	0
Physician	Question stating if it is for Physician.	Field	Radio Button	1
Primary Pharmacist Name	Name of the primary Pharmacist.	Field	Alphanumeric	30
Respiratory Care	Question stating if is for Respiratory Care. Other fields are required if 'Yes' is selected.	Field	Radio Button	1
Respiratory Care Board License Expiration Date	The date for which the license will expire.	Field	Date (MM/DD/CCYY)	8
Respiratory Care Board License Issue Date	The date for which the license was issued.	Field	Date (MM/DD/CCYY)	8
Respiratory Care Board License Number	The license number assigned.	Field	Alphanumeric	11
Water Transport	Question stating if it is for Water Transport.	Field	Radio Button	1
Wheelchair Van	Question stating if it is for Wheelchair Van.	Field	Radio Button	1

### Field Edits – Optional Services – Organization

Field	Field Type	Error Code	Error Message	To Correct
Air Fixed Wing	Field	1	YES/NO response to Air Fixed Wing	Enter YES/NO to Air Fixed Wing

Field	Field Type	Error Code	Error Message	To Correct
			question is required.	question.
Air Rotary	Field	1	YES/NO response to Air Rotary question is required.	Enter YES/NO to Air Rotary.
Audiologist License Expiration Date	Field	1	Audiologist License Expiration Date is required.	Enter Audiologist License Expiration Date.
	Field	2	Audiologist License Expiration Date must be greater than Audiologist License Issue Date.	Enter Audiologist License Expiration Date greater than Audiologist License Issue Date.
Audiologist License Issue Date	Field	1	Audiologist License Issue Date is required.	Enter Audiologist License Issue Date.
	Field	2	Audiologist License Issue Date must be earlier than or equal to today.	Enter Audiologist License Issue Date earlier than or equal to today.
Audiologist License Number	Field	1	Audiologist License Number is required.	Enter Audiologist License Number.
Audiology	Field	1	YES/NO response to Audiology question is required.	Enter YES/NO to Audiology question.
DME Supplier	Field	1	YES/NO response to DME Supplier question is required.	Enter YES/NO to DME Supplier question.
Hearing Aid Dispenser	Field	1	YES/NO response to Hearing Aid Dispenser question is required.	Enter YES/NO to Hearing Aid Dispenser question.
Hearing Aid Dispenser License Expiration Date	Field	1	Hearing Aid License Expiration Date is required.	Enter Hearing Aid License Expiration Date.
	Field	2	Hearing Aid License Expiration Date must be greater than Hearing Aid License Issue Date.	Enter Hearing Aid License Expiration Date greater than Hearing Aid License Issue Date.
Hearing Aid Dispenser License Issue Date	Field	1	Hearing Aid License Issue Date is required.	Enter Hearing Aid License Issue Date.
	Field	2	Hearing Aid License Issue Date must be earlier than or equal to	Enter Hearing Aid License Issue Date earlier than or equal

Field	Field Type	Error Code	Error Message	To Correct
			today.	to today.
Hearing Aid Dispenser License Number	Field	1	Hearing Aid License Number is required.	Enter Hearing Aid License Number.
Land Ambulance	Field	1	YES/NO response to Land Ambulance question is required.	Enter YES/NO to Land Ambulance question.
ORCB Licensed DME Supplier	Field	1	YES/NO response to ORCB Licensed DME Supplier question is required.	Enter YES/NO to ORCB Licensed DME Supplier question.
Orthotics and Prosthetics	Field	1	YES/NO response to Orthotics and Prosthetics question is required.	Enter YES/NO to Orthotics and Prosthetics question.
Orthotics/Prosthetics License Expiration Date	Field	1	Orthotics and Prosthetics License Expiration Date is required.	Enter Orthotics and Prosthetics License Expiration Date.
	Field	2	Orthotics and Prosthetics License Expiration Date must be greater than Orthotics and Prosthetics License Issue Date.	Enter Orthotics and Prosthetics License Expiration Date greater than Orthotics and Prosthetics License Issue Date.
Orthotics/Prosthetics License Issue Date	Field	1	Orthotics and Prosthetics License Issue Date is required.	Enter Orthotics and Prosthetics License Issue Date.
	Field	2	Orthotics and Prosthetics License Issue Date must be earlier than or equal to today.	Enter Orthotics and Prosthetics License Issue Date earlier than or equal to today.
Orthotics/Prosthetics License Number	Field	1	Orthotics and Prosthetics License Number is required.	Enter Orthotics and Prosthetics License Number.
Pharmacist License Number	Field	1	Pharmacist License Number is required.	Enter Pharmacist License Number.
Pharmacy	Field	1	YES/NO response to Pharmacy question is required.	Enter YES/NO to Pharmacy question.
Pharmacy DEA	Field	1	Pharmacy DEA	Enter Pharmacy

Field	Field Type	Error Code	Error Message	To Correct
Registration Number			Registration Number is required.	DEA Registration Number.
Pharmacy License Expiration Date	Field	1	Pharmacy License Expiration Date is required.	Enter Pharmacy License Expiration Date.
	Field	2	Pharmacy License Expiration Date must be greater than Pharmacy License Issue Date.	Enter Pharmacy License Expiration Date greater than Pharmacy License Issue Date.
Pharmacy License Issue Date	Field	1	Pharmacy License Issue Date is required.	Enter Pharmacy License Issue Date.
	Field	2	Pharmacy License Issue Date must be earlier than or equal to today.	Enter Pharmacy License Issue Date earlier than or equal to today.
Pharmacy License Number	Field	1	Pharmacy License Number is required.	Enter Pharmacy License Number.
Pharmacy License Type	Field	1	Pharmacy License Type is required.	Enter Pharmacy License Type.
Physician	Field	1	YES/NO response to Physician question is required.	Enter YES/NO to Physician question.
Respiratory Care	Field	1	YES/NO response to Respiratory Care question is required.	Enter YES/NO to Respiratory Care question.
Respiratory Care Board License Expiration Date	Field	1	Respiratory Care Board License Expiration Date is required.	Enter Respiratory Care Board License Expiration Date.
	Field	2	Respiratory Care Board License Expiration Date must be greater than Respiratory Care Board License Issue Date.	Enter Respiratory Care Board License Expiration Date greater than Respiratory Care Board License Issue Date.
Respiratory Care Board License Issue Date	Field	1	Respiratory Care Board License Issue Date is required.	Enter Respiratory Care Board License Issue Date.
	Field	2	Respiratory Care Board License Issue Date must be earlier	Enter Respiratory Care Board License Issue Date earlier

Field	Field Type	Error Code	Error Message	To Correct
			than or equal to today.	than or equal to today.
Respiratory Care Board License Number	Field	1	Respiratory Care Board License Number is required.	Enter Respiratory Care Board License Number.
Water Transport	Field	1	YES/NO response to Water Transport question is required.	Enter YES/NO to Water Transport question.
Wheelchair Van	Field	1	YES/NO response to Wheelchair Van question is required.	Enter YES/NO to Wheelchair Van question.

## Address Information – Organization

The Address Information panel is used by an enrolling organization to provide address information. At least one Practice Location address must be entered.

### Tasks for this panel

To enter **address** information:

1. Select values from the **Address Type**, **County**, and **State** drop down list boxes.
2. Enter valid values in the **Address 1**, **City**, **Zip**, and **Phone 1** fields.
3. Enter values in the: **Address 2**, 4-digit **Zip** extension, **E-Mail Address**, **Contact Name**, **Phone 2**, **Fax 1**, **Fax 2**, and **TDD** fields, if applicable.
4. Select values from the **Phone 1** and **Phone 2** phone type drop down list boxes, if applicable.
5. Select the **add** button to add another address information record.
6. Select the **delete** button to delete a selected address information record.
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.

9. To exit the application, select the **exit** button.

### Field Descriptions – Address Information – Organization

Field	Description	Length	Data Type	Field Type
add	Inserts a new address record. Proper permissions are required to perform an add.	0	N/A	Button
delete	Deletes the selected record. Proper permissions are required to perform a delete.	0	N/A	Button
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	0	N/A	Button
next	Navigates to the next panel in the provider enrollment wizard.	0	N/A	Button
previous	Navigates to the previous panel in the provider enrollment wizard.	0	N/A	Button
Address 1	First line of the address specified by Address Type.	60	Character	Field
Address 2	Second line of the address specified by Address Type.	60	Character	Field
Address Type	Type of address.	0	Drop Down List Box	Field
City	City of the address specified by Address Type.	30	Character	Field
Contact Name	Name of the contact at the specified address.	40	Character	Field
County	County of the address specified by Address Type.	0	Drop Down List Box	Field
E-mail Address	Email address for the business.	50	Character	Field
Fax 1	First fax number for provider at the specified Address Type.	10	Number	Field
Fax 2	Second fax number for provider at the specified Address Type.	10	Number	Field
Phone 1	First phone number for the provider at the address specified by Address Type.	10	Number	Field
Phone 2	Second phone number for the provider at the address specified by Address Type.	10	Number	Field
Phone Ext 1	First phone extension for the provider (no label on panel).	4	Number	Field

Field	Description	Length	Data Type	Field Type
Phone Ext 2	Second phone extension for the provider (no label on panel).	4	Number	Field
Phone Type 1	First phone type (no label on panel).	0	Drop Down List Box	Field
Phone Type 2	Second phone type (no label on panel).	0	Drop Down List Box	Field
State	State of the address specified by Address Type.	0	Drop Down List Box	Field
TDD	Telecommunications Device for the Deaf number of the address specified by Address Type.	10	Number	Field
Zip	Zip code of the address specified by Address Type.	5	Number	Field
Zip + 4	Zip code extension of the address specified by Address Type (no label on panel).	4	Number	Field
Address 1 (List)	First line of the address specified by Address Type.	60	Character	Listview
Address Type (List)	Type of address.	20	Character	Listview
City (List)	City of the address specified by Address Type.	30	Character	Listview
Phone 1 (List)	First phone number for the provider at the address specified by Address Type.	10	Number	Listview
State (List)	State of the address specified by Address Type.	2	Character	Listview
Zip (List)	Zip code of the address specified by Address Type.	5	Number	Listview

### Field Edits – Address Information – Organization

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	0	Address 1 is required.	This field must be completed.
Address Type	Field	0	Address Type is required.	This field must be completed.
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields

Field	Field Type	Error Code	Error Message	To Correct
				must only contain A - Z and 0 - 9.
All fields	Field	1	Field exceeds max length.	Ensure that the entered data does not exceed the maximum length.
City	Field	0	City is required.	This field must be completed.
Contact Name	Field	1	Contact Name is required.	Enter a name in the field.
County	Field	0	County is required.	This field must be completed.
E-mail Address	Field	1	E-mail Address is required.	Enter a valid email address.
Phone 1	Field	0	Phone is required.	This field must be completed.
State	Field	0	State is required.	This field must be completed.
Zip	Field	0	Zip is required.	This field must be completed.

## Type and Specialty – Organization

The Type and Specialty panel is used by an enrolling organization to specify the organization's primary specialty and any additional specialties. If the option is available to choose a Primary Specialty, the applicant must select one before continuing the enrollment.

### Tasks for this panel

To specify **provider type** and **specialty**:

1. Select a value from the **Specialty** and **License Type** drop down list boxes.

**Note:** Depending on the provider type chosen, the Specialty drop down list box and Primary Specialty? check box may or may not display.

2. Select the **Primary Specialty?** check box.
3. Enter valid values in the **License Number, License Issue Date, License Expiration Date,** and **Primary Taxonomy Code** fields.
4. To search for a primary taxonomy code, click the **[Search]** hyperlink adjacent to the **Primary Taxonomy Code** field.
5. A secondary search panel for **Primary Taxonomy Code** displays.

The screenshot shows a window titled "Primary Taxonomy Code" with a "Search" header. Below the header are two input fields: "Taxonomy" and "Description". To the right of these fields are "search" and "clear" buttons. Below the input fields is a "Search Results" section which currently displays the text "\*\*\* No rows found \*\*\*".

- a. Enter a value for the **Taxonomy** code, **Description** of the taxonomy, or both.
- b. Select the **search** button. Taxonomy information that matches the search criteria displays in the Search Results area.

The screenshot shows the same "Primary Taxonomy Code" search window. The "Taxonomy" field now contains the value "103". The "Search Results" section displays a table of results:

Taxonomy	Description
103TC1900X	PSYCHOLOGIST - COUNSELING
103TC2200X	PSYCHOLOGIST - CLINICAL CHILD & ADOLESCENT
103TE1000X	PSYCHOLOGIST - EDUCATIONAL
103TE1100X	PSYCHOLOGIST - EXERCISE & SPORTS
103TF0000X	PSYCHOLOGIST - FAMILY
103TF0200X	PSYCHOLOGIST - FORENSIC
103TH0004X	PSYCHOLOGIST - HEALTH
103TH0100X	PSYCHOLOGIST - HEALTH SERVICE
103TM1700X	PSYCHOLOGIST - MEN & MASCULINITY
103TM1800X	PSYCHOLOGIST - MENTAL RETARDATION & DEVELOPMENTAL DISABILITIES

At the bottom of the results table, there are navigation links: "< Previous 1 2 3 Next >".

- c. To view additional codes press **Next>**. To return to previously viewed codes press **<Previous**.
  - d. Select the **line** with the taxonomy code that is appropriate for the enrolling provider.
  - e. The selected code displays in the **Primary Taxonomy** field in the **Type and Specialty** panel.
  - f. Select **[Close]** in the upper right corner of the **Primary Taxonomy Code** search panel.
6. If desired, enter a valid value in one or more of the **Ancillary Taxonomy Code** fields.
  7. To search for an Ancillary Taxonomy code, click the **[Search]** hyperlink adjacent to the **Ancillary Taxonomy Code** field.

8. A secondary search panel for **Ancillary Taxonomy Code** displays.

The screenshot shows the 'Ancillary Taxonomy Code' search panel. The title bar is red with '[ Close ]' on the right. Below is a blue 'Search' header with a help icon and an up arrow. The main area has two input fields: 'Taxonomy' (empty) and 'Description' (empty). There are 'search' and 'clear' buttons on the right. Below the search area is a blue 'Search Results' header, and the content area displays '\*\*\* No rows found \*\*\*'.

- Enter a value for the **Taxonomy** code, **Description** of the taxonomy, or both.
- Select the **search** button. Taxonomy information that matches the search criteria displays in the **Search Results** area.

The screenshot shows the 'Ancillary Taxonomy Code' search panel with search results. The 'Taxonomy' field contains '203'. The 'Search Results' area displays a table with the following data:

Taxonomy	Description
203BA0300X	ANESTHESIOLOGY: ANESTHESIOLOGY - N/A
203BA0401X	UNCATEGORIZED: ADDICTION MEDICINE - N/A
203BA0501X	UNCATEGORIZED: ADOLESCENT ONLY, UNDER 16 - N/A
203BA0502X	UNCATEGORIZED: ADOLESCENT ONLY, UNDER 21 - N/A
203BA0503X	UNCATEGORIZED: AGE SPECIFIC, GREATER THAN 1 YEAR OLD - N/A
203BA0504X	UNCATEGORIZED: AGE SPECIFIC, NEWBORNS ONLY - N/A
203BB0000X	PATHOLOGY: BLOOD BANKING - N/A
203BB0001X	PATHOLOGY: BLOOD BANKING & TRANSFUSION MEDICINE - N/A
203BB0100X	RADIOLOGY: BODY IMAGING - N/A
203BC0000X	INTERNAL MEDICINE: CARDIAC ELECTROPHYSIOLOGY - N/A

At the bottom of the results table, there are navigation buttons: '< Previous', '1 2 3 4 5 6 7 8 9 10 ...', and 'Next >'.

- To view additional codes press **Next>**. To return to previously viewed codes press **<Previous**.
  - Select the line with the taxonomy code that is appropriate for the enrolling provider.
  - The selected code displays in the **Ancillary Taxonomy Code** field in the **Type and Specialty** panel.
  - Select **[Close]** in the upper right corner of the **Ancillary Taxonomy Code** search panel.
9. Select the **previous** button to review information entered in previous panels, if desired.
10. Select the **next** button to proceed to the next enrollment panel.
11. To exit the application, select the **exit** button.

### Field Descriptions – Type and Specialty – Organization

Field	Description	Field Type	Data Type	Length
add	Inserts a new specialty record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	permissions are required to perform a delete.			
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Effective Date	Effective date of the specified specialty.	Field	Date (MM/DD/CCYY)	8
End Date	Expiration date of the specified specialty.	Field	Date (MM/DD/CCYY)	8
License Expiration Date	Expiration date of the specified license.	Field	Date (MM/DD/CCYY)	8
License Issue Date	Date when the specified specialty license was issued.	Field	Date (MM/DD/CCYY)	8
License Number	Applicant's license number.	Field	Character	15
License Type	Type of license specified. Example valid value: Nursing Board.	Field	Drop Down List Box	0
Primary Specialty?	Indicator of applicant's primary specialty.	Field	Check Box	1
Primary Taxonomy Code	Primary taxonomy code of the specified specialty. Click [Search] to search for and select a taxonomy code.	Field	Alphanumeric	9
Specialty	Applicant's specialty. Example valid value: 929-Physician Assistant.	Field	Drop Down List Box	0
Provider Type	Type of provider.	Label	Character	0
Effective Date [List]	Effective date of the specified specialty.	Listview	Date (MM/DD/CCYY)	8
End Date [List]	Expiration date of the specified specialty.	Listview	Date (MM/DD/CCYY)	8
License Expiration Date [List]	Expiration date of the specified license.	Field	Date (MM/DD/CCYY)	8

Field	Description	Field Type	Data Type	Length
License Issue Date [List]	Date when the specified specialty license was issued.	Field	Date (MM/DD/CCYY)	8
License Number [List]	Applicant's license number.	Field	Character	15
Primary?	Indicator of applicant's primary specialty.	Listview	Character	0
Specialty Desc	Applicant's specialty. Example valid value: 929-Physician Assistant.	Listview	Character	10

### Field Edits – Type and Specialty – Organization

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the datatype as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
	Field	1	Field exceeds max length.	Ensure that the entered data does not exceed the maximum length.
Ancillary Taxonomy Code	Field	1	Second Ancillary Taxonomy Code entered is not valid.	Enter a valid Taxonomy Code.
	Field	1	First Ancillary Taxonomy Code entered is not valid.	Enter a valid Taxonomy Code.
	Field	1	Third Ancillary Taxonomy Code entered is not valid.	Enter a valid Taxonomy Code.
	Field	2	Cannot have a duplicate (Primary/Ancillary) Taxonomy Code.	Remove duplicate Taxonomy Code that was entered.
	Field	2	Previous Ancillary Taxonomy Code is required when next Ancillary Taxonomy Code is entered.	Enter the Previous Ancillary Taxonomy Code before the next.
	Field	2	Previous Ancillary Taxonomy Code is required when next Ancillary	Enter the Previous Ancillary Taxonomy Code before the next.

Field	Field Type	Error Code	Error Message	To Correct
			Taxonomy Code is entered.	
	Field	3	Cannot have a duplicate (Primary/Ancillary) Taxonomy Code.	Remove duplicate Taxonomy Code that was entered.
	Field	3	Cannot have a duplicate (Primary/Ancillary) Taxonomy Code.	Remove duplicate Taxonomy Code that was entered.
License Expiration Date	Field	0	License Expiration Date is required.	This field must be completed if enrollment type is Individual Practitioner.
License Issue Date	Field	0	License Issue Date [MM/DD/CCYY HH:MM AM or PM] must be less than or equal to License Expiration Date MM/DD/CCYY HH:MM AM or PM]	Ensure that Issue Date is on or before Expiration Date.
	Field	1	License Issue Date is required.	This field must be completed if enrollment type is Individual Practitioner.
License Number	Field	1	License Number is required.	This field must be completed if enrollment type is Individual Practitioner.
License Type	Field	0	License Type is required.	This field must be completed if enrollment type is Individual Practitioner.
Primary Specialty?	Field	0	Primary Specialty not found.	A primary specialty must be selected.
	Field	1	More than 1 Primary Specialty found.	Ensure that Primary Specialty isn't selected for more than one specialty.
Primary Taxonomy Code	Field	1	A valid Primary Taxonomy Code is required.	Enter a valid Taxonomy Code.
	Field	2	Cannot have a duplicate (Primary/Ancillary) Taxonomy Code.	Remove duplicate Taxonomy Code that was entered.
Specialty	Field	0	Specialty is required.	This field must be completed.

## Language – Organization

The Language panel allows an enrolling organization to specify language information.

Language ?

\*\*\* No rows found \*\*\*

Select row above to update -or- click Add button below.

delete add

previous next exit

### Tasks for this panel

To specify **language** information:

1. If the enrolling provider does not conduct business in a language other than English, select the **next** button,
2. Select the **add** button to add a language record. The **Language** panel redisplay with active fields.

Language ?

Language	Effective Date	End Date
FRENCH	01/01/2002	12/31/2004
ITALIAN	01/01/2000	12/31/2299

Type data below for new record.

delete add

\*Language FRENCH \*Effective Date 01/01/2002 \*End Date 12/31/2004

previous next exit

3. Select the preferred language for the enrolling provider(s) from the **Language** drop down list box.
4. Enter the **Effective Date** for use of the selected language.
5. Enter the **End Date** for use of the selected language.
6. Select the **add** button to add another language record.
7. Select the **delete** button to delete a selected language record.
8. Select the **previous** button to review information entered in previous panels, if desired.
9. Select the **next** button to proceed to the next enrollment panel.
10. To exit the application, select the **exit** button.

### Field Descriptions – Language – Organization

Field	Description	Field Type	Data Type	Length
add	Adds a new language record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment -	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	Instructions panel.			
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Effective Date	Date when the specified language becomes effective.	Field	Date (MM/DD/CCYY)	8
End Date	Date when the specified language is no longer used.	Field	Date (MM/DD/CCYY)	8
Language	Description of the language.	Field	Drop Down List Box	0
Effective Date [List]	Date when the specified language becomes effective.	Listview	Date (MM/DD/CCYY)	8
End Date [List]	Date when the specified language is no longer used.	Listview	Date (MM/DD/CCYY)	8
Language [List]	Description of the language.	Listview	Character	0

### Field Edits – Language – Organization

Field	Field Type	Error Code	Error Message	To Correct
next	Button	0	Duplicate selected Language.	Duplication of selected languages. Correct or remove the duplicated languages.
Effective Date	Field	0	Effective Date is required.	Enter an Effective Date.
Effective Date	Field	1	Effective Date must be less than or equal to End Date.	Verify entry. The Effective Date must be less than or equal to End Date.
End Date	Field	0	End Date is required.	Enter a valid End Date.
Language	Field	0	Language is required.	Select a language from the drop-down-list box.
Language	Field	1	Duplicate selected Languages.	Remove the duplicate language.

## Ambulance Wheelchair Transportation Services – Organization

The Ambulance Wheelchair Transportation Services panel displays for all enrolling Organization providers using the Wizard that select transportation options of Air Fixed Wing, Air Fixed Rotary, Water Transport, Wheelchair Van, and Van Ambulance and Organization providers using the Organization Wizard that select transportation options of Air Fixed Wing, Air Fixed Rotary, Water Transport, Wheelchair Van, and Van Ambulance.

### Tasks for this panel

To **provide information** about ambulance wheelchair transportation services:

1. Select a value from the **Are you currently publicly owned and operated?** drop down list box.
2. Enter valid values in the **Ambulance License Number**, **Ambulance License Issue Date**, **Wheelchair Van License Number**, and **Wheelchair Van License Issue Date** fields.
3. Enter values in the **If no, enter your State Medical Transportation Board License Number here:** and **Medicare Certification Number** fields, if applicable.
4. Select the **previous** button to review information entered in previous panels, if desired.
5. Select the **next** button to proceed to the next enrollment panel.
6. To exit the application, select the **exit** button.

### Field Descriptions – Ambulance Wheelchair Transportation Services – Organization

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the Provider Enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the Provider Enrollment wizard.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
Ambulance License Issue Date	Date that the Ambulance License was issued.	Field	Date (MM/DD/CCYY)	8
Ambulance License Number	A number issued to the medical service organization indicating that specified vehicles are authorized to provide ambulance services.	Field	Alphanumeric	6
Are you currently publicly owned and operated?	Are you currently publicly owned and operated?	Field	Drop Down List Box	1
Medicare Certification Number	A number issued to the medical service organization indicating they are certified by Medicare to perform transportation services.	Field	Alphanumeric	11
State Medical Transportation Board License Number	A number issued to the medical service organization indicating they are certified to perform one or more type of transportation service.	Field	Alphanumeric	11
Wheelchair Van License Issue Date	Date that the Wheelchair Van License was issued.	Field	Date (MM/DD/CCYY)	8
Wheelchair Van License Number	A number issued to the medical service organization indicating that specified vehicles are authorized to provide wheelchair van services.	Field	Alphanumeric	11

### Field Edits – Ambulance Wheelchair Transportation Services – Organization

Field	Field Type	Error Code	Error Message	To Correct
Ambulance License Issue Date	Field	1	Ambulance License Issue Date is required.	Enter Ambulance License Issue Date.
	Field	2	Ambulance License Issue Date must be earlier than or equal to today.	Enter Ambulance License Issue Date earlier than or equal to today.
Ambulance License Number	Field	1	Ambulance License Number is required.	Enter Ambulance License Number.
Are you currently	Field	1	YES/No response to	Choose YES/No to

Field	Field Type	Error Code	Error Message	To Correct
publicly owned and operated?			currently publicly owned and operated question is required.	currently publicly owned and operated question.
Medicare Certification Number	Field	1	Medicare Certification Number is required.	Enter Medicare Certification Number.
State Medical Transportation Board License Number	Field	1	State Medical Transportation Board License Number is required.	Enter State Medical Transportation Board License Number.
Wheelchair Van License Issue Date	Field	1	Wheelchair Van License Issue Date is required.	Enter Wheelchair Van License Issue Date.
	Field	2	Wheelchair Van License Issue Date must be earlier than or equal to today.	Enter Wheelchair Van License Issue Date earlier than or equal to today.
Wheelchair Van License Number	Field	1	Wheelchair Van License Number is required.	Enter Wheelchair Van License Number.

## Ambulance Wheelchair Van Personnel – Organization

The Ambulance Wheelchair Van Personnel panel displays for all enrolling Hospital providers using the Hospital Wizard that select transportation options of Air Fixed Wing, Air Fixed Rotary, Water Transport, Wheelchair Van, and Van Ambulance and Organization providers using the Organization Wizard that select transportation options of Air Fixed Wing, Air Fixed Rotary, Water Transport, Wheelchair Van, and Van Ambulance.

**Ambulance Wheelchair Van Personnel** ?

Role	Last Name	First Name	First Aid	Expiration Date	CPR	Completion Date	EMT Card
ATTENDANT - AMBULANCE	FIRST	FIRST	NO		NO		
DRIVER - AMBULANCE	TEST	TEST	YES	12/01/2009	NO		123WAW

Type data below for new record.

*Ambulance Providers: All drivers must have EMT certification (include a copy of EMT card for each driver with the application).*

*Wheelchair Van providers: A copy of each driver's driving record from the Bureau of Motor Vehicles to be submitted with the application. Each driver and each attendant must have a current card as proof of successful completion of the "American Red Cross" (or equivalent certifying organization) basic course in first aid and a CPR certification. Each card must be signed and a copy of each driver's card, front and back, must be included with the application OR EMT certification for each driver/attendant (include a copy of each driver's/attendant's EMT card with the application).*

*Instructions: List the driver/attendant information below. Be sure to include the appropriate certification cards with the application for each driver/attendant.*

*Role	DRIVER - AMBULANCE	First Aid	YES	*Certification Number	123WAW
*Last Name	TEST	CPR	NO	*Expiration Date	12/01/2009
*First Name, MI	TEST J	Certification Number		Completion Date	
Suffix		*EMT Card Number (Required for Ambulance Drivers)	123WAW	*EMT Issue Date	12/01/2008
		*EMT Expiration Date	12/01/2010		

## Tasks for this panel

To **enter** information about ambulance wheelchair van personnel:

1. Select a value from the **Role** drop down list box.
2. Enter valid values in the **Last Name, First Name, MI, EMT Card Number, EMT Issue Date, EMT Expiration Date, Certification Number, and Expiration Date** fields.
3. Select a **Yes** or **No** response from the **First Aid** drop down list box.
  - a. If **Yes** is selected, enter valid values in the first aid **Certification Number** and **Expiration Date** fields.
4. Select a **Yes** or **No** response from the **CPR** drop down list box.
  - a. If **Yes** is selected, enter valid values in the CPR **Certification Number** and **Completion Date** fields.
5. Enter a value in the **Suffix** field, if applicable.
6. Select the **previous** button to review information entered in previous panels, if desired.
7. Select the **next** button to proceed to the next enrollment panel.
8. To exit the application, select the **exit** button.

## Field Descriptions – Ambulance Wheelchair Van Personnel – Organization

Field	Description	Field Type	Data Type	Length
add	Adds a new record to the data list.	Button	N/A	0
delete	Deletes the currently selected record from the data list.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the Provider Enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the Provider Enrollment wizard.	Button	N/A	0
CPR	Indicates whether the ambulance or wheelchair van employee is certified to perform CPR.	Field	Drop Down List Box	2
Certification Number [CPR]	A number issued to the ambulance or wheelchair van employee indicating he/she has passed the mandated CPR exam.	Field	Alphanumeric	11
Completion Date	Date that the CPR certification	Field	Date	8

Field	Description	Field Type	Data Type	Length
	will expire.		(MM/DD/CCYY)	
EMT Card Number	A number issued to the ambulance or wheelchair van employee indicating he/she has passed the mandated EMT certification exam.	Field	Alphanumeric	6
EMT Expiration Date	Date that the EMT certification will expire.	Field	Date (MM/DD/CCYY)	8
EMT Issue Date	Date that the EMT Card was issued.	Field	Date (MM/DD/CCYY)	8
Expiration Date	Date that the First Aid certification will expire.	Field	Date (MM/DD/CCYY)	8
First Aid	Indicates whether the ambulance or wheelchair van employee is certified to perform first aid.	Field	Drop Down List Box	2
First Aid Certification Number	A number issued to the ambulance or wheelchair van employee indicating he/she has passed the mandated First Aid exam.	Field	Alphanumeric	11
First Name, MI	First name and middle initial of the ambulance or wheelchair van employee.	Field	Character	14
Last Name	Last name of the ambulance or wheelchair van employee.	Field	Character	25
Role	Role of the ambulance or wheelchair van employee.	Field	Drop Down List Box	0
Suffix	Suffix of the ambulance or wheelchair van employee.	Field	Character	3

### Field Edits – Ambulance Wheelchair Van Personnel – Organization

Field	Field Type	Error Code	Error Message	To Correct
Certification Number [CPR]	Field	1	CPR Certification Number is required.	Enter CPR Certification Number.
Completion Date	Field	1	CPR Expiration Date is required.	Enter CPR Expiration Date.
	Field	2	CPR Expiration Date must be greater than today.	Enter CPR Expiration Date greater than today.

Field	Field Type	Error Code	Error Message	To Correct
EMT Card Number	Field	1	EMT Card Number is required.	Enter EMT Card Number.
EMT Expiration Date	Field	1	EMT Expiration Date is required.	Enter EMT Expiration Date.
	Field	2	EMT Expiration Date must be greater than EMT Issue Date.	Enter EMT Expiration Date greater than EMT Issue Date.
EMT Issue Date	Field	1	EMT Issue Date is required.	Enter EMT Issue Date.
	Field	2	EMT Issue Date must be earlier than or equal to today.	Enter EMT Issue Date earlier than or equal to today.
Expiration Date	Field	1	First Aid Expiration Date is required.	Enter First Aid Expiration Date.
	Field	2	First Aid Expiration Date must be greater than today.	Enter First Aid Expiration Date greater than today
First Aid Certification Number	Field	1	First Aid Certification Number is required.	Enter First Aid Certification Number.
First Name, MI	Field	1	First Name and MI is required.	Enter First Name and MI.
Last Name	Field	1	Last Name is required.	Enter Last Name.
Role	Field	1	Role is required.	Choose a valid Role.

## Requirements for Wheelchair Vehicle Providers – Organization

The Requirements for Wheelchair Vehicle Providers panel allows the enrolling provider to certify that it meets requirements for wheelchair van vehicle providers.

Requirements for Wheelchair Vehicle Providers <span style="float: right;">?</span>	
<b>Requirements for Wheelchair Van Vehicle Providers Documents to be included with the application</b>	
You must include, with your application, copies of documents for each item listed on this page. In addition, all wheelchair van vehicle providers must have documented proof on file of compliance with the following requirements, to be available upon request from the Department of Job and Family Services. Check each question to certify compliance and include required documentation.	
*1a. The number of vehicles the wheelchair van service is operating.	<input type="text" value="0"/>
* b. The provider maintains a valid current vehicle license registration with the Ohio Bureau of Motor Vehicles for each vehicle. Include a copy of the vehicle registration for each vehicle.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*2. Each vehicle displays the company logo, insignia, or name on both sides and rear of the vehicle. Include photos of each vehicle for verification.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*3. The provider maintains liability insurance coverage in the amount of not less than five hundred thousand dollars per occurrence and not less than five hundred thousand dollars in the aggregate, for any cause for which the provider would be liable. Include proof of insurance.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*4. The provider maintains bodily injury and property damage insurance with solvent and responsible insurers licensed to do business in this state for any loss or damage resulting from any occurrence arising out of or caused by the operation or use of any wheelchair van vehicle. The insurance plan shall insure each vehicle for the sum of not less than one hundred thousand dollars for bodily injury to or death of more than one person in any one accident and for the sum of fifty thousand dollars for damage to property arising from any one accident. Include proof of insurance.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*5. Each driver and attendant must submit himself or herself for criminal background checks in accordance with section 109.572 of the Revised Code. Any applicant or employee who has been indicted, convicted, or pleaded guilty to violation cited in divisions (A)(1)(a), (A)(2)(a), (A)(4)(a), and/or (A)(5)(a) of section 109.572 of the revised code shall not provide services to Medicaid patients unless the exceptions set forth in paragraphs (A) and (B) of rule 3701-13-06 of the Administrative Code apply. Include a copy of the BCI criminal background check results.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*6. Each driver and each attendant has current cards issued as proof of successful completion of the "American Red Cross" (or equivalent) basic or community course in first aid and CPR. Each card must be signed on the back by the driver or attendant who completed the course. Include a copy of each card for each driver and attendant with the application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*7. Each driver must have a copy of his or her driving record provided from the Bureau of Motor Vehicles. The date of the driving record submitted at the time of the application must be no more than fourteen days prior to the date of application for employment. Persons with six or more points on their driving record in accordance with section 4507.02 of the Revised Code cannot be a wheelchair van driver. Include a copy of each driver's driving record with the application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*8. The qualifications of each driver and each attendant must comply with local, state, and federal laws and regulations, including a valid driver's license and be eighteen years or older. Include a copy of a valid driver's license for each driver.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*9. Each vehicle is specifically designed to transport one or more patients sitting in wheelchairs and has fasteners to secure the wheelchair to the floor or side of the vehicle to prevent wheelchair movement. In addition, the vehicle is equipped with restraints to secure the patient in the wheelchair.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*10. Each vehicle has a minimum ceiling to floor height of fifty-six inches.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*11. Each vehicle is equipped with a communication system capable of two-way communication.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*12. Each vehicle is equipped with a stable access ramp or hydraulic lift.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*13. The provider must conduct daily inspection and testing of the hydraulic lift or access ramp.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*14. Each vehicle is equipped with, at a minimum, a fire extinguisher and an emergency first-aid kit.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*15. Each vehicle has provisions for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and driver in the event of an accident.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*16. The provider must complete vehicle inspection documentation in the form of a checklist to include at a minimum wheelchair restraints, wheelchair lifts, lights, windshield wipers/washers, emergency equipment, mirrors, and brakes.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*17. The provider maintains on file evidence that at least an annual vehicle inspection was completed by the Ohio State Highway Patrol Safety Inspection Unit, or a certified mechanic and each vehicle has been determined to be in good working condition.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*18. Each wheelchair van driver and each attendant has an identification card available to the patient identifying his or her complete name and company affiliation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*19. The provider maintains on file a signed statement from a licensed physician for each driver and attendant declaring that they do not have physical, including vision and hearing, or mental limitation likely to interfere with safe driving, passenger assistance, or emergency activity and does not have a communicable disease that could jeopardize the health or welfare of patients being transported.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*20. Each wheelchair van driver has undergone testing for alcohol and controlled substances in accordance with 49 CFR 382.	<input type="checkbox"/> Yes <input type="checkbox"/> No
*21. Each wheelchair van and each attendant has completed a passenger assistance training course to include at a minimum the basic characteristics of major disabling conditions affecting ambulation, basic considerations for functional factors, management of wheelchairs, assistance and transfer techniques, environmental considerations, and emergency procedures.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<a href="#">previous</a> <a href="#">next</a> <a href="#">exit</a>	

## Tasks for this panel

To **enter** information on wheelchair vehicle providers:

1. Enter a numerical value in the question **1a.** field.
2. Select either **Yes** or **No** for the remaining question fields **1b.** through **21.**

3. Select the **previous** button to review information entered in previous panels, if desired.
4. Select the **next** button to proceed to the next enrollment panel.
5. To exit the application, select the **exit** button.

### Field Descriptions – Requirements for Wheelchair Vehicle Providers – Organization

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the Provider Enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the Provider Enrollment wizard.	Button	N/A	0
10. Each vehicle has a minimum ceiling to floor height of fifty-six (56) inches.	Indicates if vehicle meets minimum height requirement. Valid values: Yes or No.	Field	Radio Button	0
11. Each vehicle is equipped with a communication system capable of two-way communication.	Indicates if vehicle has two-way communication system. Valid values: Yes or No.	Field	Radio Button	0
12. Each vehicle is equipped with a stable access ramp or hydraulic lift.	Indicates if vehicle has wheelchair access. Valid values: Yes or No.	Field	Radio Button	0
13. The provider must conduct daily inspection and testing of the hydraulic lift or access ramp.	Indicates if vehicle access system is inspected and tested daily. Valid values: Yes or No.	Field	Radio Button	0
14. Each vehicle is equipped with, at a minimum, a fire extinguisher and an emergency first-aid kit.	Indicates if vehicle has minimum required fire and emergency equipment. Valid values: Yes or No.	Field	Radio Button	0
15. Each vehicle has provisions for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and driver in the event of an accident.	Indicates if vehicle provides safe and secure storage space. Valid values: Yes or No.	Field	Radio Button	0
16. The provider must complete vehicle	Indicates if provider has completed the required vehicle inspection	Field	Number	0

Field	Description	Field Type	Data Type	Length
inspection documentation in the form of a checklist to include at a minimum wheelchair restraints, wheelchair lifts, lights, windshield wipers/washers, emergency equipment, mirrors, and brakes.	checklist. Valid values: Yes or No.			
17. The provider maintains on file evidence that at least an annual vehicle inspection was completed by the Ohio State Highway Patrol Safety Inspection Unit, or a certified mechanic and each vehicle has been determined to be in good working condition.	Indicates if required evidence of vehicle inspection is on file. Valid values: Yes or No.	Field	Radio Button	0
18. Each Wheelchair Van driver and each attendant has an identification card available to the patient identifying his or her complete name and company affiliation.	Indicates if van personnel carry required identification. Valid values: Yes or No.	Field	Radio Button	0
19. The provider maintains on file a signed statement from a licensed physician for each driver and attendant declaring that they do not have physical, including vision and hearing, or mental limitation likely to interfere with safe driving, passenger assistance, or emergency activity and does not have a communicable disease that could jeopardize the health or welfare of patients being transported.	Indicates if provider maintains required health certificates for van personnel. Valid values: Yes or No.	Field	Radio Button	0
1a. The number of vehicles the wheelchair van service is operating.	Indicates the number of vehicles in operation.	Field	Number	4
1b. The provider maintains a valid current vehicle license registration	Indicates if provider maintains vehicle registrations. Valid values:	Field	Radio Button	0

Field	Description	Field Type	Data Type	Length
with the Ohio Bureau of Motor Vehicles for each vehicle. Include a copy of the vehicle registration for each vehicle.	Yes or No.			
2. Each vehicle displays the company logo, insignia, or name on both sides and rear of the vehicle. Include photos of each vehicle for verification.	Indicates if vehicle bears company identification markings. Valid values: Yes or No.	Field	Radio Button	0
20. Each wheelchair van driver has undergone testing for alcohol and controlled substances in accordance with 49 CFR 382.	Indicates if driver(s) has been tested for controlled substances. Valid values: Yes or No.	Field	Radio Button	0
21. Each wheelchair van driver and each attendant has completed a passenger assistance training course to include at a minimum the basic characteristics of major disabling conditions affecting ambulation, basic considerations for functional factors, management of wheelchairs, assistance and transfer techniques, environmental considerations, and emergency procedures.	Indicates if van personnel have completed required training to assist passengers. Valid values: Yes or No.	Field	Radio Button	0
3. The provider maintains liability insurance coverage in the amount of not less than five hundred thousand dollars per occurrence in the aggregate, for any cause for which the provider would be liable. Include proof of insurance.	Indicates if provider has required liability coverage. Valid values: Yes or No.	Field	Radio Button	0
4. The provider maintains bodily injury and property damage insurance with solvent and responsible insurers licensed to do business in this state for	Indicates if provider maintains required injury and property damage insurance. Valid values: Yes or No.	Field	Radio Button	0

Field	Description	Field Type	Data Type	Length
	any loss or damage resulting from any occurrence arising out of or caused by the operation or use of any wheelchair van vehicle. The insurance plan shall insure each vehicle for the sum of not less than one hundred thousand dollars for bodily injury to or death of more than one person in any one accident and for the sum of fifty thousand dollars for damage to property arising from any one accident. Include proof of insurance.			
5. Each driver and attendant must submit himself or herself for criminal background checks in accordance with section 109.572 of the Revised Code. Any applicant or employee who has been indicted, convicted, or pleaded guilty to violation cited in divisions (A)(1)(a), (A)(2)(a), (A)(4)(a), and/or (A)(5)(a) of section 109.572 of the revised code shall not provide services to Medicaid patients unless the exceptions set forth in paragraphs (A) and (B) of Rule 3701-13-06 of the Administrative Code apply. Include a copy of the BCI criminal background check results.	Indicates if van personnel have had requisite criminal background checks. Valid values: Yes or No.	Field	Radio Button	0
6. Each driver and each attendant has current cards issued as proof of successful completion of the "American Red Cross" (or equivalent) basic or community course in first aid and CPR. Each card	Indicates if van personnel have proof of required first aid and CPR training. Valid values: Yes or No.	Field	Radio Button	0

Field	Description	Field Type	Data Type	Length
	must be signed on the back by the driver or attendant who completed the course. Include a copy of each card for each driver and attendant with the application.			
7. Each driver must have a copy of his or her driving record provided from the Bureau of Motor Vehicles. The date of the driving record submitted at the time of the application must be no more than fourteen days prior to the date of application for employment. Persons with six or more points on their driving record in accordance with Section 4507.02 of the Revised Code cannot be a wheelchair van driver. Include a copy of each driver's driving record with the application.	Indicates if van driver has copy of driving record. Valid values: Yes or No.	Field	Radio Button	0
8. The qualifications of each driver and each attendant must comply with local, state, and federal laws and regulations, including a valid driver's license and be eighteen years or older. Include a copy of a valid driver's license for each driver.	Indicates if van personnel comply with all relevant local, State, and Federal regulations. Valid values: Yes or No.	Field	Radio Button	0
9. Each vehicle is specifically designed to transport one or more patients sitting in wheelchairs and has fasteners to secure the wheelchair to the floor or side of the vehicle to prevent wheelchair movement. In addition, the vehicle is equipped with restraints to secure the patient in the wheelchair.	Indicates if vehicle is designed to transport patients in wheelchairs. Valid values: Yes or No.	Field	Radio Button	0

## Field Edits – Requirements for Wheelchair Vehicle Providers – Organization

Field	Field Type	Error Code	Error Message	To Correct
Question 1a	Field	1	The number of vehicles operating must be greater than zero.	Enter number of vehicles greater than zero.

## Criminal Offense I – Organization

The Criminal Offense I panel is used by Group, Organization, and Individual providers to add or update associated criminal information during the enrollment process.

### Tasks for this panel

To **add** or **update** associated criminal information:

1. If no owner or controlling interest has ever been indicted or convicted, select the **No** option, then the **next** button.
2. If any owner or controlling interest has ever been indicted or convicted, select the **Yes** option to activate the panel fields.
3. Enter valid values in the **Name**, **Offense**, **SSN/FEIN**, and **Date of Offense** fields.
4. Select values from the **Type**, **Role**, and **Disposition** drop down list boxes.
5. Select the **add** button to add another criminal offense record.
6. Select the **delete** button to delete a selected criminal offense record.
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.
9. To exit the application, select the **exit** button.

**Field Descriptions – Criminal Offense I – Organization**

Field	Description	Field Type	Data Type	Length
add	Inserts a new record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Criminal Offense I [Panel] - Group/Individual	Have you or any individuals or organizations having a direct or indirect ownership or controlling interest of 5 percent or more in the professional association or practice been indicted or convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX or XX?	Field	Radio Button	1
Criminal Offense I [Panel] - Organization	Are there any individuals or organizations having a direct or indirect ownership or controlling interest of 5 percent or more in the institution, organization, agency, or practice that have been indicted or convicted of a criminal offense related to the involvement of such person or organizations in any of the programs established by the Titles XVII, XIX, or XX? Choose Yes or No.	Field	Radio Button	1
Date of Offense [Panel]	Date of offense.	Field	Date (MM/DD/CCYY)	10
Disposition [Panel]	Disposition of offense.	Field	Drop Down List Box	0

Field	Description	Field Type	Data Type	Length
Name [Panel]	Name of individual or organization.	Field	Character	50
Offense [Panel]	Type of criminal offense.	Field	Character	30
Role [Panel] - Individual/Organization	Role of individual or organization charged with criminal offense.	Field	Drop Down List Box	0
SSN/FEIN [Panel] - Individual/Organization	Social Security number or Federal Employer Identification number of individual or organization charged with criminal offense.	Field	Number	9
Type [Panel] - Individual/Organization	Type of Tax ID. Valid values are: SSN and FEIN.	Field	Drop Down List Box	1
Click here for Role Definitions [Panel]	Link to see role definitions.	Hyperlink	N/A	0
Answer [List]	Answer to criminal offense question.	Listview	Character	0
Date of Offense [List]	Date of offense.	Listview	Date (MM/DD/CCYY)	10
Disposition [List]	Disposition of offense.	Listview	Drop Down List Box	0
Name [List]	Name of individual or organization.	Listview	Character	50
Offense [List]	Type of criminal offense.	Listview	Character	30
Role [List] - Individual/Organization	Role of individual or organization charged with criminal offense.	Listview	Drop Down List Box	0
SSN/FEIN [List] - Individual/Organization	Social Security number or Federal Employer Identification number of individual or organization charged with criminal offense.	Listview	Number	9

### Field Edits – Criminal Offense I – Organization

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	0	Invalid number / Invalid date. Format is mm/dd/ccyy / Invalid character data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	1	Field exceeds max length.	Ensure that the number of characters entered does not exceed the length of the field as documented in the field descriptions above.
Criminal Offense I [Panel] - Organization	Field	0	YES/NO response to this question is required.	Choose Yes or No.
Criminal Offense I [Panel] - Organization	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
Criminal Offense I [Panel] - Organization	Field	2	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.
Date of Offense [Panel]	Field	0	Date of Offense is required.	Enter a valid date of offense.
Disposition [Panel]	Field	0	Disposition is required.	Select a disposition from the drop-down list box.
Name [Panel]	Field	0	Name is required.	Enter an individual or organization name.
Offense [Panel]	Field	0	Offense is required.	Enter a criminal offense.
Role [Panel] - Individual/Organization	Field	0	Role is required.	Select a role from the drop-down list box.
SSN/FEIN [Panel] - Individual/Organization	Field	0	SSN/FEIN is required.	Enter a valid Social Security number or Federal Employer Identifier number.
Type [Panel] - Individual/Organization	Field	0	Type is required.	Choose SSN or FEIN.

## Criminal Offense II – Organization

The Criminal Offense II panel is used by Group, Organization, and Individual providers to add or update associated criminal information during the enrollment process.

### Tasks for this panel

To **add** or **update** associated criminal information:

1. If no executives or agents of the organization have ever been indicted or convicted, select the **No** option, then the **next** button.
2. If any executives or agents of the organization have ever been indicted or convicted, select the **Yes** option to activate the panel fields.
3. Enter valid values in the **Name**, **Offense**, **SSN/FEIN**, and **Date of Offense** fields.
4. Select values from the **Type**, **Role**, and **Disposition** drop down list boxes.
5. Select the **add** button to add another criminal offense record.
6. Select the **delete** button to delete a selected criminal offense record.
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.
9. To exit the application, select the **exit** button.

### Field Descriptions – Criminal Offense II – Organization

Field	Description	Field Type	Data Type	Length
add	Inserts a new record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	and exits to the Provider Enrollment - Instructions panel.			
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Date of offense [Panel]	Date of the offense.	Field	Date (MM/DD/CCYY)	8
Disposition [Panel]	Disposition of the offense.	Field	Drop Down List Box	0
Name [Panel]	Name of the individual, group, or organization.	Field	Character	50
Offense [Panel]	Type of criminal offense.	Field	Character	50
Role [Panel]	Role of individual or organization charged with criminal offense.	Field	Drop Down List Box	0
SSN/FEIN [Panel]	Social Security number or Federal Employer Identification number of the individual or organization charged with criminal offense.	Field	Number	9
Type [Panel]	Type of Tax ID. Valid values are: SSN and FEIN.	Field	Drop Down List Box	0
Are there any directors, officers, agents, or managing employees of the institution, agency organization, or practice who have ever been indicted or convicted of a criminal offense	Indicates if any individual with the practice has ever been indicted for, or convicted of, certain criminal offenses. Valid values: Yes or No.	Field	Radio Button	0

Field	Description	Field Type	Data Type	Length
related to the involvement in such programs established by Titles XVIII, XIX, or XX?				
Click here for Role Definitions	Link to list of roles and definitions.	Hyperlink	N/A	0
Answer	Answer to criminal offense question.	Listview	Character	0
Date of offense [List]	Date of the offense.	Listview	Date (MM/DD/CCYY)	8
Disposition [List]	Disposition of the offense.	Listview	Drop Down List Box	0
Name [List]	Name of the individual, group, or organization.	Listview	Character	50
Offense [List]	Type of criminal offense.	Listview	Character	50
Role [List]	Role of individual or organization charged with criminal offense.	Listview	Character	0
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the individual or organization charged with criminal offense.	Listview	Number	9

### Field Edits – Criminal Offense II – Organization

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
All fields	Field	1	Field exceeds max length.	Ensure that the number of characters entered does not exceed the length of the field as documented in the field descriptions above.

Field	Field Type	Error Code	Error Message	To Correct
Date of offense [Panel]	Field	0	Date of Offense is required.	Enter a valid date.
Disposition [Panel]	Field	0	Disposition is required.	Select a disposition from the drop-down list box.
Name [Panel]	Field	0	Name is required.	Enter an individual, group, or organization name.
Offense [Panel]	Field	0	Offense is required.	Enter a criminal offense.
Role [Panel]	Field	0	Role is required.	Select a role from the drop-down list box.
SSN/FEIN [Panel]	Field	0	SSN/FEIN is required.	Enter a valid Social Security number or Federal Employer Identification number.
Type [Panel]	Field	0	Type is required.	Choose SSN or FEIN.
Are there any directors, officers, agents, or managing employees of the institution, agency organization, or practice who have ever been indicted or convicted of a criminal offense related to the involvement in such programs established by Titles XVIII, XIX, or XX?	Field	0	YES/NO response to this question is required.	Choose Yes or No.
	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
	Field	2	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.

## Violations of State or Federal Law – Organization

The Violations of State or Federal Law panel is used to enter information regarding violations of State or Federal laws.

### Tasks for this panel

To **enter** information regarding violations of state or federal laws:

1. If neither the enrolling organization, any of its employees, nor any other business associates has ever had a State or Federal violation, select the **No** option, then the **next** button.
2. If the enrolling organization, any of its employees, or any other business associates has ever had a State or Federal violation, select the **Yes** option.
3. The **Name**, **Type**, **SSN/FEIN**, **Role**, **Offense**, **Disposition**, and **Date of Offense** fields become active.
4. Enter valid values for the **Name**, **Offense**, and **Date of Offense** fields.
5. Select values for the **Type**, **Role**, and **Disposition** drop down list boxes.
6. Select the **add** button to add another violation of State or Federal law record.
7. Select the **delete** button to delete a selected violation of State or Federal law record.
8. Select the **previous** button to review information entered in previous panels, if desired.
9. Select the **next** button to proceed to the next enrollment panel.
10. To exit the application, select the **exit** button.

### Field Descriptions – Violations of State or Federal Law – Organization

Field	Description	Field Type	Data Type	Length
add	Inserts a new record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Date of offense [Panel]	Date of the offense.	Field	Date (MM/DD/CCYY)	8
Disposition [Panel]	Disposition of the offense.	Field	Drop Down List Box	0
Name [Panel]	Name of the individual, group, or organization.	Field	Character	50
Offense [Panel]	Type of criminal offense.	Field	Character	50
Role [Panel]	Role of individual or organization charged with criminal offense.	Field	Drop Down List Box	0
SSN/FEIN [Panel]	Social Security number or Federal Employer Identification number of the individual or organization charged with criminal offense.	Field	Number	9
Type [Panel]	Type of Tax ID. Valid values are: SSN and FEIN.	Field	Drop Down List Box	0
Have you as Provider or any Owner, Authorized Agent, Associate Manager, Employee, Directors, or Officers of the Institution, Agency, Organization, or Practice ever been indicted or convicted of	Indicates if individual with practice has ever been indicted under, or convicted of, State or Federal law violation. Valid values: Yes or No.	Field	Radio Button	0

Field	Description	Field Type	Data Type	Length
a violation of State or Federal Law?				
Answer	Answer to violation of State or Federal law question.	Listview	Character	0
Date of offense [List]	Date of the offense.	Listview	Date (MM/DD/CCYY)	8
Disposition [List]	Disposition of the offense.	Listview	Drop Down List Box	0
Name [List]	Name of the individual, group, or organization.	Listview	Character	50
Offense [List]	Type of criminal offense.	Listview	Character	50

### Field Edits – Violations of State or Federal Law – Organization

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
All fields	Field	1	Field exceeds max length.	Ensure that the number of characters entered does not exceed the length of the field as documented in the field descriptions above.
Date of offense [Panel]	Field	0	Date of Offense is required.	Enter a valid date.
Disposition [Panel]	Field	0	Disposition is required.	Select a disposition from the drop-down list box.
Name [Panel]	Field	0	Name is required.	Enter an individual, group, or organization name.
Offense [Panel]	Field	0	Offense is required.	Enter a criminal offense.
Role [Panel]	Field	0	Role is required.	Select a role from the drop-down list box.
Type [Panel]	Field	0	Type is required.	Choose SSN or FEIN.
Have you as Provider or any	Field	0	YES/NO response to this question is	Choose Yes or No.

Field	Field Type	Error Code	Error Message	To Correct
Owner, Authorized Agent, Associate Manager, Employee, Directors, or Officers of the Institution, Agency, Organization, or Practice ever been indicted or convicted of a violation of State or Federal Law?			required.	
	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
	Field	2	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.
	Field	0	YES/NO response to this question is required.	Choose Yes or No.
	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
	Field	2	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.
	Field	0	YES/NO response to this question is required.	Choose Yes or No.
	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
	Field	2	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.

## Type of Entity or Practice – Organization

The Type of Entity or Practice panel captures the type of business that is represented in the application.

**Type of Entity or Practice** ?

\*Type of Entity or Practice

If Other, specify

previous
next
exit

### Tasks for this panel

To **enter** information on the type of business:

1. Select a value for the type of group enrolling in the **Type of Entity or Practice** drop down list box.
2. If the type of organization does not appear in the **Type of Entity or Practice** list, enter text for the type of organization enrolling in the **If Other, specify** field.
3. Select the **previous** button to review information entered in previous panels, if desired.
4. Select the **next** button to proceed to the next enrollment panel.
5. To exit the application, select the **exit** button.

### Field Descriptions – Type of Entity – Organization

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
If Other, specify	Different description that is used when Other (Specify) is selected.	Field	Character	50
Type of Entity or Practice	Type of business.	Field	Drop Down List Box	0

### Field Edits – Type of Entity – Organization

Field	Field Type	Error Code	Error Message	To Correct
If Other, specify	Field	1	If Other, specify is required.	Enter a value in this field when Other (Specify) is selected.
Type of Entity or Practice	Field	1	Type of Entity or Practice is required.	Select a value for Entity or Practice.

## Change of Ownership or Control – Organization

The Change of Ownership or Control panel captures information pertaining to a change of ownership or control.

### Tasks for this panel

To **capture** information pertaining to a change of ownership or control:

1. Select a **Yes** or **No** response to the question **Has there been any change in ownership or control within the year?**
2. If the response is **No**, select the **next** button to proceed to the next enrollment panel.
3. If the response is **Yes**, the **Date of Transaction**, **Is Explanation Attached?**, and **Explanation** fields become active
4. Enter the expected date of the change of ownership in the **Date of Transaction** field.
5. Select **Yes** or **No** from the **Is Explanation Attached?** drop down list box.
6. Select **Yes** if the explanation will be included as a mailed or faxed attachment to the enrollment application.
7. If **No** is selected, enter text in the **Explanation** field to explain why no explanation is attached with the enrollment application.
8. Select the **previous** button to review information entered in previous panels, if desired.
9. Select the **next** button to proceed to the next enrollment panel.
10. To exit the application, select the **exit** button.

### Field Descriptions – Change of Ownership or Control – Organization

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	provider enrollment wizard.			
Date of Transaction	Date transaction occurred.	Field	Date (MM/DD/CCYY)	8
Enter Explanation Here	Description of the change in ownership or control.	Field	Character	300
Is Explanation Attached?	Indicates if an attachment will be appended to the application with an explanation of the change of ownership or control. Valid values: Yes or No	Field	Drop Down List Box	1
Has there been any change in ownership or control within the year?	Indicates if practice owner has changed in last year. Valid values: Yes or No.	Field	Radio Button	0

### Field Edits – Change of Ownership or Control – Organization

Field	Field Type	Error Code	Error Message	To Correct
Date of Transaction	Field	1	Date is required.	Enter a valid date.
Date of Transaction	Field	2	Date is invalid.	Enter a valid date.
Date of Transaction	Field	3	Date of Transaction must be between today and year from today.	Enter a valid date.
Enter Explanation Here	Field	1	Enter Explanation Here is required.	Enter a value in this field or select Explanation Attached.
Is Explanation Attached?	Field	1	Explanation Attached is required.	Select YES or NO.
Has there been any change in ownership or control within the year?	Field	1	Change of Ownership is required.	Select YES or NO.

## Anticipated Change of Ownership or Control – Organization

The Anticipated Change of Ownership panel captures information pertaining to an expected change of ownership or control.

### Tasks for this panel

To **enter** information pertaining to an expected change of ownership or control:

1. Select a **Yes** or **No** response to the question **Do you anticipate any change in ownership or control within the year?**
2. If the response is **No**, select the **next** button to proceed to the next enrollment panel.
3. If the response is **Yes**, the **Anticipated Date of Transaction**, **Is Explanation Attached?**, and **Explanation** fields become active.
4. Enter the expected date of the change of ownership in the **Anticipated Date of Transaction** field.
5. Select **Yes** or **No** from the **Is Explanation Attached?** drop down list box.
6. Select **Yes** if the explanation will be included as a mailed or faxed attachment to the enrollment application.
7. If **No** is selected, enter text in the **Explanation** field to explain why no explanation is attached with the enrollment application.
8. Select the **previous** button to review information entered in previous panels, if desired.
9. Select the **next** button to proceed to the next enrollment panel.
10. To exit the application, select the **exit** button.

### Field Descriptions – Anticipated Change of Ownership or Control – Organization

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0

Field	Description	Field Type	Data Type	Length
Anticipated Date of Transaction	Date anticipated transaction will occur.	Field	Date (MM/DD/CCYY)	8
Enter Explanation Here	Description of the anticipated change in ownership or control.	Field	Character	300
Is Explanation Attached?	Is there an attachment that will be appended to the application with an explanation in the change of ownership or control? Valid values: Yes or No	Field	Drop Down List Box	0
Do you anticipate any change in ownership or control within the year?	Indicates if a change in ownership or control is expected in the coming year. Valid values: Yes or No.	Field	Radio Button	0

### Field Edits – Anticipated Change of Ownership or Control – Organization

Field	Field Type	Error Code	Error Message	To Correct
Anticipated Date of Transaction	Field	1	Date is required.	Enter a valid date.
Anticipated Date of Transaction	Field	2	Date is invalid.	Enter a valid date.
Anticipated Date of Transaction	Field	3	Anticipated Date of Transaction must be between today and year from today.	Enter a valid date.
Enter Explanation Here	Field	1	Enter Explanation Here is required.	Enter a value in this field or select Explanation Attached.
Is Explanation Attached?	Field	1	Explanation Attached is required.	Select YES or NO.
Do you anticipate any change in ownership or control within the year?	Field	1	Change of Ownership is required.	Select YES or NO.

## Management Company or Leased – Organization

The Management Company or Leased panel captures information about whether the organization is owned by a management company or is leased.

### Tasks for this panel

To **enter** information on whether the business is owned by a management company or leased:

1. Select a **Yes** or **No** response to the question **Is this entity or practice operated by a management company, or leased in whole or part by another organization?**
2. If the response is **No**, select the next button to proceed to the next enrollment panel.
3. If the response is **Yes**, the **Change of Operations Date** field becomes active.
4. Enter the date the management lease became effective in the **Change of Operations Date** field.
5. Select the **previous** button to review information entered in previous panels, if desired.
6. Select the **next** button to proceed to the next enrollment panel.
7. To exit the application, select the **exit** button.

### Field Descriptions – Management Company or Leased – Organization

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Change of Operations Date	Date of the change of operations.	Field	Date (MM/DD/CCYY)	8
Is this entity or practice operated by a management company, or leased in whole or part by another organization?	Indicates if organization is managed or leased by another organization. Valid values: Yes or No.	Field	Radio Button	0

## Field Edits – Management Company or Leased – Organization

Field	Field Type	Error Code	Error Message	To Correct
Change of Operations Date	Field	1	Change of Operations Date is required.	Enter a valid date.
Change of Operations Date	Field	2	Change of Operations Date is invalid.	Enter a valid date.
Change of Operations Date	Field	3	Change of Operations Date must be past or current date.	Enter a valid date
Is this entity or practice operated by a management company, or leased in whole or part by another organization?	Field	1	Question is required.	Select YES or NO.

## Previously Participated – Organization

The Previously Participated panel captures the previous provider IDs for Long Term Care provider applicants.

### Tasks for this panel

To **enter** information on previous provider IDs for Long Term Care provider applicants:

1. Select a **Yes** or **No** response to the question **Have you ever been issued an Ohio Medicaid 7-digit Provider or 10-digit NPI ID?**
2. If the response is **No**, select the **next** button to proceed to the next enrollment panel.
3. If the response is **Yes**, the **Previous Provider ID** field becomes active.
4. Enter the provider ID previously used for Medicaid business in the **Previous Provider ID** field.
5. Select the **add** button to add another previous provider ID record.
6. Select the **delete** button to delete a selected previous provider ID record.
7. Select the **previous** button to review information entered in previous panels, if desired.
8. Select the **next** button to proceed to the next enrollment panel.

9. To exit the application, select the **exit** button.

### Field Descriptions – Previously Participated – Organization

Field	Description	Field Type	Data Type	Length
add	Inserts a new previous provider ID record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Have you ever been issued an Ohio Medicaid 7-digit Provider or 10-digit NPI ID?	Indicates if organization has a previous Ohio Medicaid provider ID number. Valid values: Yes or No.	Field	Radio Button	0
Previous Provider ID [Detail]	Previous provider identification number of the applicant.	Field	Character	10
Answer	Answer to Previously Participated Question.	Listview	Character	0
Previous Provider ID [List]	Previous provider identification number of the applicant.	Listview	Character	10

### Field Edits – Previously Participated – Organization

Field	Field Type	Error Code	Error Message	To Correct
Have you ever been issued an Ohio Medicaid 7-digit Provider or 10-digit NPI ID?	Field	0	YES/NO response to this question is required.	Choose Yes or No.
	Field	1	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.

Field	Field Type	Error Code	Error Message	To Correct
	Field	2	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
Previous Provider ID [Detail]	Field	0	Previous Provider ID is required.	Enter a Previous Provider ID.
Previous Provider ID [Detail]	Field	1	Previous Provider ID must be 7 or 10 digits in length.	Enter a value for Previous Provider ID.

## Corporation Name and List of Directors – Organization

The Corporation Name and List of Directors panel captures information pertaining to a corporation, such as names and addresses of directors and the corporation.

### Tasks for this panel

To **enter** information pertaining to a corporation:

1. Select a **Yes** or **No** response to the question **Is the disclosing entity or practice a corporation, LLC, or non profit?**
2. If the response is **No**, select the **next** button to proceed to the next enrollment panel.
3. If the response is **Yes**, the **Name**, **Type**, **SSN/FEIN**, **Street Address**, **City**, **State**, and **Zip** fields become active
4. Enter valid values in the **Name**, **SSN/FEIN**, **Street Address**, **City**, and **Zip** fields.
5. Select values from the **Type** and **State** drop down list boxes.
6. Enter a value in the 4-digit **Zip** extension field, if applicable.
7. Select the **add** button to add another corporation name record.

8. Select the **delete** button to delete a selected corporation name record.
9. Select the **previous** button to review information entered in previous panels, if desired.
10. Select the **next** button to proceed to the next enrollment panel.
11. To exit the application, select the **exit** button.

### Field Descriptions – Corporation Name and List of Directors – Organization

Field	Description	Field Type	Data Type	Length
Is the disclosing entity or practice a corporation, LLC, or non profit?	Valid values: Yes or No.	Button	Radio Button	0
Answer (List)		Field	Character	3
City (Detail)	Represents the city in which a Director, associated with a corporation, is located and the city in which the parent corporation is located, if applicable. For individual entities, this represents the city in which the individual resides.	Field	Character	50
Name (Detail)	Represents the name of a Director associated with a Corporation and the name of the parent corporation, if applicable. For individual entities, this represents the individual's name.	Field	Character	50
Name (List)	Represents the name of a Director associated with a Corporation and the name of the parent corporation, if applicable. For individual entities, this represents the individual's name.	Field	Character	50
SSN/FEIN (Detail)	Represents the SSN of a Director, associated with a corporation and the EIN of the parent corporation, if applicable. For Individual entities, this represents the SSN of the Individual.	Field	Number	9
State (Detail)	Represents the state in which a Director, associated with a corporation, is located and the city in which the parent corporation is located, if applicable. For individual entities, this represents the state in which the individual resides.	Field	Drop Down List Box	0
Street	Represents the address of the Director	Field	Alphanumeric	60

Field	Description	Field Type	Data Type	Length
Address (Detail)	associated with a corporation and the address of the parent corporation if applicable. For individual entities, this represents the address of the individual.			
Zip (Detail)	Represents the five digit zip code plus the additional 4 digits of the zip code in which the Director, associated with a corporation, is located and the zip code of the parent corporation if applicable. For individual entities, this represents the zip code in which the individual is located.	Field	Number	9
Zip (List)	Represents the five digit zip code plus the additional 4 digits of the zip code in which the Director, associated with a corporation, is located and the zip code of the parent corporation if applicable. For individual entities, this represents the zip code in which the individual is located.	Field	Number	9
City (List)	Represents the city in which a Director, associated with a corporation, is located and the city in which the parent corporation is located, if applicable. For individual entities, this represents the city in which the individual resides.	Listview	Character	0
State (List)	Represents the state in which a Director, associated with a corporation, is located and the city in which the parent corporation is located, if applicable. For individual entities, this represents the state in which the individual resides.	Listview	Character	0
Street Address (List)	Represents the address of the Director associated with a corporation and the address of the parent corporation if applicable. For individual entities, this represents the address of the individual.	Listview	Alphanumeric	60
Type (Detail)	Represents the type of identifier number (SSN) of a Director, associated with a corporation and the type of identifier (EIN) of the parent corporation, if applicable. For Individual entities, this represents the type of identifier number (SSN) of the Individual.	Listview	Character	0

## Field Edits – Corporation Name and List of Directors – Organization

Field	Field Type	Error Code	Error Message	To Correct
Is the disclosing entity or practice a corporation, LLC, or non profit?	Button	1	Cannot have a "YES" and a "NO" response to the Question.	Delete appropriate "YES" or "NO" record.
	Button	2	Can only answer "NO" to the Question once	Delete duplicate "NO" response
	Button	5100	A "YES" or "NO" response to the Question is required when click on "Add"	Click "YES" or "NO"

## Owners of Other Medicare/Medicaid Facilities – Organization

The Owners of Other Medicare/Medicaid Facilities panel captures the owners of other Medicaid/Medicare facilities information for organization providers.

### Tasks for this panel

To **enter** information on owners of other Medicaid and/or Medicare facilities:

1. Select a **Yes** or **No** response to the question **Are any owners of the disclosing entity also owners of other Medicaid/Medicare facilities?**
2. If the response is **No**, select the **next** button to proceed to the next enrollment panel.
3. If the response is **Yes**, the **Name**, **Medicare Type**, **Medicare Provider Number**, **Medicaid Provider Number**, **Vendor Number**, **Street Address**, **City**, **State**, and **Zip** fields become active.
4. Enter valid values in the **Name**, **Medicaid Provider Number**, **Vendor No.**, **Street Address**, **City**, and **Zip** fields.

5. Select values from the **Medicare Type** and **State** drop down list boxes.
6. Enter values in the **Medicare Provider Number** and 4-digit **Zip** extension fields, if applicable.
7. Select the **add** button to add another owners of other facilities record.
8. Select the **delete** button to delete a selected owners of other facilities record.
9. Select the **previous** button to review information entered in previous panels, if desired.
10. Select the **next** button to proceed to the next enrollment panel.
11. To exit the application, select the **exit** button.

### Field Descriptions – Owners of Other Medicare/Medicaid Facilities – Organization

Field	Description	Field Type	Data Type	Length
add	Inserts a new owner record. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record. Proper permissions are required to perform a delete.	Button	N/A	0
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
City [Detail]	City of the owner.	Field	Character	30
Medicaid Provider Number [Detail]	Provider's identification number.	Field	Number	10
Medicare Provider Number [Detail]	Medicare Provider Number	Field	Number	10
Medicare Type [Detail]	Medicare Type PTAN/CCN	Field	Drop Down List Box	0
Name [Detail]	Name of the individual who is an owner of another Medicaid or Medicare facility.	Field	Character	50
Are any owners of the disclosing entity also owners of other Medicaid/Medicare facilities? (Example, sole	Indicates if any organization owners are owners of other Medicaid and/or Medicare facilities. Valid values: Yes or No.	Field	Radio Button	0

Field	Description	Field Type	Data Type	Length
proprietor, partnership, or members of the Board of Directors.)				
State [Detail]	State of the owner.	Field	Drop Down List Box	0
Street Address [Detail]	Street address of the owner.	Field	Character	60
Vendor No.	Provider's vendor number.	Field	Alphanumeric	9
ZIP [Detail]	Zip code of the owner.	Field	Number	5
ZIP+4	Zip code extension of the owner.	Field	Number	4
Answer	Response to the other ownership question.	Listview	Character	0
City [List]	City of the owner.	Listview	Character	0
Medicaid Provider Number [List]	Provider's identification number.	Listview	Number	10
Medicare Provider Number [List]	Medicare Provider Number.	Listview	Number	10
Medicare Type [List]	Medicare Type PTAN/CCN.	Listview	Character	4
Name [List]	Name of the individual who is an owner of another Medicaid or Medicare facility.	Listview	Character	50
State [List]	State of the owner.	Listview	Character	0
Street Address [List]	Street address of the owner.	Listview	Character	0
ZIP [List]	Zip code of the owner.	Listview	Number	5

### Field Edits – Owners of Other Medicare/Medicaid Facilities – Organization

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	1	Field exceeds max length.	Ensure that the number of characters entered does not exceed the length of the field as documented in the field descriptions above.
City [Detail]	Field	0	City is required.	Enter a city.
Medicaid Provider Number [Detail]	Field	0	Provider ID is required.	Enter a Provider ID.
Medicaid Provider Number [Detail]	Field	1	Provider ID must be 7 or 10 digits in length.	Enter a valid provider ID.
Medicare Provider Number [Detail]	Field	1	When Medicare Type is selected Medicare Provider Number is required.	Enter Medicare Provider Number.
Medicare Type [Detail]	Field	1	When Medicare Provider Number is selected Medicare Type is required.	Enter Medicare Type.
Name [Detail]	Field	0	Name is required.	Enter a Name.
Are any owners of the disclosing entity also owners of other Medicaid/Medicare facilities? (Example, sole proprietor, partnership, or members of the Board of Directors.)	Field	0	YES/NO response to this question is required.	Choose Yes or No.
	Field	1	Can not have a YES and a NO answer to this question.	You cannot have a mix of No and Yes answers.
	Field	2	Only answer NO to this question once.	You cannot have a mix of No and Yes answers or multiple No answers.
State [Detail]	Field	0	A valid State is required.	Select a valid State value.
Street Address	Field	0	Street Address is	Enter a street address.

Field	Field Type	Error Code	Error Message	To Correct
[Detail]			required.	
Vendor No.	Field	0	Vendor No. is required.	Enter a Vendor No.
Vendor No.	Field	1	Required input must be between 6 And 9.	Enter a 6 to 9 alphanumeric value of Vendor No.
ZIP [Detail]	Field	0	Zip is required.	Enter a Zip code.
ZIP [Detail]	Field	1	Enter a valid value.	Enter a 5 digits value of Zip.
ZIP+4	Field	0	Enter a valid value.	Enter a 4 digits value of Zip+4.

## Disclosure and Ownership – Organization

The Provider Enrollment-Questions1 panel allows organization provider applicants to respond to related question information during the enrollment process. This panel provides information administrative changes, chain affiliations, and hospital bed changes.

### Tasks for this panel

To **enter** information on administrative changes, chain affiliations, and hospital bed changes:

- Select a **Yes** or **No** response to the question **Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?**
  - If **No** is selected, select the **next** button to proceed to the next enrollment panel.
  - If **Yes** is selected, select a **Yes** or **No** response to the question **Is this entity chain affiliated?**
  - If **No** is selected, select the **next** button to proceed to the next enrollment panel.
  - If **Yes** is selected, the **Name, FEIN, Street Address, City, State,** and **Zip** fields become active.
- Enter valid values for the **Name, FEIN, Street Address, City,** and **Zip** fields.
- Select a value from the **State** drop down list box.

4. Enter a value in the **4-digit Zip** extension, if applicable.
5. Select the **previous** button to review information entered in previous panels, if desired.
6. Select the **next** button to proceed to the next enrollment panel.
7. To exit the application, select the **exit** button.

### Field Descriptions – Disclosure and Ownership – Organization

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
State	State of entity chain affiliation.	Combo Box	Character	2
City	City of entity chain affiliation.	Field	Character	30
FEIN	Federal Employer Identification number of entity chain affiliation.	Field	Number	9
Name	Name for the entity chain affiliation.	Field	Character	50
Question 1	Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? Valid options: Yes or No.	Field	Radio Button	1
Question 2	Is this entity chain affiliated? Valid options: Yes or No.	Field	Radio Button	1
Question 3	What is the total number of Hospital beds?	Field	Number	5
Street Address	Address of entity chain affiliation.	Field	Character	60
Zip	Zip code and Zip + 4 for entity chain affiliation.	Field	Number	5
Zip + 4	Zip code extension	Field	Number	4

### Field Edits – Disclosure and Ownership – Organization

Field	Field Type	Error Code	Error Message	To Correct
State	Combo Box	1	State is required.	Enter state for entity chain affiliation.
All fields	Field	0	Invalid number /	Ensure that the field matches the data type as

Field	Field Type	Error Code	Error Message	To Correct
			Invalid date / Invalid character data.	documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
All fields	Field	1	Field exceeds max length.	Ensure that the number of characters entered does not exceed the length of the field as documented in the field descriptions above.
City	Field	1	City is required.	Enter a city for entity chain affiliation.
FEIN	Field	1	FEIN is required.	Enter a FEIN for entity chain affiliation.
Name	Field	0	Name is required.	Enter the name for the entity chain affiliation.
Question 1	Field	0	YES or NO response to administration change question is required.	YES or NO response to administration change question is required.
Question 2	Field	1	YES or NO response to chain affiliation question is required.	YES or NO response to chain affiliation question is required.
Question 3	Field	1	Number of Hospital beds is required.	Enter number of hospital beds.
Street Address	Field	1	Address is required.	Enter an address for entity chain affiliation.
Zip	Field	1	Zip code is required.	Enter zip code for entity chain affiliation.

## Addendum – Organization

The Provider Enrollment - Addendum C panel is used by a provider applicant to indicate compliance with the eligibility requirements necessary to become a certified provider. The user is then able to electronically sign the agreement by entering their name in the provided field.

The Addendum panel that displays is specific to the type of provider selected in the **Request Type** panel:

Addendum	
<b>Addendum A</b>	
60 - MC Home Health Agency -- MEDICARE CERTIFIED HHA	
SMITH, JOHN D	
(675) 675-6756 (cell)	
Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliant with the Provider agreement.	
My name typed below serves as verification that the entity complies with the requirement for enrollment as an ODJFS Waiver provider for the provision of Medicare-Certified Home Health as set forth in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04, including the provision of personal care and nursing services;	
*The entity agrees to comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity is a Medicare-certified Home Health Agency (* Attach Medicare Certification letter with effective date);	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will comply with federal non-discrimination regulations as set forth in 42 CFR Part 80(1964);	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will be a part of an interdisciplinary team with all providers involved with the consumer's care under the Ohio Home Care Program to develop the consumer's All Services Plan;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will maintain a record keeping system which includes information necessary for carrying out the goals of the All Services Plan;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will have available back-up staff to provide services when the entity's regularly scheduled staff cannot or do not meet their obligation to provide services to a consumer;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will have at least one representative attend all required ODJFS/CMA provider training sessions;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity is operated under a single administrative unit responsible for the overall management and conduct of program activities;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity has a set of written policies and procedures which reflect the objectives of the program and govern the provision of services to consumers;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will provide appropriate training and supervision of staff to ensure adherence to the consumer's All Services Plan AND will ensure Personal Care Aides complete eight hours of continuing education annually;	<input type="checkbox"/> YES <input type="checkbox"/> NO
*The entity will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).	<input type="checkbox"/> YES <input type="checkbox"/> NO
*I attest that all employees who have in-person contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Investigation (BCI) for individuals under final consideration for employment with a home health agency. As enumerated in OAC 5101:3-12-25 (* Attach copy of background check policy);	<input type="checkbox"/> YES <input type="checkbox"/> NO
I certify that I am the officer, chief executive officer, or general partner of the business organization applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.	
*Signature - Type name here to indicate that you agree	Date 04/24/2009

Addendum		?
<b>Addendum B</b>		
<b>16 - Other Accredited Home Health Agency -- OTHER ACCREDITED HOME HEALTH AGENCY</b>		
SMITH, JOHN D		
(675) 675-6756 (cell)		
Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliant with the Provider agreement.		
My name typed below serves as verification that the entity complies with the requirement for enrollment as an ODJFS Waiver provider for the provision of Other Accredited Home Health Agency as set forth in Ohio Administrative Code (OAC) 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04, including the provision of personal care and nursing services;		
*The entity will comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will comply with federal nondiscrimination regulations as set forth in 42 CFR Part 80(1964);	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity has and maintains a Joint Commission on Accreditation of Healthcare (JCAHO) Certificate of Accreditation for the provision of both home health services and personal care and support services (Attach a copy of certification); And/Or The entity has and maintains a Community Health Accreditation Program (CHAPS) Certificate of Accreditation for the provision of nursing, homemaker and home health aide services (Attach a copy of certification); And/Or The entity has and maintains any other certification of accreditation if the entity does not have JCAHO or CHAP certification (Attach a copy of certification).	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity agrees refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will have at least one representative attend all required ODJFS/CMA provider training sessions;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity is a part of an interdisciplinary team with all providers involved with the consumer's care under the Ohio Home Care Program to develop the consumer's all services plan;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will maintain a record keeping system which includes information necessary for carrying out the goals of the all services plan;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity is operated under a single administrative unit responsible for the overall management and conduct of program activities;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity has a set of written policies and procedures which reflect the objectives of the program and govern the provision of services to consumers;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will provide appropriate training and supervision of staff to ensure adherence to the consumer's all services plan;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advance notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case-by-case basis);	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*I attest that all employees who have in-person contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Investigation (BCI) for individuals under final consideration for employment with a home health agency as enumerated in OAC 5101:3-12-25. (*Attach copy of background check policy)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I certify that I am the officer, chief executive officer, or general partner of the business organization applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.		
*Signature - Type name here to indicate that you agree	<input type="text"/>	Date 04/24/2009

Addendum		?
<b>Addendum C</b>		
<b>25 - Non-Agency Personal Care Aide -- ODJFS WAIVER</b>		
<b>SMITH, JOHN D</b>		
<b>(675) 675-6756 (cell)</b>		
<b>Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliant with the Provider agreement.</b>		
<b>My name typed below serves as verification that I comply with the requirements for enrollment as a non-agency personal care aide as set forth in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04;</b>		
<b>*I agree to comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*I am at least 18 years of age, have a valid Social Security card, and another form of identification as indicated in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04.;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*I have obtained certificate of completion within the last twenty-four (24) months for either nurse aide competency evaluation program conducted by the Ohio Department of Health in accordance with section 3721.31 of the Revised Code; or the Medicare competency evaluation for home health aides as specified in 47 CFR 484(2005); or other equivalent training program as specified in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04.; (* Attach a copy of the certificate documentation to this form).</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*I have obtained and will maintain first aid certification; (* Attach copy of valid first aid documentation)</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*I agree to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*I agree to attend all required ODJFS/CMA training sessions;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*I understand that I am required to complete eight hours of continuing education annually;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*I will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>Relationship to consumer</b>		
<b>*I meet eligibility requirements for a provider severing a consumer as specified in OAC 5101:3-45-04, 5101:3-47-04 and 5101:3-50-04;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>Ohio residency – please select 'YES' to ONLY one</b>		
<b>*I HAVE been a resident of Ohio for at least the past five (5) years and I have successfully completed a criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&amp;I) as enumerated in OAC 5101:3-12-26;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*I HAVE NOT been a resident of Ohio for at least the past five (5) years and I have successfully completed a criminal records check conducted by the Bureau of Criminal Identification and Investigation (BCI&amp;I) and an additional FBI criminal check;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>I certify that I am the officer, chief executive officer, or general partner of the business organization applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.</b>		
<b>*Signature - Type name here to indicate that you agree</b>	<input type="text"/>	<b>Date</b> 04/24/2009

Addendum		?
<b>Addendum E</b>		
<b>38 - Private Duty Nurse -- LPN - PDN AND/OR WAIVER HOME CARE NURSING</b>		
SMITH, JOHN D (675) 675-6756 (cell)		
Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a requirement must check all applicable boxes in order to be in compliance with their Provider Agreement.		
My name typed below serves as verification that I comply with the requirements for enrollment as a ODJFS Non-agency Waiver Service Provider – Non-agency RN/Non-agency LPN as a provider of home and community-based nursing as set forth in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04;		
*I agree to comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*I agree to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative; ;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*I agree to attend all required ODJFS/CMA training sessions;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*I agree to be part of the interdisciplinary team with all providers involved with the consumer's care under the Ohio Home Care Program to develop the consumer's all service's plan;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*I am an Ohio Licensed Registered Nurse (RN) OR an Ohio Licensed Practical Nurse (LPN) under the direction of an RN practicing within the scope of my nursing license pursuant to Chapter 4723 of the Revised Code (* Attach a copy of license);	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*If LPN, give RN Supervisor	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Supervisor Name	<input type="text"/>
	License # RN	<input type="text"/>
*I will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Relationship to consumer		
*I meet eligibility requirements for a provider severing a consumer as specified in OAC 5101:3-45-04, 5101:3-47-04 and 5101:3-50-04;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Ohio residency – please select 'YES' to ONLY one		
*I HAVE been a resident of Ohio for at least the past five (5) years and I have successfully completed a criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&I) as enumerated in OAC 5101:3-12-26;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*I HAVE NOT been a resident of Ohio for at least the past five (5) years and I have successfully completed a criminal records check conducted by the Bureau of Criminal Identification and Investigation (BCI&I) and an additional FBI criminal check;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I certify that I am the individual practitioner who is applying for the provider number. I further agree to be bound by this agreement and certify that the information I have given on this application is factual.		
*Signature - Type name here to indicate that you agree	<input type="text"/>	Date 04/24/2009

Addendum		?
<b>Addendum F</b>		
<b>45 - Waived Services -- ADULT DAY HEALTH</b>		
SMITH, JOHN D (675) 675-6756 (cell)		
<b>Enrollment Requirement(s):</b> Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliance with their Provider Agreement.		
My name typed below serves as verification that the entity complies with the requirement for enrollment as an ODJFS Waiver Service Provider – Adult Day Health Center Services Provider as set forth in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04, including the provision of personal care and nursing services;		
*The entity will comply with all the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity is not eligible to enroll as either a Medicare Certified Home Health Agency or JCAHO Accredited Home Health Agency;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will comply with federal non-discrimination regulations as set forth in 42 CFR Part 80(1964);	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity agrees to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will be a part of an interdisciplinary team with all providers involved with the consumer's care under the Ohio Home Care Program to develop the consumer's All Services Plan;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will maintain a record keeping system which includes information necessary for carrying out the goals of the All Services Plan;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity is operated under a single administrative unit responsible for the overall management and conduct of program activities;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity has a set of written policies and procedures which reflect the objectives of the program and govern the provision of services to consumers;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity provides appropriate training and supervision of staff to ensure adherence to the consumer's All Services Plan;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*I attest that all employees who have personal contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&I) as enumerated in OAC 5101:3-12-26. ;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I certify that I am the officer, chief executive officer, or general partner of the business organization applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.		
*Signature - Type name here to indicate that you agree	<input type="text"/>	Date 04/24/2009

## Addendum



## Addendum G

## 45 - Waived Services -- HOME DELIVERED MEALS

SMITH, JOHN D

(675) 675-6756 (cell)

Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliance with their Provider Agreement.

My name typed below serves as verification that the entity complies with the requirement for enrollment as an ODJFS Waiver Service Provider – Home Delivered Meal Services Provider in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;

\*The entity will comply with all the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-4;  YES  NO

\*The entity holds a valid food vendor's license;  YES  NO

\*The entity is aware that all meals are prepared and delivered in compliance with all applicable federal, state, county, and local laws and regulations concerning the preparation, handling and transportation of food;  YES  NO

\*The entity will maintain documentation as outlined in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;  YES  NO

\*The entity will maintain a record for each consumer service that contains a copy of the initial and all subsequent All Services Plans and all dietary instructions prepared by the dietician as outlined in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;  YES  NO

\*The entity will procure and make available to ODJFS or its designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;  YES  NO

\*The entity agrees to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;  YES  NO

\*The entity will comply with all of the standards of the "patients rights" Medicare Conditions of Participation as found in 42 CFR 484;  YES  NO

\*The entity has at least one representative attend all required ODJFS/CMA provider training sessions;  YES  NO

\*The entity must have available back-up staff to provide service with the entity's regularly scheduled staff cannot or do not meet their obligation to provide services to a consumer;  YES  NO

\*The entity will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case-by-case basis).  YES  NO

\*The entity attests that all employees who have in-person contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&I) as enumerated in OAC 5101:3-12-26;  YES  NO

I further certify that I am the officer, chief executive officer, or general partner of the business organization applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.

\*Signature - Type name here to indicate that you agree  Date 04/25/2009

Addendum	
<b>Addendum H</b>	
45 - Waived Services -- HOME MODIFICATIONS	
SMITH, JOHN D	
(675) 675-6756 (cell)	
Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliance with their Provider Agreement.	
My typed name below serves as verification that the entity complies with the requirement for enrollment as an ODJFS Waiver Service Provider – Home Modification Services Provider in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;	
*The entity will comply with all of the Conditions of Participation and Provider Requirements of as set forth in OAC 5101:3-45-10, 5101:3-46- 04, 5101:3-47-04, and 5101:3-50-04;	<input type="radio"/> YES <input type="radio"/> NO
*The entity is insured and bonded for general contracting services within Ohio and have submitted proof of insurance;	<input type="radio"/> YES <input type="radio"/> NO
*The entity has knowledge and experience with general contracting principles and concepts pertaining to the home modification project;	<input type="radio"/> YES <input type="radio"/> NO
*The entity will ensure that the work performance is consistent with prevailing trade standards and in conformance with state and local building codes and complies with the ADA;	<input type="radio"/> YES <input type="radio"/> NO
*The entity will assure that home modification are completed in accordance with the agreed upon specifications using all the materials and equipment cited in the bid. The entity will also obtain a final written approval from the consumer and the designated Case Management Agency after completion of the home modification service;	<input type="radio"/> YES <input type="radio"/> NO
*The entity will maintain documentation on consumers as outlined in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;	<input type="radio"/> YES <input type="radio"/> NO
*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;	<input type="radio"/> YES <input type="radio"/> NO
*The entity agrees to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;	<input type="radio"/> YES <input type="radio"/> NO
*The entity will comply with the standards of the "patients rights" Medicare Conditions of Participation as found in 42 CFR 484;	<input type="radio"/> YES <input type="radio"/> NO
*The entity will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).	<input type="radio"/> YES <input type="radio"/> NO
*The entity attests that all employees who have in-person contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&I) as enumerated in OAC 5101:3-12-26;	<input type="radio"/> YES <input type="radio"/> NO
I certify that I am the officer, chief executive officer, or general partner of the business organization applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.	
*Signature - Type name here to indicate that you agree <input type="text"/>	Date 04/25/2009

Addendum		?
<b>Addendum I</b>		
<b>45 - Waived Services -- JFS WAIVER TRANSPORT SERVICES</b>		
<b>SMITH, JOHN D</b>		
<b>(675) 675-6756 (cell)</b>		
<b>Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliance with their Provider Agreement.</b>		
<b>My name typed below serves as verification that the entity complies with the enrollment requirements as an ODJFS Waiver Service Provider – Supplemental Transportation Provider in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;</b>		
*The entity will comply with all the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-4;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity has agreed to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity has at least one representative attend all required ODJFS/CMA provider training sessions;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity is responsible for having available back-up staff to provide service when the entity's regularly scheduled staff cannot or do not meet their obligation to provide services to a consumer;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will maintain log with documentation as outlined in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will comply with all of the standards of the "patients rights" Medicare Conditions of Participation as found in 42 CFR 484;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity is aware the transportation provider must assist in transferring the consumer from the point of pick-up to the vehicle and from the vehicle to the destination point;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*I attest that all employees who have in-person contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&I) as enumerated in OAC 5101:3-12-26;	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case-by-case basis).	<input type="checkbox"/> YES	<input type="checkbox"/> NO
*The entity must: 1) provide ODJFS with a current list of drivers and a copy of the Ohio Driver's license for each driver; 2) possess collision and liability insurance for each vehicle and driver used in the provision of supplemental transportation services; and 3) have valid motor vehicle inspection from the Ohio Highway Patrol for each vehicle to be used in the provision of supplemental transportation services.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I certify that I am the officer, chief executive officer, or general partner of the business organization applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.		
*Signature - Type name here to indicate that you agree	<input type="text"/>	Date 04/25/2009

Addendum		?
<b>Addendum J</b>		
<b>45 - Waived Services -- JFS OUT OF HOME RESPITE</b>		
<b>SMITH, JOHN D</b>		
<b>(675) 675-6756 (cell)</b>		
<b>Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all applicable boxes in order to be in compliance with their Provider agreement.</b>		
<b>My name typed below serves as verification that the entity complies with the requirement for enrollment as an ODJFS Waiver Provider for the provision of out-of-home Respite Services as set forth in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04, including the provision of personal care and nursing services;</b>		
<b>*The entity will comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*The entity will comply with federal nondiscrimination regulations as set forth in 42 CFR Part 80(1964);</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*The Conditions of Participation for ODJFS-administered waiver providers as set forth in OAC 5101:3-45-10;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*The entity is not eligible to enroll as either a Medicare-certified Home Health Agency or JCAHO/CHAP- accredited Home Health Agency;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*The entity agrees to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*For ICF-MR and NF settings, the entity meets the licensure and certification standards for the facility, including Requirements set forth in OAC 5101:3-3-02 and 5101:3-3-02.3;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*The entity is a part of an interdisciplinary team with all providers involved with the consumer's care under the Ohio Home Care Program to develop the consumer's all services plan;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*The entity will maintain a record keeping system which includes information necessary for carrying out the goals of the All Services Plan;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*The entity will have at least one representative attend all required ODJFS/CMS provider training sessions;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>*The entity will have available back-up staff to provide service when the entity's regularly scheduled staff cannot or do not meet their obligation to provide services to a consumer;</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>I certify that I am the officer, chief executive officer, or general partner of the business organization applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.</b>		
<b>*Signature - Type name here to indicate that you agree</b>	<input type="text"/>	<b>Date 04/25/2009</b>

Addendum		?
<b>Addendum K</b> <b>45 - Waived Services -- JFS EMERGENCY RESPONSE SYSTEM</b> <b>SMITH, JOHN D</b> <b>(675) 675-6756 (cell)</b>		
<b>Enrollment Requirement(s): Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all boxes in order to be in compliance with their Provider Agreement.</b>		
<b>My name typed below serves as verification that the entity, agency or organization complies with the requirement for enrollment as an Waiver Service Provider – Emergency Response Services Provider in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;</b>		
*The entity will comply with all the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-4;	<input type="radio"/>	YES <input type="radio"/>
*The entity will operate an emergency response center that is staffed 24-hours-a-day, 365-days-a-year to receive and respond to emergency signals and assure that the emergency response center has back-up monitoring capacity to handle all monitoring functions and incoming emergency signals in the event the primary system malfunctions;	<input type="radio"/>	YES <input type="radio"/>
*The entity will assure that the emergency response systems meet all applicable quality assurance/quality control industry standards and conduct monthly testing of emergency response systems to assure proper operation;	<input type="radio"/>	YES <input type="radio"/>
*The entity will provide consumers, their authorized representatives, and caregivers with initial and ongoing training/assistance regarding the use of the emergency response system;	<input type="radio"/>	YES <input type="radio"/>
*The entity will assure that emergency response center staff respond to alarm messages within 60 seconds of receipt and furnish a replacement emergency response system or an activation device within 24 hours of notification of a malfunction;	<input type="radio"/>	YES <input type="radio"/>
*The entity maintain documentation on consumers as outlined in OAC 5101:3-46-04, 5101:3-47-04 and 5101:3-50-4;	<input type="radio"/>	YES <input type="radio"/>
*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;	<input type="radio"/>	YES <input type="radio"/>
*The entity agrees to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;	<input type="radio"/>	YES <input type="radio"/>
*The entity will comply with all of the standards of the "patients rights" Medicare Conditions of Participation as found in 42 CFR 484;	<input type="radio"/>	YES <input type="radio"/>
*The entity has at least one representative attend all required ODJFS/CMA provider training sessions;	<input type="radio"/>	YES <input type="radio"/>
*The entity will submit written notification to the consumer and to ODJFS or its designee at least thirty (30) calendar days prior to the last date of service if terminating the provision of home care services. (The advanced notification is not required in the cases when the consumer is hospitalized, is subject to unexpected emergency placement in long term care facility, or expires. The notification may be waived by ODJFS or its designee for other reasons on a case- by-case basis).	<input type="radio"/>	YES <input type="radio"/>
*The entity attests that all employees who have in-person contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Identification and Investigation (BCI&I) as enumerated in OAC 5101:3-12-26;	<input type="radio"/>	YES <input type="radio"/>
<b>I certify that I am the officer, chief executive officer, or general partner of the business organization applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.</b>		
*Signature - Type name here to indicate that you agree	<input type="text"/>	Date 04/25/2009

Addendum	
<b>Addendum L</b> 45 - Waived Services -- SPECIALIZED MEDICAL EQUIPMENT SMITH, JOHN D (675) 675-6756 (cell)	
<b>Enrollment Requirement(s):</b> Failure to complete this addendum and/or supply all required information shall result in the applicant being denied for enrollment as a Medicaid Provider. Current Providers submitting this form as a compliance requirement must check all applicable boxes in order to be in compliance with their Provider agreement.	
<b>My name typed below serves as verification that the entity complies with the requirement for enrollment as an ODJFS Waiver provider for the provision of Supplemental Adaptive and Assistive Devices as set forth in Ohio Administrative Code (OAC) 5101:3-12-28, 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04;</b>	
<b>*The entity agrees to comply with the Conditions of Participation and Provider Requirements as set forth in OAC 5101:3-45-10, 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04;</b>	<input type="radio"/> YES <input type="radio"/> NO
<b>*The entity is not eligible to enroll as either a Medicare-Certified Home Health Agency or JCAHO-Accredited Home Health Agency;</b>	<input type="radio"/> YES <input type="radio"/> NO
<b>*The entity agrees to refrain from using or disclosing any information concerning a consumer, except with the written consent of the consumer or other authorized representative;</b>	<input type="radio"/> YES <input type="radio"/> NO
<b>*The entity will have at least one representative attend all required ODJFS/CMA provider training sessions;</b>	<input type="radio"/> YES <input type="radio"/> NO
<b>*The entity will assure that the supplemental adaptive and assistive device is tested and is in proper working order, and is subject to warranty in accordance with industry standards prior to submitting a claim;</b>	<input type="radio"/> YES <input type="radio"/> NO
<b>*The entity will maintain a clinical record for each consumer served in the manner that protects the confidentiality of these records as outlined in OAC 5101:3-46-04, 5101:3-47-04, and 5101:3-50-04.</b>	<input type="radio"/> YES <input type="radio"/> NO
<b>*The entity will procure and make available to ODJFS or it's designee, upon request, all necessary licenses required by local, state, and federal law, certification, proof of insurance, special training or other credentials relating to qualifications;</b>	<input type="radio"/> YES <input type="radio"/> NO
<b>*The entity will comply with all of the standards of the "patients rights" Medicare Conditions of Participation as found in 42 CFR 484;</b>	<input type="radio"/> YES <input type="radio"/> NO
<b>*I attest that all employees who have in-person contact with consumers have successfully completed criminal records check equivalent to those conducted by the Bureau of Criminal Investigation (BCI) for individuals under final consideration for employment with a home health agency.;</b>	<input type="radio"/> YES <input type="radio"/> NO
<b>I certify that I am the officer, chief executive officer, or general partner of the business organization applying for the provider number. I further agree to be bound by this agreement, and certify that the information I have given on this application is factual.</b>	
<b>*Signature - Type name here to indicate that you agree</b> <input type="text"/>	<b>Date</b> 04/25/2009

## Tasks for this panel

To **indicate** compliance with necessary eligibility requirements:

1. Read each question, then select a **Yes** or **No** response.
2. Type the enrolling provider's name in the **Signature** field.

## Field Descriptions – Addendum – Organization

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Date	Current date that agreement was signed.	Field	Date (MM/DD/CCYY)	0

Field	Description	Field Type	Data Type	Length
Signature	Entry of the provider's name to serve as an electronic signature for the agreement.	Field	Character	0
Supername	Supervising Nurse Name	Field	Character	35
all fields	All Yes/No fields	Field	Radio Button	0
license RN	Supervising Nurse License Number	Field	Alphanumeric	12
question1	1 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question10	10 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question11	11 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question13	13 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question14	14 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question15	15 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question16	16 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question17	17 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question2	2 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question3	3 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question4	4 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question5	5 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0

Field	Description	Field Type	Data Type	Length
question6	6 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question7	7 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question8	8 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question9	9 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
question12	12 of a possible 17 total questions depending on which Addendum displayed to the user.	Field	Radio Button	0
Phone Number	Contact Phone number from the Address panel.	Label	N/A	0
Provider Name	The Provider's Name as identified in the Identification panel.	Label	N/A	0
Provider Type and Specialty	The selected Provider Type and Specialty Description	Label	N/A	0
Title	The title of the Addendum, format is Addendum x	Label	N/A	0

### Field Edits – Addendum – Organization

Field	Field Type	Error Code	Error Message	To Correct
all fields	Field	1	YES/NO response to this question is required.	Select Yes or No.
all fields	Field	2	You must answer 'YES' to all questions in order to proceed with Application.	Either select Yes to all questions or exit application without submitting.

### Certification – Organization

The Certification panel contains a legal certification agreement to ensure that the information provided by the applicant is true, accurate, and complete.

Certification	
*Legal Entity Name	<input type="text"/>
Legal Entity Name must match the Legal Entity Name as it appears on IRS documentation such as the W-9, IRS 147 or IRS CP578	
*Individual Last Name	PECKOWITZ
First, MI	SYDNEY <input type="text"/> U <input type="text"/>
Click this printable <a href="#">Enrollment Checklist</a> link to ensure a complete provider enrollment request.	
Legal Provider Primary Practice Address:	
*Address 1	<input type="text"/>
Address 2	<input type="text"/>
*City	<input type="text"/>
*State	<input type="text"/>
*Zip	<input type="text"/>
E-Mail Address	<input type="text"/>
*Preferred Contact Method	<input type="text"/>
*Social Security Number	<input type="text"/>
*Tax Identification Number	<input type="text"/>
<b>All Providers must read the statements below and agree to the terms</b>	
<b>Executive Order 2007-01S Agreement</b>	
In accordance with Executive Order 2007-01S, Vendor or Grantee, by signature on this document, certifies: (1) it has reviewed and understands Executive Order 2007-01S, (2) has reviewed and understands the Ohio ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Vendor or Grantee understands that failure to comply with Executive Order 2007-01S is, in itself, grounds for termination of this contract or grant and may result in the loss of other contracts or grants with the State of Ohio.	
<input checked="" type="radio"/> do not accept the terms and conditions <input type="radio"/> accept the terms and conditions	
A copy of the Executive Order can be found on our website at <a href="http://jfs.ohio.gov/ohp">http://jfs.ohio.gov/ohp</a>	
<b>False Statement Agreement</b>	
Whoever knowingly and willfully makes, or causes to be made, a false statement or representation on this statement, may be prosecuted under applicable federal or state laws. In addition, if a person knowingly and willfully fails to fully and accurately disclose the information requested ODJFS may deny the request to participate or, if the entity already participates, may terminate the agreement or contract as appropriate.	
<input checked="" type="radio"/> do not accept the terms and conditions <input type="radio"/> accept the terms and conditions	
<b>Ohio Medicaid Provider Agreement</b>	
This provider agreement is a contract between the Ohio Department of Job and Family Services (the Department) and the undersigned provider Administrative Code rules, and Federal statutes and rules, and agrees and certifies to	
1. Render medical assistance services as medically necessary for the patient and only in the amount required by the patient without regard to race, creed, color, age, sex, national origin, source(s) of payment, or handicap, submit claims only for services actually performed, and bill the Department for no more than the usual and customary fee charged other patients for the same service. 2. Ascertain and recoup any third-party resource(s) available to the recipient prior to billing the Department. The Department will then pay any unpaid balance up to the lesser of the provider's billed charge or the	
<input checked="" type="radio"/> do not accept the terms and conditions <input type="radio"/> accept the terms and conditions	
Agreement Date	01/12/2010
Certain provider agreements may be retroactive (up to 12 months) to encompass dates on which the provider covered services to a Medicaid consumer and the service has not been billed to Medicaid.	
ProvisionCheck	<input type="checkbox"/> If you meet this provision, please check the box
A failure to check this box shall be taken by ODJFS to mean that you waive your rights to a retroactive period of months prior to the date ODJF approves your application. This agreement is limited to 3 years from the effective date.	
*Type Full Name Here	<input type="text"/> 01/12/2010

## Tasks for this panel

To certify the enrollment information:

1. Enter values in the **Legal Entity Name**, **Individual Last Name**, **Address 1**, **City**, **Zip**, **Social Security Number**, **Tax Identification Number**, and **Type Full Name Here** fields.

2. Select values from the **State** and **Preferred Contact Method** drop down list boxes.
3. If desired, enter values in the **First, MI, Address 2,** and **E-Mail Address** fields.
4. Check the **terms and conditions** radio buttons, as applicable.
5. Check the **ProvisionCheck** checkbox as described on the panel.
6. Select the **previous** button to review information entered in previous panels, if desired.
7. Select the **next** button to proceed to the next enrollment panel.
8. To exit the application, select the **exit** button.

### Field Descriptions – Certification – Organization

Field	Description	Field Type	Data Type	Length
exit	Exits the provider enrollment process.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Abbreviated Organization Name	Abbreviated name of the applying organization. (This field to be determined.)	Field	Character	25
Address 1	First line of the address.	Field	Character	60
Address 2	Second line of the address.	Field	Character	60
Agreement Date	Date the applicant certified the application.	Field	Date (MM/DD/CCYY)	10
City	City of the address.	Field	Character	30
Doing Business As Name	Operating name of the business or organization that is different than the legal name. (This field to be determined.)	Field	Character	25
E-Mail Address	Email address of the applicant.	Field	Character	50
Electronic Signature Date	Pre-populated current date associated with the electronic signature. Please note that there is no label associated with this field on the panel.	Field	Date (MM/DD/CCYY)	10
Employer Identification Number	Employer ID number of applicant. (This field to be	Field	Number	9

Field	Description	Field Type	Data Type	Length
	determined.)			
Executive Order 2007-01S Agreement	Applicant selects a radio button option to indicate acceptance or refusal of the terms of the Executive Order 2007-01S Agreement.	Field	Radio Button	1
False Statement Agreement	Applicant selects a radio button option to indicate acceptance or refusal of the terms of the False Statement Agreement.	Field	Radio Button	1
First	Applicant's first name.	Field	Character	25
Individual Last Name	Applicant's last name.	Field	Character	50
Legal Entity Name	Applicant or organization legal entity name.	Field	Character	50
Middle Name	Applicant's middle initial.	Field	Character	1
Occupational Therapist Specific Qualifying Statement	Applicant selects a radio button option to accept or decline the terms of the Occupational Therapist Statement. (This field to be determined.)	Field	Radio Button	1
Ohio Medicaid Provider Agreement	Applicant selects a radio button option to indicate acceptance or refusal of the terms of the Enrollment Agreement.	Field	Radio Button	1
Organization Name	Name of the applying organization. (This field to be determined.)	Field	Character	50
Preferred Contact Method	Preferred method of contact for the applicant. Default value: E-Mail.	Field	Drop Down List Box	0
Primary Business Address	Primary business address of business.	Field	Character	60
Proprietor Social Security Number	Social Security number of the business proprietor. (This field to be determined.)	Field	Number	9
ProvisionCheck	Indicates that the provider has covered services to a Medicaid consumer and the	Field	Check Box	0

Field	Description	Field Type	Data Type	Length
	service has not been billed to Medicaid in the last 12 months. This checkbox is not visible during the re-enrollment process.			
Social Security Number	Social Security number of the applicant.	Field	Number	9
State	State of the address.	Field	Drop Down List Box	0
Tax Identification Number	Tax ID number of the applicant.	Field	Number	9
Type Full Name Here	Individual, Group, or Organization name used to certify the enrollment details.	Field	Character	50
Zip	Zip code of the address.	Field	Character	5
Zip + 4	Zip code extension of the address.	Field	Character	4
Enrollment Checklist	Link to display checklists associated with different provider types.	Hyperlink	N/A	0
Website Address	Link to the Ohio Department of Job and Family Services Web site.	Hyperlink	N/A	0

### Field Edits – Certification – Organization

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	0	Address 1 is required	This field must be completed.
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid alphanumeric data.	Ensure that the field matches the datatype as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
	Field	1	Field exceeds max length.	Ensure that the entered data does not

Field	Field Type	Error Code	Error Message	To Correct
				exceed the maximum length.
City	Field	0	City is required	This field must be completed.
Doing Business As Name	Field	1	Doing Business As Name is required.	This field must be completed.
Employer Identification Number	Field	0	Employer Identification Number is required	This field must be completed
Legal Entity Name	Field	0	Legal Entity Name is required.	This field must be completed.
Occupational Therapist Specific Qualifying Statement	Field	0	If Occupational/Therapist 'I do not accept the terms and conditions' is selected you are not allowed to continue.	Click the I accept terms and conditions radio button.
Ohio Medicaid Provider Agreement	Field	0	If Provider Agreement 'I do not accept the terms and conditions' is selected you are not allowed to continue.	Click the I accept terms and conditions radio button.
Social Security Number	Field	0	Social Security Number is required	This field must be completed
State	Field	0	State is required	This field must be completed
Type Full Name Here	Field	0	Provider's Full Name is required.	This field must be completed.
Zip	Field	0	Zip code is required	This field must be completed

## Notes – Organization

The Notes panel is used to enter additional information or notes associated with the application for the enrolling organization. The body of the panel is a free-text area where any additional information can be typed.



### Tasks for this panel

To **submit** additional information associated with a provider application:

1. Enter any additional information that should be included for consideration in the request for enrollment.
2. Select the **previous** button to review information entered in previous panels, if desired.
3. Select the **submit** button to submit the enrollment request.
4. To exit the application, select the **exit** button.

### Field Descriptions – Notes – Organization

Field	Description	Field Type	Data Type	Length
exit	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
next	Navigates to the next panel in the provider enrollment wizard.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Notes	Free form text of the notes.	Field	Character	5000

### Field Edits – Notes – Organization

None.

### Confirmation of Receipt – Organization

The Confirmation of Receipt panel displays the Application Tracking Number for the submitted application.

**Note:** It is important to retain this number. It is needed to check the status of the enrollment application, or to continue the enrollment process at a later time if exit was selected from any of the enrollment panels.

**Confirmation of Receipt** ?

Your enrollment application for QUINN has been submitted.

Tracking Number: 403015

**IMPORTANT - This Application Tracking Number (ATN) is necessary for accessing the status of submitted applications and for editing an application that was returned for additional information. Please write this number down and keep it for your records PRIOR TO EXITING.**

\*\*\* Please retain the tracking number for your records. The tracking number will be used as the key for tracking the status of the application. \*\*\*

Please remember to submit the following required documents.

- Anticipated Change of Ownership or Control

**WHAT'S NEXT?**

- *Upload required documents.*
- You are required to print, sign and submit the agreement via mail.
- Additional required documents can be mailed or uploaded.
  - A cover page is required for documents that are sent by mail. *Print Cover Page.*
- Print a copy of the application for your records *Print Application*

For attachments submitted via mail, not electronically attached, please send to the appropriate address below.

Ohio Department of Job and Family Services  
Provider Network Management Section  
PO Box 1461  
Columbus, Ohio 43216-1461

You can check the status of an application from the Check Application status link on the Enrollment Page.

exit

## Tasks for this panel

To **complete** the enrollment:

1. Be sure to record the **Application Tracking Number** shown in bold on the second line of the panel.
2. Note the document(s) listed under **Please remember to submit the following required documents:** that must be submitted.
3. Follow the **WHAT'S NEXT?** Instructions:
  - a. If electronically attaching supporting documents, click the **Upload required documents** link. (See **Attachment Uploads** for further instructions on attaching supporting documents electronically.)
  - b. Click the **Print Cover Page** link to print the required cover sheet for any documents that will be sent to ODJFS - Provider Enrollment Unit by mail. (See **Attachment Cover** for an image of this document.)
  - c. Click the **Print Application** link to print a copy of the enrollment application.
4. To exit the application, select the **exit** button.

## Field Descriptions – Confirmation of Receipt – Organization

Field	Description	Field Type	Data Type	Length
exit	Exit to the provider enrollment landing page.	Button	N/A	0
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Agreement	Link to the provider enrollment agreement.	Hyperlink	N/A	0
MCP Addendum Terms	Link to MCP Addendum Terms	Hyperlink	N/A	0
Summary	Link to view summary of the provider enrollment application.	Hyperlink	N/A	0
Submit Information	Application tracking number that is assigned when the application is submitted.	Label	N/A	0

## Field Edits – Confirmation of Receipt – Organization

None.

## Attachment Upload – Organization

The Attachments Upload panel enables a user to upload files for claims, prior authorizations, and provider enrollments.

Attachment Upload		
Type of Document	Reference	Received
EXPLANATION OF BENEFITS	2309351050001 017033877000014989101	YES
OPERATIVE NOTE	2309351050001 017033877000014989102	IN PROCESS
PERIODONTAL CHARTS	2309351050001 017033877000014989103	IN PROCESS
RADIOLOGY REPORTS	2309351050001 017033877000014989104	YES
SUPPORT DATA FOR CLAIM	2309351050001 017033877000014989105	NO

Please note the following important parameters when uploading files:

- File size cannot be greater than 50MB (51200KB).
- Only file types of gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.
- For claim attachments: Select row from the list above and then use the below panel to select the file for upload.

Attachment Upload	
upload attachment	
Type of Document	EXPLANATION OF BENEFITS
Reference	2309351050001 017033877000014989101
* File to Upload	<input type="text"/> <input type="button" value="Browse..."/>

### Tasks for this panel

To **upload** an attachment:

- Select a row in the **Attachment Upload** list section of the panel.
- Click the **browse** button and select the file to upload.
- Click the **upload attachment** button.

**Field Descriptions – Attachment Upload – Organization**

Field	Description	Field Type	Data Type	Length
Browse	Allows the user to navigate and select a local file to upload.	Button	N/A	0
upload attachment	Initiate the file upload.	Button	N/A	0
File to Upload	The navigational path of the file to be uploaded including the file name. Is a required field.	Field	Character	256
Upload	Bound file input - for direction on which file to upload.	Field	Character	0
Reference	Control number assigned to the attachment for identification purposes.	Label	N/A	0
Type of Document	Description of the uploaded file.	Label	N/A	0
Received	Indicates if the attachment has been received (This field will visible only for Claims attachment).	Listview	Character	10
Reference	Control number assigned to the attachment for identification purposes.	Listview	Character	35
Type of Document	Description of the uploaded file.	Listview	Character	75

**Field Edits – Attachment Upload – Organization**

Field	Field Type	Error Code	Error Message	To Correct
Upload Attachment	Button	0	File type must be either tiff or pdf.	Select a file of the proper format to be uploaded.
File to Upload	Field	0	Please select a file to upload.	Click the browse button to select a file to upload into the Web Portal.

**Attachment Cover – Organization**

The Attachment Cover panel displays the provider enrollment attachment cover page. Providers print this page and include it when mailing required documents to the fiscal agent.

[Reviewer Note: cover sheet image has old Ohio MITS logo. See current logo in footer of this document. Also this looks cut off---is there any other info that needs to be shown on bottom half of page?]]

## Attachment Cover-Provider Enrollment Layout

 <b>EDMS COVER SHEET</b>	
<b>Fax Information:</b>	
Name: _____	Date: _____ No. of Pages: _____ (Including this cover sheet)
Phone: _____	
<small>To FAX documents, please set fax machine's quality settings to High or Fine. Failing to do so may result in a delay in processing of your documents.</small>	
<b>Document Type:</b>	
<input checked="" type="radio"/> Provider <input type="radio"/> Recipient <input type="radio"/> Correspondence <input type="radio"/> Prior authorization <input type="radio"/> Supporting documents for claim <input type="radio"/> Accounts receivable <input type="radio"/> Payment deduction <input type="radio"/> Expenditure <input type="radio"/> Hospital cost settlement <input type="radio"/> LTC cost settlement <input type="radio"/> Declaration of election of hospice benefit <input type="radio"/> Attending physician written certification <input type="radio"/> Revocation of hospice benefit <input type="radio"/> Statement of termination of hospice benefit <input type="radio"/> Selection of a different hospice provider <input type="radio"/> IDG written certification <input type="radio"/> Programs <input type="radio"/> RetroDUR patient profile <input type="radio"/> RetroDUR survey <input type="radio"/> RetroDUR reports <input type="radio"/> RetroDUR other documents	
<small>Sub Categories for Prior Authorization Documents</small>	
<input type="radio"/> Compression Garments <input type="radio"/> Decubitus Care Equipment <input type="radio"/> Dental <input type="radio"/> Dressings, Surgical <input type="radio"/> Enteral Nutrition & Supplies <input type="radio"/> EPSDT <input type="radio"/> Hospital Beds <input type="radio"/> Hospital Inpatient <input type="radio"/> Hospital Outpatient <input type="radio"/> Hearing Aids <input type="radio"/> Incontinence Supplies <input type="radio"/> Increased State Plan Home Health <input type="radio"/> Misc Equipment <input type="radio"/> Orthodontics <input type="radio"/> Orthotics (MTA) <input type="radio"/> Orthotics/Prosthetics (Nurses) <input type="radio"/> PDN <input type="radio"/> Repairs <input type="radio"/> Respiratory (MTA) <input type="radio"/> Respiratory (Nurses) <input type="radio"/> Supplies (Misc) <input type="radio"/> Speech Generating Devices <input type="radio"/> Transportation <input type="radio"/> Therapies <input type="radio"/> Vision <input type="radio"/> Wheelchairs <input type="radio"/> Others	
<b>Index Field &amp; Values (if applicable):</b>	
Application Tracking Number:	Prior Authorization Number:
4 0 2 7 7 9	
NPI:	Medicaid Provider ID:
ICN:	Contact Tracking Number:
Financial Record Number:	Status: Program Control Number:
Hospice Enrollment ID:	Hospice Attachment ID: Intervention ID:
	
<b>Confidentiality Notice:</b>	
<small>The sender of this facsimile transmission intends to communicate the contents of this transmission only to the Ohio Department of Job and Family Services. This transmission may contain information that is privileged, confidential or otherwise exempt from disclosure under applicable law. If you are not the designated recipient or the employee or agent responsible for delivering this transmission to the designated recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone at 1-800-686-1516 and promptly destroy the original transmission. Thank you for your assistance.</small>	
JFS 00000 (Rev. 02/23/2010)	Ohio Department of Job and Family Services

### Tasks for this panel

There are no tasks to perform in this panel.

**Field Descriptions – Attachment Cover – Organization**

Field	Description	Field Type	Data Type	Length
Control Number	Control number assigned to the attachment for identification purposes.	Label	Number	80
Date Submitted	Date the enrollment application was submitted.	Label	Date (MM/DD/CCYY)	8
Name	Name of the provider or business.	Label	Character	30
SSN/FEIN	Social Security number or Federal Employer Identification number of the provider or business.	Label	Character	10

**Field Edits – Attachment Cover – Organization**

None.

This is the end of the Organization enrollment process.

**What’s Happens After Enrollment?**

When ODJFS has approved each enrollment application, the applicant will be sent a letter with a personal identification number (PIN) and instructions for completing portal registration. When this PIN letter is received, please refer to the “Getting Started” section in Volume 2 of this user manual, *Provider Medicaid Portal User Manual: Introduction*.

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