



Medicaid Information
Technology System

Provider Medicaid Portal User Manual

Volume 3C

**Enrollment - Long Term Care and Intermediate Care
Facilities for the Mentally Retarded**

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1 PROVIDER ENROLLMENT – LONG TERM CARE AND ICF-MR

Instructions for enrollment presented in this section of the Provider Medicaid Portal User Manual address the following categories of new enrollment:

- Enrollment for (LTC) long term care facilities.
- Enrollment for (ICF-MR) intermediate care facilities for the mentally retarded.

Long term care, and intermediate care facilities for the mentally retarded providers who have not previously worked with 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 who need assistance 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. Note: 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.
?	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. 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. Click on the ODJFS base page **URL** or **Web address**:

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

If this link does not work, **copy**, then **paste** it in the **Address** field at the top of the browser, and press **Enter**.

3. The ODJFS Medicaid Welcome Page displays. The Provider Medicaid Portal is accessed from this page.

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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Job & Family Services Ohio Medicaid

Medicaid Home
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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 & Family Services Ohio Medicaid

Medicaid Home
MITS
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Provider Info
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Acronyms
ADA Compliance
External Link Disclaimer
Contact Us
Feedback/
Case-Specific Concerns
Help/FAQs
Media Inquiries
Privacy Statement
Recent Additions
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Site Map

Welcome Providers

Resources for Ohio Medicaid Providers

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

Billing

- 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

Enrollment & Support

- New!** **Provider Enrollment**
- Provider Assistance
- Sanctioned/Terminated Providers
- Federal Requirement for Revalidation/Re-enrollment

News

- 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> <hr/> <p>Acronyms</p> <p>ADA Compliance</p> <p>External Link Disclaimer</p> <p>Contact Us</p> <p>Feedback/ Case-Specific Concerns</p> <p>Help/FAQs</p> <p>Media Inquiries</p> <p>Privacy Statement</p> <p>Recent Additions</p> <p>Site Index</p> <p>Site Map</p>	<p style="text-align: center;">Provider Enrollment</p> <p>Important Enrollment Updates: CLICK HERE TO ENROLL</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 click here to enroll as a new Medicaid Provider, click here to check enrollment status or click here 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>Please listen to the entire message before making your selection Telephone: 1-800-686-1516, select option 3, then option 1, then option 1 again, then option 4</p> <p>Monday through Friday, 8:00 a.m. to 4:30 p.m</p> <p>Background Checks Required for Ohio Home Care Providers: 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&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 DIRECTLY to ODJFS from BCI&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&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&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&I. A listing of WebCheck agencies can be found on the Ohio Attorney General's website at the following link: WebCheck Community Listing. You may also contact BCI&I by telephone at (877) 224-0043.</p> <p>Direct Deposit</p> <p>To receive payments via direct deposit please complete the Direct Deposit Authorization Agreement.</p>	<p>MITS</p> <p>Enroll as a New Provider</p> <p>Check Provider Enrollment Status</p> <p>Update Demographic Information</p> <p>Contact Enrollment 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>Documents:</p> <p>Group Information Form</p> <p>CSTO-Other Equivalent Training Option-Forms</p> <p>IRS - W-9</p> <p>Executive Order #2007 - 01S</p> <p>Confirmation from Consumer - JFS 0624</p> <p>Documentation of Training if not STNA or recently completed nurse aide training - JFS 0622</p> <p>Home Care Attendant Addendum M - JFS 02391</p> <p>Home Care Attendant Skilled Task Authorization - JFS 02390</p> <p>Home Care Attendant Medication Authorization - JFS 2389</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

Panels for enrollment presented in this section of the Provider Medicaid Portal User Manual show the following categories of new enrollment:

- Enrollment for long term care facilities.
- Enrollment for intermediate care facilities for the mentally retarded.

General Enrollment Instructions

The **Instructions** panel is the first enrollment panel and provides 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:

To **begin** the enrollment process:

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 the information in each panel before proceeding to the next one.
5. To exit the Provider Enrollment application and return to the **Instructions** page, 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 ODJFS 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 (http://www.odjfs.state.oh.us/forms/inter.asp).	Hyperlink	N/A	0
ODJFS eManuals	Links to the ODJFS Provider eManuals website (http://emanuals.odjfs.state.oh.us/emanuals/).	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.

The screenshot shows a web-based search interface. At the top, there is a 'Search' header with a help icon. Below it, there are two input fields: '*ATN' with the value '401359' and '*Business OR Last Name' with the value 'LAST'. To the right of these fields are 'search' and 'clear' buttons. Below the input fields is a 'Search Results' section. It contains a table with the following data:

ATN	Name	Document	Date Received	Status
401359	LAST FIRST	ONLINE ENROLLMENT APPLICATION	12/03/2008	NOT SUBMITTED

At the bottom of the results section, there are 'previous', 'next', and 'exit' buttons.

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

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	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	search panel.			
ATN	Unique code assigned to the application for identification purposes.	Field	Number	9
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

A provider applicant can view the status of, or upload additional documentation for, an enrollment application. The Enrollment Tracking Search panel is used by a provider to check the status of 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 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
Document	List of required documents.	Field	Character	25

Field	Description	Field Type	Data Type	Length
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 **Request Type** panel is used by an enrolling provider applicant to select the type of enrollment and provider type for the application.

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 **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 – 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	Field Type	Error Code	Error Message	To Correct
CHOP	Field	1	CHOP is required	Answer the CHOP question.
Provider	Field	0	A valid Provider Type is	Select a provider type from

Field	Field Type	Error Code	Error Message	To Correct
Type			required.	the drop-down list box.

Enrollment by Provider Type – Long Term Care Enrollment

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:

- Long Term Care and Intermediate Care Facilities for the Mentally Retarded

Providers who practice under a legal entity that provides long term care nursing services, or intermediate care services for the mentally retarded use a provider type of Long Term Care Nursing Facility / Intermediate Care Facility for the Mentally Retarded (ICF-MR) to enroll to use the Provider Medicaid Portal.

LTC Identifying Information Panel – Long Term Care/ICF – MR

The LTC Identifying Information panel allows an enrolling applicant to enter identifying information associated with a long term care nursing facility or intermediate care facility for the mentally retarded.

Tasks for this panel

To **enter** LTC identifying information:

1. Enter valid values in the **Legal Name**, **FEIN**, **Proprietor SSN**, and **NPI** fields.
2. Select values from the **Ownership Type**, **Business Structure?**, **Licensed by/to be Licensed by?**, and **Facility Care Setting** drop down list boxes.
3. If a value of "Other" is selected for **Facility Care Setting**, enter a brief description in the **Facility Care Setting (if 'Other' selected)** field.
4. Enter values in the **Doing Business As Name**, **Accreditation?**, **Other Business Structure Type?**, **ODDD License Number**, **Residential Facility License Date of Issue**, **Residential Facility License Date of Expiration**, **ODH Home Number**, and **ODDD Facility Number** fields, 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 – LTC Identifying Information – LTC/ICF – MR

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

Field	Description	Field Type	Data Type	Length
Accreditation?	If accredited, enter your accreditation granting agency name and type here e.g. JC, CARF, etc.	Field	Alphanumeric	100
Business Structure?	Business structure type.	Field	Drop Down List Box	0
Doing Business As Name	Name for individual or entity applicants doing business under a trade or company name.	Field	Character	50
FEIN	Federal Employer Identification number.	Field	Number	9
Facility Care Setting	Code for facility care setting.	Field	Drop Down List Box	0
Facility Care Setting (If 'Other' selected)	Description for facility care setting if 'Other' is selected.	Field	Character	60
Legal Name	Legal name of the care facility.	Field	Character	50
Licensed by/to be Licensed by?	Licensed by/to be Licensed by?	Field	Drop Down List Box	0
NPI	National Provider Identifier number. If an individual, enter NPI associated with SSN.	Field	Number	10
ODDD Facility Number	Ohio Department of Developmental Disabilities facility number.	Field	Number	15
ODDD License Number	Ohio Department of Developmental Disabilities license number.	Field	Character	10
ODH Home Number	Ohio Department of Health home number.	Field	Character	TBD
Other Business Structure Type?	Type of Business Structure for "Other" category.	Field	Alphanumeric	50
Ownership Type	Type of ownership.	Field	Drop Down List Box	1
Proprietor SSN	Proprietor's Social Security number.	Field	Number	9
Residential Facility License Date of Expiration	Enter Residential Facility License Date of Expiration.	Field	Date (MM/DD/CCYY)	8
Residential Facility License Date of Issue	Enter Residential Facility License Date of Issue.	Field	Date (MM/DD/CCYY)	8

Field Edits – LTC Identifying Information – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Accreditation?	Field	1	Accreditation is required.	This field must be completed.
Business Structure?	Field	1	Business Structure is required.	Choose a valid business structure from the dropdown.
Doing Business As Name	Field	0	Doing Business As Name (D/B/A) is required.	This field must be completed.
FEIN	Field	1	FEIN is required.	This field must be completed.
Facility Care Setting	Field	1	Facility Care Setting is required.	Choose a facility care setting from the dropdown.
Facility Care Setting (If 'Other' selected)	Field	1	Facility Care Setting (If 'Other' selected) is required.	Enter a value.
Legal Name	Field	1	Legal Name is required.	This field must be completed.
Licensed by/to be Licensed by?	Field	1	Licensed By is required.	This field must be completed.
NPI	Field	1	NPI is required.	This field must be completed.
Other Business Structure Type?	Field	1	Other Business Structure Type is required.	This field must be completed.
Ownership Type	Field	1	Ownership Type is required	Choose a value from the dropdown.
Proprietor SSN	Field	1	Proprietor SSN is required.	This field must be completed.
Residential Facility License Date of Issue	Field	1	Operator License Issue Date[10/1/2009 12:00:00 AM] must be less than or equal to Operator License Expiration Date[10/10/2000 12:00:00 AM]	Enter a date less than or equal to the Expiration Date

Tax ID – Long Term Care/ICF – MR

LTC 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 – LTC/ICF – MR

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.	Field	Drop Down List Box	0
Address 1	Provider's street address 1.	Field	Character	60
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	0

Field	Description	Field Type	Data Type	Length
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	Drop Down List Box	0
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	0
W9 Form	Indicates whether the provider provided a W-9 form.	Field	Drop Down List Box	0
Zip	Provider zip code.	Field	Number	5
Zip+4	Provider 4-character zip code extension.	Field	Number	4

Field Edits – Tax ID – LTC/ICF – MR

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 Form, or Form 147.	Select 'YES' for either TaxIDExempt, W9 Form, or 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	Field	1	IRS End Date is required.	Enter an IRS End Date.

Field	Field Type	Error Code	Error Message	To Correct
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 either 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 either 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.

CHOP – Long Term Care/ICF – MR

The CHOP panel captures basic information pertaining to a change of operator for an LTC facility.

CHOP ?

Change of Operator Transaction Type

Click [Multistep](#) or [CHOP Help](#) for more information.

*Is the Entering Operator Accepting Assignment of the Exiting Provider's Medicare Agreement? Yes No

*Is the Entering Operator Accepting Assignment of the Exiting Provider's National Provider Identifier Number (NPI)? Yes No

Last Day for Exiting Provider

First Day of Entering Operator

Previous Operator (Exiting) Medicaid ID

Previous Operator (Exiting) Doing Business As Name

Pre-CHOP CMS Certification Number (CCN)

Pre-CHOP National Provider Identifier Number (NPI)

Pre-CHOP Federal ID (As applicable)

Tasks for this panel

To **enter** information pertaining to a change of operator for a Long Term Care facility:

1. Select a value from the **Change of Operator Transaction Type?** list field.
2. Select a **Yes** or **No** response to the first operator question.
3. Select a **Yes** or **No** response to the second operator question.
4. If known, enter values in the **Previous (Exiting) Operator Medicaid ID, Last Date for Exiting First Day of Entering Operator, Pre-CHOP CMA Certification Number, Pre-CHOP National Provider Identifier, and Pre-CHOP Federal ID** fields.
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 – CHOP – LTC/ICF – MR

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 Operator Transaction Type	Type of Change of Operator Transactions.	Field	Drop Down List Box	1
First Day for Entering Provider	The First Day for Entering Provider.	Field	Date (MM/DD/CCYY)	8

Field	Description	Field Type	Data Type	Length
Last Day for Exiting Provider	The Last Day for Exiting Provider.	Field	Date (MM/DD/CCYY)	8
Pre-CHOP CMS Certification Number (CCN)	The existing CCN number on file.	Field	Number	15
Pre-CHOP Federal ID (As applicable)	Existing Federal ID number if it exists.	Field	Number	10
Pre-Chop Provider Identifier Number (NPI)	Current NPI number for the exiting Provider.	Field	Number	10
Previous Operator (Exiting) Medicaid ID	The seven digit Medicaid number.	Field	Number	7
Previous Operator (Exiting) DBA Name	The exiting provider Doing Business As name.	Field	Alphanumeric	50
Question 1	Yes/No values for accepting the assignment of the existing provider's agreement.	Field	Drop Down List Box	1
Question 2	Yes/No values for accepting the assignment of the existing provider's NPI.	Field	Drop Down List Box	1

Field Edits – CHOP – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Question 1	Field	1	Question is required.	Select YES or NO from the dropdown.
Question 2	Field	1	Question is required.	Select YES or NO from the dropdown.

CHOP Seller – Long Term Care/ICF – MR

The CHOP Seller panel captures seller information pertaining to a change of operator for a LTC facility.

CHOP Seller ?

*** No rows found ***

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

delete add

previous next exit

Tasks for this panel

To **enter** seller information pertaining to a change of operator for a Long Term Care facility:

1. Select the **add** button to add a CHOP seller record. The CHOP Seller panel redisplay with active fields.

2. Enter valid values in the **Seller’s Legal Name, Seller’s DBA, Address 1, City, Zip, SSN/FEIN, Contact Name, and Phone** fields.
3. If desired, enter values in the **Address 2, Zip** plus four extension, **National Provider Identifier (NPI), Explanation of "Other", Contact Title, Phone** extension, **Alternative Phone, Alternative Phone** extension, **Fax, and E-Mail Address** fields.
4. Select values from the **State, Asset(s) Sold, and SSN or FEIN** drop down list boxes.
5. If desired, select values from the **County, Phone** type, and **Alternative Phone** type drop down list boxes.
6. Select the **add** button to add another CHOP seller record.
7. Select the **delete** button to delete an existing CHOP seller 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 – CHOP Seller – LTC/ICF – MR

Field	Description	Field Type	Data Type	Length
Address 1	First line of the address.	Field	Alphanumeric	25
Address 2	Second optional line of address.	Field	Alphanumeric	25
Alternative Ext	An alternate phone number extension for the seller.	Field	Number	4
Alternative Phone	An alternate phone for the seller.	Field	Number	10
Alternative Type	An alternate phone type for the seller.	Field	Drop Down	1

Field	Description	Field Type	Data Type	Length
			List Box	
Asset(s) Sold	Listing of assets that were sold related to the CHOP.	Field	Drop Down List Box	20
City	The city for the address.	Field	Alphanumeric	15
Contact Name	Contact Name of the seller.	Field	Alphanumeric	25
Contact Title	The title of the contact's seller.	Field	Alphanumeric	15
County	The County address on file.	Field	Alphanumeric	15
Email	The Email for the seller.	Field	Alphanumeric	50
Explanation of	Free form explanation of other type of assets sold.	Field	Alphanumeric	500
Fax	Fax number for the seller.	Field	Number	10
National Provider Identifier (NPI) (If Applicable)	The individual's National Provider Identification.	Field	Number	10
Phone	Phone Number of the seller.	Field	Number	10
Phone Ext	Phone Ext of the seller.	Field	Number	4
Phone Type	Type of Phone of the seller.	Field	Number	1
SSN or FEIN	The SSN/FEIN type selection.	Field	Drop Down List Box	1
SSN/FEIN	The actually Numeric SSN or FEIN entered without formatting.	Field	Number	9
Sellers DBA	Sellers Doing Business As name.	Field	Alphanumeric	25
Sellers Legal Name	The legal name of the seller.	Field	Alphanumeric	25
State	The State address on file	Field	Drop Down List Box	2
Zip	A 5 digit zip code.	Field	Number	5
Zip+4	The +4 part of the zip code.	Field	Number	4

Field Edits – CHOP Seller – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Enter a value in Address 1.
Asset(s) Sold	Field	1	Asset(s) Sold is required.	Select a value from the

Field	Field Type	Error Code	Error Message	To Correct
				dropdown.
City	Field	1	City is required.	Enter a value.
Contact Name	Field	1	Contact Name is required.	Enter a value.
Explanation of	Field	1	Explanation of "Other" is required.	Enter a value or choose a different option from the Asset(s) Sold dropdown.
Phone	Field	1	Phone is required.	Enter a 10 digit phone.
SSN or FEIN	Field	1	SSN or FEIN is required.	Select a value from the dropdown.
SSN/FEIN	Field	1	SSN/FEIN is required.	Enter a valid SSN or FEIN.
Sellers DBA	Field	1	Sellers DBA is required.	Enter a value.
Sellers Legal Name	Field	1	Sellers Legal Name is required.	Enter a value.
State	Field	1	State is required.	Select a value from the dropdown.

CHOP Purchaser – Long Term Care/ICF – MR

The CHOP Purchaser panel captures purchaser information pertaining to a change of operator for a LTC facility.

CHOP Purchaser

Purchaser's Legal Name	DBA	Address 1	City	State	Zip	Contact Name	Phone
TEST	TEST	1231 TEST	ETERTE	NC	34543	YRDY	(534)543-5345

Type data below for new record.

Instructions: To be completed when the CHOP includes a Sale/Purchase.

*Purchaser's Legal Name
 Complete for a sale or multi-step transaction which includes a sale
 TEST

*Purchaser's DBA
 TEST

*Address 1
 1231 TEST

Address 2

*City
 ETERTE

County
 Geauga

*State
 NC

*Zip
 34543

National Provider Identifier (NPI)
 (If Applicable)

*Asset(s) Purchased
 BUILDING IN WHICH THE FACILITY IS LOCATED ONLY

Explanation of "Other"

Allocation of Lease Amount (If applicable, otherwise "N/A" or "Undetermined", if not yet determined)

*Land
 N/A

*Building
 N/A

*Other
 N/A

*Explanation of Other

*SSN or FEIN
 FEIN

*SSN/FEIN
 354354353

*Contact Name
 YRDY

Contact Title

*Phone
 (534)543-5345 CELL PHONE

Alternative Phone
 CELL PHONE

Fax

E-Mail Address

*Total Purchase Price
 \$123,132.00

Tasks for this panel

To **enter** purchaser information pertaining to a change of operator for a Long Term Care facility:

1. Select the **add** button to add a CHOP purchaser record. The CHOP Purchaser panel redisplayes with active fields.
2. Enter valid values in the **Purchaser's Legal Name, Purchaser's DBA, Address 1, City, Zip, Land, Building, Other, SSN/FEIN, Contact Name, Phone, and Total Purchase Price** fields.
3. If desired, enter values in the **Address 2, 4-digit Zip extension, National Provider Identifier (NPI), Explanation of "Other", Contact Title, Phone extension, Alternative Phone, Alternative Phone extension, Fax, and E-Mail Address** fields.
4. Select values from the **State, Asset(s) Purchased, and SSN or FEIN** drop down list boxes.
5. If desired, select values from the **County, Phone type, and Alternative Phone type** drop down list boxes.
6. Select the **add** button to add another CHOP seller record.
7. Select the **delete** button to delete an existing CHOP seller 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 – CHOP Purchaser – LTC/ICF – MR

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
Address 1	First line of the address.	Field	Alphanumeric	25
Address 2	Second optional line of address.	Field	Alphanumeric	25
Alternative Ext	An alternate phone number extension for the purchaser.	Field	Number	4
Alternative Phone	An alternate phone for the purchaser.	Field	Number	10
Alternative Type	An alternate phone type for the purchaser.	Field	Drop Down List Box	1
Asset(s) Purchased	Listing of assets that were purchased related to the CHOP.	Field	Drop Down List Box	20
Building	How much was paid for the building.	Field	Number	9
City	The city for the address.	Field	Alphanumeric	15
Contact Name	Contact Name of the purchaser.	Field	Alphanumeric	25
Contact Title	The title of the contact's purchaser.	Field	Alphanumeric	15
County	The County address on file.	Field	Alphanumeric	15
Email	The Email for the purchaser.	Field	Alphanumeric	50
Explanation of	Free form explanation of other type of assets purchased.	Field	Alphanumeric	500
Explanation of Other	An explanation for the Other Purchased price.	Field	Alphanumeric	200
FAX	Fax number for the purchaser.	Field	Number	10
Land	How much was paid for the land.	Field	Number	9
National Provider Identifier (NPI) (If Applicable)	The individual's National Provider Identification.	Field	Number	10
Other	How much was paid for other.	Field	Number	9

Field	Description	Field Type	Data Type	Length
Phone	Phone Number of the purchaser.	Field	Number	10
Phone Ext	Phone extension of the purchaser.	Field	Number	4
Phone Type	Type of Phone of the purchaser.	Field	Drop Down List Box	1
Purchasers DBA	Purchasers Doing Business As name.	Field	Alphanumeric	25
Purchasers Legal Name	The legal name of the Purchaser.	Field	Alphanumeric	25
SSN or FEIN	The SSN/FEIN type selection.	Field	Drop Down List Box	0
SSN/FEIN	The actual Numeric SSN or FEIN entered without formatting.	Field	Number	9
State	The State address on file.	Field	Drop Down List Box	2
Title	The title of the contact's purchaser.	Field	Alphanumeric	15
Total Purchase Price	The total purchase price paid to the seller.	Field	Number	9
Zip	A 5 digit zip code.	Field	Number	5
Zip+4	The +4 part of the zip code.	Field	Number	4

Field Edits – CHOP Purchaser – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Enter a value.
Asset(s) Purchased	Field	1	Asset(s) Purchased is required.	Select a value from the dropdown.
Building	Field	1	Building is required.	Enter a value.
City	Field	1	City is required.	Enter a value.
Contact Name	Field	1	Contact Name is required.	Enter a value.
Explanation of	Field	1	Explanation of "Other" is required.	Enter a value or choose a different option from the Asset(s) Purchased dropdown.
Explanation of Other	Field	1	Explanation of Other is required.	Enter a value.

Field	Field Type	Error Code	Error Message	To Correct
Land	Field	1	Land is required.	Enter a value.
Other	Field	1	Other is required.	Enter a value.
Phone	Field	1	Phone is required.	Enter a 10 digit phone.
Purchasers DBA	Field	1	Purchasers DBA is required.	Enter a value.
Purchasers Legal Name	Field	1	Purchasers Legal Name is required.	Enter a value.
SSN or FEIN	Field	1	SSN or FEIN is required.	Select a value from the dropdown.
SSN/FEIN	Field	1	SSN/FEIN is required.	Enter a valid SSN or FEIN.
State	Field	1	State is required.	Select a value from the dropdown.
Total Purchase Price	Field	1	Total Purchase Price is required.	Enter a value.

Facility Re – Entering Medicaid – Long Term Care/ICF – MR

The Facility Re-Entering Medicaid panel captures prior enrollment information for a LTC facility re-entering the Medicaid program.

Facility Re-Entering Medicaid ?

Following involuntary termination of the medicaid provider agreement for a nursing facility, the provider agreement effective date of a facility re-entering the medicaid program shall be the same effective date as the date CMS issues for the facility's Medicare provider agreement.

Re-entry may occur only after the successful completion of a reasonable assurance period as determined by CMS.

Previous Name for Facility

Previous Operator Name

Previous Medicaid ID

Previous NPI

Previous CCN

*Was this a Voluntary Withdrawal? Yes No

*Was this an Involuntary Termination? Yes No

Tasks for this panel

To **add** prior enrollment information for a Long Term Care facility re-entering the Medicaid program:

1. Enter valid data in the **Previous Name for Facility**, **Previous Operator Name**, **Previous Medicaid ID**, **Previous NPI**, and **Previous CCN** fields.
2. Answer the questions **Was this a Voluntary Withdrawal?** and **Was this an Involuntary Termination?** by selecting the **Yes** or **No** option, as applicable.

Field Descriptions – Facility Re – Entering Medicaid – LTC/ICF – MR

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
Previous CCN	The Previous CCN assigned.	Field	Number	15
Previous Medicaid ID	The 7 digit assign Medicaid ID number.	Field	Number	7
Previous NPI	The previous NPI number assigned.	Field	Number	10
Previous Name for Facility	The Previous Name for Facility.	Field	Alphanumeric	50
Previous Operator Name	The Previous Operator name.	Field	Alphanumeric	35
Was this a Voluntary Withdrawal?	Question with a YES/NO response required.	Field	Drop Down List Box	1
Was this an Involuntary Termination?	Question with a YES/NO response required.	Field	Drop Down List Box	1

Field Edits – Facility Re – Entering Medicaid – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Was this a Voluntary Withdrawal?	Field	1	YES/NO response to Voluntary Withdrawal question.	Answer YES/NO to Voluntary Withdrawal question
Was this an Involuntary Termination?	Field	1	YES/NO response to Involuntary Termination question	Answer YES/NO to Involuntary Termination question

Beds by Licensure/Registration Category – Long Term Care/ICF – MR

The Beds by Licensure/Registration Category panel captures information pertaining to licensed beds registered for an LTC facility.

Tasks for this panel

To **enter** information pertaining to licensed beds registered for a Long Term Care facility:

1. Enter values in the **Ohio Department of Health – Nursing Home Beds**, **Out of Service**, **Other**, **“Other” Licensed Bed Category Description**, **Total Licensed Beds**, **Total Non-Licensed Beds**, **Total Available Beds**, and **Ohio Department of Developmental Disabilities (ODDD) – Residential Facility** fields, if applicable.
2. Select either **Yes** or **No** from the **Has the Licensed Capacity Changed?** and **Has the number of Registered Beds Changed?** drop down list boxes, if applicable.
3. If **Yes** is selected for either question, enter a description of and reason for the change in the associated **If “Yes”, Describe Change/Reason for Change** field.
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 – Beds by Licensure/Registration Category – LTC/ICF – MR

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	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	in the provider enrollment wizard.			
Has The Licensed Capacity Changed?	Dropdown list box with a YES/NO combination.	Field	Drop Down List Box	0
Has the number of Registered Beds Changed?	Dropdown to indicate if there was a change in the number of beds currently registered.	Field	Drop Down List Box	0
If "Yes", Describe Change/Reason For Change [Licensed Capacity]	Description for the change in numbers.	Field	Alphanumeric	200
If "Yes", Describe Change/Reason For Change [Registered Beds]	Description for the change in bed capacity.	Field	Alphanumeric	200
Ohio Department of Developmental Disabilities (ODDD) – Residential Facility	Number of beds.	Field	Number	6
Ohio Department of Health - Nursing Home Beds	Number of nursing home beds.	Field	Number	6
Ohio Department of Health - Residential Care Beds	Number of beds.	Field	Drop Down List Box	6
Other	Other is used to describe other conditions that are defined in existing questions.	Field	Number	6
"Other" Licensed Bed Category Description	Description for "Other".	Field	Alphanumeric	15
Out of Service	Number of beds that are out of service.	Field	Number	6
Registered Hospital Licensed as Nursing Home	Number of beds.	Field	Number	6
Registered Hospital Not	Number of beds.	Field	Number	6

Field	Description	Field Type	Data Type	Length
Licensed as a Nursing Home				
Total Available Beds	Total number of all beds.	Field	Number	6
Total Licensed Beds	Total number of beds.	Field	Number	6
Total Non-Licensed Beds	Total number of beds.	Field	Number	6

Field Edits – Beds by Licensure/Registration Category – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
If "Yes", Describe Change/Reason For Change	Field	1	Registered Beds - Describe Change/Reason For Change is required.	Enter a value.
	Field	1	License Capacity - Describe Change/Reason For Change is required.	Enter a value.

Beds for Certification by Category – Long Term Care/ICF – MR

The Beds for Certification by Category panel captures information pertaining to beds to be certified for an LTC facility.

Beds For Certification By Category

Waiver of ICFMR Licensed Bed Capacity Beds

ICF/MR Beds

Total Certified Beds

Has the number of Beds for Certification Changed?

If "Yes", Describe Change/Reason For Change

previous next exit

Tasks for this panel

To **enter** information pertaining to beds to be certified for a Long Term Care facility:

1. Enter values in the **Waiver of ICFMR Licensed Bed Capacity Beds, ICF/MR Beds, and Total Certified Beds** fields.
2. Select either **Yes** or **No** from the **Has the number of Beds for Certification Changed?** drop down list box, if applicable.
3. If **Yes** is selected, enter a description of and reason for the change in the **If “Yes”, Describe the Change/Reason for Change** field.
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 – Beds for Certification by Category – LTC/ICF – MR

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
Has the number of Beds for Certification Changed?	Dropdown YES/NO question.	Field	Number	0
ICF-MR Beds	Number of beds.	Field	Number	6
If "Yes", Describe Change/Reason For Change	Describe reason for change in beds.	Field	Alphanumeric	250
Total Certified Beds	Number of beds.	Field	Number	6
Waiver of ICFMR Licensed Bed Capacity Beds	Number of beds.	Field	Number	6

Field Edits – Beds for Certification by Category – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
If "Yes", Describe Change/Reason For Change	Field	1	Certification Beds - Describe Change/Reason For Change is required.	Enter a description.

Facility Real Estate Owner Information – Long Term Care/ICF – MR

The Facility Real Estate Owner Information panel captures information for a business that owns real estate.

The screenshot shows a web-based form titled "Facility Real Estate Owner Information". At the top, there are tabs for "Owner's Legal Name", "Doing Business As Name", "Address 1", "City", "State", "Zip", "Contact Name", and "Phone 1". Below the tabs, there are "delete" and "add" buttons. The main form area contains several input fields and dropdown menus. On the left side, there are fields for "Owner's Legal Name", "Doing Business As Name", "Address 1", "Address 2", "City", "County", "State", "Zip", and "This Entity Owns". On the right side, there are fields for "Type", "SSN/FEIN", "Contact Name", "Contact Title", "Phone 1", "Fax", "TDD", and "E-Mail Address". There are also dropdown menus for "State", "County", "Phone 1" (with a "CELL PHONE" option), and "This Entity Owns". A note at the bottom right explains that "Is This the Entity to Become the Provider?" means an operator with a provider agreement, not a management company. At the bottom of the form, there are "previous", "next", and "exit" buttons.

Tasks for this panel

To **add** information for a business that owns real estate:

1. Enter valid values in the **Owner's Legal Name**, **Address 1**, **City**, **Zip**, **SSN/FEIN**, **Contact Name**, and **Phone 1** fields.
2. Select values from the **State**, **This Entity Owns**, **Type**, and **Is This the Entity to Become the Provider?** drop down list boxes.
3. If **Other** is selected in the **This Entity Owns** field, enter an explanation in the **Explanation of "Other" or For Manual Entry** field.
4. Enter values in the **Doing Business As Name**, **Address 2**, 4-digit **Zip** extension, **Contact Title**, **Phone 1** phone extension, **Fax**, **TDD**, and **E-Mail Address** fields, if applicable.
5. Select values from the **County** and **Phone 1** phone type drop down list boxes, if applicable.
6. Select the **add** button to add another facility real estate owner information record.
7. Select the **delete** button to delete a selected facility real estate owner information 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 – Facility Real Estate Owner Information – LTC/ICF – MR

Field	Description	Field Type	Data Type	Length
add	Inserts a new address record. Proper permissions are required	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	to perform an add.			
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.	Field	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
Address 1	First line of address.	Field	Alphanumeric	35
Address 2	Second optional line in the address.	Field	Alphanumeric	35
City	The city for the address.	Field	Alphanumeric	25
Contact Name	The name of the contact.	Field	Alphanumeric	35
Contact Title	The title that the contact uses.	Field	Alphanumeric	35
County	The county where the address is located.	Field	Alphanumeric	25
DBA Name	Doing Business As Name.	Field	Alphanumeric	50
Email	The email for the individual.	Field	Alphanumeric	50
Explanation for Other if Applicable	Explanation if "Other" is active.	Field	Alphanumeric	100
FAX	The FAX number for the individual.	Field	Number	10
Is this the Entity becoming the Provider?	Question to be answered.	Field	Drop Down List Box	1
Phone	The ten digit phone number.	Field	Number	10
Phone Ext	The extension for the phone number.	Field	Number	4
Real Estate Owner's Legal Name	Legal name of the Real Estate Owner.	Field	Alphanumeric	50
SSN or FEIN	Type of ID to be provided in the SSN/FEIN.	Field	Drop Down List Box	1
SSN/FEIN	The unformatted Social Security Number or Federal Identification Number.	Field	Number	9
State	The state for the address.	Field	Drop Down List Box	2

Field	Description	Field Type	Data Type	Length
TDD	The 10 digit TDD number.	Field	Number	10
This Entity Owns	A list of items that can be picked from.	Field	Drop Down List Box	15
Type of Phone	A dropdown of different phone types.	Field	Drop Down List Box	0
Zip	The 5 digit zip code.	Field	Number	5
Zip+4	The last 4 digits of the two part zip code.	Field	Number	4

Field Edits – Facility Real Estate Owner Information – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Enter a value.
City	Field	1	City is required.	Enter a value.
Contact Name	Field	1	Contact Name is required.	Enter a value.
DBA Name	Field	1	DBA Name is required.	Enter a value.
Is this the Entity becoming the Provider?	Field	1	Is this the Entity becoming the Provider is required.	Select a value from the dropdown.
Phone	Field	1	Phone is required.	Enter a value.
Real Estate Owner's Legal Name	Field	1	Real Estate Owner's Legal Name is required.	Enter a value.
SSN or FEIN	Field	1	SSN or FEIN is required.	Select a value.
SSN/FEIN	Field	1	SSN/FEIN is required.	Enter a valid number.
State	Field	1	State is required.	Select a value.
This Entity Owns	Field	1	This Entity Owns is required.	Select a value.
Zip	Field	1	Zip is required.	Enter a numeric value.

Operating Entity Information – Long Term Care/ICF – MR

The Operating Entity Information panel captures information for a non-lease operating business entity.

Tasks for this panel

To **enter** information for a non-lease operating business entity:

1. Enter valid values in the **Non-Lease Entering Operator’s Legal Name**, **Address 1**, **City**, **Zip**, **SSN/FEIN**, **Contact Name**, and **Phone** fields.
2. Select values from the **State**, **Relationship to Owner of Real Estate**, **Type**, and **Is This the Entity to Become the Provider?** drop down list boxes.
3. If **Other** is selected from the **Relationship to Owner of Real Estate** drop down list box, enter an explanation in the **Explanation of Other or For Manual Entry** field.
4. Enter values for the **Doing Business As Name**, **Address 2**, 4-digit **Zip** extension, **Contact Title**, **Phone** extension, **Fax**, **TDD**, and **E-Mail Address** fields, if applicable.
5. Select a value from the **County** drop down list box, if applicable.
6. Select the **add** button to add another operating entity information record.
7. Select the **delete** button to delete a selected operating entity information 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 –Operating Entity Information – LTC/ICF – MR

Field	Description	Field Type	Data Type	Length
add	Inserts a new address 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

Field	Description	Field Type	Data Type	Length
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
Address 1	First line of the address.	Field	Alphanumeric	35
Address 2	Second line of the address.	Field	Alphanumeric	35
City	The city in the listed address.	Field	Alphanumeric	25
Contact Name	The name of the contact.	Field	Alphanumeric	35
Contact Title	The title of the contact.	Field	Alphanumeric	35
County	Name of the county for the address.	Field	Alphanumeric	35
DBA Name	Doing Business As name.	Field	Alphanumeric	50
Email	The email for the individual.	Field	Alphanumeric	50
Explanation for "Related" Relationship to Owner	Brief description for when answering "Related" to the above question.	Field	Alphanumeric	30
FAX	The FAX number for the individual.	Field	Number	10
Is this the Entity becoming the Provider?	Question to be answered.	Field	Drop Down List Box	1
Non-Lease Entering Operator's Legal Name	Legal name of the individual.	Field	Alphanumeric	50
Phone	The phone number for the individual.	Field	Number	10
Phone Ext	The extension for the phone number.	Field	Number	4
Relationship to Owner of Real Estate	Question to answer.	Field	Drop Down List Box	25
SSN or FEIN	Selectable value to determine the type of value that will be entered, SSN or FEIN.	Field	Drop Down List Box	1
SSN/FEIN	The numeric SSN or FEIN.	Field	Number	9
State	The state for the address.	Field	Drop Down List Box	2
TDD	The 10 digit TDD number.	Field	Number	10
Type of Phone	A dropdown of different phone types.	Field	Drop Down List Box	0
Zip	The 5 digit zip code.	Field	Number	5

Field	Description	Field Type	Data Type	Length
Zip+4	The last 4 digits of the two part zip code.	Field	Number	4

Field Edits –Operating Entity Information – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Enter a value.
City	Field	1	City is required.	Enter a value.
Contact Name	Field	1	Contact Name is required.	Enter a value.
DBA Name	Field	1	DBA Name is required.	Enter a value.
Explanation for "Related" Relationship to Owner	Field	1	Explanation for "Related" Relationship to Owner is required.	Enter a value.
Is this the Entity becoming the Provider?	Field	1	Is this the Entity becoming the Provider is required.	Select a value from the dropdown.
Non-Lease Entering Operator's Legal Name	Field	1	Non-Lease Entering Operator's Legal Name is required.	Enter a value.
Phone	Field	1	Phone is required.	Enter a value.
Relationship to Owner of Real Estate	Field	1	Relationship to Owner of Real Estate is required.	Select a value from the dropdown.
Zip	Field	1	Zip is required.	Enter a 5 digit zip.

Primary Lessor Information – Long Term Care/ICF – MR

The Primary Lessor Information panel captures primary lessor information for a business that is operated under a lease.

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Primary Lessor Information

Detail

Primary Lessor's Operator's Legal Name Doing Business As Name Address 1 City State Zip Contact Name Phone 1

Type data below for new record.

delete add

Instructions: Complete for Single Lessee Lease Structure or for Initial Lessor in a Multi-Level Lease Structure.

*Primary Lessor's Operator's Legal Name

Doing Business As Name

*Address 1

Address 2

*City

County

*State

*Zip

*Primary Lessor is Lessor of

Explanation of "Other" or For Manual Entry

*Relationship to Owner of Real Estate (See ORC Chapter 5111.20 and OAC Section 5101:3-3-01 for definitions of "related party")

Explanation for Related Relationship to Owner

*Type

*SSN/FEIN

*Contact Name

Contact Title

*Phone 1 CELL PHONE

Fax

TDD

E-Mail Address

previous next exit

Tasks for this panel

To **enter** primary lessor information for a business operated under a lease:

1. Enter valid values in the **Primary Lessor’s Operator’s Legal Name, Address 1, City, Zip, SSN/FEIN, Contact Name, and Phone 1** fields.
2. Select values from the **State, Primary Lessor is Lessor of, Relationship to Owner of Real Estate, and Type** drop down list boxes.
3. If **Other** is selected in the **Primary Lessor is Lessor of** drop down list box, enter an explanation in the **Explanation of Other or For Manual Entry** field.
4. Enter values for the **Doing Business As Name, Address 2, 4-digit Zip extension, Contact Title, Phone 1** phone extension, **Fax, TDD, and E-Mail Address** fields, if applicable.
5. Select a value from the **County** drop down list box, if applicable.
6. Select the **add** button to add another primary lessor information record.
7. Select the **delete** button to delete a selected primary lessor information 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 – Primary Lessor Information – LTC/ICF – MR

Field	Description	Field Type	Data Type	Length
add	Inserts a new address 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
Address 1	First line of the address.	Field	Alphanumeric	50
Address 2	Second line of the address.	Field	Alphanumeric	50
City	City on the address.	Field	Alphanumeric	35
Contact Name	The name of the contact.	Field	Alphanumeric	35
Contact Title	The title of the contact.	Field	Alphanumeric	35

Field	Description	Field Type	Data Type	Length
County	County on the address.	Field	Alphanumeric	35
DBA Name	Doing Business As name.	Field	Alphanumeric	50
Email	The email address for the individual.	Field	Alphanumeric	50
Explanation for Related Relationship to Owner	Free form explanation of primary lessor's relationship to owner of real estate.	Field	Alphanumeric	200
Explanation of "Other" Selection	If "Other" is selected in dropdown list of types of lessors, a free form explanation is entered to describe the details.	Field	Alphanumeric	200
FAX Phone	The FAX number for the individual.	Field	Number	10
Phone / EXT	The phone number for the individual.	Field	Number	10
Phone Ext	The extension for the phone number.	Field	Number	4
Phone Type	A dropdown of different phone types.	Field	Drop Down List Box	0
Primary Lessor Operator's Legal Name	The legal name of the lessor.	Field	Alphanumeric	50
Primary Lessor is Lessor of	Dropdown list of types of lessors.	Field	Drop Down List Box	20
Relationship to Owner of Real Estate	Dropdown of available relationships.	Field	Drop Down List Box	25
SSN/FEIN	Social Security number of the individual or Federal Employer Identification number of the business entity.	Field	Number	11
State	State on the address.	Field	Drop Down List Box	2
TDD	The 10 digit TDD number.	Field	Number	10
Type	Type of tax ID. Valid value: SSN or FEIN	Field	Drop Down List Box	0
Zip	The 5-digit zip code.	Field	Number	5
Zip + 4	The last 4 digits for a zip code.	Field	Number	4

Field Edits – Primary Lessor Information – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	0	Address 1 is required.	Enter Address 1.
City	Field	0	City is required.	Enter City.
Contact Name	Field	0	Contact Name is required.	Enter Contact Name.
Doing Business As Name	Field	1	Doing Business As Name is required.	Enter a value.
Phone 1	Field	0	Phone 1 is required.	Enter the Phone 1 number.
Primary Lessor is Lessor of	Field	0	Primary Lessor is Lessor of is required.	Select a Primary Lessor.
Primary Lessors Operators Legal Name	Field	0	Primary Lessor's Operator's Legal Name is required.	Enter the Primary Lessor's Operator's Legal Name.
Relationship to Owner of Real Estate	Field	0	Relationship to Owner is required.	Select a Relationship to Owner.
SSN/FEIN	Field	0	SSN/FEIN is required.	Enter SSN or FEIN.
State	Field	0	A valid State is required.	Select a State.
Type	Field	0	Type is required.	Select Type.
Zip	Field	0	Zip is required.	Enter Zip code.

Master Lessee – Long Term Care/ICF – MR

The Master Lessee panel captures master lessee information for a business that is operated under a lease.

Tasks for this panel

To enter master lessee information:

1. Enter valid values in the **Master Lessee's Legal Name, Address 1, City, Zip, Date Lease, Term of Lease, Number and Length of Renewal Terms, Total Initial Annual Lease Amount, Land, Building, Other, Explanation of Other, SSN/FEIN, Contact Name, and Phone** fields.
2. Select values from the **State, Master Lessee is Lessee of, Was This Lease Assigned To This Lessee or Is It A New Lease?, Type, Is This the Entity to Become the Provider?, Relationship to Owner of Real Estate, and Relationship to Primary Lessor** drop down list boxes.
 - a. If **Other** is selected from the **Master Lessee is Lessee of** drop down list box, enter an explanation in the **Explanation of "Other" or For Manual Entry** field.
 - b. If **Assigned Lease** is selected from the **Was This Lease Assigned To This Lessee or Is It A New Lease?** drop down list box, enter a name in the **If Assigned, Who Was the Prior Lessee ("Assignor")?** field.

- c. If **Related** is selected from the **Relationship to Owner of Real Estate** drop down list box, enter an explanation in the **Explanation for Related Relationship to Owner** field.
 - d. If **Related** is selected from the **Relationship to Primary Lessor** drop down list box, enter an explanation in the **Explanation for Related Relationship to Primary Lessor** field.
3. Enter values in the **Doing Business As Name, Address 2, 4-digit Zip extension, Contact Title, Phone extension, Fax, TDD, and E-Mail Address** fields, if applicable.
 4. Select values from the **County** and **Phone** type drop down list boxes, if applicable.
 5. Select the **add** button to add another master lessee record.
 6. Select the **delete** button to delete a selected master lessee 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 – Master Lessee – LTC/ICF – MR

Field	Description	Field Type	Data Type	Length
add	Inserts a new address 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
Master Lessee's Legal Name	The legal name of the lessee.	Combo Box	Alphanumeric	50
Address 1	First line of the address.	Field	Alphanumeric	50
Address 2	Second line of the address.	Field	Alphanumeric	50
Building	Total Lease amount for building.	Field	Number	9
City	The city in the listed address.	Field	Alphanumeric	35
Contact Name	The name of the contact.	Field	Alphanumeric	35
Contact Title	The title of the contact.	Field	Alphanumeric	35

Field	Description	Field Type	Data Type	Length
County	Name of the county for the address.	Field	Alphanumeric	35
DBA Name	Doing Business As name.	Field	Alphanumeric	50
Date Lease	Date of Lease.	Field	Date (MM/DD/CCYY)	10
Email	The email address for the individual.	Field	Alphanumeric	50
Explanation of "Other: or For Manual Entry	Free form field to allow explanation that doesn't exist in the dropdown.	Field	Alphanumeric	250
Explanation of Other	Explanation of Total Lease amount for Other.	Field	Alphanumeric	200
FAX	The FAX number for the individual.	Field	Number	10
If Assigned, Who Was the Prior Lessee ("Assignor")?	Name on the prior lease.	Field	Alphanumeric	35
Is This the Entity to Become the Provider?	Question to be answered.	Field	Drop Down List Box	0
Land	Total Lease amount for land.	Field	Number	9
Master Lessee is Lessee of	Dropdown of types of Lessees.	Field	Drop Down List Box	20
Number and Length of Renewal Terms	Lease renewal terms.	Field	Alphanumeric	200
Other	Total Lease amount for Other.	Field	Number	9
Phone / EXT	The phone number for the individual.	Field	Number	10
Phone Ext	The extension for the phone number.	Field	Number	4
Phone Type	A dropdown of different phone types.	Field	Drop Down List Box	0
Relationship to Owner of Real Estate	Dropdown of available relationships.	Field	Drop Down List Box	25
Relationship to Primary Lessor	The relationship to the Primary Lessor.	Field	Drop Down List Box	25
SSN/FEIN	Social Security number of the individual or Federal Employer Identification number of the business entity.	Field	Number	11
State	The state for the address.	Field	Drop Down List	2

Field	Description	Field Type	Data Type	Length
			Box	
TDD	The 10 digit TDD number.	Field	Number	10
Total Initial Annual Lease Amount	The total dollar amount of the lease amount.	Field	Number	9
Type	Type of tax ID. Valid value: SSN or FEIN	Field	Drop Down List Box	0
Was This Lease Assigned To This Lessee or Is it A New	Type of Lease.	Field	Drop Down List Box	25
Zip	The 5-digit zip code.	Field	Number	5
Zip + 4	The last 4 digits for a zip code.	Field	Number	4

Field Edits – Master Lessee – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Master Lessee's Legal Name	Combo Box	1	Master Lessee's Legal Name is required.	Enter a value.
Address 1	Field	1	Address 1 is required.	Enter a value.
Building	Field	1	Building is required.	Enter a value.
City	Field	1	City is required.	Enter a value.
Contact Name	Field	1	Contact name is required.	Enter a value.
DBA Name	Field	1	DBA Name is required.	Enter a value.
Date Lease	Field	1	Date Lease is required.	Enter a value.
Explanation of "Other: or For Manual Entry	Field	1	Explanation of "Other: or For Manual Entry is required.	Enter a value.
Explanation of Other	Field	1	Explanation for Other is required.	Enter a value.
If Assigned, Who Was the Prior Lessee ("Assignor")?	Field	1	If Assigned, Who Was the Prior Lessee ("Assignor")? is required.	Enter a value.
Is This the Entity to Become the Provider?	Field	1	Is This the Entity to Become the Provider? is required.	Select a value from the dropdown.
Land	Field	1	Land is required.	Enter a value.
Master Lessee is Lessee of	Field	1	Master Lessee is Lessee of is required.	Enter a value.
Number and Length	Field	1	Number and Length of	Enter a value.

Field	Field Type	Error Code	Error Message	To Correct
of Renewal Terms			Renewal Terms is required.	
Other	Field	1	Other is required.	Enter a value.
Phone / EXT	Field	1	Phone is required.	Enter a value.
Relationship to Owner of Real Estate	Field	1	Relationship to Owner of Real Estate is required.	Select a value.
Relationship to Primary Lessor	Field	1	Relationship to Primary Lessor is required.	Select a value.
SSN/FEIN	Field	1	SSN/FEIN is required.	Enter a value.
State	Field	1	State is required.	Select a value.
Total Initial Annual Lease Amount	Field	1	Total Initial Annual Lease Amount is required.	Enter a value.
Type	Field	1	SSN or FEIN is required.	Select a value.
Was This Lease Assigned To This Lessee or Is it A New	Field	1	Was This Lease Assigned To This Lessee or Is it A New is required.	Select a value.
Zip	Field	1	Zip is required.	Enter a value.

Sub-lessee Information – Long Term Care/ICF – MR

The Sub-lessee Information panel captures sub-lessee information for a business that is operated under a lease.

Sublessee Information Detail

Sublessee's Legal Name Doing Business As Name Address 1 City State Zip Contact Name Phone 1

delete add

Type data below for new record.

Instructions: Instructions: Complete for a Multi-Level Lease Structure.

*Sublessee's Legal Name

Doing Business As Name

*Address 1

Address 2

*City

County

*State

*Zip

*This Entity Is The

Explanation of "Other" or For Manual Entry

*And Is Leasing

Explanation of Is Leasing "Other"

*Date Lease

*Was This Lease Assigned To This Lessee or Is it A New Lease?

If Assigned, Who Was The Prior Lessee ("Assignor")?

*Term of Lease
Note: If a lease amount is to change during the term of the lease, provide detail of date spans and lease amounts

*Number and Length of Renewal Terms

*Total Initial Annual Lease Amount

Allocation of Lease Amount (if applicable, otherwise "N/A" or "Undetermined", if not yet determined)

*Land

*Building

*Other

*Explanation of Other

*Type

*SSN/FEIN

*Contact Name

Contact Title

*Phone 1 CELL PHONE

Fax

TDD

E-Mail Address

*Relationship to Owner of Real Estate (See ORC Chapter 5111.20 and OAC Section 5101:3-3-01 for definitions of "related party")

Explanation for Related Relationship to Owner

*Relationship to Primary Lessor (See ORC Chapter 5111.20 and OAC Section 5101:3-3-01 for definitions of "related party")

Explanation for Related Relationship to Primary Lessor

*Relationship to Master Lessor (See ORC Chapter 5111.20 and OAC Section 5101:3-3-01 for definitions of "related party")

Explanation for Related Relationship to Master Lessor

*Relationship to Subsequent Lessee(s) (See ORC Chapter 5111.20 and OAC Section 5101:3-3-01 for definitions of "related party")

Explanation for Related Relationship to Subsequent Lessee(s)

* Is This the Entity to Become the Provider? (This means an operator with a provider agreement, not a management company. See ORC Chapter 5111.20 and OAC Section 5101:3-3-01 for definitions)

previous next exit

Tasks for this panel

To **enter** sub-lessee information for a business operated under a lease:

1. Enter valid values in the **Sublessee's Legal Name, Address 1, City, Zip, Date Lease, Term of Lease, Number and Length of Renewal Terms, Total Initial Annual Lease Amount, Land, Building, Other, Explanation of Other, SSN/FEIN, Contact Name, and Phone 1** fields.
2. Select values from the **State, This Entity Is The, And Is Leasing, Was This Lease Assigned To This Lessee or Is It A New Lease?, Type, Relationship to Owner of**

Real Estate, Relationship to Primary Lessor, Relationship to Master Lessor, and Relationship to Subsequent Lessee(s) drop down list boxes.

- a. If **Other** is selected from the **This Entity Is The** drop down list box, enter an explanation in the **Explanation of “Other” or For Manual Entry** field.
 - b. If **Other** is selected from the **And Is Leasing** drop down list box, enter an explanation in the **Explanation of Is Leasing “Other”** field.
 - c. If **Assigned Lease** is selected from the **Was This Lease Assigned To This Lessee or Is It A New Lease?** drop down list box, enter a name in the **If Assigned, Who Was the Prior Lessee (“Assignor”)?** field.
 - d. If **Related** is selected from the **Relationship to Owner of Real Estate** drop down list box, enter an explanation in the **Explanation for Related Relationship to Owner** field.
 - e. If **Related** is selected from the **Relationship to Primary Lessor** drop down list box, enter an explanation in the **Explanation for Related Relationship to Primary Lessor** field.
 - f. If **Related** is selected from the **Relationship to Master Lessor** drop down list box, enter an explanation in the **Explanation for Related Relationship to Master Lessor** field.
 - g. If **Related** is selected from the **Relationship to Subsequent Lessee(s)** drop down list box, enter an explanation in the **Explanation for Related Relationship to Subsequent Lessee(s)** field.
3. Enter values in the **Doing Business As Name, Address 2, 4-digit Zip extension, Contact Title, Phone 1 extension, Fax, TDD, and E-Mail Address** fields, if applicable.
 4. Select values from the **County** and **Phone 1** phone type drop down list boxes, if applicable.
 5. Select the **add** button to add another sub-lessee information record.
 6. Select the **delete** button to delete a selected sub-lessee 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 – Sub-lessee Information – LTC/ICF – MR

Field	Description	Field Type	Data Type	Length
add	Inserts a new address 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

Field	Description	Field Type	Data Type	Length
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
Address 1	First line of the address.	Field	Alphanumeric	50
Address 2	Second line of the address.	Field	Alphanumeric	50
And Is Leasing	Sub-lessee leasing arrangement.	Field	Drop Down List Box	1
Building	Dollar amount of the allocation of the lease amount for building, if applicable, otherwise "N/A" or "Undet.", if not yet determined.	Field	Alphanumeric	12
City	The city in the listed address.	Field	Alphanumeric	35
Contact Name	The name of the contact.	Field	Alphanumeric	35
Contact Title	The title of the contact.	Field	Alphanumeric	35
County	Name of the county for the address.	Field	Alphanumeric	35
DBA Name	Sublessee's Doing Business As name.	Field	Alphanumeric	50
Date Lease Commenced	The date that the lease commenced.	Field	Date (MM/DD/CCYY)	10
Email	The email for the individual.	Field	Alphanumeric	50
Explanation for	Explanation for "Related" relationship to owner of real estate.	Field	Alphanumeric	100
Explanation for	Explanation for "Related" relationship to primary lessor.	Field	Alphanumeric	100
Explanation for	Explanation for "Related" relationship to Master Lessee.	Field	Alphanumeric	100
Explanation for	Explanation for "Related" relationship to subsequent Sub-lessee(s).	Field	Alphanumeric	100
Explanation of	Explanation of "Other".	Field	Alphanumeric	100
Explanation of	Explanation of "Other" scenario.	Field	Alphanumeric	100
Explanation of Other	Explanation of "other" allocation.	Field	Alphanumeric	100
FAX	The FAX number for the individual.	Field	Number	10
If Assigned, Who Was The	If the lease was assigned, the prior Lessee ("Assignor") name is	Field	Alphanumeric	50

Field	Description	Field Type	Data Type	Length
Prior Lessee ("Assignor")?	entered here.			
Is this the Entity becoming the Provider?	Question to be answered.	Field	Drop Down List Box	1
Land	Dollar amount of the allocation of the lease amount for land, if applicable, otherwise "N/A" or "Undet.", if not yet determined.	Field	Alphanumeric	12
Number and Length of Renewal Terms	The number and length of the renewal terms.	Field	Alphanumeric	250
Other	Dollar amount of the allocation of the lease amount for "other" category, if applicable, otherwise "N/A" or "Undet.", if not yet determined.	Field	Number	12
Phone / EXT	The phone number for the individual.	Field	Number	10
Phone Ext	The extension for the phone number.	Field	Number	4
Phone Type	A dropdown of different phone types.	Field	Drop Down List Box	0
Relationship to Master Lessee	Relationship to Master Lessee.	Field	Drop Down List Box	1
Relationship to Owner of Real Estate	Relationship to Owner of Real Estate.	Field	Drop Down List Box	1
Relationship to Primary Lessor	Relationship to primary lessor.	Field	Drop Down List Box	1
Relationship to Subsequent Sub-lessee(s)	Relationship to Subsequent Sub-lessee(s).	Field	Drop Down List Box	1
SSN/FEIN	Social Security number of the individual or Federal Employer Identification number of the business entity.	Field	Number	11
State	The state for the address.	Field	Drop Down List Box	1
Sublessee's Legal Name	Sublessee's legal name.	Field	Alphanumeric	50

Field	Description	Field Type	Data Type	Length
*Sublessee's Legal Name				
TDD	The 10 digit TDD number.	Field	Number	10
Term of Lease	Term of the Lease. If a lease amount is to change during the term of the lease, provide detail of date spans and lease amounts.	Field	Alphanumeric	250
This Entity is the	Type of Sub-lessee.	Field	Drop Down List Box	1
Total Initial Annual Lease Amount	The total initial annual lease amount.	Field	Number	15
Type	Type of tax ID. Valid value: SSN or FEIN	Field	Drop Down List Box	1
Was This Lease Assigned To This Lessee or Is it A New Lease?	Lease assigned to the Lessee or is it a new lease?	Field	Drop Down List Box	1
Zip	The 5-digit zip code.	Field	Number	5
Zip + 4	The last 4 digits for a zip code.	Field	Number	4
Allocation of Lease Amount	Allocation of Lease Amount (If applicable, otherwise "N/A" or "Undet.", if not yet determined)	Label	N/A	0

Field Edits – Sub-lessee Information – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Enter a value.
Building	Field	1	Building is a required field.	Enter a value.
City	Field	1	City is required.	Enter a value.
Contact Name	Field	1	Contact Name is required.	Enter a value.
DBA Name	Field	1	DBA Name is required.	Enter a value.
Explanation for	Field	1	Explanation for "Related" Relationship to Owner of Real Estate is a required field when "Related" value is selected.	Enter a value.
	Field	1	Explanation for "Related" Relationship to Primary Lessor is required when	Enter a value.

Field	Field Type	Error Code	Error Message	To Correct
			"Related" value is selected.	
	Field	1	Explanation for "Related" Relationship to Master Lessee is required when the "Related" value is chosen.	Select a value.
	Field	1	Explanation for "Related" Relationship to Subsequent Sub-lessee(s) is required if "Related" value is chosen.	Enter a value.
Explanation of	Field	1	Explanation is required with "Other" value is selected.	Enter a value.
	Field	1	Explanation is required with "Other" value is selected.	Enter a value.
If Assigned, Who Was The Prior Lessee ("Assignor")?	Field	1	"If Assigned, Who Was The Prior Lessee ("Assignor")?" is required if the "Assigned" value was selected.	Enter a value.
Is this the Entity becoming the Provider?	Field	1	Is This the Entity to Become the Provider? requires an answer.	Select a value.
Land	Field	1	Land is a required field.	Enter a value.
Number and Length of Renewal Terms	Field	1	Number and Length of Renewal Terms is a required field.	Enter a value.
Other	Field	1	Other is a required field.	Enter a value.
Phone / EXT	Field	1	Phone is a required field.	Enter a value.
Relationship to Master Lessee	Field	1	Relationship to Master Lessee is a required field.	Select a value.
Relationship to Owner of Real Estate	Field	1	Relationship to Owner of Real Estate is a required field.	Select a value.
Relationship to Primary Lessor	Field	1	Relationship to Primary Lessor is a required field.	Select a value.
SSN/FEIN	Field	1	SSN/FEIN is a required field.	Enter a value.
State	Field	1	State is required.	Select a value.
Term of Lease	Field	1	Term of Lease is a required field.	Enter a value.
This Entity is the	Field	1	This Entity is the...is a required field.	Select a value.
Total Initial Annual Lease Amount	Field	1	Total Initial Annual Lease Amount is a required field.	Enter a value.

Field	Field Type	Error Code	Error Message	To Correct
Type	Field	1	SSN or FEIN type is required.	Select a value
Was This Lease Assigned To This Lessee or Is it A New Lease?	Field	1	"Was This Lease Assigned To This Lessee or Is it A New Lease?" question is required.	Select a value.
Zip	Field	1	Zip Code is required.	Enter a value.
Allocation of Lease Amount	Label	1	Allocation of Lease Amount is a required field.	Enter a value.

LTC Management Company Information – Long Term Care/ICF – MR

The LTC Management Company Information panel captures information for a business that is contracted to provide services for a facility.

LTC Management Company Information

Answer Mgmt Company's Legal Name DBA Address 1 City State Zip Contact Name Phone

No

Type data below for new record.

delete add

Instructions: This is an entity with whom the entering provider applicant contracts to provide management services. This entity will not be the provider.

*Does this apply? Yes No

Management Company's Legal Name

DBA Name

Address 1

Address 2

City

County

State

Zip

Relationship to Owner of Real Estate (See ORC Chapter 5111.20 and OAC Section 5101:3-3-01 for definitions of "related party")

Explanation for "Related" Relationship to Owner of Real Estate.

Relationship to Non-Lease Operating Entity (If applicable. See ORC Chapter 5111 and OAC Section 5101:3-3- for definitions of "related party")

Explanation for "Related" Relationship to Non-Lease Operating Entity.

Relationship to Primary Lessor (If applicable. See ORC Chapter 5111 and OAC Section 5101:3-3- for definitions of "related party")

Explanation for "Related" Relationship to Primary Lessor.

Type

SSN/FEIN

Contact Name

Contact Title

Phone CELL PHONE

Fax

TDD

E-Mail Address

Relationship to Master Lessee (If applicable. See ORC Chapter 5111 and OAC Section 5101:3-3- for definitions of "related party")

Explanation for "Related" Relationship to Master Lessee.

Relationship to sublessee(s) (If applicable. See ORC Chapter 5111 and OAC Section 5101:3-3- for definitions of "related party")

Explanation for "Related" Relationship to Sublessee(s).

previous next exit

Tasks for this panel

To enter information for a business providing facility management services:

1. Enter valid values in the **Management Company's Legal Name, DBA Name, Address 1, City, Zip, SSN/FEIN, Contact Name, and Phone** fields.
2. Select values from the **State, Type, Relationship to Owner of Real Estate, Relationship to Non-Lease Operating Entity, Relationship to Primary Lessor, Relationship to Master Lessee, and Relationship to sub-lessee(s)** drop down list boxes.
 - a. If **Related** is selected from the **Relationship to Owner of Real Estate** drop down list box, enter an explanation in the **Explanation for Related Relationship to Owner** field.
 - b. If **Related** is selected from the **Relationship to Non-Lease Operating Entity** drop down list box, enter an explanation in the **Explanation for Related Relationship to Non-Lease Operating Entity** field.
 - c. If **Related** is selected from the **Relationship to Primary Lessor** drop down list box, enter an explanation in the **Explanation for Related Relationship to Primary Lessor** field.
 - d. If **Related** is selected from the **Relationship to Master Lessor** drop down list box, enter an explanation in the **Explanation for Related Relationship to Master Lessor** field.
 - e. If **Related** is selected from the **Relationship to sub-lessee(s)** drop down list box, enter an explanation in the **Explanation for Related Relationship to Sub-lessee(s)** field.
3. Enter values in the **Address 2, 4-digit Zip extension, Contact Title, Phone extension, Fax, TDD, and E-Mail Address** fields, if applicable.
4. Select values from the **County** and **Phone** type drop down list boxes, if applicable.
5. Select the **add** button to add another management company information record.
6. Select the **delete** button to delete a selected management company 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 – LTC Management Company Information – LTC/ICF – MR

Field	Description	Field Type	Data Type	Length
add	Inserts a new address 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	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	provider enrollment wizard.			
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Address 1	First line of the address.	Field	Alphanumeric	35
Address 2	Second line of the address.	Field	Alphanumeric	35
City	The city in the listed address.	Field	Alphanumeric	25
Contact Name	The name of the contact.	Field	Alphanumeric	35
Contact Title	The title of the contact.	Field	Alphanumeric	35
County	Name of the county for the address.	Field	Alphanumeric	35
DBA Name	Doing Business As name.	Field	Alphanumeric	50
Email	The email for the individual.	Field	Alphanumeric	50
Explanation for "Related" Relationship to Master Lessee	Free form text area used to describe other relationship.	Field	Alphanumeric	250
Explanation for "Related" Relationship to Non-Lease	Free form text area used to describe other relationship.	Field	Alphanumeric	250
Explanation for "Related" Relationship to Owner of Real Estate.	Free form text area used to describe other relationship.	Field	Alphanumeric	250
Explanation for "Related" Relationship to Primary Lessor	Free form text area used to describe other relationship.	Field	Alphanumeric	250
Explanation for "Related" Relationship to Sub-lessee(s)	Free form text area used to describe other relationship.	Field	Alphanumeric	250
FAX	The FAX number for the individual.	Field	Number	10
Management Company's Legal Name	The legal name of the management company.	Field	Alphanumeric	50
Phone / EXT	The phone number for the individual.	Field	Number	10

Field	Description	Field Type	Data Type	Length
Phone Ext	The extension for the phone number.	Field	Number	4
Phone Type	A dropdown of different phone types.	Field	Drop Down List Box	5
Relationship to Master Lessee	Dropdown containing a list of relationships.	Field	Drop Down List Box	25
Relationship to Non-Lease Operating Entity	Dropdown containing a list of relationships.	Field	Drop Down List Box	25
Relationship to Owner of Real Estate	Dropdown containing a list of relationships.	Field	Drop Down List Box	25
Relationship to Primary Lessor	Dropdown containing a list of relationships.	Field	Drop Down List Box	25
Relationship to Sub-lessee(s)	Dropdown containing a list of relationships.	Field	Drop Down List Box	25
SSN/FEIN	Social Security number of the individual or Federal Employer Identification number of the business entity.	Field	Number	11
State	The state for the address.	Field	Drop Down List Box	2
TDD	The 10 digit TDD number.	Field	Number	10
Type	Type of tax ID. Valid value: SSN or FEIN	Field	Drop Down List Box	1
Zip	The 5-digit zip code.	Field	Number	5
Zip + 4	The last 4 digits for a zip code.	Field	Number	4

Field Edits – LTC Management Company Information – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Enter a value.
City	Field	1	City is required.	Enter a value.
Contact Name	Field	1	Contact Name is required.	Enter a value.
DBA Name	Field	1	DBA Name is required.	Enter a value.
Explanation for "Related"	Field	1	Explanation for	Enter a value.

Field	Field Type	Error Code	Error Message	To Correct
Relationship to Master Lessee			"Related" Relationship to Master Lessee is required.	
Explanation for "Related" Relationship to Non-Lease	Field	1	Explanation for "Related" Relationship to Non-Lease is required.	Enter a value.
Explanation for "Related" Relationship to Owner of Real Estate.	Field	1	Explanation for "Related" Relationship to Owner of Real Estate is required.	Enter a value.
Explanation for "Related" Relationship to Primary Lessor	Field	1	Explanation for "Related" Relationship to Primary Lessor is required.	Enter a value.
Explanation for "Related" Relationship to Sub-lessee(s)	Field	1	Explanation for "Related" Relationship to Sub-lessee(s) is required.	Enter a value.
Management Company's Legal Name	Field	1	Management Company's Legal Name is required.	Enter a value.
Phone / EXT	Field	1	Phone is required.	Enter a value.
Relationship to Master Lessee	Field	1	Relationship to Master Lessee is required.	Select a value.
Relationship to Non-Lease Operating Entity	Field	1	Relationship to Non-Lease Operating Entity is required.	Select a value.
Relationship to Owner of Real Estate	Field	1	Relationship to Owner of Real Estate is required.	Select a value.
Relationship to Primary Lessor	Field	1	Relationship to Primary Lessor is required.	Select a value.
Relationship to Sub-lessee(s)	Field	1	Relationship to Sub-lessee(s) is required.	Select a value.
SSN/FEIN	Field	1	SSN/FEIN is required.	Enter a value.
State	Field	1	State is required.	Select a value.

Field	Field Type	Error Code	Error Message	To Correct
Type	Field	1	SSN or FEIN is required.	Select a value.
Zip	Field	1	Zip is required.	Enter a value.

Disclosure of Ownership or Control Interest in the Provider Applicant / ICF – MR

The Disclosure of Ownership or Control Interest in the Provider Applicant panel captures information for persons having an ownership or controlling interest in the entity.

Disclosure of Ownership or Control Interest in the Provider Applicant

Answer Entity Name Last First Related Relationship Address 1 City State

No: _____

delete add Type data below for new record.

INSTRUCTIONS FOR ALL ENTERING OPERATORS (INCLUDING CHOPS): Federal regulations require, as a condition for participation, certification, or recertification, full and complete disclosure as to the identity of each person with an ownership or control interest in the entity who is the provider applicant. For purposes of the Disclosure and Ownership Interest panel, "person" includes corporations, companies, associations, firms, partnerships, societies, and joint stock companies as well as individuals. If the "person" is not an individual, provide a list including the information required in the Disclosure and Ownership Interest panel for each individual with an ownership or control interest in the entity. "Disclosing entity" means the Medicaid provider applicant. "Ownership or control interest" means direct or indirect ownership interest of five percent (5%) or more in the disclosing entity, ownership of a whole or part interest in any mortgage, deed of trust, note or other obligation secured (in whole or in part) by the disclosing entity or any of the property or assets thereof, if that interest is equal to, or exceeds, five percent (5%) of the total value of the property and assets of the disclosing entity. Ownership or control interest also includes an officer, director, partner, etcetera. "Indirect ownership" means an ownership interest in an entity that has an ownership interest in the disclosing entity, including an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. "Subcontractor" means an individual, agency, or organization to which the disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to the residents. Add additional records on this Disclosure of Ownership or Control Interest in the Provider Applicant panel as needed to provide the required full disclosure of ownership or control interest. For any Disclosure of Ownership or Control Interest in the Provider Applicant panel completed for a legal entity other than an individual, complete a Disclosure of Individuals Comprising an Entity panel for each individual with an ownership or control interest in that legal entity. If this is a non-profit entity with no individual or organizational owners, send documentation verifying the entity's non-profit status along with the names and addresses of the board members, managers, etcetera. Send the documentation to the "Long-Term Care Enrollment/CHOP Co-ordinator, Ohio Department of Job & Family Services, Office of Ohio Health Plans, Bureau of Provider Services, Network Management Section, P.O. Box 182709, Columbus, Ohio 43218-2709."

Is provider applicant a non-profit entity with no individual or organizational owners? Yes No

Entity Name _____

OR

Last Name _____

First Name, MI, Suffix _____

Is this person related to any other person with an ownership or control interest in the disclosing entity, or to any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more as a spouse, parent, child or sibling? _____

Relationship _____

Relative Last Name _____

Relative First Name, MI, Suffix _____

Type _____

SSN/FEIN _____

Address 1 _____

Address 2 _____

City _____

State _____

Are you an Officer, Director, or Partner of the disclosing entity? _____

County _____

Zip _____

What is the nature of the ownership interest? _____

Explanation of this interest
Instructions: Detail the specific interest and percentages of interest in each

previous next exit

Tasks for this panel

To enter information for persons having an ownership or controlling interest in the entity:

1. Enter valid values in the **Address 1, City, Zip Code,** and **Explanation of this interest** fields.
2. Select values from the **State, Are you an Officer, Director, or Partner of the disclosing entity?,** and **What is the nature of the ownership interest?** drop down list boxes.
3. Enter values in the **Entity Name** or the **Last Name and First Name, MI, Suffix** fields, if applicable.
4. Select values from the **Is a person related to any other person with an ownership or controlling interest in the enrolling entity, or to any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more, as a spouse, parent, child or sibling?, Relationship, Type,** and **County** drop down list boxes, if applicable.
5. Enter values in the **Relative Last Name, Relative First, Name, MI, Suffix, SSN/FEIN, Address 2,** and **4-digit Zip Code** extension fields, if applicable.

6. Select the **add** button to add another disclosure of ownership or control interest in the provider applicant record.
7. Select the **delete** button to delete a selected disclosure of ownership or control interest in the provider applicant 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 – Disclosure of Ownership or Control Interest in the Provider Applicant – LTC/ICF – MR

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
Question: Does this apply?	Is provider applicant a non-profit entity with no individual or organizational owners?	Check Box	Radio Button	0
Address 1	First line of the address.	Field	Alphanumeric	50
Address 2	Second line of the address.	Field	Alphanumeric	50
Are you an Officer, Director, or Partner of the disclosing entity	Question.	Field	Drop Down List Box	1
City	City on the address.	Field	Alphanumeric	25
County	County on the address.	Field	Alphanumeric	25
Entity Name	The name of the Legal Entity.	Field	Alphanumeric	35
Explanation of this interest	Free form Explanation of this interest.	Field	Alphanumeric	0
First Name, MI, Suffix	The person's first name and optional middle initial and suffix.	Field	Alphanumeric	25
Last Name	The last name of the person.	Field	Alphanumeric	35

Field	Description	Field Type	Data Type	Length
Question 1	What is the nature of the ownership interest?	Field	Drop Down List Box	50
Question 2	Is this person related to any other persons with an ownership or controlling interest in the disclosing entity has direct or indirect ownership of 5% or more as a spouse, parent, child, or sibling?	Field	Drop Down List Box	1
Question 3	Are you an Officer, Director, or Partner of the disclosing entity?	Field	Drop Down List Box	0
Relationship	The relationship involved.	Field	Drop Down List Box	1
Relative First Name, MI, Suffix	The relative's first name and optional middle initial and suffix.	Field	Alphanumeric	25
Relative Last Name	The Last Name of Relative.	Field	Alphanumeric	35
SSN/FEIN	The SSN or FEIN to be entered.	Field	Number	9
State	Dropdown that lists the states.	Field	Drop Down List Box	2
Type	Type of tax ID. Valid value: SSN or FEIN	Field	Drop Down List Box	1
Zip	The 5 digit zip code.	Field	Number	5
Zip+4	The last 4 digits for a zip code.	Field	Number	4

Field Edits – Disclosure of Ownership or Control Interest in the Provider – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Enter a value.
City	Field	1	City is required.	Enter a value.
Entity Name	Field	1	Last Name or Legal Entity name is required.	Enter a value.
Entity Name	Field	2	Only a Last Name or Legal Entity name is allowed.	Remove value from one of the fields.
Explanation of this interest	Field	1	Explanation is required.	Enter a value.
First Name, MI, Suffix	Field	1	First Name is required when a last name is entered.	Enter a value.

Field	Field Type	Error Code	Error Message	To Correct
First Name, MI, Suffix	Field	2	First Name not allowed when Legal Entity name is entered.	Remove value from one of the fields.
Last Name	Field	1	Last Name or Legal Entity name is required.	Enter a value.
Last Name	Field	2	Only a Last Name or Legal Entity name is allowed.	Remove value from one of the fields.
Question 1	Field	1	Question is required.	Enter a value.
Question 2	Field	1	Question is required.	Enter a value.
Relationship	Field	1	Relationship is required.	Enter a value.
Relative First Name, MI, Suffix	Field	1	Relative First Name is required.	Enter a value.
SSN/FEIN	Field	1	SSN/FEIN is required.	Enter a value.
State	Field	1	State is required.	Select a value from the dropdown.
Type	Field	1	SSN or FEIN is required.	Select a value from the dropdown.
Zip	Field	1	Zip is required.	Enter a value.

Disclosure of Subcontractor – Long Term Care/ICF – MR

The Disclosure of Subcontractor panel captures information for providers having an ownership or controlling interest in a subcontractor.

Disclosure of Subcontractor

Assessor Legal Entity Name Last First Related Relationship Address 1 City State

Yes

Type data below for new record.

INSTRUCTIONS FOR ALL ENTERING OPERATORS (INCLUDING CHOP): Federal regulations require, as a condition for participation, certification, or recertification, full and complete disclosure as to the identity of each subcontractor in which the provider applicant has an ownership or control interest. For purposes of this Disclosure of Subcontractor panel, "person" includes corporations, companies, associations, firms, partnerships, societies, and joint stock companies as well as individuals. If the "person" is not an individual, provide a list including the information required in the Disclosure of Subcontractor panel for each individual with an ownership or control interest in the entity. "Subcontractor" means an individual, agency, or organization to which the disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to the residents. "Disclosing entity" means the Medicaid provider applicant. "Ownership or control interest" means direct or indirect ownership interest of five percent (5%) or more in the subcontractor, ownership of a whole or part interest in any mortgage, deed of trust, note or other obligation secured (in whole or in part) by the subcontractor, or any of the property or assets thereof, if that interest is equal to, or exceeds, five percent (5%) of the total value of the property and assets of the subcontractor. Ownership or control interest also includes an officer, director, partner, solicitor. "Indirect ownership" means an ownership interest in an entity that has an ownership interest in the subcontractor, including an ownership interest in any entity that has an indirect ownership interest in the subcontractor. Add additional records on this Disclosure of Subcontractor panel as needed to provide the required full disclosure of each subcontractor in which the provider applicant has an ownership or control interest. For any Disclosure of Subcontractor panel completed for a legal entity other than an individual, complete a Disclosure of Individuals comprising an Entity panel for each individual with an ownership or control interest in that legal entity. If this is a non-profit entity with no individual or organizational owners, send documentation verifying the entity's non-profit status along with the names and addresses of the board members, managers, etcetera. Send the documentation to the "Long-Term Care Enrollment/CHOP Co-ordinator, Ohio Department of Job & Family Services, Office of Ohio Health Plans, Bureau of Provider Services, Network Management Section, P.O. Box 192709, Columbus, Ohio 43219-2709."

*Does this apply? Yes No

Legal Entity Name

OR

Last Name

First Name, MI, Suffix

Is a person related to any other person with an ownership or control interest in the disclosing entity, or to any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more, as a spouse, parent, child or sibling? Yes (No selectables) (If Yes, Full Legal Name of Relative(s) including "Sr.", "Jr.", "III", etc.) & Relationship

Relationship

Relative Last Name

Relative First Name, MI, Suffix

Type

SSN/FEIN

*Address 1

Address 2

*City

*State

*Zip

*Are you an Officer, Director, or Partner of the subcontractor?

If combination of roles or other roles, please provide details

*Explanation of this interest
 Instructions: Detail the specific interest and percentages of interest in each

previous next end

Tasks for this panel

To enter information for providers having an ownership or controlling interest in a subcontractor:

1. Enter valid values in the **Address 1**, **City**, **Zip Code**, and **Explanation** of this interest fields.
2. Select values from the **State**, **Are you an Officer, Director, or Partner of the subcontractor**, and **What is the nature of the ownership interest?** drop down list boxes.
3. If **Combination of Roles** or **Other Entity** is selected from the **Are you an Officer, Director, or Partner of the subcontractor** drop down list box, enter a valid value in the **If combination of roles or other role, please provide details** field.
4. Enter values in the **Entity Name** or the **Last Name** and **First Name, MI, Suffix** fields, if applicable.
5. Select values from the **Is a person related to any other person with an ownership or controlling interest in the enrolling entity, or to any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more, as a spouse, parent, child or sibling**, **Relationship, Type**, and **County** drop down list boxes, if applicable.
6. Enter values in the **Relative Last Name**, **Relative First Name, MI, Suffix, SSN/FEIN, Address 2**, and 4-digit **Zip** extension fields, if applicable.
7. Select the **add** button to add another disclosure of subcontractor record.
8. Select the **delete** button to delete a selected disclosure of subcontractor 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 – Disclosure of Subcontractor – LTC/ICF – MR

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
Does this apply?	Answer "No" and click "next" if the instructions on this panel do not apply.	Check Box	Radio Button	0
Address 1	First line of the address.	Field	Alphanumeric	50
Address 2	Second line of the address.	Field	Alphanumeric	50

Field	Description	Field Type	Data Type	Length
City	City on the address.	Field	Alphanumeric	30
County	County on the address.	Field	Drop Down List Box	0
Explanation of this interest	Free form Explanation of this interest.	Field	Alphanumeric	250
First Name, MI, Suffix	The person's first name and optional middle initial and suffix.	Field	Alphanumeric	25
If combination of roles or other role, please provide details	Free form text describing combination of roles or other role.	Field	Alphanumeric	250
Last Name	The last name of the person.	Field	Alphanumeric	30
Legal Entity Name	The name of the Legal Entity.	Field	Alphanumeric	50
Question 1	What is the nature of the ownership interest?	Field	Drop Down List Box	0
Question 2	Is a person related to any other person with an ownership or control interest in the disclosing entity, or to any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more, as a spouse, parent, child or sibling? (Yes/No selectable) (If Yes, Full Legal Name of Relative(s) (Including "Jr.", "Sr.", "I", "II", etc.) & Relationship)	Field	Drop Down List Box	0
Question 3	Are you an Officer, Director, or Partner of the subcontractor?	Field	Drop Down List Box	0
Relationship	The relationship of the relative to the individual.	Field	Drop Down List Box	0
Relative First Name, MI, Suffix	The relative's first name and optional middle initial and suffix.	Field	Alphanumeric	25
Relative Last Name	The last name of the relative.	Field	Alphanumeric	30
SSN/FEIN	The SSN of the individual or FEIN of the legal entity.	Field	Number	9
State	State on the address.	Field	Drop Down List Box	0
Type	Type of tax ID. Valid value: SSN or FEIN	Field	Drop Down	0

Field	Description	Field Type	Data Type	Length
			List Box	
Zip	The 5-digit zip code.	Field	Number	5
Zip + 4	The last 4 digits for a zip code.	Field	Number	4

Field Edits – Disclosure of Subcontractor – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Does this apply?	Check Box	0	Does this apply? is required.	Select a yes or no answer.
Address 1	Field	0	Address 1 is required.	Enter the Address 1.
City	Field	0	City is required.	Enter a City.
Explanation of this interest	Field	0	Explanation of this interest is required.	Enter the Explanation of this interest.
First Name, MI, Suffix	Field	1	First Name is required	Enter the First Name.
Last Name	Field	1	Legal Entity Name or Last/First Name is required	Enter the Legal Entity Name or Last/First Name.
Legal Entity Name	Field	1	Legal Entity Name or Last/First Name is required	Enter the Legal Entity Name or Last/First Name.
Question 1	Field	0	What is the nature of the ownership interest is required.	Select a value from the dropdown list.
Question 2	Field	1	Is a person related to any other person with an ownership or control interest in the disclosing entity, or to any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more, as a spouse, parent, child or sibling? (Yes/No selectable) (If Yes, Full Legal Name of Relative(s) (Including “Jr.”, “Sr.”, “I”, “II”, etc.) & Relationship) is required.	select the value from dropdown list for question: Is this person related to any other person with an ownership or control interest in the disclosing entity, or to any subcontractor in which the subcontractor has direct or indirect ownership of five percent (5%) or more, as a spouse, parent, child or sibling? (If Yes, Full Legal Name of Relative(s) (Including “Jr.”, “Sr.”, “I”, “II”, etc.) & Relationship)
Question 2	Field	2	Is a person related to any other person with an ownership or control interest in the disclosing entity, or to any subcontractor in	select blank from dropdown list.

Field	Field Type	Error Code	Error Message	To Correct
			which the disclosing entity has direct or indirect ownership of five percent (5%) or more, as a spouse, parent, child or sibling? (Yes/No selectable) (If Yes, Full Legal Name of Relative(s) (Including "Jr.", "Sr.", "I", "II", etc.) & Relationship) should be blank	
Question 3	Field	0	Are you an Officer, Director, or Partner of the subcontractor is required.	Select a value from the dropdown list.
Relationship	Field	1	Relationship is required	Select a value from the dropdown list.
Relationship	Field	2	Relationship should be blank	Select blank value from dropdown list.
Relative First Name, MI, Suffix	Field	1	Relative Last and First Name are required	Enter the Relative Last and First Name.
Relative First Name, MI, Suffix	Field	2	Relative First Name is required	Enter the Relative First Name.
Relative First Name, MI, Suffix	Field	3	Relative Last Name, First Name, MI and Suffix should be blank	Remove values from Relative Last Name, First Name, MI and Suffix.
Relative Last Name	Field	1	Relative Last and First Name are required	Enter the Relative Last and First Name.
Relative Last Name	Field	2	Relative Last Name is required	Enter the Relative Last Name.
Relative Last Name	Field	3	Relative Last Name, First Name, MI and Suffix should be blank	Remove values from Relative Last Name, First Name, MI and Suffix.
State	Field	0	A valid State is required	Select a State from the dropdown list.
Zip	Field	0	Zip is required.	Enter a Zip code.

Disclosure of Individuals Comprising an Entity – Long Term Care/ICF – MR

The Disclosure of Individuals Comprising an Entity panel captures information for individuals having an ownership or controlling interest in the provider entity.

The screenshot shows a web form titled "Disclosure of Individuals Comprising an Entity". At the top, there are fields for "Entity Name", "Last", "First", "Address 1", "City", "State", "Zip", and "Phone". Below these are "delete" and "add" buttons. The main section contains instructions: "Instructions: Complete the Disclosure of Individuals Comprising an Entity panel for any legal entity, other than an individual, listed on the Disclosure of Ownership or Control Interest in the Provider Applicant panel or the Disclosure of Subcontractor panel to provide disclosure of the individuals with an ownership or control interest in the legal entity listed on those panels." The form fields include:

- *Entity Name (text box)
- *Individual Associated to Entity, Last Name (text box)
- *First Name, MI, Suffix (text boxes)
- *Address 1 (text box)
- Address 2 (text box)
- *City (text box)
- County (dropdown menu)
- *State (dropdown menu)
- *Zip (text boxes)
- SSN (text box)
- *Role (dropdown menu)
- Phone (text box)
- Fax (text box)
- E-Mail Address (text box)

 At the bottom, there are "previous", "next", and "exit" buttons.

Tasks for this panel

To enter information for individuals comprising an entity:

1. Enter valid values for the **Entity Name**, **Individual Associated to Entity**, **Last Name**, **First Name**, **MI**, **Suffix**, **Address 1**, **City**, **Zip Code**, and **Role** fields.
2. Select a value from the **State** drop down list box.
3. Enter values in the **Address 2**, 4-digit **Zip Code** extension, **SSN**, **Phone**, **Fax**, and **E-Mail Address** fields, if applicable.
4. Select a value from the **County** drop down list box, if applicable.
5. Select the **add** button to add another disclosure of individuals comprising an entity record.
6. Select the **delete** button to delete a selected disclosure of individuals comprising an entity 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 – Disclosure of Individuals Comprising an Entity – LTC/ICF – MR

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	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
Address 1	The first line of an address.	Field	Alphanumeric	50
Address 2	The second line of an address.	Field	Alphanumeric	50
City	The City for the address.	Field	Alphanumeric	25
County	County for the address.	Field	Drop Down List Box	10
E-Mail Address	The email of the individual.	Field	Alphanumeric	50
Entity Name	Name of the individual having an ownership of controlling interest in the disclosing entity.	Field	Alphanumeric	50
FAX	The FAX number of the individual.	Field	Number	10
First Name, MI, Suffix	The first name (15 characters), MI, and Suffix (4 characters) of the individual.	Field	Alphanumeric	20
Individual Associated to Entity, Last Name	The last name of the individual.	Field	Alphanumeric	25
MI	The middle initial of the individual.	Field	Character	1
Phone	The phone number of the individual.	Field	Number	10
Role	The role of the individual.	Field	Alphanumeric	250
SSN	The individual's SSN.	Field	Number	9
State	A dropdown for the address that lists the states.	Field	Drop Down List Box	2
Suffix	The name suffix of the individual.	Field	Alphanumeric	4
Zip	A 5 digit zip code.	Field	Number	5
Zip+4	The +4 part of the zip code.	Field	Number	4

Field Edits – Disclosure of Individuals Comprising an Entity

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	1	Address 1 is required.	Enter a value.
City	Field	1	City is required.	Enter a value.
Entity Name	Field	1	Entity Name or Individual Associated to Entity, Last Name is required.	Enter a value in one of the fields.
First Name, MI, Suffix	Field	1	First Name is required.	Enter a value.
Individual Associated to Entity, Last Name	Field	1	Entity Name or Individual Associated to Entity, Last Name is required.	Enter a value in one of the fields.
Role	Field	1	Role is required.	Enter a value.
State	Field	7	State is required	Select a state from the dropdown
Zip	Field	8	Zip Code is required	Enter a zip code

Replacement Facility – Long Term Care/ICF – MR

The Replacement Facility panel captures the Long Term Care replacement facility information.

Tasks for this panel

To enter LTC replacement facility information:

1. Select a **Yes** or **No** response to the question **Is the Entering Operator Accepting Assignment of the Exiting Provider's National Provider Identifier Number (NPI)?**.
 - a. If the response is **Yes**, enter valid values in the **Previous Medicaid ID** and **Previous Facility Name** fields.

2. Select a **Yes** or **No** response to the question **Are all sources of replacement beds entered?**
 - a. If the response is **Yes**, enter valid values in the **Number of Licensed Beds to Replacement Facility** and **Number of Certified Beds to Replacement Facility** fields.
3. Select the **add** button to add another replacement facility record.
4. Select the **delete** button to delete a selected replacement facility record.
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 – Replacement Facility – LTC/ICF – MR

Field	Description	Field Type	Data Type	Length
add	Inserts a new replacement facility 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
Are all source of replacement beds entered?	Question regarding entry of replacement bed sources. Valid options: Yes or No.	Field	Radio Button	1
Is the Entering Operator Accepting Assignment of the Exiting	Question regarding the entering operator accepting assignment of the exiting provider's National Provider Identifier (NPI) number. Valid options: Yes or No.	Field	Radio Button	1
Number of Certified Beds to Replacement Facility [Detail]	Number of certified beds in the facility.	Field	Number	9
Number of Licensed Beds to Replacement Facility [Detail]	Number of licensed beds in the facility.	Field	Number	9
Previous Facility	Name of the previous facility.	Field	Character	50

Field	Description	Field Type	Data Type	Length
Name [Detail]				
Previous Medicaid ID [Detail]	Previous Medicaid provider ID number.	Field	Character	15
Accepting Assignment? [List]	Response to the question regarding the entering operator accepting assignment of the exiting provider's National Provider Identifier (NPI) number.	Listview	Character	0
Number of Certified Beds to Replacement Facility [List]	Number of certified beds in the facility.	Listview	Number	9
Number of Licensed Beds to Replacement Facility [List]	Number of licensed beds in the facility.	Listview	Number	9
Previous Facility Name [List]	Name of the previous facility.	Listview	Character	50
Previous Medicaid ID [List]	Previous Medicaid provider ID number.	Listview	Character	15

Field Edits – Replacement Facility – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Is the Entering Operator Accepting Assignment of the Exiting	Field	0	Entering Operator Accepting Assignment is required.	Respond to the question by selecting Yes or No.

Address Information – Long Term Care/ICF – MR

The Address Information panel is used by a provider applicant to provide address information during the enrollment process. 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**, **E-Mail Address**, **Contact Name**, and **Phone 1** fields.
3. Enter values in the **Address 2**, 4-digit **Zip** extension, **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 – LTC/ICF – MR

Field	Description	Field Type	Data Type	Length
add	Inserts a new address 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

Field	Description	Field Type	Data Type	Length
previous	Navigates to the previous panel in the provider enrollment wizard.	Button	N/A	0
Address 1	First line of the address specified by Address Type.	Field	Character	60
Address 2	Second line of the address specified by Address Type.	Field	Character	60
Address Type	Type of address.	Field	Drop Down List Box	0
City	City of the address specified by Address Type.	Field	Character	30
Contact Name	Name of the contact at the specified address.	Field	Character	40
County	County of the address specified by Address Type.	Field	Drop Down List Box	0
E-Mail Address	Email address for the business.	Field	Character	50
Fax 1	First fax number for provider at the specified Address Type.	Field	Number	10
Fax 2	Second fax number for provider at the specified Address Type.	Field	Number	10
Phone 1	First phone number for the provider at the address specified by Address Type.	Field	Number	10
Phone 2	Second phone number for the provider at the address specified by Address Type.	Field	Number	10
Phone Ext 1	First phone extension for the provider (no label on panel).	Field	Number	4
Phone Ext 2	Second phone extension for the provider (no label on panel).	Field	Number	4
Phone Type 1	First phone type (no label on panel).	Field	Drop Down List Box	0
Phone Type 2	Second phone type (no label on panel).	Field	Drop Down List Box	0
State	State of the address specified by Address Type.	Field	Drop Down List Box	0
TDD	Telecommunications Device for the Deaf number of the address specified by Address Type.	Field	Number	10
Zip	Zip code of the address specified by Address Type.	Field	Number	5
Zip + 4	Zip code extension of the	Field	Number	4

Field	Description	Field Type	Data Type	Length
	address specified by Address Type (no label on panel).			
Address 1 (List)	First line of the address specified by Address Type.	Listview	Character	60
Address Type (List)	Type of address.	Listview	Character	20
City (List)	City of the address specified by Address Type.	Listview	Character	30
Phone 1 (List)	First phone number for the provider at the address specified by Address Type.	Listview	Number	10
State (List)	State of the address specified by Address Type.	Listview	Character	2
Zip (List)	Zip code of the address specified by Address Type.	Listview	Number	5

Field Edits – Address Information – LTC/ICF – MR

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 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	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

Operator Address Info – Long Term Care/ICF – MR

The Operator Address Info panel is used by a provider applicant to enter LTC operators' address information during the enrollment process.

Tasks for this panel

To enter **address** information for a Long Term Care operator:

1. Enter valid values in the **Address 1**, **City**, **Zip**, and **Phone 1** fields.
2. Select a value from the **State** drop down list box.
3. Enter values in the **Entity's Legal Name**, **Entity's DBA**, **Address 2**, 4-digit **Zip** extension, **Contact Name**, **Contact First Name**, **Phone 2**, **Fax 1**, **Fax 2**, and **TDD** fields, if applicable.
4. Select values from the **Address Type**, **County**, and **Phone 1** and **Phone 2** phone type drop down list boxes, if applicable.
5. Select the **add** button to add another operator address info record.
6. Select the **delete** button to delete a selected operator address info 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 – Operator Address Info – LTC/ICF – MR

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

Field	Description	Field Type	Data Type	Length
Address 1	First line of the address specified by Address Type.	Field	Alphanumeric	60
Address 2	Second line of the address specified by Address Type.	Field	Alphanumeric	60
Address Type	Type of address.	Field	Drop Down List Box	20
City	City of the address specified by Address Type.	Field	Alphanumeric	30
Contact First Name, MI	First Name and Middle Initial of the contact at the specified address.	Field	Alphanumeric	16
Contact Last Name	Last Name of the contact at the specified address.	Field	Alphanumeric	30
Contact MI	Contact middle initial of the address specified by Address Type.	Field	Alphanumeric	1
County	County of the address specified by Address Type.	Field	Drop Down List Box	10
Entity's DBA	Entity's Doing Business As name.	Field	Alphanumeric	50
Entity's Legal Name	Entity's legal name.	Field	Alphanumeric	50
Fax 1	Fax number 1 of the address specified by Address Type.	Field	Number	10
Fax 2	Fax Number 2 of the address specified by Address Type.	Field	Number	10
Phone 1	Phone number 1 of the address specified by Address Type.	Field	Number	10
Phone 2	Phone number 2 of the address specified by Address Type.	Field	Number	10
Phone Ext 1	Extension for Phone Number 1 of the address specified by Address Type.	Field	N/A	4
Phone Ext 2	Extension for Phone Number 2 of the address specified by Address Type.	Field	Number	4
Phone Type 1	Phone type for Phone Number 1 of the address specified by Address Type.	Field	Alphanumeric	10
Phone Type 2	Phone type for Phone Number 2 of the address specified by Address Type.	Field	Alphanumeric	10
State	State of the address specified by Address Type.	Field	Drop Down List Box	2
TDD	TDD number of the address specified by Address Type.	Field	Number	10
Zip	Zip code of the address specified by	Field	Number	5

Field	Description	Field Type	Data Type	Length
	Address Type.			
Zip + 4	Zip extension number.	Field	Number	4

Field Edits – Operator Address Info – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	0	Address 1 is required.	This field must be entered.
Address Type	Field	1	Address Type is a duplicate.	Enter a different address type
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;
	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.
Phone 1	Field	0	Phone 1 is required.	This field must be completed.
State	Field	0	A valid State is required.	This field must be completed.
Zip	Field	0	Zip is required.	This field must be completed.

Related Entity Address Info – Long Term Care/ICF – MR

The Related Entity Address Info panel is used by a provider applicant to enter LTC related entities' address information during the enrollment process.

Tasks for this panel

To **enter** LTC-related entities' address information:

1. Select a **Yes** or **No** response to the question **Operating Entity is in a Lease?**
2. Enter valid values in the **Address 1**, **City**, **Zip**, and **Phone 1** fields.
3. Select a value from the **State** drop down list box.
4. Enter values in the **Entity's Legal Name**, **Entity's DBA**, **Address 2**, 4-digit **Zip** extension, **Contact Name**, **Contact First Name**, **Phone 2**, **Fax 1**, **Fax 2**, and **TDD** fields, if applicable.
5. Select values from the **Address Type**, **County**, and **Phone 1** and **Phone 2** phone type drop down list boxes, if applicable.
6. Select the **add** button to add another related entity address info record.
7. Select the **delete** button to delete a selected related entity address info 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 – Related Entity Address Info – LTC/ICF – MR

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
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.			
save	Saves the data on the current panel and exits to the Provider Enrollment - Instructions panel.	Button	N/A	0
Address 1	First line of the address specified by Address Type.	Field	Alphanumeric	60
Address 2	Second line of the address specified by Address Type.	Field	Alphanumeric	60
Address Type	Type of address. Values: key="serviceLocation" value="SERVICE LOCATION" key="payTo" value="PAY TO" key="homeOffice" value="HOME OFFICE" key="mailTo" value="MAIL TO" key="physical" value="PHYSICAL LOCATION" key="franchise" value="FRANCHISE FEE"	Field	Drop Down List Box	20
Chop Transaction Type	Change of Operator/Provider transaction type. DDL values: key="1" value="SALE OR TRANSFER OF OWNERSHIP INTEREST" key="2" value="INITIAL LEASE" key="3" value="SUB-LEASE" key="4" value="TERMINATION OR NON-RENEWAL OF LEASE" key="5" value="ASSIGNMENT OF LEASE" key="6" value="CHANGE IN FORM OF LEGAL ORGANIZATION" key="7" value="CHANGE IN COMPOSITION OF PARTNERSHIP OR LLP" key="8" value="DISSOLUTION OF PARTNERSHIP OR LLP" key="9" value="CHANGE IN LIMITED LIABILITY COMPANY (LLC)" key="10" value="DISSOLUTION OF LIMITED LIABILITY COMPANY" key="11" value="CORPORATE MERGER - SURVIVING CORPORATION" key="12" value="CORPORATE CONSOLIDATION - FORMED NEW" key="13" value="CORPORATION DISSOLUTION OF CORPORATION" key="14" value="MULTI-STEP TRANSACTION (SEE EXPLANATION)" key="15" value="OTHER (SEE EXPLANATION)"	Field	Drop Down List Box	2
City	City of the address specified by Address Type.	Field	Alphanumeric	30
Contact First Name,	First Name (15) and optional Middle Initial (1) of the contact at the specified address.	Field	Alphanumeric	16

Field	Description	Field Type	Data Type	Length
MI				
Contact Last Name	Last Name of the contact at the specified address.	Field	Alphanumeric	30
County	County of the address specified by Address Type.	Field	Drop Down List Box	10
Entity's DBA	Entity's Doing Business As name.	Field	Alphanumeric	50
Entity's Legal Name	Entity's legal name.	Field	Alphanumeric	50
Fax 1	Fax number 1 of the specified address.	Field	Number	10
Fax 2	Fax number 2 of the specified address.	Field	Number	10
Lease	Yes/No answer to the question of "Operating Entity is in a Lease?"	Field	Radio Button	1
Phone 1	Phone number 1 (10) , optional extension (4), and phone type (10) at the specified address. Phone Type values: key="personal" value="PERSONAL" key="office" value="OFFICE" key="cell" value="CELL PHONE"	Field	Number	24
Phone 2	Phone number 2 (10) , optional extension (4), and phone type (10) at the specified address. Phone Type values: key="personal" value="PERSONAL" key="office" value="OFFICE" key="cell" value="CELL PHONE"	Field	Number	24
State	State code of the specified address.	Field	Alphanumeric	2
TDD	TDD number for the specified address.	Field	Number	10
Zip	Zip code (5) and optional 4-digit extension (4) at the specified address.	Field	Number	9

Field Edits – Related Entity Address Info – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Address 1	Field	0	Address 1 is required.	This field must be entered.
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;
	Field	1	Field exceeds max length.	Ensure that the entered data does not exceed the maximum

Field	Field Type	Error Code	Error Message	To Correct
				length.
City	Field	0	City is required.	This field must be completed.
Phone 1	Field	0	Phone 1 is required.	This field must be entered.
State	Field	0	A valid State is required.	This field must be completed.
Zip	Field	0	Zip is required.	This field must be completed.

Type and Specialty – Long Term Care/ICF – MR

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 values 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?** checkbox may or may not display.
2. Select the **Primary Specialty?** check box, if applicable.
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.

Primary Taxonomy Code [Close]

Search ? ⬆

Taxonomy Description

search clear

Search Results

*** 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.

Primary Taxonomy Code [Close]

Search ? ⬆

Taxonomy Description

search clear

Search 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

< 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 Code** 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.

Ancillary Taxonomy Code [Close]

Search ? ⬆

Taxonomy Description

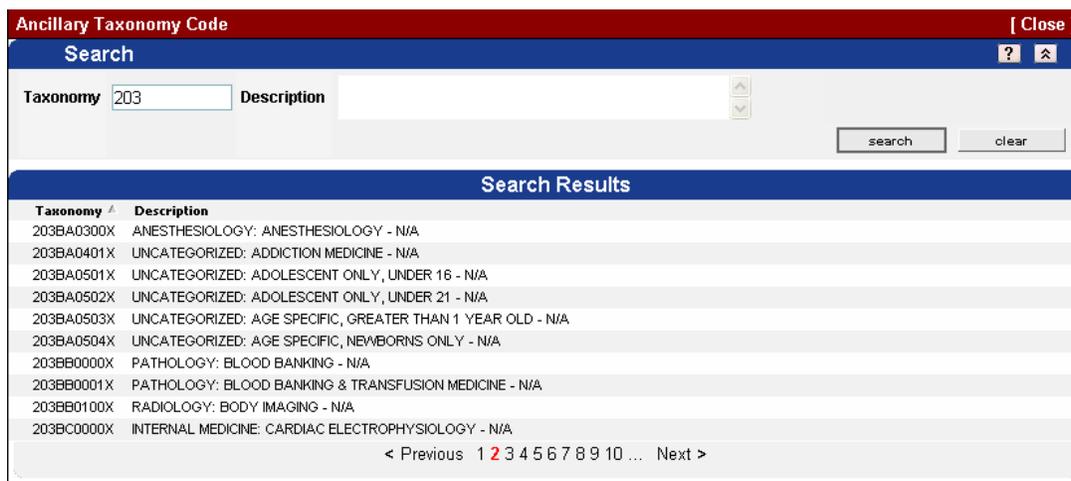
search clear

Search Results

*** No rows found ***

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



- 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 **Ancillary Taxonomy Code** field in the **Type and Specialty** panel.
 - f. 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 – LTC/ICF – MR

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 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	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	provider enrollment wizard.			
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
Taxonomy Code	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
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

Field	Description	Field Type	Data Type	Length
Specialty Desc	Applicant's specialty. Example valid value: 929-Physician Assistant.	Listview	Character	10

Field Edits – Type and Specialty – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
next	Button	0	Our records indicate that an application has already been submitted for the specified name, tax identification number, and provider type.	Ensure that the correct name, tax identification number, and provider type are specified. Check the status of an application on the Enrollment Tracking Search page.
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 entered data does not exceed the maximum length.
Effective Date	Field	0	Effective Date must be less than or equal to End Date.	Ensure that Effective Date is on or before End Date.
Effective Date	Field	1	Effective Date is required.	Enter a date.
End Date	Field	0	Effective Date must be less than or equal to End Date.	Ensure that Effective Date is on or before End Date.
End Date	Field	1	End Date is required.	Enter in a date.
License Expiration Date	Field	0	License Expiration Date is required.	This field must be completed if enrollment type is Individual Practitioner.
License Expiration Date	Field	1	License Issue Date must be less than or equal to License Expiration Date.	Ensure that Issue Date is on or before Expiration Date.
License Issue Date	Field	0	License Issue Date must be less than or equal to License Expiration Date.	Ensure that Issue Date is on or before Expiration Date.
License Issue Date	Field	1	License Issue Date is required.	This field must be completed if enrollment type is Individual Practitioner.

Field	Field Type	Error Code	Error Message	To Correct
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.
Primary Specialty?	Field	1	More than 1 Primary Specialty found.	Ensure that Primary Specialty isn't selected for more than one specialty.
Primary Taxonomy Code	Field	0	The Taxonomy Code entered is not valid.	Enter a valid Taxonomy Code.
Primary Taxonomy Code	Field	1	Taxonomy Code is required.	This field must be completed.
Specialty	Field	0	Specialty is required.	This field must be completed.

Language – Long Term Care/ICF – MR

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 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 – LTC/ICF – MR

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 - 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	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 – LTC/ICF – MR

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.

Group Members – Long Term Care/ICF – MR

The Group Members panel allows a provider applicant to add or update associated group member information during the enrollment process. This panel is read-only for the re-enrollment process.

The screenshot shows a software interface titled "Group Members". At the top, there is a header bar with a question mark icon. Below the header is a table with columns: Member ID, Member Type, Member Name, Effective Date, and End Date. The table is currently empty. Below the table, there is a prompt: "Type data below for new record." followed by two buttons: "delete" and "add". Below these are four input fields: "*Member ID", "Member Name", "*Effective Date", and "*End Date". At the bottom of the panel, there are three buttons: "previous", "next", and "exit".

Tasks for this panel

To **add** or **update** associated group member information:

1. Select the **add** button. The **Group Members** panel redisplay with active fields.
2. Enter values for the **Group ID**, **Effective Date**, and **End Date** fields.
3. Select the **add** button to add another group members record.
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 – Group Members – LTC/ICF – MR

Field	Description	Field Type	Data Type	Length
add	Inserts a new group provider 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
Effective Date [Panel]	Effective date of the group.	Field	Date (MM/DD/CCYY)	8
End Date [Panel]	End date of the group.	Field	Date (MM/DD/CCYY)	8
Member ID [Panel]	Member ID associated with the group.	Field	Number	15
Member Name [Panel] (Read Only)	Name of the member associated with the group.	Field	Character	50
Effective Date [List]	Effective date of the group.	Listview	Date (MM/DD/CCYY)	8
End Date [List]	End date of the group.	Listview	Date (MM/DD/CCYY)	8
Member ID [List]	Member ID associated with the group.	Listview	Character	15
Member Name [List] (Read Only)	Name of the member associated with the group.	Listview	Character	50
Member Type [List] (Read Only)	Type of member ID.	Listview	Character	3

Field Edits – Group Members – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Effective Date [Panel]	Field	0	Effective Date must be less than or equal to	Ensure Effective Date less than or equal to

Field	Field Type	Error Code	Error Message	To Correct
			End Date.	End Date.
	Field	1	Effective Date is required.	Enter a valid Effective Date.
	Field	2	Effective Date must be less than or equal to 12/31/2299.	Enter an Effective Date less than or equal to 12/31/2299.
	Field	3	Effective Date must be greater than or equal to 01/01/1900.	Enter an Effective Date greater than or equal to 01/01/1900.
	Field	4	Effective Date: Invalid date. Format is mm/dd/ccyy.	Enter an Effective Date with the format mm/dd/ccyy.
End Date [Panel]	Field	0	End Date is required.	Enter a valid End Date.
	Field	1	End Date must be less than or equal to 12/31/2299.	Enter an End Date less than or equal to 12/31/2299.
	Field	2	End Date must be greater than or equal to 01/01/1900.	Enter an End Date greater than or equal to 01/01/1900.
	Field	3	End Date: Invalid date. Format is mm/dd/ccyy.	Enter an End Date with the format mm/dd/ccyy.
Member ID [Panel]	Field	0	Member ID is required.	Enter a valid Member ID
	Field	1	Member ID does not exist.	Enter a valid Member ID.
	Field	2	Member ID must be at least 9 characters in length.	Enter a valid Member ID

Previously Participated – Long Term Care/ICF – MR

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

Previously Participated

Answer	Previous Provider ID
Yes	1234567890

Type data below for new record.

delete add

*Have you ever been issued an Ohio Medicaid 7-digit Provider or 10-digit NPI ID? Yes No

*Previous Provider ID

previous next exit



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 – LTC/ICF – MR

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 an 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 practice have previously been issued a Medicaid or Provider ID. 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	Previous provider identification number of the	Listview	Character	10

Field	Description	Field Type	Data Type	Length
ID [List]	applicant.			

Field Edits – Previously Participated – LTC/ICF – MR

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	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.

Convicted or Indicted – Long Term Care/ICF – MR

The Convicted or Indicted panel is used by Facility providers to disclose criminal indictments or convictions resulting from involvement in Medicare or any state health care programs..

Convicted or Indicted ?

Answer Name SSN/FEIN Role Date of Final Action

Type data below for new record.

delete
add

***A. Has any person having ownership or control interest in, or that is an agent or managing employee of, the disclosing entity been convicted, or indicted, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs?** Yes No

Name

Type

SSN/FEIN

Role

Circumstances

Final Action

Date of Final Action

previous
next
exit

Tasks for this panel

To **enter** information on criminal indictments or convictions:

1. Select a **Yes** or **No** response to question **A**.
2. If **No** is selected, select the **next** button to proceed to the next enrollment panel.
3. If **Yes** is selected, enter valid values in the **Name**, **SSN/FEIN**, **Circumstances**, **Final Action**, and **Date of Final Action** fields.
4. Select values from the **Type** and **Role** drop down list boxes.
5. Select the **add** button to add another convicted or indicted record.
6. Select the **delete** button to delete a selected convicted or indicted 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 – Convicted or Indicted – LTC/ICF – MR

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
Question	Acknowledgment of conviction or indictment. Valid values: Yes or No.	Check Box	Radio Button	0
Circumstances [Detail]	Description of circumstances surrounding the conviction or indictment.	Field	Alphanumeric	250
Date of Final Action [Detail]	Date of ruling on the conviction or indictment.	Field	Date (MM/DD/CCYY)	10
Final Action [Detail]	Description of the final disposition related to the conviction or indictment.	Field	Alphanumeric	250
Name [Detail]	Name of the individual associated with the conviction or indictment.	Field	Character	50
Role [Detail]	Role or relationship of the individual to the provider group.	Field	Drop Down List Box	0

Field	Description	Field Type	Data Type	Length
SSN/FEIN [Detail]	Social Security number or Federal Employer Identification number of the individual associated with the conviction or indictment.	Field	Number	9
Type [Detail]	Type of tax ID. Valid values: SSN and FEIN.	Field	Drop Down List Box	0
Answer [List]	Answer to convicted or indicted question.	Listview	Character	0
Date of Final Action [List]	Date of ruling on the conviction or indictment.	Listview	N/A	10
Name [List]	Name of the individual associated with the conviction or indictment.	Listview	Character	50
Role [List]	Role or relationship of the individual to the provider group	Listview	N/A	0
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the individual associated with the conviction or indictment.	Listview	Number	9

Field Edits – Convicted or Indicted – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Question	Check Box	1	YES/NO response to this question is required.	Choose either yes or no for the question response.
	Check Box	2	Cannot have both a YES and a NO answer to this question.	Only have a No or multiple Yes responses
	Check Box	3	Only answer NO to this question once.	Remove all but one NO answer.
Circumstances [Detail]	Field	4	Circumstances is required.	Enter a description of circumstances in the field.
Date of Final Action [Detail]	Field	5	Date of Final Action is required.	Enter a valid Date of Final Action.
Final Action [Detail]	Field	6	Final Action is required.	Enter a final action.
Name [Detail]	Field	7	Name is required.	Enter a name in the field.
Role [Detail]	Field	8	Role is required.	Choose a role from

Field	Field Type	Error Code	Error Message	To Correct
				the drop down list.
SSN/FEIN [Detail]	Field	9	SSN/FEIN is required.	Enter an SSN or FEIN in the field.
Type [Detail]	Field	10	Type is required.	Select either SSN or FEIN from the drop down list box.

Service Abuse Convictions – Long Term Care/ICF – MR

The Provider Enrollment-Service Abuse Convictions panel is used by Facility providers to disclose criminal convictions resulting from the delivery of health care services or the abuse of health care patients.

Tasks for this Panel

To enter information on criminal convictions resulting from delivery of health care services or abuse of health care patients:

1. Select a **Yes** or **No** response to question **B**.
2. Enter valid values in the **Name**, **SSN/FEIN**, **Circumstances**, **Final Action**, and **Date of Final Action** fields.
3. Select values from the **Type** and **Role** drop down list boxes.
4. Select the **add** button to add another service delivery offense record.
5. Select the **delete** button to delete a selected service delivery offense record.
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 Service Abuse Convictions – Long Term Care/ICF – MR

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
Question	Acknowledgment of service/abuse convictions. Valid values: Yes or No.	Check Box	Radio Button	0
Circumstances [Detail]	Description of circumstances surrounding the service/abuse convictions.	Field	Alphanumeric	250
Date of Final Action [Detail]	Date of ruling on the service/abuse convictions.	Field	Date (MM/DD/CCYY)	10
Final Action [Detail]	Description of the final action related to the service/abuse convictions.	Field	Alphanumeric	250
Name [Detail]	Name of the individual associated with the service/abuse convictions.	Field	Alphanumeric	50
Role [Detail]	Role or relationship of the individual to the provider group.	Field	Drop Down List Box	0
SSN/FEIN [Detail]	Social Security number or Federal Employer Identification number of the individual associated with the service/abuse convictions.	Field	Number	9
Type [Detail]	Type of tax ID. Valid values: SSN and FEIN.	Field	Drop Down List Box	0
Answer [List]	Answer to service/abuse convictions question.	Listview	Character	0
Date of Final Action [List]	Date of ruling on the service/abuse convictions.	Listview	N/A	10
Name [List]	Name of the individual associated with the service/abuse convictions.	Listview	Alphanumeric	50
Role [List]	Role or relationship of the individual to the provider group.	Listview	N/A	0

Field	Description	Field Type	Data Type	Length
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the individual associated with the service/abuse convictions.	Listview	Number	9

Field Edits Service Abuse Convictions – Long Term Care/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Question	Check Box	1	YES/NO response to this question is required.	Choose either yes or no for the question response.
Question	Check Box	2	Cannot have both a YES and a NO answer to this question.	Only have a No or multiple Yes responses
Question	Check Box	3	Only answer NO to this question once.	Remove all but one NO answer.
Circumstances [Detail]	Field	4	Circumstances is required.	Enter a description of circumstances in the field.
Date of Final Action [Detail]	Field	5	Date of Final Action is required.	Enter a valid Date of Final Action.
Final Action [Detail]	Field	6	Final Action is required.	Enter a final action.
Name [Detail]	Field	7	Name is required.	Enter a name in the field.
Role [Detail]	Field	8	Role is required.	Choose a role from the drop down list.
SSN/FEIN [Detail]	Field	9	SSN/FEIN is required.	Enter an SSN or FEIN in the field.
Type [Detail]	Field	10	Type is required.	Select either SSN or FEIN from the drop down list box.

Delivery Financial Felonies – Long Term Care/ICF – MR

The Provider Enrollment-Delivery Financial Felonies panel is used by Facility providers to disclose felony criminal convictions (such as fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct offenses) resulting from the delivery of health care services.

Delivery/Financial Felonies - Question D ?

Answer Name SSN/FEIN Role Date of Final Action

Type data below for new record.

delete
add

*D. Has any person having ownership or control interest in, or that is an agent or managing employee of, the disclosing entity been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in question B) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct? Yes No

Name

Type

SSN/FEIN

Role

Circumstances

Final Action

Date of Final Action

previous
next
exit

Tasks for this panel

To **add** information about felony criminal convictions:

1. Select a **Yes** or **No** response to question **D**.
2. Enter valid values in the **Name**, **SSN/FEIN**, **Circumstances**, **Final Action**, and **Date of Final Action** fields.
3. Select values from the **Type** and **Role** drop down list boxes.
4. Select the **add** button to add another delivery/financial felonies record.
5. Select the **delete** button to delete a selected delivery/financial felonies record.
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 – Delivery Financial Felonies – LTC/ICF – MR

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

Field	Description	Field Type	Data Type	Length
previous	Navigates to the previous panel in the Provider Enrollment wizard.	Button	N/A	0
Question	Acknowledgment of financial felonies. Valid values: Yes or No	Check Box	Radio Button	0
Circumstances [Detail]	Description of circumstances surrounding the financial felonies.	Field	Alphanumeric	250
Date of Final Action [Detail]	Date of ruling on the financial felonies.	Field	Date (MM/DD/CCYY)	10
Final Action [Detail]	Description of the final action related to the financial felonies.	Field	Alphanumeric	250
Name [Detail]	Name of the individual associated with the financial felonies.	Field	Alphanumeric	50
Role [Detail]	Role or relationship of the individual to the provider group.	Field	Drop Down List Box	0
SSN/FEIN [Detail]	Social Security number or Federal Employer Identification number of the individual associated with the financial felonies.	Field	Number	9
Type [Detail]	Type of tax ID. Valid values: SSN and FEIN.	Field	Drop Down List Box	0
Answer [List]	Answer to financial felonies question.	Listview	Character	0
Date of Final Action [List]	Date of ruling on the financial felonies.	Listview	N/A	10
Name [List]	Name of the individual associated with the financial felonies.	Listview	Alphanumeric	50
Role [List]	Role or relationship of the individual to the provider group.	Listview	N/A	0
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the individual associated with the financial felonies.	Listview	Number	9

Field Edits – Delivery Financial Felonies – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Question	Check	1	YES/NO response to this	Choose either yes or no for

Field	Field Type	Error Code	Error Message	To Correct
	Box		question is required.	the question response.
Question	Check Box	2	Cannot have both a YES and a NO answer to this question.	Only have a No or multiple Yes responses
Question	Check Box	3	Only answer NO to this question once.	Remove all but one NO answer.
Circumstances [Detail]	Field	4	Circumstances is required.	Enter a description of circumstances in the field.
Date of Final Action [Detail]	Field	5	Date of Final Action is required.	Enter a valid Date of Final Action.
Final Action [Detail]	Field	6	Final Action is required.	Enter a final action.
Name [Detail]	Field	7	Name is required.	Enter a name in the field.
Role [Detail]	Field	8	Role is required.	Choose a role from the drop down list.
SSN/FEIN [Detail]	Field	9	SSN/FEIN is required.	Enter an SSN or FEIN in the field.
Type [Detail]	Field	10	Type is required.	Select either SSN or FEIN from the drop down list box.

Felony Controlled Substance – Long Term Care/ICF – MR

The Felony Controlled Substance panel is used by Facility providers to disclose felony criminal convictions related to controlled substances.

Felony Controlled Substance ?

Answer Name SSN/FEIN Role Date of Final Action

Type data below for new record.

delete add

*E. Has any person having ownership or control interest in, or that is an agent or managing employee of, the disclosing entity been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? Yes No

Name

Type

SSN/FEIN

Role

Circumstances

Final Action

Date of Final Action

previous next exit

Tasks for this panel

To **enter** information on felony criminal convictions related to controlled substances:

1. Select a **Yes** or **No** response to question **E**.
2. Enter valid values in the **Name**, **SSN/FEIN**, **Circumstances**, **Final Action**, and **Date of Final Action** fields.
3. Select values from the **Type** and **Role** drop down list boxes.
4. Select the **add** button to add another felony controlled substance record.
5. Select the **delete** button to delete a selected felony controlled substance record.
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 – Felony Controlled Substance – LTC/ICF – MR

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
Question	Acknowledgment of felony controlled substance. Valid values: Yes or No.	Check Box	Radio Button	0
Circumstances [Detail]	Description of circumstances surrounding the felony controlled substance.	Field	Alphanumeric	250
Date of Final Action [Detail]	Date of ruling on the felony controlled substance.	Field	Date (MM/DD/CCYY)	10
Final Action [Detail]	Description of the final action related to the felony controlled substance.	Field	Alphanumeric	250
Name [Detail]	Name of the individual associated with the felony controlled substance.	Field	Character	50
Role [Detail]	Role or relationship of the individual to the provider group.	Field	Drop Down List Box	0
SSN/FEIN	Social Security number or Federal	Field	Number	9

Field	Description	Field Type	Data Type	Length
[Detail]	Employer Identification number of the individual associated with the felony controlled substance.			
Type [Detail]	Type of tax ID. Valid values: SSN and FEIN.	Field	Drop Down List Box	0
Answer [List]	Answer to felony controlled substance question.	Listview	Character	0
Date of Final Action [List]	Date of ruling on the felony controlled substance.	Listview	N/A	10
Name [List]	Name of the individual associated with the felony controlled substance.	Listview	Character	50
Role [List]	Role or relationship of the individual to the provider group.	Listview	N/A	0
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the individual associated with the felony controlled substance.	Listview	Number	9

Field Edits – Felony Controlled Substance – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Question	Check Box	1	YES/NO response to this question is required.	Choose either yes or no for the question response.
	Check Box	2	Cannot have both a YES and a NO answer to this question.	Only have a No or multiple Yes responses
	Check Box	3	Only answer NO to this question once.	Remove all but one NO answer.
Circumstances [Detail]	Field	4	Circumstances is required.	Enter a description of circumstances in the field.
Date of Final Action [Detail]	Field	5	Date of Final Action is required.	Enter a valid Date of Final Action.
Final Action [Detail]	Field	6	Final Action is required.	Enter a final action.
Name [Detail]	Field	7	Name is required.	Enter a name in the field.
Role [Detail]	Field	8	Role is required.	Choose a role from the drop down list.
SSN/FEIN [Detail]	Field	9	SSN/FEIN is	Enter an SSN or

Field	Field Type	Error Code	Error Message	To Correct
			required.	FEIN in the field.
Type [Detail]	Field	10	Type is required.	Select either SSN or FEIN from the drop down list box.

Financial Misdemeanor – Long Term Care/ICF – MR

The Financial Misdemeanor panel is used by Facility providers to disclose misdemeanor criminal convictions (such as fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct offenses) resulting from the delivery of health care services..

Tasks for this panel

To **enter** information about misdemeanor criminal convictions:

1. Select a **Yes** or **No** response to question **F**.
2. Enter valid values in the **Name**, **SSN/FEIN**, **Circumstances**, **Final Action**, and **Date of Final Action** fields.
3. Select values from the **Type** and **Role** drop down list boxes.
4. Select the **add** button to add another financial misdemeanor record.
5. Select the **delete** button to delete a selected financial misdemeanor record.
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 – Financial Misdemeanor – LTC/ICF – MR

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
Question	Acknowledgment of felony controlled substance. Valid values: Yes or No.	Check Box	Radio Button	0
Circumstances [Detail]	Description of circumstances surrounding the felony controlled substance.	Field	Alphanumeric	250
Date of Final Action [Detail]	Date of ruling on the felony controlled substance.	Field	Date (MM/DD/CCYY)	10
Final Action [Detail]	Description of the final action related to the felony controlled substance.	Field	Alphanumeric	250
Name [Detail]	Name of the individual associated with the felony controlled substance.	Field	Character	50
Role [Detail]	Role or relationship of the individual to the provider group.	Field	Drop Down List Box	0
SSN/FEIN [Detail]	Social Security number or Federal Employer Identification number of the individual associated with the felony controlled substance.	Field	Number	9
Type [Detail]	Type of tax ID. Valid values: SSN and FEIN.	Field	Drop Down List Box	0
Answer [List]	Answer to felony controlled substance question.	Listview	Character	0
Date of Final Action [List]	Date of ruling on the felony controlled substance.	Listview	N/A	10
Name [List]	Name of the individual associated with the felony controlled substance.	Listview	Character	50

Field	Description	Field Type	Data Type	Length
Role [List]	Role or relationship of the individual to the provider group.	Listview	N/A	0
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the individual associated with the felony controlled substance.	Listview	Number	9

Field Edits – Financial Misdemeanor – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Question	Check Box	1	YES/NO response to this question is required.	Choose either yes or no for the question response.
	Check Box	2	Cannot have both a YES and a NO answer to this question.	Only have a No or multiple Yes responses
	Check Box	3	Only answer NO to this question once.	Remove all but one NO answer.
Circumstances [Detail]	Field	4	Circumstances is required.	Enter a description of circumstances in the field.
Date of Final Action [Detail]	Field	5	Date of Final Action is required.	Enter a valid Date of Final Action.
Final Action [Detail]	Field	6	Final Action is required.	Enter a final action.
Name [Detail]	Field	7	Name is required.	Enter a name in the field.
Role [Detail]	Field	8	Role is required.	Choose a role from the drop down list.
SSN/FEIN [Detail]	Field	9	SSN/FEIN is required.	Enter an SSN or FEIN in the field.
Type [Detail]	Field	10	Type is required.	Select either SSN or FEIN from the drop down list box.

Obstruction of Investigation – Long Term Care/ICF – MR

The Obstruction of Investigation panel is used by Facility providers to disclose criminal convictions resulting from the obstruction of investigations into possible criminal offenses.

Tasks for this panel

To **enter** information on obstruction of investigation into possible criminal offenses:

1. Select a **Yes** or **No** response to question **G**.
2. Enter valid values in the **Name**, **SSN/FEIN**, **Circumstances**, **Final Action**, and **Date of Final Action** fields.
3. Select values from the **Type** and **Role** drop down list boxes.
4. Select the **add** button to add another obstruction of investigation record.
5. Select the **delete** button to delete a selected obstruction of investigation record.
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 – Obstruction of Investigation – LTC/ICF – MR

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
Question	Acknowledgment of felony controlled substance. Valid values: Yes or No.	Check Box	Radio Button	0

Field	Description	Field Type	Data Type	Length
Circumstances [Detail]	Description of circumstances surrounding the felony controlled substance.	Field	Alphanumeric	250
Date of Final Action [Detail]	Date of ruling on the felony controlled substance.	Field	Date (MM/DD/CCYY)	10
Final Action [Detail]	Description of the final action related to the felony controlled substance.	Field	Alphanumeric	250
Name [Detail]	Name of the individual associated with the felony controlled substance.	Field	Character	50
Role [Detail]	Role or relationship of the individual to the provider group.	Field	Drop Down List Box	0
SSN/FEIN [Detail]	Social Security number or Federal Employer Identification number of the individual associated with the felony controlled substance.	Field	Number	9
Type [Detail]	Type of tax ID. Valid values: SSN and FEIN.	Field	Drop Down List Box	0
Answer [List]	Answer to felony controlled substance question.	Listview	Character	0
Date of Final Action [List]	Date of ruling on the felony controlled substance.	Listview	N/A	10
Name [List]	Name of the individual associated with the felony controlled substance.	Listview	Character	50
Role [List]	Role or relationship of the individual to the provider group.	Listview	N/A	0
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the individual associated with the felony controlled substance.	Listview	Number	9

Field Edits – Obstruction of Investigation – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Question	Check Box	1	YES/NO response to this question is required.	Choose either yes or no for the question response.
	Check Box	2	Cannot have both a YES and a NO answer to this question.	Only have a No or multiple Yes responses

Field	Field Type	Error Code	Error Message	To Correct
	Check Box	3	Only answer NO to this question once.	Remove all but one NO answer.
Circumstances [Detail]	Field	4	Circumstances is required.	Enter a description of circumstances in the field.
Date of Final Action [Detail]	Field	5	Date of Final Action is required.	Enter a valid Date of Final Action.
Final Action [Detail]	Field	6	Final Action is required.	Enter a final action.
Name [Detail]	Field	7	Name is required.	Enter a name in the field.
Role [Detail]	Field	8	Role is required.	Choose a role from the drop down list.
SSN/FEIN [Detail]	Field	9	SSN/FEIN is required.	Enter an SSN or FEIN in the field.
Type [Detail]	Field	10	Type is required.	Select either SSN or FEIN from the drop down list box.

Misdemeanor Controlled Substance – Long Term Care/ICF – MR

The Misdemeanor Controlled Substance panel is used by Facility providers to disclose misdemeanor criminal convictions related to controlled substances.

Tasks for this panel

To **enter** information for misdemeanor criminal convictions related to controlled substances:

1. Select a **Yes** or **No** response to question **H**.
2. Enter valid values in the **Name**, **SSN/FEIN**, **Circumstances**, **Final Action**, and **Date of Final Action** fields.

3. Select values from the **Type** and **Role** drop down list boxes.
4. Select the **add** button to add another misdemeanor controlled substance record.
5. Select the **delete** button to delete a selected misdemeanor controlled substance record.
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 – Misdemeanor Controlled Substance – LTC/ICF – MR

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
Question	Acknowledgment of felony controlled substance. Valid values: Yes or No.	Check Box	Radio Button	0
Circumstances [Detail]	Description of circumstances surrounding the felony controlled substance.	Field	Alphanumeric	250
Date of Final Action [Detail]	Date of ruling on the felony controlled substance.	Field	Date (MM/DD/CCYY)	10
Final Action [Detail]	Description of the final action related to the felony controlled substance.	Field	Alphanumeric	250
Name [Detail]	Name of the individual associated with the felony controlled substance.	Field	Character	50
Role [Detail]	Role or relationship of the individual to the provider group.	Field	Drop Down List Box	0
SSN/FEIN [Detail]	Social Security number or Federal Employer Identification number of the individual associated with the felony controlled substance.	Field	Number	9
Type [Detail]	Type of tax ID. Valid values: SSN and FEIN.	Field	Drop Down List Box	0
Answer [List]	Answer to felony controlled	Listview	Character	0

Field	Description	Field Type	Data Type	Length
	substance question.			
Date of Final Action [List]	Date of ruling on the felony controlled substance.	Listview	N/A	10
Name [List]	Name of the individual associated with the felony controlled substance.	Listview	Character	50
Role [List]	Role or relationship of the individual to the provider group.	Listview	N/A	0
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the individual associated with the felony controlled substance.	Listview	Number	9

Field Edits – Misdemeanor Controlled Substance – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Question	Check Box	1	YES/NO response to this question is required.	Choose either yes or no for the question response.
	Check Box	2	Cannot have both a YES and a NO answer to this question.	Only have a No or multiple Yes responses
	Check Box	3	Only answer NO to this question once.	Remove all but one NO answer.
Circumstances [Detail]	Field	4	Circumstances is required.	Enter a description of circumstances in the field.
Date of Final Action [Detail]	Field	5	Date of Final Action is required.	Enter a valid Date of Final Action.
Final Action [Detail]	Field	6	Final Action is required.	Enter a final action.
Name [Detail]	Field	7	Name is required.	Enter a name in the field.
Role [Detail]	Field	8	Role is required.	Choose a role from the drop down list.
SSN/FEIN [Detail]	Field	9	SSN/FEIN is required.	Enter an SSN or FEIN in the field.
Type [Detail]	Field	10	Type is required.	Select either SSN or FEIN from the drop down list box.

Civil Monetary Penalties – Long Term Care/ICF – MR

The Civil Monetary Penalties panel is used by Facility providers to disclose monetary penalties imposed as a result of civil judgments under Section 1128A of the Social Security Act.

Tasks for this panel

To **disclose** monetary penalties imposed as a result of civil judgments:

1. Select a **Yes** or **No** response to question I.
2. If **No** is selected, select the **next** button to proceed to the next enrollment panel.
3. If **Yes** is selected, enter valid values in the **Name**, **SSN/FEIN**, **Circumstances**, **Final Action**, and **Date of Final Action** fields.
4. Select values from the **Type** and **Role** drop down list boxes.
5. Select the **add** button to add another civil monetary penalties record.
6. Select the **delete** button to delete a selected civil monetary penalties 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 – Civil Monetary Penalties – LTC/ICF – MR

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

Field	Description	Field Type	Data Type	Length
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
Question	Acknowledgment of felony controlled substance. Valid values: Yes or No.	Check Box	Radio Button	0
Circumstances [Detail]	Description of circumstances surrounding the felony controlled substance.	Field	Alphanumeric	250
Date of Final Action [Detail]	Date of ruling on the felony controlled substance.	Field	Date (MM/DD/CCYY)	10
Final Action [Detail]	Description of the final action related to the felony controlled substance.	Field	Alphanumeric	250
Name [Detail]	Name of the individual associated with the felony controlled substance.	Field	Character	50
Role [Detail]	Role or relationship of the individual to the provider group.	Field	Drop Down List Box	0
SSN/FEIN [Detail]	Social Security number or Federal Employer Identification number of the individual associated with the felony controlled substance.	Field	Number	9
Type [Detail]	Type of tax ID. Valid values: SSN and FEIN.	Field	Drop Down List Box	0
Answer [List]	Answer to felony controlled substance question.	Listview	Character	0
Date of Final Action [List]	Date of ruling on the felony controlled substance.	Listview	N/A	10
Name [List]	Name of the individual associated with the felony controlled substance.	Listview	Character	50
Role [List]	Role or relationship of the individual to the provider group.	Listview	N/A	0
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the individual associated with the felony controlled substance.	Listview	Number	9

Field Edits – Civil Monetary Penalties – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Question	Check Box	1	YES/NO response to this question is required.	Choose either yes or no for the question response.
	Check Box	2	Cannot have both a YES and a NO answer to this question.	Only have a No or multiple Yes responses
	Check Box	3	Only answer NO to this question once.	Remove all but one NO answer.
Circumstances [Detail]	Field	4	Circumstances is required.	Enter a description of circumstances in the field.
Date of Final Action [Detail]	Field	5	Date of Final Action is required.	Enter a valid Date of Final Action.
Final Action [Detail]	Field	6	Final Action is required.	Enter a final action.
Name [Detail]	Field	7	Name is required.	Enter a name in the field.
Role [Detail]	Field	8	Role is required.	Choose a role from the drop down list.
SSN/FEIN [Detail]	Field	9	SSN/FEIN is required.	Enter an SSN or FEIN in the field.
Type [Detail]	Field	10	Type is required.	Select either SSN or FEIN from the drop down list box.

Exclusions – Long Term Care/ICF – MR

The Exclusions panel is used by Facility providers to disclose exclusions from Medicare or any state health care programs.

Tasks for this panel

To **enter** information on exclusions from Medicare or any state health care programs:

1. Select a **Yes** or **No** response to question **J**.
2. Enter valid values in the **Name**, **SSN/FEIN**, **Circumstances**, **Final Action**, and **Date of Final Action** fields.
3. Select values from the **Type** and **Role** drop down list boxes.
4. Select the **add** button to add another exclusions record.
5. Select the **delete** button to delete a selected exclusions record.
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 – Exclusions – LTC/ICF – MR

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

Field	Description	Field Type	Data Type	Length
Question	Acknowledgment of felony controlled substance. Valid values: Yes or No.	Check Box	Radio Button	0
Circumstances [Detail]	Description of circumstances surrounding the felony controlled substance.	Field	Alphanumeric	250
Date of Final Action [Detail]	Date of ruling on the felony controlled substance.	Field	Date (MM/DD/CCYY)	10
Final Action [Detail]	Description of the final action related to the felony controlled substance.	Field	Alphanumeric	250
Name [Detail]	Name of the individual associated with the felony controlled substance.	Field	Character	50
Role [Detail]	Role or relationship of the individual to the provider group.	Field	Drop Down List Box	0
SSN/FEIN [Detail]	Social Security number or Federal Employer Identification number of the individual associated with the felony controlled substance.	Field	Number	9
Type [Detail]	Type of tax ID. Valid values: SSN and FEIN.	Field	Drop Down List Box	0
Answer [List]	Answer to felony controlled substance question.	Listview	Character	0
Date of Final Action [List]	Date of ruling on the felony controlled substance.	Listview	N/A	10
Name [List]	Name of the individual associated with the felony controlled substance.	Listview	Character	50
Role [List]	Role or relationship of the individual to the provider group.	Listview	N/A	0
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the individual associated with the felony controlled substance.	Listview	Number	9

Field Edits – Exclusions – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Question	Check Box	1	YES/NO response to this question is required.	Choose either yes or no for the question response.
	Check	2	Cannot have both a	Only have a No or

Field	Field Type	Error Code	Error Message	To Correct
	Box		YES and a NO answer to this question.	multiple Yes responses
	Check Box	3	Only answer NO to this question once.	Remove all but one NO answer.
Circumstances [Detail]	Field	4	Circumstances is required.	Enter a description of circumstances in the field.
Date of Final Action [Detail]	Field	5	Date of Final Action is required.	Enter a valid Date of Final Action.
Final Action [Detail]	Field	6	Final Action is required.	Enter a final action.
Name [Detail]	Field	7	Name is required.	Enter a name in the field.
Role [Detail]	Field	8	Role is required.	Choose a role from the drop down list.
SSN/FEIN [Detail]	Field	9	SSN/FEIN is required.	Enter an SSN or FEIN in the field.
Type [Detail]	Field	10	Type is required.	Select either SSN or FEIN from the drop down list box.

Family or Household – Long Term Care/ICF – MR

[Reviewer Note: Content to be determined in a future submission.]

Decertification – Long Term Care/ICF – MR

The Decertification panel captures the decertification or termination information for Long Term Care providers.

Decertified, Terminated, Suspended, or Excluded

Answer I	Answer II	Name	SSN/FEIN	Role	Date of Final Action
No	No				

Type data below for new record.

*L. Has the facility been decertified by the Ohio Department of Health (ODH) and/or the United States Department of Health and Human Services, or has the provider applicant been terminated, suspended or excluded by the Medicare program and/or by the United States Centers for Medicare and Medicaid Services (CMS)? Yes No

*Additionally, has the provider applicant had any license, permit, or certificate that is required by ODJFS or the terms of a provider agreement denied, suspended, revoked, or not renewed? Yes No

Name

Type

SSN/FEIN

Role

Circumstances

Final Action

Date of Final Action

Tasks for this panel

To **add** decertification or termination information for Long Term Care providers:

1. Select a **Yes** or **No** response to question **L**.
2. Enter valid values in the **Name**, **SSN/FEIN**, **Circumstances**, **Final Action**, and **Date of Final Action** fields.
3. Select values from the Type and Role drop down list boxes.
4. Select the **add** button to add another decertification record.
5. Select the **delete** button to delete a selected decertification record.
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 – Decertification – LTC/ICF – MR

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
Question	Acknowledgment of felony controlled substance. Valid values: Yes or No.	Check Box	Radio Button	0
Circumstances [Detail]	Description of circumstances surrounding the felony controlled substance.	Field	Alphanumeric	250
Date of Final Action [Detail]	Date of ruling on the felony controlled substance.	Field	Date (MM/DD/CCYY)	10
Final Action [Detail]	Description of the final action related to the felony controlled substance.	Field	Alphanumeric	250
Name [Detail]	Name of the individual associated with the felony controlled substance.	Field	Character	50
Role [Detail]	Role or relationship of the individual to the provider group.	Field	Drop Down List Box	0
SSN/FEIN	Social Security number or Federal	Field	Number	9

Field	Description	Field Type	Data Type	Length
[Detail]	Employer Identification number of the individual associated with the felony controlled substance.			
Type [Detail]	Type of tax ID. Valid values: SSN and FEIN.	Field	Drop Down List Box	0
Answer [List]	Answer to felony controlled substance question.	Listview	Character	0
Date of Final Action [List]	Date of ruling on the felony controlled substance.	Listview	N/A	10
Name [List]	Name of the individual associated with the felony controlled substance.	Listview	Character	50
Role [List]	Role or relationship of the individual to the provider group.	Listview	N/A	0
SSN/FEIN [List]	Social Security number or Federal Employer Identification number of the individual associated with the felony controlled substance.	Listview	Number	9

Field Edits – Decertification – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
Question	Check Box	1	YES/NO response to this question is required.	Choose either yes or no for the question response.
	Check Box	2	Cannot have both a YES and a NO answer to this question.	Only have a No or multiple Yes responses
	Check Box	3	Only answer NO to this question once.	Remove all but one NO answer.
Circumstances [Detail]	Field	4	Circumstances is required.	Enter a description of circumstances in the field.
Date of Final Action [Detail]	Field	5	Date of Final Action is required.	Enter a valid Date of Final Action.
Final Action [Detail]	Field	6	Final Action is required.	Enter a final action.
Name [Detail]	Field	7	Name is required.	Enter a name in the field.
Role [Detail]	Field	8	Role is required.	Choose a role from the drop down list.
SSN/FEIN [Detail]	Field	9	SSN/FEIN is	Enter an SSN or

Field	Field Type	Error Code	Error Message	To Correct
			required.	FEIN in the field.
Type [Detail]	Field	10	Type is required.	Select either SSN or FEIN from the drop down list box.

Civil Action – Long Term Care/ICF – MR

[Reviewer Note: Content to be determined in a future submission.]

Owners of Other Medicare/Medicaid Facilities – LTC/ICF – MR

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 becomes active.
4. Enter valid values in the **Name, Medicaid Provider Number, Vendor Number, 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 – LTC/ICF – MR

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?	Indicates if any organization owners are owners of other Medicaid	Field	Radio Button	0

Field	Description	Field Type	Data Type	Length
(Example, sole proprietor, partnership, or members of the Board of Directors.)	and/or Medicare facilities. Valid values: Yes or No.			
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 – LTC/ICF – MR

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	0	Invalid number / Invalid date / Invalid character data / Invalid	Ensure that the field matches the data type as documented in the field descriptions above. Number fields must only

Field	Field Type	Error Code	Error Message	To Correct
			alphanumeric data	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 [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.

Field	Field Type	Error Code	Error Message	To Correct
State [Detail]	Field	0	A valid State is required.	Select a valid State value.
Street Address [Detail]	Field	0	Street Address is required.	Enter a street address.
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.

Certification – LTC/ICF – MR

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**

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**
 First, MI

Click this printable [Enrollment Checklist](#) link to ensure a complete provider enrollment request.

Legal Provider Primary Practice Address:

***Address 1**
Address 2
***City**
***State**
***Zip**

E-Mail Address ***Type**

***SSN/Tax Identification Number**

***Preferred Contact Method**

All Providers must read the statements below and agree to the terms

Executive Order 2007-01S Agreement

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.

do not accept the terms and conditions
 accept the terms and conditions

A copy of the Executive Order can be found on our website at <http://jfs.ohio.gov/ohp>

False Statement Agreement

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.

do not accept the terms and conditions
 accept the terms and conditions

Ohio Medicaid Provider Agreement

11. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in 42 CFR 489, Subpart I and 42 CFR 417.436(d). This provider agreement may be canceled by either party upon 30 days written notice prior to termination date. I further certify that I am the individual practitioner who is applying for the provider number, or in the case of a business organization, I am the officer, chief executive officer, or general partner of the business organization that 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.

do not accept the terms and conditions
 accept the terms and conditions

Agreement Date

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 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 7 years from the effective date.

***Type Full Name Here**

previous
next
exit

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 – LTC/ICF – MR

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	Employer ID number of applicant. (This field to be determined.)	Field	Number	9

Field	Description	Field Type	Data Type	Length
Number				
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 service has not been billed to Medicaid in the last 12 months. This checkbox is not visible during the re-enrollment process.	Field	Check Box	0

Field	Description	Field Type	Data Type	Length
SSN/Tax Identification Number	SSN/Tax Identification Number of the applicant.	Field	Number	9
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	Type of SSN/Tax ID. Valid values are: SSN and Tax Identification Number.	Field	Drop Down List Box	0
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 – LTC/ICF – MR

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 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	1	Field exceeds max	Ensure that the entered

Field	Field Type	Error Code	Error Message	To Correct
			length.	data does not 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 – LTC/ICF – MR

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 – LTC/ICF – MR

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 – LTC/ICF – MR

None

Confirmation of Receipt – LTC/ICF – MR

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 – LTC/ICF – MR

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 – LTC/ICF – MR

None.

Attachment Uploads – LTC/ICF – MR

The Attachments Uploads 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"/> 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.

3. Click the **upload attachment** button.

Field Descriptions – Attachment Uploads – LTC/ICF – MR

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 Uploads – LTC/ICF – MR

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 – LTC/ICF – MR

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.



EDMS COVER SHEET

Fax Information:

Name: _____ Date: 4/21/2010 No. of Pages: _____ (Including this cover sheet)
 Phone: _____ 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.

Document Type:

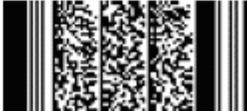
Provider
 Recipient
 Correspondence
 Prior authorization
 Supporting documents for claim
 Accounts receivable
 Payment deduction
 Expenditure
 Hospital cost settlement
 LTC cost settlement
 Declaration of election of hospice benefit
 Attending physician written certification
 Revocation of hospice benefit
 Statement of termination of hospice benefit
 Selection of a different hospice provider
 IDG written certification
 Programs
 RetroDUR patient profile
 RetroDUR survey
 RetroDUR reports
 RetroDUR other documents

Sub Categories for Prior Authorization Documents

Compression Garments
 Decubitus Care Equipment
 Dental
 Dressings, Surgical
 Enteral Nutrition & Supplies
 EPSDT
 Hospital Beds
 Hospital Inpatient
 Hospital Outpatient
 Hearing Aids
 Incontinence Supplies
 Increased State Plan Home Health
 Misc Equipment
 Orthodontics
 Orthotics (MTA)
 Orthotics/Prosthetics (Nurses)
 PDN
 Repairs
 Respiratory (MTA)
 Respiratory (Nurses)
 Supplies (Misc)
 Speech Generating Devices
 Transportation
 Therapies
 Vision
 Wheelchairs
 Others

Index Field & Values (if applicable):

Application Tracking Number: _____ Recipient ID: _____ Prior Authorization Number: _____
 NPI: _____ Medicaid Provider ID: _____ Use only if you do not have NPI.
 ICN: _____ Contact Tracking Number: _____
 Financial Record Number: _____ Status: _____ Program Control Number: _____
 Hospice Enrollment ID: _____ Hospice Attachment ID: _____ Intervention ID: _____



Confidentiality Notice:

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.

JFS 00000 (Rev. 02/23/2010) Ohio Department of Job and Family Services



Tasks for this panel

To **add** Mail hard-copy attachments:

1. Press the **add** button.
2. The required fields for entering information display in the **Hard-Copy Attachments** panel.
3. Enter the Control Number. Select **Mail** for the **Transmission** value. Select a **Report Type** to describe the general content of the attachment.
4. Determine if additional attachments should accompany the claim.
5. If no additional hard-copy mail attachments are to accompany the claim, information entered for this panel is complete.
6. If no additional attachments will accompany the claim, it ready to submit.

To **add** an additional electronic attachment:

1. Press the **add** button.
2. The required fields for entering information display in the **Hard-Copy Attachments** panel.
3. Enter the **Control Number**. Select **Electronic Upload** for the **Transmission** value. Select a **Report Type** to describe the general content of the attachment.
4. Determine that no additional attachments should accompany the claim.
5. If no additional electronic attachments should accompany the claim, the claim is ready to submit.

To **delete** the current attachment information:

1. On a new claim or an adjudicated claim, select the detail row for deletion and press the **delete** button.
2. The message displays: **Are you sure this is the row you want marked for deletion?** Press **OK** to delete the row of Hard-Copy Attachment information entered in the panel.
3. Enter new attachment information, if desired.

Field Descriptions – Attachment Cover – LTC/ICF – MR

Field	Description	Field Type	Data Type	Length
Claim ICN	The claim's internal control number.	Label	Number	13
Control Number	Control number assigned to the attachment for identification purposes.	Label	Number	80
Date of Service	Date of first service on the claim.	Label	Date (MM/DD/CCYY)	10
Medicaid ID	The recipient's Medicaid identification number.	Label	Alphanumeric	12
Patient Account #	The patient's account number on the Provider's system.	Label	Alphanumeric	38

Field	Description	Field Type	Data Type	Length
Provider ID	Identification number and service location of the provider.	Label	Alphanumeric	15

Field Edits – Attachment Cover – LTC/ICF – MR

None.

This is the end of the LTC / ICF-MR enrollment process.

What 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*.