VIVA HEALTH, INC.

417 20th Street North | Ste 1100
Birmingham, AL 35203

ANCILLARY & FACILITY APPLICATION

Please complete all applicable sections of the application

GENERAL INFORMATION		**Type of facility:**	
Legal or Corporate Name of Company		Telephone Number	Fax Number
Corporate Address	City	State	ZIP
Company Contact Name/Title	Email Address:		County

DBA Name		Telephone Number	Fax Number
Location Address	**City**	**State**	**ZIP**
Contact Name/Title	**Email Address:**		**County**
Federal TIN#	**NPI# (All ten digits)**		
Credentialing Contact Name/Title		**Telephone Number**	**Fax Number**

Please provide listing of all additional locations in your service area **by county.** [Include address, telephone contact person, and federal TIN on each] if more space is needed, please attach a separate sheet.

County	Address		Telephone Number	Federal TIN#
Contact			Fax Number	NPI#

County	Address		Telephone Number	Federal TIN#
Contact			Fax Number	NPI#

County	Address		Telephone Number	Federal TIN#
Contact			Fax Number	NPI#

County	Address		Telephone Number	Federal TIN#
Contact			Fax Number	NPI#

Remit to Address:			
Billing Contact Person	Title	Telephone Number	FAX Number

Additional Service Locations: Please provide a list of each location and the corresponding billing information on a separate sheet, if different for primary billing address.

Please note the service provided by your organization:

Include a description of all services provided by your company that you wish to be included under your contract.

Date Service Began	*Service*	*Yes*	*No*	*Adult*	*Pediatric*
	Home Health Care				
	IV Pharmaceutical				
	Home Health Nurses				
	24-Hour Private Duty Nursing				
	Durable Medical Equipment				
	Orthotics/Prosthesis				
	Supplies				
	Physical Therapy				
	Occupational Therapy				
	Speech Therapy				
	Outpatient Surgery				
	Outpatient Diagnostics				
	Nutritional Services				
	Other:				

If any of the services listed on the previous page are provided by a sub-contractor, please list the subcontractors below:

Name of Subcontractor	Services Provided	
Address	Contact	Telephone #
Name of Subcontractor	Services Provided	
Address	Contact	Telephone #
Name of Subcontractor	Services Provided	
Address	Contact	Telephone #
Name of Subcontractor	Services Provided	
Address	Contact	Telephone #

Hours of Operation:

MONDAY	_____	**am/pm to**	_____	**am/pm**	☐	**Closed**
TUESDAY	_____	**am/pm to**	_____	**am/pm**	☐	**Closed**
WEDNESDAY	_____	**am/pm to**	_____	**am/pm**	☐	**Closed**
THURSDAY	_____	**am/pm to**	_____	**am/pm**	☐	**Closed**
FRIDAY	_____	**am/pm to**	_____	**am/pm**	☐	**Closed**
SATURDAY	_____	**am/pm to**	_____	**am/pm**	☐	**Closed**
SUNDAY	_____	**am/pm to**	_____	**am/pm**	☐	**Closed**

STAFFING

•PLEASE ATTACH AN ORGANIZATION CHART OF YOUR COMPANY LISTING THE NAMES AND TITLES OF SENIOR MANAGEMENT PERSONNEL.

List below the percentage of your staff that is full time, part time , as needed, subcontracted:

	FULL TIME	PART TIME	PER DIEM	SUBCONTRACTED
NURSES:				
RN				
LPN				
Nursing Assistant Staff				
PHARMACISTS:				
THERAPISTS:				
Physical Therapists: RPT, LPT, PTA				
Occupational Therapists: OTR, COTA				
Speech Therapists				
SOCIAL WORKERS:				
MEDICAL DIRECTORS:				
OTHER:				

CERTIFICATION (Please attach CMS Letter and/or other documentation)

Is your agency Medicare/Medicaid certified?	MEDICARE CERTIFICATION NUMBER	MEDICAID CERTIFICATION NUMBER
☐ Yes ☐ No		

(If multiple sites, please provide the Medicare number for each site)

Date of Last State Inspection: _____

Date of last Medicare Inspection:_____

Any corrective action items? ____Yes ____ No **(Please provide copy of summary report)**

Is your company JCAHO certified?	Date of Certification	Expiration Date of Certification
☐ Yes ☐ No	/ /	/ /

Please indicate if organization is accredited. Indicate all that apply and attach proof for each site or specify if accreditation applies to all sites.

CORF ☐ Yes ☐ No Expiration Date:_____

CARF ☐ Yes ☐ No Expiration Date:_____

NCQA ☐ Yes ☐ No Expiration Date:_____

AAAHC ☐ Yes ☐ No Expiration Date:_____

ACR ☐ Yes ☐ No Expiration Date:_____

Other ☐ Yes ☐ No Specify _____Expiration _____

PROFESSIONAL and GENERAL LIABILITY INSURANCE (Please attach document)

Current Carrier Name _____ Policy #_____

Policy Begin Date _____ End Date _____ Retroactive Date_____

Coverage Limits: _____ Occurrence _____ Aggregate

If self-insured,
Current Reinsurance entity: _____ Risk Management Contact _____

LICENSURE (Please attach all documents)

Please provide information for all state, federal or pharmacy licenses, including DEA & CLIA certificates. If more than three, please attach an additional sheet of paper with the requested information.

Alabama Board Health License #_____ Expiration Date_____

Business/City License #_____ Expiration Date_____

CLIA Waiver #_____ Expiration Date_____

Other Licenses

License #_____ Expiration Date_____

License Type_____ Licensing Body_____

License #_____ Expiration Date_____

License Type_____ Licensing Body_____

INTERNAL PROCESS (Please answer all questions) If "no", please provide explanation.

Does entity have a process for assessing the professional qualifications, licensure and lack of Medicare sanctions/ inclusion on the state abuse list prior to hiring new staff? ____Yes ____No

Does entity monitor professional staff for current and unencumbered licensure on an ongoing basis? ____Yes ____No

Are professional staff required to participate in continuing education or provided with additional training opportunities after hire? ____Yes ____No

QUALITY IMPROVEMENT & UTILIZATION MANAGEMENT

Does entity have a quality monitoring or utilization management program in place to assess organizational performance and needs? ____Yes ____No

Please list the person responsible for implementation of the Quality Assurance plan

If no, please provide an explanation. We are unable to move forward without a program in place and a contact on file.

QUESTIONNAIRE

1. Has your Facility been named in any malpractice action within the last five (5) years?	☐ Yes	☐ No
2. Has your Facility had their insurance canceled, non-renewed, restricted or special rated within the last five (5) years?	☐ Yes	☐ No
3. Has your Facility ever been disciplined by any state licensing or other authorizing agency or have you ever been reprimanded, or fined by any state agency that disciplines healthcare facilities?	☐ Yes	☐ No
4. Has any government agency investigated, suspended or revoked your license or taken any adverse action against your Facility or staff members' license to practice within the last five (5) years or are any of these actions currently pending?	☐ Yes	☐ No
4. At any time, has any license, certification or eligibility been revoked, reduced, denied or suspended by the issuing entity or voluntarily given up by the Facility within the last five (5) years or are any of these actions currently pending?	☐ Yes	☐ No
5. Has any criminal, ethical investigations, convictions, or legal actions ever been made against your Facility within the last five (5) years or currently pending?	☐ Yes	☐ No
6. Has your Facility or any staff member ever been reprimanded, censured, restricted, suspended, or disqualified by the Medicare, Medicaid, CLIA Program or any Federal Program?	☐ Yes	☐ No
7. Has your Facility's DEA registration or Pharmacy license ever been denied, suspended, revoked, or otherwise limited for any reason within the last five (5) years?	☐ Yes	☐ No
8. Has your Facility been removed, sanctioned or suspended from membership in a professional association for violation(s) of its code of ethics within the last five (5) years?	☐ Yes	☐ No

PROFESSIONAL AND GENERAL LIABILITY QUESTIONNAIRE

If you respond "yes" to any of the above questions, you must submit an explanation describing the incidents or cases involved. Please omit any patient names from any documents. Examples would include:

- Three (3) year claim history from your insurance carrier
- Copies of sanction letters and related documents from any licensing, certifying or credentialing organization.
- Settlement agreements, petitions, complaints, responses to complaints
- A brief chronology of events in any sanction activity, malpractice suit, etc, including actions taken by you in response to or to correct the situation. Describe any changes in policies and procedures that resulted from the event(s) or incident(s).
- Description of relevant quality assurance activities.

Please note that these documents will be reviewed in order to determine acceptance into VIVA's networks. Submitting complete information will facilitate this process.

BEFORE YOU SIGN, BE SURE TO CHECK YOUR APPLICATION FOR COMPLETENESS AND CORRECTNESS. INCOMPLETE OR MISSING INFORMATION WILL DELAY THE PROCESSING AND APPROVAL OF YOUR APPLICATION.

VIVA Health, Inc. Attestation and Consent

Attestation:

The Applicant hereby warrants and represents that all information supplied to VIVA Health, Inc., including, but not limited to, licensure, insurance and malpractice history, is true, accurate and complete. The Applicant further understands that any information entered in this document by Applicant which subsequently is found to be false could result in denial of acceptance into VIVA Health, Inc.'s network or termination of any agreement with VIVA Health, Inc. The Applicant agrees to maintain appropriate licensing and professional and general liability coverage while contracted with VIVA Health, Inc.

Consent and Release:

In order to verify the organization's credentials, Applicant hereby authorizes VIVA Health, Inc. to perform the necessary functions as required by an accrediting or regulatory agency.

Applicant agrees to update VIVA Health, Inc. with current information regarding questions contained in this application as such information becomes available and impacts Applicant's ability to provide services.

Applicant grants permission and consent for VIVA Health, Inc., its authorized representatives and any third parties to obtain and verify information contained on the application and consents to the release of any person, organization, or other entity to VIVA Health, Inc., and/or its representatives, of all information that may be reasonably relevant to an evaluation of, including, but not limited to, the Organization's ability to render services in a professional, competent and ethical manner. The Applicant expressly waives any privilege, confidentiality right or privacy right to which the Organization may be entitled. The Applicant agrees to hold harmless any such person, organization or other entity from any cause of action based on the release of such information, in good faith, to VIVA and/or its authorized representative pursuant to this consent. The Applicant releases VIVA Health, Inc. and its authorized representatives from any liability for any reports, records, recommendations, claims information and claims history, or any other information related to the Organization that are provided to VIVA Health, Inc. or its authorized representatives by a third part, including otherwise privileged and confidential information given in good faith and related to the credentialing process. The Organization further understands that participation as a provider for VIVA Health, Inc. is dependent upon successful completion of the credentialing process. Applicant agrees that a photocopy of this authorization shall be deemed equivalent to the original.

It is understood by both parties hereto that any and all information obtained by VIVA Health, Inc. shall be proprietary, privileged and confidential, except as otherwise required by law. VIVA Health, Inc. proprietary, privileged and confidential information shall mean any of its internal proprietary information and/or proprietary information of third parties from which VIVA collects information in order to perform necessary functions.

I certify that I am authorized to make the above warranties, representations, authorizations and releases on behalf of this provider organization and to sign this application on behalf of this organization.

_____	_____
Provider Organization/Facility Name (Please Print)	**Authorized Representative Name/Title (Please print)**
_____	_____
Date	Signature of Authorized Representative

Please retain a copy of this application for your files.

VIVA HEALTH, INC.
ADDITIONAL COMMENTS OR INFORMATION

CREDENTIALING Application Checklist:

All documentation must be included at the time of submission of the application.

_____ **Copy of current *JCAHO Accreditation Certificate and/or other Accreditation certificate*. (If applicable)**

_____ **Copy of current *Alabama State Board of Health License and/or City License*.**

_____ **Copy of current *Federal DEA Certificate and Alabama Board of Pharmacy License.***

_____ **Copy of current *Alabama Dept of Public Health Site Survey and Corrective Action Plan.* (If applicable).**

_____ **Copy of current *Professional & General Liability Insurance Policy.* (**Must show on the face sheet, the policy number, coverage amount, and expiration date.)

_____ **Copy of current *Medicare Certificate/Letter/Documentation.***

_____ **Copy of letter listing individual *NPI# (s)* .**

_____ **List of services provided by facilities (i.e. brochure).**

_____ **Copy of current *CLIA Laboratory Certificate of Waiver.***

_____ **Copy of current *American College of Radiology (ACR) Certificate.***

_____ **Completed and signed *Federal W-9 Form*.**

_____ **Copy of current *Individual State License for Occupational, Physical, and Speech Therapists*. (Ambulance License required for Hospitals).**

If application is received **WITHOUT ALL ATTACHMENTS**, the application **WILL BE RETURNED TO YOU** and will **NOT** be processed until received complete.

Contact person at your office:_____ Phone:_____

Contact person's email address: _____

Should you have any questions regarding this application please call 205-558-7474

417 20th Street North, Suite 1100, Birmingham, Alabama 35203
Phone (205) 939-1718 • www.vivahealth.corn

Form **W-9**
(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ---------- ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
| | | | - | | - | | | | |

or

Employer identification number
| | | - | | | | | | | |

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here **Signature of U.S. person** ► **Date** ►

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,