Beacon Health Strategies
Initial Practitioner Network Application
*For Credentialing Purposes – **Group and Solo providers only.***
(Not needed for Facility based clinicians.)

Please type your responses or print clearly. All questions must be answered and all requested supporting documentation must be attached prior to submission. If the answer to any question on the application is not applicable, please write "N/A" or "none" in the space provided as confirmation that the applicant has read the question. Any response that cannot be completed in the space provided may be included on supplementary sheets of paper.

Please Note: Incomplete applications cannot be processed.

SECTION I

1. Applicant's Name:_____
   Last First Middle Suffix
2. Any Other Name Used (include maiden): _____
3. Credentialing Contact Address: 4010 Dupont Circle 582
   Street Suite #
   Louisville KY 40207-4888 502-899-5411tlloyd@transformationsllc.net
   City/State/Zip Phone/Email
4. a. *Date of Birth___/___/___ b. Place of Birth _____
   City State
   c. Visa Status: U.S. Citizen born U.S. Citizen Naturalized Permanent Residence
   d. Gender:____Male ___Female
5. * Social Security Number _____
6. E.C.F.M.G. # (if a foreign graduate)_____(Please attach a legible copy)
7. *Medical or Graduate School _____ Graduation Date ___/___/___
   Degree Received _____

Are you registered with CAQH?

Yes ☐ CAQH _____ Please complete ***Clinician Information*** & ***Site Information*** forms

No ☐ Please continue to page 2

**This information is required to verify your status with the National Practitioner Data Bank. Beacon Health Strategies & any of its affiliates or contractors shall maintain the confidentiality of all credentialing information.*

SECTION II

8. ***Work History:*** *List employment for the past 5 years, giving the month & year you started and ended each job. If you are applying through a group practice, please give us the date you joined (or will join) the group practice. Start with current employment date and work backward. Provide an explanation for any gaps between jobs that are longer than 3 months on a separate sheet of paper. Please also attach an up-to-date, detailed CV or resume, describing what duties each job entailed.*

Name of Practice/Facility	Address/City/State	Date From	Date To
		___/___/___	___/___/___
		___/___/___	___/___/___
		___/___/___	___/___/___
		___/___/___	___/___/___

9. **License ID#(s): Please Attach a Legible Copy of your valid, (non-expired), State License**

a. _____ State_____ Expiration Date___/___/___

b. _____ State_____ Expiration Date___/___/___

10. **Malpractice Insurance: Please attach a copy of your current malpractice coverage face sheet**

Name of Insurance Carrier: _____

Address: _____ Policy #: _____

Effective Date___/___/___ Termination Date___/___/___

Amount of Coverage: _____

(NY MD's must have min. $1.3m/$3.9m coverage for certain plans)

11. **Previous Malpractice coverage: (past 5 years)**

Name of Insurance Carrier: _____

Address: _____

Policy #:_____

Effective Date___/___/___

Termination Date___/___/___

Amount of Coverage: _____

SECTION III PHYSICIANS & NURSES ONLY

PART A – MD/DO PHYSICIAN LICENSEES ONLY

12. Are you certified by the American Board of Medical Specialty (ABMS), American Board of Psychiatry & Neurology (ABPN), or an American Osteopathic Specialty Board? YES ☐ NO ☐
(If yes, please attach a legible copy of your board certificate)

12a. If answer is no, are you Eligible? YES ☐ NO ☐

12b. If answer is no, are you certified by any other Board? YES ☐ NO ☐

Board _____ Date Awarded ___/___/___

Exp. Date___/___/___ Field of certification_____

13. Internship _____ From___/___ To___/___

Department_____

14. Residency _____ From___/___ To___/___

Department _____

15. Fellowship _____ From___/___ To___/___

16. Name only hospitals at which you **currently have active admitting** privileges.

Hospital	Phone #	Scope of Privileges	Hospital NPI
Hospital	Phone #	Scope of Privileges	Hospital NPI
Hospital	Phone #	Scope of Privileges	Hospital NPI

PART B – PHYSICIANS & PRESCRIBING NURSES (MD/DO/RN/CS/NP)

17. DEA # _____ Expiration Date___/___/___
(Please attach a Legible Copy of the License)

18. CDS # _____ Expiration Date___/___/___
(Please attach a Legible Copy of your State Controlled Substance Distribution License)

PART C – NURSES ONLY

19. Are you certified by the **American Nurses Credentialing Center (ANCC)**or any other specialty board?
YES ☐ NO ☐
(If yes, Please attach a legible copy of the certificate)

Board_____Date Awarded___/___/___

Exp. Date___/___/___ Field of certification_____

SECTION IV – DISCLOSURE QUESTIONS *(A response is required to each question)*

LICENSURE

☐ Yes ☐ No 1. Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?

☐ Yes ☐ No 2. Has there been any challenge to your licensure, registration or certification?

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

☐ Yes ☐ No 3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?

☐ Yes ☐ No 4. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?

☐ Yes ☐ No 5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?

EDUCATION, TRAINING AND BOARD CERTIFICATION

☐ Yes ☐ No 6. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?

☐ Yes ☐ No 7. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?

☐ Yes ☐ No 8. Have any of your board certifications or eligibility ever been revoked?

☐ Yes ☐ No 9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

☐ Yes ☐ No 10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

☐ Yes ☐ No 11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?

OTHER SANCTIONS OR INVESTIGATIONS

☐ Yes ☐ No 12. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

☐ Yes ☐ No 13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?

☐ Yes ☐ No 14. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?

SECTION IV – Continued *(A response is required to each question)*

OTHER SANCTIONS OR INVESTIGATIONS *(Continued)*

☐ Yes ☐ No 15. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?

☐ Yes ☐ No 16. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

☐ Yes ☐ No 17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?

☐ Yes ☐ No 18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?

MALPRACTICE CLAIMS HISTORY

☐ Yes ☐ No 19. Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?

If yes, provide information for each case.

CRIMINAL/CIVIL HISTORY

☐ Yes ☐ No 20. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?

☐ Yes ☐ No 21. In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

☐ Yes ☐ No 22. Have you ever been court-martialed for actions related to your duties as a medical professional?

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

ABILITY TO PERFORM JOB

☐ Yes ☐ No 23. Are you currently engaged in the illegal use of drugs?

("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

☐ Yes ☐ No 24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

☐ Yes ☐ No 25. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?

☐ Yes ☐ No 26. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?

Attestation Statement

I understand and agree that, as part of the credentialing application process for participation in Beacon Health Strategies (Beacon) provider network(s), I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by Beacon for determining initial and ongoing eligibility for Participation. Beacon and its affiliates, representatives, employees, contactors and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that Beacon will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Beacon is not an application for employment with Beacon and that acceptance of my application by Beacon will not result in my employment by Beacon.

Authorization of Investigation and Release of Information Concerning Application for Participation. I authorize Beacon, its representatives, employees, and/or designated agent(s); Beacon affiliated entities and their representatives, employees, and/or designated agents; and Beacon designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow Beacon and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation. I further authorize Beacon to release to any of its affiliates and/or contractors, any information that is included in this application or obtained during such investigation related to my application, as permitted by law.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to Beacon and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, Beacon. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to Beacon and/or its Agent(s). As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless Beacon, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of Beacon, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue Beacon, its Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of Beacon, its Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to Beacon, its Agent(s), and/or other third party

include their respective employees, directors, officers, advisors, counsel, and agents. its Agent(s) and/or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation in one or more of Beacon's provider networks. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization.

I understand that my failure to promptly provide another consent may be grounds for termination or discipline by Beacon in accordance with the applicable bylaws, rules, and regulations, and requirements of Beacon, or grounds for my termination of Participation with Beacon. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify Beacon and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by Beacon, and must be submitted in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that Beacon will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to Beacon and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Name: _____
(Please print or type)

Signature: _____

Date: _____

This space is provided for a detailed response to any of the disclosure questions.

QUESTION # **RESPONSE**

Beacon Health Strategies
Practitioner Rights

Beacon Health Strategies conducts a rigorous, source-verification credentialing process in keeping with NCQA (National Committee on Quality Accreditation) standards. Accordingly, we wish to inform provider applicants of their rights during the credentialing process.

You have a right to:

- **Be informed, upon request, of the status of your credentialing application.** To obtain information about the status of your application, please call our Credentialing Specialist at 781-994-7500.

- **Be informed if Beacon obtains information that contradicts or does not support information reported by the provider.** Our Credentialing Specialist will notify you if we learn of any actions on your licensure, malpractice claims history, or board certification status that is different from information reported on your application.

- **Review your credentialing file and correct any erroneous information.** Providers have the right to review and submit corrections to their credentialing applications when notified by Beacon 1) of information obtained from a verifying source that doesn't support, or contradicts, the credentialing information submitted by the provider; and 2) that the Credentialing Committee has not accepted the applicant into Beacon's network. Within 14 days of receiving either of these notices, the provider may submit a written request to the Credentialing Specialist to view his/her credentialing file. The Credentialing Specialist will forward a copy of the file, excluding information obtained by Beacon from the National Practitioner Data Base (NPDB)* to the requesting party, within 5 business days. The provider will then have 14 business days to submit evidence that the information is erroneous. This additional information will be sent to the Credentialing Committee for further review and disposition.

  *Note that Beacon is not authorized to release information obtained from NPDB but providers may query NPDB directly.

- **Appeal Beacon's credentialing decisions.** In the event that Beacon obtains notice of a negative report, disciplinary action, or evidence of serious quality deficiencies regarding a provider who has been credentialed, a process is in place for the reduction, suspension, and/or termination of network participation status of credentialed providers. The provider will be notified and will have thirty (30) days to file an appeal according to procedures enclosed with such a notice.

Beacon Health Strategies Network Application
Supporting Documentation
Checklist

Did you remember to attach the following?

✓W-9 Tax Form indicating practice's legal name and tax identification number

For each clinician:

- ☐ Curriculum Vitae or Resume
- ☐ State License
- ☐ Malpractice Coverage Face Sheet
- ☐ American Board of Medical Specialties, American Board of Psychiatry & Neurology, AOA, or ANCC Board Certificates (if applicable)
- ☐ DEA License (if applicable)
- ☐ State Controlled Substance Distribution License (if applicable)
- ☐ E.C.F.M.G. # (if a foreign graduate)

☎ For assistance in completing this application, please call **781.994.7556** ☎

📪 **Completed applications may be returned to:** 📪

Beacon Health Strategies, LLC
Attn: Credentialing Department
500 Unicorn Park Drive, Suite 103
Woburn, MA 01801
Fax Number: 781-994-7667

beacon
health options

CLINICIAN INFORMATION FORM

Site Name: Transformations		Beacon ID#: 1169040	
Address:		Tax ID: 61-1351752	Accepting new referrals? Yes □ X No □
Clinician First:	Clinician Last:	Middle Initial:	Date of Birth:
Gender: Male □ Female □	Clinician License #:	Clinician NPI #:	
Medicaid ID/TPI#:	Medicare#:	Taxonomy:	
CANS (*MA Only*): NA			

Licensure:

□ MD	□ DO	□ APRN / NP	□ RNCS	□ PHD	□ PSYD
□ EDD	□ LICSW	□ LCSW	□ LMHC	□ LMFT	□ LPC
□ LADAC	□ BCBA	□ Other (specify):	□ Masters Level (Facility Based only)		

Ethnicity:

□ African American	□ Asian	□ Caucasian	□ Latino / Hispanic
□ Native American	□ Other (specify):		

Language(s):

□ American Sign Language	□ Cambodian	□ English	□ French
□ Haitian Creole	□ Laotian	□ Portuguese	□ Russian
□ Spanish	□ Vietnamese	□ Other (specify)	

Specialties: Please indicate top 10 areas of expertise. Shaded specialties require submission of attached **Specialty Verification Form**. To qualify as "disability competent" in RI, at least one asterisked (*) specialty must be checked.

Minimum Age:_____ Maximum Age:_____ Practice Limitations: □ Male only □ Female only

□ Abuse (Physical)	□ Children w/Special Health Care Needs	□ Low Income Populations*
□ Abuse (Sexual) *	□ Cultural Diversity*	□ Medical Co-Morbidity
□ Addiction Psychiatry	□ DBT (Please include certification)	□ Mood Disorders
□ Addictions/Substance Abuse	□ Depression	□ Neuropsychological Testing
□ ADHD	□ DID/MPD	□ OCD
□ Adolescents	□ Disabilities – Developmental/MR*	□ Pastoral Counseling
□ Adoption	□ Disabilities – Hearing Impaired*	□ Personality Disorders
□ Affective Disorders	□ Disabilities – Learning*	□ Post-Partum / Pre-Partum Depression
□ Agoraphobia	□ Disabilities – Physical*	□ Psychiatry & Neurology
□ Alzheimer/Dementia	□ Disabilities- Visually Impaired*	□ Psychiatry
□ Anger Management	□ Domestic Violence*	□ Psychological Testing
□ Anxiety Disorder	□ Dual Diagnosis (MH/SA)*	□ Psychology
□ Applied Behavioral Analysis	□ EAP	□ Psychopharmacology
□ Asperger's Syndrome	□ Eating Disorder	□ Psychotherapy
□ Attachment/Reactive Attachment Disorder	□ ECT	□ Psychotic Disorders
□ Autism Spectrum Disorders	□ EMDR (Please include certification)	□ PTSD
□ Bariatric Counseling	□ Family	□ Refugees
□ Bereavement	□ Fire-Setting	□ School Based
□ Borderline Personality Disorder	□ Forensic	□ Sex Offenders
□ Certified Drug/Alcohol Counselor	□ Gambling	□ Sexual Addictions
□ Certified Social Worker	□ Gay/Lesbian/Bisexual	□ Sexual Disorders
□ Child Abuse	□ Gender Identity	□ Sexual Dysfunction
□ Child Oppositional Defiant	□ Geriatric	□ Sleep Disorders
□ Child Psychiatry	□ Group Therapy (Specify type) _____	□ SPMI (Severe & Persistently Mentally Ill)
□ Child Psychopharmacology	□ Head Injury/Traumatic Brain Injury	□ Suboxone / Buprenorphine (prescribing)
□ Child/Pediatric	□ HIV/AIDS	□ Terminal Illness
□ Chronic Pain	□ Home Visits*	□ Transgender
□ Cognitive Behavioral Therapy	□ Homeless/Outreach	□ Veteran's Issues
□ Couples	□ Immigrant Populations	□ Victim Awareness
		□ Vivitrol / Naltrexone (prescribing)

Specialty Verification Form

Clinicians who have indicated specialties in: **Abuse (Physical), Abuse (Sexual), Addictions/Substance Abuse, Child Abuse, DID/MPD, Eating Disorder, Fire-Setting, Forensics, Geriatrics, Neuropsychological Testing, Post- Partum Depression, Psychological Testing, Sex Offenders,** and **Sexual Addictions; must attest to the following criteria:**

- Independent licensure
- 10-20 hours of documented training (continued education, etc) in past 1-2 years (and/or internship or postdoctoral fellowship in specialty)
- 200 hours of direct clinical contact in past 5 years
- Access to (*check one or both of the following*):
  - □ supervision with a professional in the field.
  - □ supervision with a peer supervision group.
- Access to a prescribing provider (network or out-of-network).

Clinicians who have indicated a specialty in **Applied Behavior Analysis** must be certified by the BACB.

Clinicians who have indicated a specialty in **Eating Disorders**, please answer the following questions:

1) What percentage of your practice involves eating disorders?_____%
2) Are you a member of a state or national Eating Disorders provider network? If so, please indicate which organization(s):_____
3) Are you prepared to do the necessary collateral work required for this population? (Work with this population requires coordination and collaboration with client's medical provider, dietician, family therapist, etc.) _____

Specialty Attestation Statement

The undersigned hereby certifies that the above information requested by BEACON HEALTH STRATEGIES, LLC is truthful, correct and complete in all respects, and the undersigned further understands that the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as a participating practitioner with BEACON HEALTH STRATEGIES, LLC. The undersigned hereby agrees to notify BEACON HEALTH STRATEGIES, LLC of any changes in the above information.

_____ _____

Signature (Original Signature Required) **Date**

_____

Printed Name/Title

SITE INFORMATION

Please provide all of the following information for each location.
(Attach extra sheets if necessary.)

Provider Corporate Name: (Practice's legal name) Transformations hope for today's families LLC	
Site Name: Transformations hope for today's families LLC	
Site Address: 4010 Dupont Circle Suite 582	**City/State/Zip:** Louisville KY 40207
Phone Number: 502-899-5411	**Fax Number:** 502-899-5411
Email Address: transformationsllc@yahoo.com	**TTY Number:**
Federal Tax Identification Number: (Please attach a W-9) 61-1351752	**Site NPI #:** 1427229483
Medicaid License #: 7100269220	**Medicare License #:** N/A
Primary Taxonomy: 251S00000X	

OP Hours: Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
9 am to 5 pm	9 am to 5 pm	9 am to 5 pm	9 am to 5 pm	9 am to 5 pm		

Site Contact Information

Executive Director Name/Address: Laura Krebs Lewis 4010 Dupont Cr #582	**Email Address/Phone/Fax:** lkrebslewis@transformationsllc.net 502-899-5411 ph &fax
CMO/Senior Clinical Director Name/Address: Teresa Lloyd 4010 Dupont Cr #582	**Email Address/Phone/Fax:** tlloyd@transformationsllc.net 502-899-5411 ph &fax
Administrator/Practice Manager Name/Address:	**Email Address/Phone/Fax:**
Contracting Contact Name/Address: Teresa Lloyd 4010 Dupont Cr #582	**Email Address/Phone/Fax:** tlloyd@transformationsllc.net 502-899-5411 ph & fax
Credentialing Contact Name/Address: Teresa Lloyd 4010 Dupont Cr#582	**Email Address/Phone/Fax:** tlloyd@transformationsllc.net 502-899-5411 ph&fax
Claims/Billing Contact Name/Address: Laura Lewis 4010 Dupont Cr #582	**Email Address/Phone/Fax:** lkrebslewis@transformationsllc.net 502-899-5411 ph&fax
Intake Coordinator Contact Name/Address: Janna Winsted 4010 Dupont Cr. #582	**Email Address/Phone/Fax:** jwinsted@transformationsllc.net 502-899-5411 ph&fax
Authorization Contact Name/Address for Authorization Letters: Teresa Lloyd 4010 Dupont Cr #582	**Email Address/Phone:** **Fax:** 502-899-5411 **(Should Authorization letters go to this fax? Yes ☒ No ☐)**

Practice Coverage Information

Who is the practice's provider of psychopharmacology services? (If not available within the practice, please include the name and address of the provider(s) to whom the practice refers members for psychopharmacological evaluations.)
Beacon requires 7 day, 24 hour coverage for patients. Please indicate and explain your procedure for ensuring that clients have 24 hour access to clinical and psychopharmacological services. **Beeper**_____ **Share Call**_____**Answering Service** Provider cellphone is available to clients
Please list the clinicians (include address and phone) who cover your practice or who are part of your call/coverage schedule.

SITE-SPECIFIC
ACCOMMODATIONS

This information will be made available to members for referral purposes.

Site Name: Transformations	
Are you currently accepting new patients? Yes / ~~No~~	
Next indicate the date of the next available opening for: **Intake** appointment: 72 hrs Child 72 hrs Adolescent 72 hrs Adult 72 hrs Geriatric **Urgent** appointment: 72 hrs Child 72hrs Adolescent 72hrs Adult 72hrs Geriatric **Meds Management** appointment: Na Child NA Adolescent NA Adult NA Geriatric	
Accessible by Public Transportation? Yes / No	**Handicapped Accessible?** Yes / No

Check all that apply in the boxes below:

We do home and site based therapy.

Physical Accessibility	**Other Accessibility**
Adjustable height exam table	Able to create/print materials that are accessible for individuals with disabilities
All services available on ground level	
Building access ramp	Answering service with one or more clinicians on call 24/7 X
X Designated handicapped parking	
X Elevator/Lift	Beeper/Direct number given to members to reach clinician on-call 24/7
X Home Visiting	
X Passenger pick-up and drop-off zone	Can print materials that are appropriate for individuals with disabilities
Patient lifts available	
Staff experienced with wheelchair transfer techniques	Can transcribe written material into Braille or have staff member read to an individual who is blind or visually impaired
Transfer boards available	
X Walkway free of stairs and obstacles	Closed captioning available (subtitles) for video or audio on website for deaf or hard of hearing users
X Wheelchair access to facility	
Wheelchair accessible lavatory	CSHCN (Personal Care)
	Display ADA compliant major access symbols
X Wheelchair accessible office entrance/reception area	Elevator buttons in Braille X
	Flexible appointment times, including evenings and/or weekends X
X Wheelchair accessible public transit routes	
X Wheelchair accessible treatment space	Provide interpreter services for individuals who are deaf or hard of hearing X
Which of the following technologies are available:	RC4 Assistance (Eating)
E-prescribing (sending prescriptions electronically)	RC4 Assistance (Home Visit)
E-referrals (sending an electronic referral to another provider)	RC4 Assistance (Personal Care)
Electronic refill reminders (receiving electronic notification that your patients' prescriptions are due to be refilled)	Signs in Braille
	Staff fluent in American Sign Language
None of these are available X	Staff fluent in languages other than English X
Current stage of Electronic Medical Record implementation:	TTY/TDD (Telephone Typewriter/Telephone Device for the Deaf)
Fully implemented X	Website content developed with consideration to the needs of users with cognitive disabilities
Partially implemented	
Not implemented-EMR vendor selected	Website is accessible to users who are vision impaired, e.g., using screen reader technology
Not implemented – no EMR vendor selected	

Disclosure of Ownership & Control Interest Statement

Addendum "A" to the Application:
Disclosure of Ownership & Control Interest Statement

Federal regulations set forth in 42 CFR Part 455 Subpart B require Provider Entities/Persons who are entering into or renewing a provider agreement to disclose to managed care organizations that contract with a Medicare/Medicaid agency: a) information on ownership and control, b) information related to business transactions, and c) information on persons who have ownership or control interest and have been convicted of crimes related to the person's involvement in Medicare, Medicaid, or the Title XX services program.

This form must be completed by an Authorized Representative, who is defined as an individual with designated authority to act on behalf of the individual, group of practitioners, or disclosing entity. If not a solo practitioner, then the authorized representative must be a partner, president, or secretary of the group of practitioners or disclosing entity. The signature on this form must be the written signature of the authorized representative and not a signature stamp.

For Definitions, please see page 8.

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by titles V, XVIII, XIX, and XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the Secretary of appropriate State agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the Secretary or appropriate State agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

Special Instructions for Title XX Providers

All title XX providers must complete part II (a) and (b) of this form. Only those title XX providers rendering medical, remedial, or health related homemaker services must complete parts II and III. Title V providers must complete parts II and III.

General Instructions

For procedures and requirements, refer to the appropriate Regulations:

Title V – 42CFR 51a.144

Title XVIII – 42CFR 420.200 – 206

Title XIX – 42CFR 455.100 – 106

Title XX – 45CFR 228.72 – 73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

This form is to be completed annually. Any substantial delay in completing the form should be reported to the State survey agency.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

Item I (a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

Item II - Self-explanatory.

Item III - List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following

devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV – VII - Changes in Provider Status Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For Items IV – VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV - (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

Item V - If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI - If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII - A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII - If yes, list the actual number of beds in the facility now and the previous number.

Disclosure timeframes

1. Disclosures of **Ownership and Control** are due to Beacon:
    a. Upon the **Provider Entity** or **Provider Person** submitting the provider application;
    b. Upon the **Provider Entity** or **Provider Person** executing the provider agreement;
    c. Within 20 days of a request from Health and Human Services or from Beacon to allow Beacon to meet its reporting requirements;
    d. Upon Beacon's request for information from the **Provider Entity** or **Provider Person** for re-credentialing/re-contracting; and
    e. When there are significant changes to the information required on this form, for example, an ownership change, the addition of a new managing employee, or the change of your business location.
2. Disclosures of **Business Transactions** are due to Beacon within 20 days of HHS' request, the request of the Secretary or from Beacon to allow Beacon to meet its reporting requirements.
3. Disclosures of **Criminal Convictions** are due to Beacon:
    a. Upon submission of the provider application;
    b. Upon execution of renewal of the provider agreement;
    c. Upon Beacon's request for information from the **Provider Entity** or **Provider Person** for re-credentialing/re-contracting; and
    d. At any time upon written request by HHS.

Business Transaction Information

List the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous 12-month period. (If yes, list the ownership of those Subcontractors below. Attach a separate sheet if additional space is needed.) 42 CFR §455.105.

N/A 1st Subcontractor Name	1st Subcontractor
Name of Owner (1)	Owner Address
Name of Owner (2)	Owner Address
2nd Subcontractor Name	2nd Subcontractor
Name of Owner (1)	Owner Address
Name of Owner (2)	Owner Address

List any significant business transactions between this provider and any Wholly Owned Supplier or any subcontractor, during the previous 5-year period? (If yes, please provide the information below.) 42 CFR §455.105.

Name of Wholly Owned Supplier/Subcontractor	Transaction Amount	Transaction Description
N/A		

Ownership and Control Information for Provider/Disclosing Entity

I. Identifying Information

Provider Person* (For sole proprietors. If a disclosing entity, use the Provider Entity section.)				
Name of Provider			DOB	Telephone No.
Provider SSN	Provider NPI #	Provider #	Medicaid/Medicare Provider #	
Provider Street Address			City, County, State	Zip Code
Provider Entity * (Whom the Provider Person works for. If you are a sole proprietor, list yourself as the Provider Entity.)				
Entity Name Transformations hope for today's families LLC		D/B/A		Telephone No. 502-899-5411
Provider TIN 61-1351752	Provider NPI # 1427229483	Provider # 1169040	Medicaid/Medicare Provider # 7100267430	Vendor #
Street Address 4010 Dupont Circle Suite 582			City, County, State Louisville, Jefferson, KY	Zip Code 40207

II. (a) **Master List**: List the name, title, address, and SSN for each individual who has any ownership or controlling interest in this provider entity. The individual's ownership or controlling interest is an ownership interest of 5% or more of this provider entity. List the name, tax ID (EIN), and address of any organization, corporation, or entity having any ownership or controlling interest in this provider entity. The ownership or controlling interest is an ownership interest of 5% or more in this provider entity. Attach additional pages as necessary to list all officers, owners, management, and ownership entities.

Name	Title	Address	SSN/EIN	% Interest
Teresa Lloyd	partner	4010 Dupont Cir 40207	61-1351752	50
Laura Krebs Lewis	partner	4010 Dupont Cir 40207	61-1351752	50

(b) Type of Entity: □ Sole Proprietorship □ Partnership □ Corporation
□ Unincorporated Associations □X Other (Specify)

(c) If the disclosing entity is a corporation, provide the information below for each member of their Board of Directors or Governing Board. Attach a separate sheet if additional space is needed.

Name	Title	Address	SSN/EIN	% Interest
N/A				

(d) List those persons named in the Master List that are related to each other (spouse, parent, child, or sibling).

Name of person 1	Relationship	Name of person 2
N/A		

List anyone on the Master List who obtained Ownership Interest as a result of transfer of ownership to an immediate family member or Member of the person's household (see definitions) in anticipation of or following a conviction, assessment of civil monetary penalty, or imposition of an exclusion? (If yes, please provide the information below)

Name (on Master List)	Name of Original Owner *	Date of Transfer
N/A		

* If an individual is identified as a potential match during Beacon's process for monitoring exclusions from participation in federal healthcare programs, the individual will be asked to provide additional information such as a Social Security Number to further validate the match.

Provide the information below for any person or entity on the Master List with an Ownership or Control Interest in any Other Disclosing Entity. (Example: sole proprietor, partnership or members of Board of Directors.) 42 CFR 455.104

Name *(on Master List)*	Other Disclosing Entity Name	% Interest
Laura Krebs Lewis	Ability! LLC	33
Other Disclosing Entity Address: *(Legal entities must provide, as applicable, their primary business address, every business location, and P.O. Box address.)* 4010 Dupont Circle Suite 580 Louisville KY 40207		
Name *(on Master List)*	Other Disclosing Entity Name	% Interest
Teresa Lloyd	Ability! LLC	33
Other Disclosing Entity Address: *(Legal entities must provide, as applicable, their primary business address, every business location, and P.O. Box address.)* 4010 Dupont Circle Suite 580 Louisville KY 40207		

List the name, title, address, and social security number of each person with an Ownership or Control Interest in any subcontractor that this disclosing entity has direct or indirect ownership of 5% or more. 42 CFR 455.104

N/A

Name *(on Master List)*	Subcontractor	% Interest
Subcontractor Address: *(Legal entities must provide, as applicable, their primary business address, every business location, and P.O. Box address.)*		
Name *(on Master List)*	Subcontractor	% Interest
Subcontractor Address: *(Legal entities must provide, as applicable, their primary business address, every business location, and P.O. Box address.)*		

Check appropriate box for each of the following questions:

III. (a) Has there been a change in ownership or control within the last year? □ Yes □X No
If yes, give date _____

(b) Do you anticipate any change of ownership or control within the year? □ Yes □X No
If yes, when? _____

(c) Do you anticipate filing for bankruptcy within the year? □ Yes □X No
If yes, when? _____

IV. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years? ☐ Yes ☐ No N/A

N/A:	X	If yes, give year of change:		Current beds:		Prior beds:	

Questions V – VII are for facilities only. Groups and individual providers skip to section entitled "Criminal Offenses and Adverse Actions"

V. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only) 42 CFR 455.104 ☐ Yes ☒ No

VI. Is this facility operated by a management company, or leased in whole or part by another organization? ☐ Yes ☒ No
If yes, give date of change in operations _____

VII. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? ☐ Yes ☒ No

VIII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN) ☐ Yes ☒ No

VIII. (b) If the answer to Question VIII.a. is No, was the facility ever affiliated with a chain? (If yes, list Name, Address of Corporation, and EIN) ☐ Yes ☒ No

Name	Address	EIN #

Criminal Offenses and Adverse Actions

Answer the following questions by checking "Yes" or "No."

I. Criminal Offenses

Have any individuals or organizations on the Master List ever been convicted of a criminal offense related to the involvement of yourself, Other Disclosing Entities or Subcontractors in any of the programs established by titles XVIII, XIX, or XX? ☐ Yes ☒ No

Have any individuals or organizations on the Master List ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct? 42 CFR 455.106 ☐ Yes ☒ No

Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by titles XVIII, XIX, or XX? ☐ Yes ☒ No

Has any individual or contractor connected with your practice ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct ? 42 CFR 455.106 □ Yes ☒ No

If the answer to any questions under I. Criminal Offenses is yes, please provide the following information for the individual(s) or contractors(s) involved. Attach additional copies of this form if necessary.

Name (on Master List)	Matter of the Offense	Conviction Date	Sanction Period (if sanctioned by the OIG)

II. Legal actions, suspension, exclusion or debarment

Has the applicant ever had any adverse legal actions imposed by Medicare, Medicaid, or any other Federal or State agency or program, or any licensing or certification agency? (If yes, attach a copy of any relevant final dispositions) 42 CFR §455.100 □ Yes ☒ No

Has any individual or entity on the Master List ever been Suspended, Excluded or Debarred from participation in federal healthcare programs (Medicare, Medicaid) in the past? □ Yes ☒ No

Name (on Master List)	Reason for Action	State Action occurred in	Date of Action	Length of Action

Has any individual or entity on the Master List ever been Terminated from a state's Medicaid program for reasons having to do with Program Integrity (fraud or abuse)? (If yes, please provide the information below) □ Yes ☒ No

Name (on Master List)	Reason for Termination	State where Termination occurred	Date of Termination

Has any individual or entity on the Master List ever had Civil Money Penalties (CMPs) assessed against them? A CMP is a type of fine assessed against a provider or entity by a governmental agency that manages a federal healthcare program. (If yes, please provide the information below) □ Yes ☒ No

Name (on Master List)	Reason for CMP	State CMP assessed in	CMP amount	CMP date

Definitions

Definitions for the terms that are used in this form are provided here for your convenience. The source of these definitions is 42 CFR § 455.101, unless otherwise noted.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Immediate Family Member means a person's husband or wife; natural or adoptive parent; child or sibling; stepchild, stepbrother or stepsister; father-, mother-, daughter-, sun-, brother- or sister-in-law; grandparent or grandchild' or spouse of a grandparent or grandchild. [Not taken from 42 CFR.]

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managed care entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Member of a household, with respect to a person, means any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of a household. [Not taken from 42 CFR.]

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes: **(a)** Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII); **(b)** Any Medicare intermediary or carrier; and **(c)** Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that—**(a)** Has an ownership interest totaling 5 percent or more in a disclosing entity; **(b)** Has an indirect ownership interest equal to 5 percent or more in a disclosing entity; **(c)** Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity; **(d)** Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; **(e)** Is an officer or director of a disclosing entity that is organized as a corporation; or **(f)** Is a partner in a disclosing entity that is organized as a partnership. See 42 CFR § 455.102 on how to determine ownership or control percentages.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—**(a)** An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or **(b)** An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Termination means—**(1)** For a—**(i)** Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and **(ii)** Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. **(2)(i)** In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary. **(ii)** The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated. **(3)** The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to—**(i)** Fraud; **(ii)** Integrity; or **(iii)** Quality.

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Attestation

I certify that information on this form, and any attached documentation has been reviewed by me and is true, accurate and complete, to the best of my knowledge. I will notify Beacon of any additions or changes to this information immediately. Additionally, I understand that false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. (42 CFR § 455.106)

For organizations:

Signature of Authorized Representative	Title: 06/10/2016
Printed Name of Authorized Representative: Teresa Lloyd	Date: 06/10/2016

For individual providers:

Signature of Provider Person	Title
Printed Name of Provider Person	Date
Name of person completing this form (if not the Provider Person)	Phone Number

(Date stamps and the signature of anyone other than the person legally authorized to sign on behalf of the entity are not acceptable.)

Remarks:

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Form **W-9**
(Rev. December 2000)
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.

Name (See **Specific Instructions** on page 2.)
Transformations hope for today's families LLC

Business name, if different from above. (See **Specific Instructions** on page 2.)

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☒ Other ◆ LLC

Address (number, street, and apt. or suite no.)
4010 Dupont Circle Suite 582

City, state, and ZIP code
Louisville KY 40207

Requester's name and address (optional)

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. 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 2.** 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 2.

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number
			–				–				
			–				–				

or

Employer identification number
6	1	–	1	3	5	1	7	5	2

Part II For U.S. Payees Exempt From Backup Withholding (See the instructions on page 2.)

◆

Part III 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 2.)

Sign Here **Signature of U.S. person ◆** [signature] **Date ◆** 06/10/2016

Purpose of Form

A person who is required to file an information return with the IRS must get 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.

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

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Corporations.

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.*

What is backup withholding? Persons making certain payments to you must withhold and pay to the IRS 31% of such payments under certain conditions. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

If you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return, payments you receive will not be subject to backup withholding. **Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part III instructions on page 2 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the Part II instructions and the separate **Instructions for the Requester of Form W-9.**

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.