Long-Term Services and Supports Provider Attestation Form

Point32Health
Harvard Pilgrim Health Care TUFTS Health Plan

Thank you for your interest in being part of the Point32Health provider network. Point32Health, which is the parent organization of Harvard Pilgrim Health Care and Tufts Health Plan, requires information about your facility/organization in order to fully evaluate your application to become a participating provider and join our network. Please complete this form, along with the Ancillary Contracting and Credentialing Information Form, and submit to provider_information_dept@point32health.org.

Facility/organization information

Name:

Medicare Certified Number:

PID/SL (for existing MassHealth providers):

Are you a MassHealth provider? Yes No If *Yes*, year of establishment:

Do you have any affiliations with other facilities, organizations, or programs, and do you hold any ownership interests in any other entities? Yes No If *Yes*, please explain:

Physical locations (*address where services are rendered, if applicable*)

1.	Site name:	NPI:	TIN:
	Address:	Phone:	
	Service(s):		

2.	Site name:	NPI:	TIN:
	Address:	Phone:	
	Service(s):		

3.	Site name:	NPI:	TIN:
	Address:	Phone:	
	Service(s):		

Facility/Organization Attestation

Facility/organization attests to the following:

Compliance with encryption software, HIPAA secure e-mail, and electronic visit verification (per regulatory requirements):
Yes No

Conducting and maintaining documentation of CORI checks on all staff pursuant to federal and/or state requirements:
Yes No

Facility/organization attests to compliance with employee training in the following:
Yes No

- Patient confidentiality/HIPPA during orientation and every twelve (12) months thereafter
- Informed consent during orientation and every twelve (12) months thereafter
- Grievance/complaint procedures during orientation and every twelve (12) months thereafter
- Patient rights and responsibilities during orientation and every twelve (12) months thereafter
- Infection control during orientation and every twelve (12) months thereafter
- Emergency procedures every twelve (12) months and thereafter
- Mandated reporter training

CLEAR FORM

Care Management Data

Hospitals and/or physician groups that refer to your organization (*Please list.*)

What languages does your staff speak? (*Please list.*)

What current capacity does your agency have to take new referrals? (*Please explain.*)

What is the current census of active members?

What is your staff/member ratio for day programs?

Does your program utilize Electronic Health Records?

Referrals (*Who should referrals be sent to?*)

Name: Title:

Email:

Phone: Fax:

Clinical contact:

Service area (*select which counties your facility/organization covers*)

- Barnstable
- Berkshire
- Bristol
- Dukes
- Essex
- Franklin
- Hampden
- Hampshire
- Middlesex
- Nantucket
- Norfolk
- Plymouth
- Suffolk
- Worcester

Statement of Understanding

I hereby certify that the information given in the enclosed document is accurate. I shall immediately forward to Point32Health written notification of any modifications, corrections or changes to such information. I understand that Point32Health may share this document with federal or state regulators and/or provider or agency partner organizations.

Signature:

Name: Title:

Facility name: Date:

CLEAR FORM