# Foundational Community Supports Provider Application

Washington | Medicaid

To apply to become a contracted Foundational Community Supports provider:

- Follow the instructions at HCA FCS (wa.gov) under *Provider enrollment and resources*.
- Complete this form and attach it to your FCS New Provider Inquiry Form submission.
- Include a copy of your IRS Form W-9 with this application.

* Required field

| Organization information | |
|---|---|
| * Agency name: | |
| * WA Medicaid provider ID: | * TIN: |
| * NPI: | * Primary taxonomy: |

* Organization type (select all that apply):

- ☐ Behavioral health agency
- ☐ Community action program
- ☐ Community-based organization
- ☐ Federally qualified health center
- ☐ Government
- ☐ Long-term care
- ☐ Reentry programs
- ☐ Homeless shelter
- ☐ Substance use disorder (SUD)
- ☐ Tribal organization
- ☐ Other: _____

Coverage provided by Wellpoint Washington, Inc.

Wellpoint Washington, Inc. profoundly acknowledges and respects the inherent sovereignty of the federally recognized Tribes in Washington state. In our efforts to promote high-quality healthcare, we honor the Tribal right of self-governance, holding in deep esteem the government-to-government relationship existing between the state and the Tribes, a bond reiterated by the Centennial Accord and established by RCW 43.376. We heartily commit to enhancing our coordination, collaboration, and recognition of the deeply rooted traditions and values of the Tribal communities.

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## Organization information

* Population(s) served (select all that apply):

- ☐ All potential FCS enrollees
- ☐ Aging and older adults
- ☐ AI/AN
- ☐ Autism population
- ☐ DDA clients
- ☐ DV survivors
- ☐ DVR clients
- ☐ Foster care
- ☐ HCBS clients
- ☐ HHCC clients
- ☐ Homeless
- ☐ LGBTQ+
- ☐ Linguistic population
- ☐ LTC clients
- ☐ Men
- ☐ MH clients
- ☐ MSS clients
- ☐ Racial and ethnic population
- ☐ Reentry/justice involved
- ☐ Students
- ☐ SUD clients
- ☐ SUD recovery clients
- ☐ Women
- ☐ Youth
- ☐ Other: _____

## Location information

| | | |
|---|---|---|
| * Primary address, street: | | |
| * City: | State: | ZIP: |
| * Phone: | Fax: | |
| * Counties served at this location: | | |
| * ADA-accessible? ☐ Yes ☐ No | | |
| | | |
| Secondary address, street: | | |
| City: | State: | ZIP: |
| * Phone: | Fax: | |
| * Counties served at this location: | | |
| * ADA-accessible? ☐ Yes ☐ No | | |

**More locations?** Attach a separate sheet for additional agency locations.

| | | |
|---|---|---|
| * Remit address, street: | | |
| City: | State: | ZIP: |
| * Phone: | Fax: | |

| Licensure and accreditation | |
|---|---|
| * Washington facility license or business license number: | |
| * License effective date: | * License expiration date: |
| * Primary address, complete mailing address, including ZIP: | |
| * Is your agency credentialed by Wellpoint for services other than FCS?† ☐ Yes ☐ No<br>If yes, what is your current credentialing expiration date? | |
| Is your agency accredited by one of the following accrediting bodies? ☐ Yes ☐ No<br>If yes, mark all that apply:<br>☐ ACHC ☐ CARF ☐ COA ☐ HFAP ☐ NCQA<br>☐ CACH ☐ CHAP ☐ DNV ☐ HQAA ☐ TJC<br>☐ Not accredited†<br>☐ Other: _____ | |
| Date of initial accreditation: _____<br>† If you are not credentialed or accredited, an FCS manager will reach out to you to set up an in-person site visit of your agency. | |

All information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify Wellpoint of any changes thereto. I understand this application does not entitle me to participate in Wellpoint. By applying for appointment as a Wellpoint participating provider, I authorize the plan, its medical director, and appropriate representatives to consult with administrators and members of other institutions

where I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character, and ethical qualifications.

I hereby further consent to the inspection by Wellpoint, its medical director, and appropriate representatives, of all records and documents, excluding medical records of nonmembers of Wellpoint plans, that may be material to an evaluation of any professional qualifications and competence to carry out the requested duties, as well as my moral and ethical qualifications for participating provider status with Wellpoint. I consent and agree that Wellpoint will complete a criminal history background check to determine if I or any subcontracted providers have any history of felony convictions, including adjudication withheld on a felony, plea, or nolo contendere to a felony, or entry into a pretrial for a felony. I agree to obtain any consents or approvals required for my subcontracted providers to undergo such background checks. I hereby release Wellpoint and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I hereby release any individuals and organizations from any liability that provide information to Wellpoint or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the Ancillary Agreement between me or my group and Wellpoint, as such terms may be applicable to me.

I understand that as an applicant for participation in Wellpoint, I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from Wellpoint, I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the Credentialing Committee if they so request. I further understand that I may appeal the Committee’s decision either in writing or by appearance before the Credentialing Committee if they so request.