

Regulatory Services, E-330
P.O. Box 149030
Austin, TX 78714-9030
(512) 438-3556
Fax: (512) 438-2727

**Application for Participation
in Title XIX Medicaid:
ICF/IID, Nursing Facility
or Rural Hospital Swingbed Program**

For DADS Use Only	
Reviewer:	_____
Contract Effective:	_____
Contract #:	_____

1. Facility Information

Program Type: <input type="checkbox"/> ICF/IID <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Rural Hospital Swingbed			
Name of Facility		Facility ID No.	NPI No.
Facility Physical Address		City	State ZIP Code
County	Facility Area Code and Telephone No.		Facility Fax No.
Number of Medicaid Beds (cannot exceed approved Medicaid beds)		Facility Email Address	
Facility Mailing Address <input type="checkbox"/> Same as Physical Address		City	State ZIP Code
Business Address <input type="checkbox"/> Same as Physical Address <input type="checkbox"/> Same as Mailing Address		City	State ZIP Code

2. Type of Application — Check all that apply.

<input type="checkbox"/> New Medicaid Contract — Type of new Medicaid contract:			
<input type="checkbox"/> Medicaid Reapplication	<input type="checkbox"/> Re-open Facility	<input type="checkbox"/> Facility Replacement	<input type="checkbox"/> New Medicaid Facility (<input type="checkbox"/> Approved Waiver or <input type="checkbox"/> High Occupancy)
<input type="checkbox"/> Change of Ownership Effective Date: _____	<input type="checkbox"/> Stock Transfer Effective Date: _____	<input type="checkbox"/> Real Estate Change Effective Date: _____	
<input type="checkbox"/> Management Company Change Effective Date: _____	<input type="checkbox"/> Facility Relocation Effective Date: _____	<input type="checkbox"/> Update Effective Date: _____	
Management Company Name (If applicable, see attachment for required additional documents.)			
Management Company Address		City	State ZIP Code

3. Applicant – Legal Entity Information

Legal Name of Applicant		Federal Tax ID or SSN, if Sole Proprietor	Fiscal Year End
Address		City	State ZIP Code
Contact Person		Contact Person Title	
Contact Area Code and Telephone No.	Contact Area Code and Fax No.	Contact Email Address	
Applicant Type of Entity: (See attachment for required legal entity certificates and documents.)			
<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Limited Liability Partnership	<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> State <input type="checkbox"/> Trust
<input type="checkbox"/> General Partnership	<input type="checkbox"/> Nonprofit Corporation	<input type="checkbox"/> Hospital District/Authority	<input type="checkbox"/> County <input type="checkbox"/> Other
<input type="checkbox"/> Limited Partnership	<input type="checkbox"/> Profit Corporation	<input type="checkbox"/> Federal	<input type="checkbox"/> City

Name of Facility	Facility ID No.
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4. Preparer Same as applicant

Legal Name of Preparer			
Address	City	State	ZIP Code
Contact Person		Contact Person Title	
Preparer Area Code and Telephone No.	Preparer Area Code and Fax No.	Preparer Email Address	

5. Lease, Sublease, Mortgage and Lien Data

Type of Obligation – Check all that apply. Provide lessor, sublessor, lien holder name, address and telephone number.

Lease Sublease Mortgage Lien Note Deed of Trust Other (specify): _____

Name of Individual or Entity		Title (i.e., Lessor/Sublessor)		
Address-Street	City	State	ZIP Code	Area Code and Telephone No.
Name of Individual or Entity		Title (i.e., Lessor/Sublessor)		
Address-Street	City	State	ZIP Code	Area Code and Telephone No.
Name of Individual or Entity		Title (i.e., Lessor/Sublessor)		
Address-Street	City	State	ZIP Code	Area Code and Telephone No.
Name of Individual or Entity		Title (i.e., Lessor/Sublessor)		
Address-Street	City	State	ZIP Code	Area Code and Telephone No.

6. Additional Applicant/Legal Entity Information

A. Has the legal entity ever been excluded, debarred or suspended from any state or federal program? Yes No

If Yes, attach a full explanation of the details and circumstances, including dates, program involved, state where incident occurred and final actions.

B. Has the legal entity ever had a license denied or revoked by the Texas Department of Aging and Disability Services (DADS)?..... Yes No

If Yes, attach a full explanation of the details and circumstances, including dates, type of license, license number and final actions.

C. Has the legal entity ever had a contract or agreement with DADS cancelled for failure to comply with any provisions of the contract or state and federal regulations?..... Yes No

If Yes, attach a full explanation of the details and circumstances, including dates, type of contract, contract number and reason for cancellation.

D. Has the legal entity ever filed for reorganization, bankruptcy or receivership based on failure or inability to meet financial obligations in the regular course of business?..... Yes No

If Yes, attach a full explanation of the details and circumstances, including dates and type of actions.

E. Has there been a change of ownership or control in the legal entity during the last 12 months?..... Yes No

If Yes, specify date and type of change: _____

F. Does the legal entity anticipate a change of ownership or control within the next 12 months?..... Yes No

If Yes, specify date and type of change: _____

Name of Facility	Facility ID No.
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G. Does the legal entity anticipate filing for reorganization, bankruptcy or receivership within the next 12 months?..... Yes No
 If Yes, specify date and type of action: _____

H. Does the legal entity contract or propose to contract with a management company to provide services related to DADS programs?..... Yes No
 If Yes, specify company name and FEIN: _____

This application does not authorize participation, and creates no obligation on the part of DADS. Only after the applicant business entity supplies a complete application will the facility and applicant receive confirmation of final enrollment. In addition, a complete application for licensure must be submitted to DADS Regulatory Services. Upon completing application requirements for a Medicaid contract, and receiving a license and Medicaid certification, a provider number and payee identification number will be supplied and the Medicaid contract will be fully executed.

Note: Upon receiving a Medicaid contract, an Electronic Data Interchange (EDI) agreement must be entered into with the Texas Medicaid Healthcare Partnership (TMHP) in order to submit electronic claims for reimbursement. **The EDI agreement may be downloaded from:** www.tmhp.com/EDI. To obtain a printed copy, contact TMHP EDI Help Desk at 1-888-863-3638, Option 3.

7. Medicaid Contract Application Affidavit

Before me, the undersigned authority personally appeared _____ who, being by me
(Name of Applicant Representative)
 duly sworn, deposes as follows:

My name is _____. I am over the age of 18, legally competent and in all respects qualified and authorized to make this affidavit.

The facts set forth in the foregoing application are true and correct. I understand that submission of false information in the foregoing application will constitute grounds for denial of participation in the Title XIX Medicaid Program. I also understand that as a condition for continued participation, the information supplied in this application must be kept up-to-date and current.

 Signature—Authorized Representative Date

SWORN TO AND SUBSCRIBED before me on this, the _____ day of _____, _____.

 Signature—Notary Public

Notary Seal

Notary Public in the State of _____