MassHealth

THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services
www.mass.gov/masshealth

Frail Elder Home- and Community-Based Services Waiver Provider Application

Provider Type 68

1. Provider name (please print)

2. Provider doing business address (for self-employed provider please enter address of self-employment)

3. City	4. State	5. Zip code (5+4 digits) –

6. Legal entity name	7. Legal entity street address

8. City	9. State	10. Zip code (5+4 digits) –

11. Telephone number (daytime)	12. Fax number (if available)

13. E-mail address	14. Tax ID no. or Social Security no.

15. Contact person	16. Telephone number of contact person

17. Do you currently have any Medicaid provider numbers (in addition to the one you are applying for) with this application? ☐ Yes ☐ No
If Yes, please explain on a separate, signed and dated piece of paper and attach it to this application.

18. Have you ever been excluded from participation in the Medicaid or Medicare program? ☐ Yes ☐ No
If Yes, please explain on a separate, signed and dated piece of paper and attach it to this application.

19. Type of ownership (check one) ☐ 01—individual applicant (sole owner) ☐ 02—partnership ☐ 03—nonprofit organization ☐ 04—government entity ☐ 05—corporation ☐ 06—trust ☐ 07—other (please specify): _____

Waiver provider application certification

Please read carefully and sign below.

This is an application to be a provider in the MassHealth program. This application will become part of, and is incorporated by reference into, the provider agreement between this applicant and MassHealth.

The applicant should make and keep a copy of this provider application as a record before submitting a signed original to MassHealth. MassHealth will retain this application for its records. Moreover, the applicant should understand that it has a continuing obligation to inform MassHealth of any change in the information submitted on or with the provider application within 14 days of the date when the applicant becomes aware of such change.

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the Provider or, in the case of a legal entity, duly authorized to act on behalf of the Provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

_____
Provider's signature
(Signature and date stamps, or the signature of anyone other than the Provider or a person legally authorized to sign on behalf of a legal entity, are not acceptable.)

_____ _____
Printed legal name of Provider — Printed legal name of individual signing (if Provider is a legal entity)

_____ ____ /____ /_____
Title — Date

Send your completed application to _____

_____

If you have questions, contact _____

Print Clear