Directions for completing the H2O Provider Participation Application.

In order to be considered for participation in the H2O program, providers must be able to comply and attest to the requirements outlined in AHCCCS Policies AMPM Exhibit 1720-1, Exhibit 1720-2 and Exhibit 1720-3. Additional resources can be found on the AHCCCS website. Any questions regarding this form, please reach out to H2OProviderNetwork@bannerhealth.com. The first page is an Organization Screening Tool to provide you insight into whether completing the full application would be appropriate.

Organization Screening Tool

The questions below indicate requirements and priorities for potential H2O Providers. If any of the questions below are answered "No" it is unlikely the application will be approved by the Provider Network Committee to move forward.

1. What services are you interested in providing as a part of H2O? (Check all that apply and indicate which county the services would be offered in.)
   - ☐ Street Outreach
     i. County/Counties?
   - ☐ Enhanced Shelter
     i. County/Counties?
   - ☐ Pre-Tenancy/Tenancy Services
     i. County/Counties?

2. Do you have experience providing services equal or similar to the H2O service(s) (Enhanced Shelter, Street Outreach, Pre-Tenancy/Tenancy) to individuals experiencing homelessness?**Only provide answers and experiences directly related to the service type(s) you are applying for. Review the following for descriptions of services** *Exhibit 1720-1 – Housing and Health Opportunities (H2O) Services*

   ☐ Yes ☐ No

   If yes, provide a brief description of the experience and program details.

   Notes (If no, but you have other experience you would like us to consider, please explain below.)

3. Do you have demonstrated quality outcomes for the services you provide?

   ☐ Yes ☐ No

   a. Please attach a report that indicates quality outcomes consistent with H2O service models.

4. Have you read through the following documents, and can you attest you could meet all the expectations?

- ☐ H2O Operations Manual
- ☐ AHCCCS H2O Policies
  - ☐ Exhibit 1720-1 – Housing and Health Opportunities (H2O) Services
  - ☐ Exhibit 1720-2 – Housing and Health Opportunities (H2O) Caseload and Contact Requirements
  - ☐ Exhibit 1720-3 – Housing and Health Opportunities (H2O) Provider Training
- ☐ H2O AHCCCS Provider Enrollment Portal (APEP) Guide

Please note any questions or concerns you have about providing these services as listed.

5. Do you have experience with federal or other contracts to provide homeless services?

☐ Yes ☐ No

Notes (If no, but you have other experience you would like us to consider, please explain below.)

6. Will you be able to provide or obtain a Certificate of Insurance that includes the minimum requirements?

☐ Yes ☐ No

If yes, please provide one of the following:

a. If you do not currently have the required insurance, please submit a quote with your application.
b. See page 9 for the Insurance Requirement Checklist.
c. See page 10 and 11 for complete details regarding AHCCCS Insurance Requirements.

7. Can you confirm that your agency did not receive any findings as part of its most recent financial audit? (If your agency has not participated in a financial audit, please select N/A.)

☐ Yes (Did not contain findings) ☐ No (Contained findings) ☐ N/A

8. Can you confirm that your agency is not currently under investigation for any compliance-related issues? ("Yes" means you are not currently under investigation.)

☐ Yes ☐ No

9. Can you confirm that your agency has no actions being taken against them for issues related to compliance and program monitoring? Actions include things such as findings from monitoring, restrictions from contracting with AHCCCS, etc." ("Yes" means you do not have any current actions being taken against your agency related to compliance or monitoring.)

☐ Yes ☐ No

For Enhanced Shelter Providers ONLY:

1. Are you able to provide a copy of the W-9 for the property owner of the enhanced shelter's physical location that is required with the application? If the legal ownership information provided by the applicant does not match what is on the County Assessor's website, the application will be rejected.

☐ Yes ☐ No

   a. If you are not the owner, will you be able to provide a Copy of the Lease Agreement?

☐ Yes ☐ No

2. CARF Accreditation is required for all enhanced shelter providers within 12 months of an executed contract. Can you confirm your agency would be able to meet that requirement?

☐ Yes ☐ No

If you are moving forward with the application, you must submit a separate Site Application for each location, but you do not need to complete the Organization Screener for each one.

1. The information is necessary to add into the Provider Directory and payment system for claims processing.
2. Ensure you provide **COMPLETE and ACCURATE** information, or your application may be delayed or rejected.
3. Please complete section III- Site Information and Check list. ***You must complete 1 form for each site that is providing a service.***
4. PLEASE TYPE OR PRINT CLEARLY AND COMPLETE THE APPLICATION IN ITS ENTIRETY
5. The following ATTACHMENTS are required to be submitted with this application. If the application is missing any of the required documents or information, your request may be rejected.

6. If your application is approved, the following will be required before rendering services
   i. AHCCCS Registration as an H2O provider type (ES and/or HO)
      i. Please notify Solari and Banner of your AHCCCS registration
   ii. HMIS Registration with Solari
      i. Please notify Solari of your HMIS registration
   iii. Community Assistor Registration with AHCCCS
      i. Please notify Solari of your Community Assistor Registration
   iv. CommunityCares onboarding

7. Providers will receive written confirmation of their effective date with the H2O PA.
   i. Members MAY NOT BE SEEN until written confirmation has been received and a contract is executed.
   ii. You cannot receive payment for services provided without an active AHCCCS H2O and HMIS registration.

H2O Provider Participation Application

Section I: Provider Information

1099 Registered Name (Required) Please attach IRS 941 voucher or accurate W-9.	Tax ID:

Legal Entity Name:

Group Practice Name (DBA) if applicable:

Group Type (check all that apply):	☐ Enhanced Shelter ☐ Outreach/Education ☐ Housing Tenancy Services (Pre & Post Tenancy)	AHCCCS ID (for renewals only):
HMIS ID (for renewals only):	# of FTEs (Outreach entities only):	# of beds per location (Enhanced Shelters only)

Do you provide services to individuals with special needs/chronic conditions? (check all that apply)

☐ Physical ☐ Developmental ☐ Behavioral ☐ Emotional ☐ None

How many AHCCCS Community Assistors do you have at this location?

Section II - Billing Information

Billing Service

(If applicable)

Name:		Contact:
Address:		Telephone:
City:	State:	Zip Code:

Pay To Address

(all payments sent to this address)

Address:		Telephone:
City:	State:	Zip Code:

Office/Application Contact

Name:		Title:
Address:		Telephone:
City:	State:	Zip Code:
Email:	Website:	

Languages other than English spoken by Provider Staff:
Describe your Medical Record Keeping System (i.e., EMR, Paper, etc.):

Electronic Claims Submission: ☐ Yes ☐ No Electronic Funds Transfer: ☐ Yes ☐ No

Section III – Site Information and Check List (One for each

Address:	☐ Enhanced Shelter ☐ Outreach/Education ☐ Housing Tenancy Services (Pre & Post Tenancy)

City and State:	County:	Telephone:

	Office Hours	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	
	Open								
	Close								

Site Specific Required Documents (Attach copies to the submitted application)
Copy of your Certificates of Insurance information that includes the minimum requirements. • If you do not currently have the required insurance, please submit a quote with your application. • See page 9 for the Insurance Requirement Checklist See page 10 and 11 for complete details regarding AHCCCS Insurance Requirements
Copy of CARF accreditation (only applicable for Enhanced Shelter provider type) If CARF accreditation is not complete at the time of initial application, provider has 12 months from date of approval to complete CARF accreditation and submit with the next annual renewal.
For Enhanced Shelter Applicants, you must also include the following:

Property Owner Name/Entity:	
Property Parcel Number:	

A copy of the W-9 for the property owner of the enhanced shelter's physical location must be provided with application. If the legal ownership information provided by the applicant does not match that on the County Assessor's website, the application will be rejected.
Copy of Lease Agreement if you are not the owner of the Enhanced Shelter Location

Please identify what accommodations you provide at **each of your practice locations** for members with cognitive or physical disabilities. If accommodations are the same at all locations, on Practice Location Address, please state ALL. Please, complete a separate Assessment for each location if accommodations vary.

Practice Location Address:

Accommodation	YES	NO	NA	Comments
Provider/Staff trained to assist individuals with a cognitive disability, i.e., autism or intellectual disabilities	☐	☐	☐	
Provider/Staff trained to assist individuals with a physical disability, i.e., mobility limitations or wheelchair bound	☐	☐	☐	
Flexible appointment times available—sick appointments, same day appts—please specify	☐	☐	☐	
Extended appointment times—before 8 am, after 5pm, Sat and/or Sunday—please specify	☐	☐	☐	
Assistance available to members to fill out forms	☐	☐	☐	

Waiting and Examinations rooms are routinely cleaned (MED 3A factor 3)*	☐	☐	☐	
Waiting room space contains seating sufficient for all scheduled appointments (MED 3A factor 4)*	☐	☐	☐	
Medical/treatment of members is fully documented (MED 3A Factor 5)*	☐	☐	☐	
Records are securely maintained in a confidential and orderly manner (MED 3 factor 5)*	☐	☐	☐	
Records are in compliance with HIPAA requirements (MED 3 factor 5)*	☐	☐	☐	
In-home and/or community services	☐	☐	☐	
Large print materials	☐	☐	☐	
Materials in electronic format	☐	☐	☐	
Augmentative/Alternative communication devices	☐	☐	☐	
TDD capabilities	☐	☐	☐	
American Sign Language translator	☐	☐	☐	
Signage with Braille and raised tactile text characters at office, elevator, stairwells, and restroom doors mounted 60in from floor	☐	☐	☐	
Visible & Audible alarms – emergency systems	☐	☐	☐	
Dimmable Lights	☐	☐	☐	
Ramps have non-slip surface material	☐	☐	☐	
Railings between 30 & 38in high. On both sides.	☐	☐	☐	
Paths are at least 36in wide and free of protruding objects	☐	☐	☐	
Cane detectible objects on ground as a warning barrier	☐	☐	☐	
Widened doorways (at least 32in clearance)	☐	☐	☐	
Offset (swing-clear) hinges	☐	☐	☐	
Power assisted or automatic door openers	☐	☐	☐	
Door handles no higher than 48in	☐	☐	☐	
Lever or loop handles vs knobs	☐	☐	☐	

Accommodation	**YES**	**NO**	**NA**	
5ft circle or T-shaped space for turning a wheelchair completely	☐	☐	☐	
A clear floor space, 30" X 48" minimum, adjacent to the exam table and adjoining accessible route make it possible to do a side transfer	☐	☐	☐	
Adjustable height exam table or chair (lowers to 17-19in from floor)	☐	☐	☐	
Positioning and support aids, such as wedges, rolled up blankets, straps and rails	☐	☐	☐	
Ceiling or floor-based patient lift	☐	☐	☐	
Gurneys and/or stretchers	☐	☐	☐	
Wheelchair accessible scales	☐	☐	☐	
Adjustable height radiologic equipment	☐	☐	☐	
Handicap parking	☐	☐	☐	
Handicap accessible restroom	☐	☐	☐	
Access ramps	☐	☐	☐	
Accessible by bus	☐	☐	☐	
Accessible by Taxis or other similar options (Uber/Lyft)	☐	☐	☐	
Accessible by Valley Metro Rail	☐	☐	☐	
Provider/Staff has completed cultural competence training	☐	☐	☐	

Do you provide Field Clinic services? (A “clinic” consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis)	☐	☐	☐	
Do you provide Virtual Clinic services? (Integrated services provided in community settings through the use of innovative strategies for care coordination such as telemedicine, integrated medical records, and virtual interdisciplinary treatment team meetings)	☐	☐	☐	

Section IV - Insurance Requirements Checklist

Please use this checklist as a tool to address all required items prior to submitting your insurance documentation.

NOTE: If you do not currently have the required insurance, please submit a quote with your application.

Commercial General Liability

☐Attached ☐NA

Policy Number Effective Date:		Policy Number Effective Date:	
General Aggregate	$2,000,000	Each Claim	$1,000,000
Products Ops Aggregate	$1,000,000	Annual Aggregate	$2,000,000
Personal & Adv. Injury	$1,000,000		
Damage to Rented Premises	$50,000		
Each Occurrence	$1,000,000		

Business Automobile Liability

☐Attached ☐NA

Policy Number Effective Date:	
Combined Single Limit	$1,000,000

Workers' Compensation Liability

☐Attached ☐NA

Policy Number Effective Date:	
Each Accident	$1,000,000
Disease – Each Employee	$1,000,000
Disease – Each Employee	$1,000,000

Your Certificates of Insurance must include the minimum requirements outlined in the tables above and the following endorsement, waiver of subrogation and/or SAM language as applicable

☐ **Endorsement – Required for Commercial General and Business Auto Liability**

This policy contains an endorsement that includes the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by the Subcontractor or on behalf of the Subcontractor or Contractor.

☐ **Waiver of Subrogation – Required for Commercial General, Business Auto Liability and Workers' Compensation Liability**

This policy contains a waiver of subrogation endorsement in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by the Subcontractor or on behalf of the Subcontractor or Contractor.

☐ **Sexual Abuse and Molestation (SAM) – Required for Commercial General Liability or Professional Liability when providing services to children and/or vulnerable adults**

Insurance Certificate(s) must provide the following statement "Sexual Abuse and Molestation coverage is included" or "Sexual Abuse and Molestation coverage is not excluded."

If you are unable to obtain SAM coverage under your General Liability because the insurance market will not support it, it should be included with the Professional Liability.

AHCCCS Insurance Requirements

The AHCCCS insurance requirements include Commercial General Liability, Business Automobile Liability and Worker's Compensation and Employers' Liability.

Your commercial general liability policy and your business automobile policy (if applicable), need to include an endorsement (see letter a. below under Commercial General Liability and letter a. below under Business Automobile Liability) and a waiver of subrogation (see letter b. below under Commercial General Liability and letter b. below under Business Automobile Liability) in the Description field of your policy.

Your worker's compensation and employers' liability policy requires only the waiver of subrogation language. Outlined below are the minimum requirements. Policy examples follow

Commercial General Liability – Occurrence Form

Policy should include bodily injury, property damage, personal and advertising injury and broad form contractual liability coverage. The amounts below are the minimum requirements.

- General Aggregate $2,000,000
- Products – Completed Operations Aggregate $1,000,000
- Personal and Advertising Injury $1,000,000
- Damage to Rented Premises $50,000
- Each Occurrence $1,000,000

a) The policy shall be endorsed **(Blanket Endorsements are not acceptable)** to include the following additional insured language: *"The State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor."* Such additional insured shall be covered to the full limits of liability purchased by the Subcontractor, even if those limits of liability are in excess of those required by this contract.

b) Policy shall contain a waiver of subrogation endorsement **(Blanket Endorsements are not acceptable)** in favor of the "State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees" for losses arising from work performed by or on behalf of the Subcontractor.

c) If direct services are provided to children and/or vulnerable adults (as defined by A.R.S §46-451(A)(9)), the policy shall include coverage for Sexual Abuse and Molestation (SAM). This SAM coverage may be sub-limited to no less than $500,000. The limits may be included within the General Liability limit, provided by separate endorsement with its own limits. If you are unable to obtain SAM coverage under your General Liability because the insurance market will not support it, it should it be included with the Professional Liability.

d) The following statement must provide on their Certificate(s) of Insurance: "Sexual Abuse and Molestation coverage is included" or "Sexual Abuse and Molestation coverage is not excluded."

Business Automobile Liability—(If no, automobiles are used in the performance of this Contract or Subcontract, then this is not applicable)

Bodily Injury and Property Damage for any owned, hired, and/or non-owned vehicles used in the performance of the services under contract. The amount below is the minimum required.

- Combined Single Limit (CSL) $1,000,000

a) The policy shall be endorsed **(Blanket Endorsements are not acceptable)** to include the following additional insured language: *"The State of Arizona and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor, involving automobiles owned, leased, hired or borrowed by the Contractor."* Such additional insured shall be covered to the full limits of liability purchased by the Subcontractor, even if those limits of liability are in excess of those required by this contract.

b) Policy shall contain a waiver of subrogation endorsement **(Blanket Endorsements are not acceptable)** in favor of the "State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees" for losses arising from work performed by or on behalf of the Subcontractor.

Worker's Compensation and Employers' Liability

- Workers' Compensation Statutory
- Employers' Liability
  - Each Accident $500,000
  - Disease – Each Employee $500,000
  - Disease – Policy Limit $1,000,00

Policy shall contain a waiver of subrogation endorsement (Blanket Endorsements are not acceptable) in favor of the "State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Subcontractor."

We are required to verify your adherence to these insurance requirements. We appreciate you submitting Certificates of Liability with required coverage levels, endorsements and waivers along with the attached checklist.

Please submit the completed application and all required additional documents to:

H2O-PA Network Department at H2OProviderNetwork@bannerhealth.com