



LTSS Ancillary Provider Participation Criteria

Thank you for your interest in becoming a Participating Provider with the Community Health Choice Network. Please take a moment to review the Ancillary Participation Criteria below and check each element with which your business complies.

Criteria Type	Criteria	Medicaid	CHIP	Health Insurance Marketplace	Indicate Criteria Met	Comments
Regulatory	Valid Texas Medicaid Number			N/A		
	Attested NPI Number			N/A		
	Medicare Number <i>(required)</i>					
	Answering Service - Access to Live Person or callback from live person within 30 minutes of call					
	Not currently on Govt. Exclusion List If Hospital has 50 beds or more: (i) has a quality assessment and performance improvement program as specified in 42 CFR 482.21; and (ii) has discharge planning as specified in 42 CFR 482.43.	N/A	N/A			
Administrative	Submission of authorization requests via Provider Portal					
	Existing Clearinghouse Partnership EDI - Electronic Claims Submission				Change Healthcare Availity	
	EDI - Electronic Funds Transfer				Relay Health Trizetto	
	EDI - Electronic Remittance Advice					
	Adherence to HIPAA Standard Transactions					

Print Name

Signature

Date

Community's Network Access Committee will consider your request and notify you once the committee renders a decision. Determinations based on network need and current availability of services. All providers are subject to Community's Credentialing requirements and applicable state and federal guidelines as set forth in the participating provider agreement. Requesting, obtaining, or submitting this form does not guarantee or imply acceptance of participation in the Community network, nor does it entitle you to payment of any services rendered.



LTSS ANCILLARY NETWORK INTEREST PROFILE FORM

Please complete this form in its entirety and return with a copy of W-9 to STARPLUSPROVIDERINQUIRY@Communityhealthchoice.org

Incomplete forms not considered.

Today's Date

Provider would like to participate in the following program(s):

- STAR
- STAR+PLUS
- CHIP
- CHIP Perinatal
- Marketplace
- D-SNP

Legal Name:

Operating / DBA Name

Home Community Support Services Agency (HCSSA) License Number

NPI	TIN	Medicare #	Medicaid #
Contact Person		Title:	
Email		Phone:	Fax:
Mailing Address		City	ST Zip

1. Area of Coverage (check all counties served):

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Austin <input type="checkbox"/> Brazoria <input type="checkbox"/> Chambers <input type="checkbox"/> Fort Bend <input type="checkbox"/> Galveston <input type="checkbox"/> Hardin <input type="checkbox"/> Harris <input type="checkbox"/> Jasper <input type="checkbox"/> Jefferson <input type="checkbox"/> Liberty | <ul style="list-style-type: none"> <input type="checkbox"/> Matagorda <input type="checkbox"/> Montgomery <input type="checkbox"/> Newton <input type="checkbox"/> Orange <input type="checkbox"/> Polk <input type="checkbox"/> San Jacinto <input type="checkbox"/> Tyler <input type="checkbox"/> Walker <input type="checkbox"/> Waller <input type="checkbox"/> Wharton |
|--|--|

2. Services provided: **(Must be licensed to provide services. Check all that apply as licensed.)**

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Adaptive Aids/Medical Supplies/Durable Medical Equipment Supplies (DME) <input type="checkbox"/> Adult Foster Care <input type="checkbox"/> Assisted Living & Residential Care Services <input type="checkbox"/> Consumer Directed Services (CDS) Agency <input type="checkbox"/> Day Activity and Health Services (DAHS) <input type="checkbox"/> Emergency Response Services (ERS) <input type="checkbox"/> Adult Foster Care <input type="checkbox"/> Consumer Directed Services (CDS) Agency <input type="checkbox"/> Minor Home Modification <input type="checkbox"/> Financial Management Services (FMS) (CDS only) <input type="checkbox"/> Habilitation Services <input type="checkbox"/> Flexible Family Supports | <ul style="list-style-type: none"> <input type="checkbox"/> Personal Attendant Services (PAS) <input type="checkbox"/> Personal Care Assistant <input type="checkbox"/> Private Duty Nursing (PDN) <input type="checkbox"/> Respite Care (facility based) <input type="checkbox"/> Respite Care (in-home) <input type="checkbox"/> Support Management <input type="checkbox"/> Supported Employment <input type="checkbox"/> Therapy - Occupational <input type="checkbox"/> Therapy - Physical <input type="checkbox"/> Therapy - Speech <input type="checkbox"/> Home Delivered Meals <input type="checkbox"/> Therapy (In-Home) - Occupational |
|--|---|

Primary Address

Address Location Name: _____ Phone: _____ Fax: _____

City: _____ State: _____ Zip: _____

Bus Route: Yes No Walk-ins Accepted: Yes No Electronic Medical Records: Yes No

Operating Hours (Ex: Mon-Fri 8am-5pm)

MON	TUE	WED	THU	FRI	SAT	SUN	HOLIDAYS
Hrs.	Hrs.	Hrs.	Hrs.	Hrs.	Hrs.	Hrs.	

Languages spoken: Arabic Chinese-Cantonese Chinese-Mandarin Hindi American Sign Language
 Spanish Vietnamese

Clearinghouse

Medicaid/CHIP: Availity Change Healthcare Relay Health Trizetto Payment Method: Direct Deposit (EFT) ERA
 Marketplace: Change Healthcare Relay Health Payment Method: Direct Deposit (EFT) ERA

Alternate Address

Address Location Name: _____ Phone: _____ Fax: _____

City: _____ State: _____ Zip: _____

Bus Route: Yes No Walk-ins Accepted: Yes No Electronic Medical Records: Yes No

Operating Hours (Ex: Mon-Fri 8am-5pm)

MON	TUE	WED	THU	FRI	SAT	SUN	HOLIDAYS
Hrs.	Hrs.	Hrs.	Hrs.	Hrs.	Hrs.	Hrs.	

Languages spoken: Arabic Chinese-Cantonese Chinese-Mandarin Hindi American Sign Language
 Spanish Vietnamese

Clearinghouse:

Medicaid/CHIP: Availity Change Healthcare Relay Health Trizetto Payment Method: Direct Deposit (EFT) ERA
 Marketplace: Change Healthcare Relay Health Payment Method: Direct Deposit (EFT) ERA

Additional locations? Yes No If yes, include a separate sheet with additional information.



Attendant Compensation Rate Enhancement Program Request for Participation Attestation

The Attendant Compensation Rate Enhancement Program (ACEP) is a Texas Health and Human Services (HHS) program that allows additional payments for services delivered by non-medical attendants who care for Texas Medicaid recipients. Assisted Living and Residential Care, Personal Attendant Services (PAS) and Day Activity and Health Services (DAHS) providers may be eligible to receive this rate enhancement. To participate, eligible providers must allocate at least 90% of the dollars received under this option to the Community Care Attendant(s) as stipulated in the rules outlined in Title 1, Texas Administrative Code (TAC) 355.112. If previously enrolled, you must attest to your participation or verify any changes each year by completing this form.

As a contracted Provider or authorized official on behalf of Provider, I, the undersigned authorized official, am required to supply Community Health Choice with verification of all cost reports submitted to participate in the Attendant Compensation Rate Enhancement Program (ACEP). Further, I hereby authorize Community to request, receive and inspect all records pertinent to this consideration.

I wish to participate in the Attendant Compensation Rate Enhancement Program with the Community Health Choice STAR+PLUS plan. This information is required by the state. You can learn more about the state guidelines at <https://pfd.hhs.texas.gov/long-term-services-supports/2025-enrollment-levels-awarded>

ATTESTATION:

I certify the information provided including but not limited to cost reports is complete, accurate, and current. I acknowledge that any misstatements, misrepresentations, or omissions from these reports constitute for denial or dismissal from the Attendant Care Enhancement Program that may result in recoupment of funds received. I have reviewed this information as of the most recent date listed below.

Name: _____ Tax ID Number: _____

Address: _____ City: _____ State: ____ Zip Code _____

NPI Number: _____ Current Rate Enhancement Level(s): Priority _____.

DADS Contract Number: _____

Signature: _____ Date: _____

Print Name: _____ Title: _____

Mail To: Community Health Choice Attn: Contracting Team-ACEP
4888 Loop Central, Suite 600
Houston, TX 77081

Email: CHC.ACEP@CommunityHealthChoice.org

This year’s rate enhancement will be effective September 1, 2024. After we receive your form and confirm your participation in the program, we’ll update your Community Health Choice STAR+PLUS Participation Agreement with the rate enhancement. If you have any questions, please call Provider Services at **888-760-2600**.

Thank you.