| Addendum

IHCP MRO Clubhouse Provider Enrollment Addendum

Overview

This addendum must be completed by mental health providers with a provider specialty **613 – MRO Clubhouse.**

The purpose of this addendum is to provide the Indiana Health Coverage Programs (IHCP) with information about the rendering clubhouse provider that will be providing psychosocial rehabilitation services. The rendering clubhouse provider must:

- Be certified by the Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DHMA).
- Be enrolled as an IHCP rendering provider linked to a DMHA-approved IHCP-enrolled Medicaid Rehabilitation Option (MRO) provider.

A copy of the DMHA certification must be attached to this addendum and included with the enrollment packet.

Please complete all sections of this form. Nonprofit providers must provide information for the business entity that owns their taxpayer identification number (TIN).

Disclosure Information
When completing this form to make changes to the list of disclosed individuals, make sure to include the names of **all** individuals that meet the disclosure requirements, even if the individuals had been previously disclosed. When an update is processed, any previously disclosed individuals that are not shown on the update form will be removed. In other words, the previous list of disclosed individuals will be **replaced** with the updated list of disclosed individuals.

Disclosure of Social Security Numbers
This addendum is used to collect information required by state and federal regulations. Social Security numbers disclosed on this form are used to determine whether persons and entities named in an enrollment packet are federally excluded parties. Refusal to provide a Social Security number will result in rejection of this enrollment packet.

Consent to Release Social Security Numbers

Submission of information on this schedule indicates that consent has been given to the Indiana FSSA and its contractors to use the information, including the Social Security number, for the sole purpose of verifying eligibility to participate in the Medicaid program through the Office of the Inspector General, the Centers for Medicare & Medicaid Services, relevant licensing bodies, and other appropriate state and federal agencies. It is further understood that the FSSA and its contractors may use a Social Security number so the office may determine eligibility for continued participation in the Medicaid program.

This addendum must be submitted with your *IHCP Rendering Provider Enrollment and Profile Maintenance Packet*.

General Information

1. Legal name of community mental health center	2. Taxpayer Identification Number (TIN)
3. Legal name of the contracting clubhouse provider	4. Taxpayer Identification Number (TIN)

Signature

I certify the information stated on this addendum is correct and complete to the best of my knowledge. I further certify that I am an authorized official of the MRO Clubhouse provider and have authority to provide and attest to the information listed on this addendum.

5. Authorized official’s name (please print)	6. Title
7. Authorized official’s signature	8. Date

Individuals with an Ownership or Control Interest and Managing Individuals

Please list **all** individuals with an ownership or control interest in the applicant. If the applicant is a not-for-profit entity, please list the board of directors or advisory board. Not-for-profit providers must also list their managing individuals: a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of the provider entity.

Include each person's name, address, date of birth (DOB), and Social Security number (SSN). Also indicate the title (for example, chief executive officer, owner, board member) and, if an owner, the percent of ownership. Attach additional pages as needed.

1a. Name of individual			
2a. Address			
3a. Title	4a. % of ownership (if applicable)	5a. Social Security number	6a. Date of birth
1b. Name of individual			
2b. Address			
3b. Title	4b. % of ownership (if applicable)	5b. Social Security number	6b. Date of birth
1c. Name of individual			
2c. Address			
3c. Title	4c. % of ownership (if applicable)	5c. Social Security number	6c. Date of birth
1d. Name of individual			
2d. Address			
3d. Title	4d. % of ownership (if applicable)	5d. Social Security number	6d. Date of birth
1e. Name of individual			
2e. Address			
3e. Title	4e. % of ownership (if applicable)	5e. Social Security number	6e. Date of birth
1f. Name of individual			
2f. Address			
3f. Title	4f. % of ownership (if applicable)	5f. Social Security number	6f. Date of birth
1g. Name of individual			
2g. Address			
3g. Title	4g. % of ownership (if applicable)	5g. Social Security number	6g. Date of birth

Relationships and Background Information

Attach additional copies of this page if space is needed for additional names.

1. Indicate whether any of the individuals listed are related through blood or marriage, or as spouse, parent, child, or sibling. Use N/A as appropriate.

1a. Name of person 1	Name of person 2	Relationship
1b. Name of person 1	Name of person 2	Relationship
1c. Name of person 1	Name of person 2	Relationship

2. Indicate whether any persons or entities listed, or any secured creditors of the provider entity, have ever been sanctioned through criminal conviction or exclusion from participation in any program under Medicare, Medicaid, or Title XX services since the inception of the programs.

2a. Name	NPI or IHCP Provider ID	Date of sanction
Type of sanction	Date sanction ended (please attach supporting documentation)	
2b. Name	NPI or IHCP Provider ID	Date of sanction
Type of sanction	Date sanction ended (please attach supporting documentation)	
2c. Name	NPI or IHCP Provider ID	Date of sanction
Type of sanction	Date sanction ended (please attach supporting documentation)	

3. Indicate if any persons or entities listed, or any secured creditors of the provider entity, have ever been placed on prepayment review.

3a. Name	NPI or IHCP Provider ID
3b. Name	NPI or IHCP Provider ID
3c. Name	NPI or IHCP Provider ID

4. Indicate if any persons or entities listed have an ownership or controlling interest in any other current or prospective IHCP provider.

4a. Name	NPI or IHCP Provider ID
4b. Name	NPI or IHCP Provider ID
4c. Name	NPI or IHCP Provider ID

5. Indicate any former agent, officer, director, partner, or managing employee who has transferred ownership to a family member (spouse, parent, child, or sibling) related through blood or marriage, in anticipation of or following a conviction or imposition of an exclusion.

5a. Name of person 1	Name of person 2	Relationship
5b. Name of person 1	Name of person 2	Relationship
5c. Name of person 1	Name of person 2	Relationship