MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

For office use only
Date received:

_____/_____/_____

MassHealth Money Follows the Person Demonstration (MFP) Services Provider Application

If you have questions, contact: ForHealth Consulting at UMass Chan Medical School Provider Network Administration Unit
1-855-300-7058 • ProviderNetwork@umassmed.edu.

1. Provider name		
2. Provider doing business address (for self-employed provider please enter self-employed address)		
3. City	**4.** State	**5.** ZIP code (enter 9-digit ZIP code, if known)
6. Legal entity name		
7. Legal entity street address		
8. City	**9.** State	**10.** ZIP code (enter 9-digit ZIP code, if known)
11. Telephone number (daytime)	**12.** Cellular telephone number (optional)	
13. Fax number (if available)	**14.** E-mail address	
15. Tax ID number or SSN	**16.** Contact person	**17.** Telephone number of contact person

18. Do you currently have any Medicaid provider numbers (**in addition to** the one you are applying for with this form)? ☐ yes ☐ no

Other (specify) and #: _____ Other (specify) and #: _____

19. Has there been any disciplinary action against you by any licensing boards or certification bodies? ☐ yes ☐ no

If **"yes,"** please explain on a separate paper attached to this application. Make sure to sign and date the paper.

20. Have you ever been excluded from participation in the Medicaid or Medicare program? ☐ yes ☐ no

If **"yes,"** please explain on a separate paper attached to this application. Make sure to sign and date the paper.

21. Type of ownership (Check one.)

☐ 01—individual applicant (sole owner) ☐ 02—partnership ☐ 03—nonprofit organization
☐ 04—government entity ☐ 05—corporation ☐ 06—trust
☐ 07—other (specify): _____

continued ➤

22. Check the services that you are applying to provide.

☐ assistive technology ☐ community engagement and navigation

23. MFP demonstration provider application certification

Please Read Carefully and Sign

This is an application to be a provider in MassHealth's Money Follows the Person Demonstration 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 keep this provider 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 on which the applicant becomes aware of such change.

I confirm under the pains and penalties of perjury that the information on this form and any statement that I have attached has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also confirm that I am the provider or, in the case of a legal entity, am duly authorized to act on behalf of the provider. I understand that if I make false statements, leave out important information, or try to hide any significant details in this document I may face civil penalties or criminal prosecution.

Provider's signature (The form can either be signed traditionally and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.)

Printed legal name of provider

Title

Printed legal name of individual signing
(if the provider is a entity)

Date

If you have any questions about this form, please email ProviderNetwork@UMassmed.edu or call (855) 300-7058.

Send Print Clear