THE COLORADO MEDICAL ASSISTANCE PROGRAM

Provider Services
P.O. Box 1100
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Provider Enrollment Application Check List and Instructions for an

Intermediate Nursing Facility

(Standard Provider Application for Direct Pay Enrollment.)

Provides a higher level of care to clients with developmental disabilities and/or mental retardation in a nursing facility.

The documents listed below are required and must be submitted with the application.

☐	**Completed Electronic Funds Transfer (EFT) Form** – The legal business name on this form must match exactly with the name on file with the IRS. The address on this form must match one of the addresses listed in the application. This form must be completed using the employer identification number assigned to the business.
☐	**Completed W-9 Form** – The legal business name on this form must match exactly with the name on file with the IRS. The address on this form must match one of the addresses listed in the application. This form must be completed using the employer identification number assigned to the business.
☐	**License-** Attach a copy of the license from the Department of Public Health and Environment.
☐	**Completed Provider Disclosures Page (Section 19 of the Application) –** The 'Legal Name & Business Category' area must be completed in its entirety. Please list those who have an ownership interest equal to, or more than five percent, or list the officers, directors, and partners of the disclosing entity and their relationship to each other. Entering N/A is not acceptable and will require resubmission of the completed area prior to approval.