

OMB Approval No. 0938-0685

## **SECTION 12: CAPITALIZATION REQUIREMENTS FOR HOME HEALTH AGENCIES**

This section has been intentionally omitted.

## **SECTION 13: CONTACT PERSON INFORMATION (OPTIONAL)**

To assist in the timely processing of the supplier's application, provide the full name, e-mail address, telephone number, and mailing address of an individual who can be reached to answer questions regarding the information furnished in this application (preferably the individual who completed this application). The supplier is not required to furnish a contact person in this section. It should be noted that if a contact person is not provided, all questions about this application will be directed to the authorized official named in Section 15B.

**A. Check Box** - If this section does not apply, check the box and skip to Section 14.

**B. Contact Person Information** – If reporting a change to existing information, check “Change,” provide the effective date of the change, complete the appropriate fields in this section, and sign and date the certification statement. Otherwise:

- Provide the name, e-mail address, telephone number, and mailing address of an individual who can answer questions about the information furnished in this application.

## **SECTION 14: PENALTIES FOR FALSIFYING INFORMATION ON THIS ENROLLMENT APPLICATION**

The supplier should review this section to understand those penalties that can be applied against it for deliberately furnishing false information to enroll or maintain enrollment in the Medicare program.