**Provider Network Application Form**

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| Organization type: | [ ]  Inpatient Psychiatric Services | **[ ]** Licensed Independent Practitioners |
|  | [ ]  Community Living Supports/SIH | [ ]  Specialized Residential (group home) |
|  | [ ]  Primary Care | [ ]  Specialized Residential (indiv. placement) |
|  | [ ]  Autism | [ ]  Vocational services |
|  | [ ]  Other (Please Specify) : |  |

|  |  |
| --- | --- |
| **Legal Name of Organization:** |  |
| **DBA:** |  |
| Mailing/Billing Address: |  |
| Payment Address (if different than above) |  |
|  |  |  |  |  |
| Phone Number: |  |  Fax: |  |

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| National Provider Identifier (NPI) Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| DUNS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Federal Tax ID (or Social Security) Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Are you exempt from Federal Income Tax? [ ] Yes\* [ ] No

*\*If Yes, please attach copy of tax exempt certificate*

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| **CORPORATE CONTACT DATA:** |
| **President/CEO:** | (Name & Title)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Email & Phone: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  |
| **Contract Manager:** | (Name & Title)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Email & Phone: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  |
| **Billing Manager:** | (Name & Title)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Email & Phone: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  |  |
| **Program/Other Manager:** | (Name & Title)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Email & Phone: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| *(Complete additional sheets for multiple sites)* |

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| **Site Name**: |  |
|  |
| Site Address: |  |
|  |  |
| Site Telephone # : |   |  Fax # : |  |
| Name of Contact Person at this site: |  |
| E-Mail Address : |  | Handicap Accessibility: | [ ] Y [ ] N |
|  | Bus Route: | [ ] Y [ ] N |
| Service Hours: |  | Nearest Intersection:  |  |
| Services Provided at this Location: |  |
|  |  |
| **Site Name**: |  |
|  |
| Site Address: |  |
|  |  |
| Site Telephone # : |   |  Fax # : |  |
| Name of Contact Person at this site: |  |
| E-Mail Address : |  | Handicap Accessibility: | [ ] Y [ ] N |
|  | Bus Route: | [ ] Y [ ] N |
| Service Hours: |  | Nearest Intersection:  |  |
| Services Provided at this Location: |  |
|  |  |
| **Site Name**: |  |
|  |
| Site Address: |  |
|  |  |
| Site Telephone # : |   |  Fax # : |  |
| Name of Contact Person at this site: |  |
| E-Mail Address : |  | Handicap Accessibility: | [ ] Y [ ] N |
|  | Bus Route: | [ ] Y [ ] N |
| Service Hours: |  | Nearest Intersection:  |  |
| Services Provided at |  |
| this Location: |  |

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| **Third Party Reimbursement Provider Numbers (if applicable):***Please list any third party reimbursement numbers* |
| Type: | [ ]  Medicare [ ]  Medicaid | *Provider Number:**Provider Number:* |  |
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|  |
| List of Third Party /Commercial Insurances Accepted: |  |
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| **CREDENTIALING / PRIVILEGING** *Please attach copies of the organization’s credentialing and privileging policies and procedures (if applicable).* |
| **PROFESSIONAL CERTIFICATION / ACCREDITATION** *If accredited, attach a copy of the last survey report issued by the organization’s accrediting or certifying body (whichever is applicable)* |
| **Certified or****Accredited by:** |  | **Expiration** **Date:** |  |
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|  |  |
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| **Medical Director Profile:** |
| Name: |  |  |
| Hospital Affiliations: |  |
| Medical Training: |  |
| Board Certification: |  |
|  |  |
| **Recipient Rights Advisor name:**  |  |
| **FINANCIAL REVIEW***Please attach copies of the organization’s most recent audited or certified financial statements or IRS Form 990 (whichever is applicable).* |

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| services provided:*Please indicate services offered and proposed rate (specify per unit or per event)*[ ] ABA Services[ ] Assertive Community Treatment (ACT)[ ] Assessment by Non-physician[ ] CLS/Support Staff[ ] Crisis Intervention[ ] Crisis Residential[ ] Crisis Stabilization[ ] CSM Face to Face Contact[ ] Family Skills Development[ ] Family Therapy[ ] Group Therapy[ ] Health Assessment[ ] Health Services[ ] Home Based Contact[ ] Individual Therapy 16-37m[ ] Individual Therapy 38-52m[ ] Individual Therapy 53+m[ ] Inpatient Hospital Day[ ] Interpreter[ ] Medication Administration[ ] Medical Certification[ ] Medication Review/ E&M[ ] Nutritional Services[ ] Occupational Therapy[ ] Peer Directed and Operated Services[ ] Physical Therapy[ ] Prevention[ ] Psychiatric Assessment on a Medical Floor[ ] Psychiatric Evaluation[ ] Psychiatric Follow Up and Subsequent Care | Proposed Rate | [ ] Psychological Testing[ ] Psychotropic Pharmacy[ ] Residential-Adult[ ] Residential-Child[ ] Respite[ ] Skill Building Assistance[ ] Speech Therapy[ ] Supported Independent Housing[ ] Transportation[ ] Treatment Planning[ ] Wraparound[ ] Supports Coordination [ ] Supported Employment[ ] Targeted Case ManagementOther: [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Proposed Rate |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **TREATMENT CAPACITY** **(Indicate how many treatment or service “slots” are available):** | \_\_\_\_\_\_ |
| **Additional Comments:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Alternative Language resources:***Please identify any staff persons fluent in a non-English language* |
| **Name & Title:** | **Language(s) spoken:** |  |
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|  **Licensure (if applicable):***Attach copies of all licenses pertaining to this application* |
| **License type:** | **license #:** |  **Expiration date:** |
| Adult Foster Care |  |  |
| CAIT (Substance Abuse Prevention) |  |  |
| Certified Addictions Counselor |  |  |
| Certified Social Worker |  |  |
| Children’s Foster Care |  |  |
| Controlled Substance |  |  |
| Driver’s License (only if transporting consumers) |  |  |
| Federal Narcotics  |  |  |
| Inpatient Psychiatric |  |  |
| Licensed Practical Nurse |  |  |
| Licensed Professional Counselor |  |  |
| Limited License Psychologist |  |  |
| Occupational Therapist |  |  |
| Outpatient Clinic |  |  |
| Partial Hospitalization |  |  |
| Physician |  |  |
| Registered Nurse |  |  |
| Registered Physical Therapist |  |  |
| Registered Social Worker |  |  |
| SARF (Substance Abuse) |  |  |
| State MD/DO |  |  |
| Social Work Technician |  |  |
| Substance Abuse Treatment (Level of Care) |  |  |
| Other |  |  |
| **County to be Served:**  |  |
| [ ]  Arenac  |  |
| [ ]  Bay |  |
| [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
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| **EXPERIENCE: POPULATION SERVED (Age Group and Gender)** *Please indicate the age groups, gender and classification for which this program provides treatment.* |
| **Age Group** | **Gender****(M/F)** | **Severely Persistently****Mentally Ill** | **Develop-****mentally****Disabled** | **Seriously****Emotionally****Disturbed** | **Substance****Use****Disorders** | **Co-Occurring** |  |
| Infant (0-5) |  |  |  |  |  |  |  |
| Child (6-12)  |  |  |  |  |  |  |  |
| Adolescent (13-17) |  |  |  |  |  |  |  |
| Adult (18-64) |  |  |  |  |  |  |  |
| Senior (65 & Up) |  |  |  |  |  |  |  |
| **insurance information:****Professional Liability Insurance** |
| *List all current professional liability insurance information. (Complete on a separate sheet if necessary)* |
|  |  |  |  |
| Carrier Name |  |  |  |
|  |  |  |  |
| Policy Number |  |  |  |
|  |  |  |  |
| Policy Limit |  |  |  |
|  |  |  |  |
| Effective Date |  | Expiration Date |  |
| ***\*\*(Attach a copy of the current certificate of insurance)*** |  |
| **General Liability Insurance** |  |  |
| *List all current general liability insurance information. (Complete on a separate sheet if necessary)* |
|  |  |  |  |
| Carrier Name |  |  |  |
|  |  |  |  |
| Policy Number |  |  |  |
|  |  |  |  |
| Policy Limit |  |  |  |
|  |  |  |  |
| Effective Date |  | Expiration Date |  |
| ***\*\*(Attach a copy of the current certificate of insurance)*** |  |
| **Worker’s Compensation Insurance** |
| *List all current worker’s compensation insurance information. (Complete on a separate sheet if necessary)* |
|  |  |  |  |
| Carrier Name |  |  |  |
|  |  |  |  |
| Policy Number |  |  |  |
|  |  |  |  |
| Policy Limit |  |  |  |
|  |  |  |  |
| Effective Date |  | Expiration Date |  |
| ***\*\*(Attach a copy of the current certificate of insurance)*** |  |

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| **Automobile Insurance (if transporting consumers)** |
| *List all current automobile insurance information. (Complete on a separate sheet if necessary)* |
|  |  |  |  |
| Carrier Name |  |  |  |
|  |  |  |  |
| Policy Number |  |  |  |
|  |  |  |  |
| Policy Limit |  |  |  |
|  |  |  |  |
| Effective Date |  | Expiration Date |  |
| ***\*\*(Attach a copy of the current certificate of insurance)*** |  |
| **Property Insurance** **(if a residential provider):** |  |
| *List all current property insurance information. (Complete on a separate sheet if necessary)* |
|  |
| Carrier Name |  |  |  |
|  |  |  |
| Policy Number |  |  |  |
|  |  |  |
| Policy Limit |  |  |  |
|  |  |  |  |
| Effective Date |  | Expiration Date |  |
| ***\*\*(Attach a copy of the current certificate of insurance)*** |  |

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| **Other Insurance (Please indicate):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |
|  |
| Carrier Name |  |
|  |  |
| Policy Number |  |
|  |  |
| Policy Limit |  |
|  |  |
| Effective Date |  |
| ***\*\*(Attach a copy of the current certificate of insurance)*** |

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| **FOR LICENSED independent pRACTIONERS ONLY:** |
| **Personal:**Are you prevented from lawfully becoming employed in this country because of Visa or Immigration Status? [ ]  Yes [ ]  No(Proof of U.S. citizenship will be required prior to entering into a contract) |
| education and experience:*Attach a current resume or curriculum vitae* |
| If the answer to any of the following questions is YES, give full details on a separate sheet: |
| 1. Have you ever had a state license or state certification revoked

 and/or suspended?  | [ ]  Yes | **[ ]** No |
| 1. Have you ever refused membership on a hospital medical or

allied health staff? | [ ]  Yes | **[ ]** No |
| 1. Has your request for any specific privileges ever been

 suspended, diminished, revoked or voluntarily or  involuntarily not renewed?  | [ ]  Yes | **[ ]** No |
| 1. Have your privileges at any hospital ever been suspended,

diminished, revoked or voluntarily or involuntarily not removed? | [ ]  Yes | **[ ]** No |
| 1. Have you ever been denied membership or renewal thereof, or

been subject to disciplinary action in any professional organization? |  [ ]  Yes | **[ ]** No |
| 1. Are you currently engaged in the use of illegal controlled

substances? | [ ]  Yes | **[ ]** No |
| 1. Do you have a mental or physical condition which in any way

may impair or limit your ability to practice medicine with reasonable skill and safety with or without reasonable accommodation? | [ ]  Yes | **[ ]** No |
| 1. Have you ever been convicted of a crime (felony or

misdemeanor)? If Yes, please explain and give dates ofconviction(s): | [ ]  Yes | **[ ]** No |
| 1. Do you have any felony charges pending against you?

If Yes, please explain:Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Yes | **[ ]** No |
|  *Criminal background checks may be conducted on prospective providers of Bay-Arenac*  *Behavioral Health. New providers may not be added to the provider network until*  *Verification is received through primary source of information.*  *Photo ID verified by \_\_\_\_\_\_\_* |
| **sanctions:**Has the organization ever been sanctioned by Medicaid, Medicare, or the Office of the Inspector General? |
| [ ] No[ ] Yes | Date of Reinstatement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Sanction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have judgments or settlements been made against you in professional liability cases or are there any pending? *(If yes, give full details on a separate sheet.)*[ ] No[ ] Yes |
| **References**: |  |  |  |
| *List three references (include full name, address and phone number)* |
|  |  |
|  |  |
|  |  |
|  |
| *I fully understand that any misstatements in, or omissions from, this application may constitute cause for denial of membership to the provider network of the Bay-Arenac Community Mental Health Services Board. All information submitted by me in this application is true to the best of my knowledge and belief. I certify that the customers listed above have given consent to serve as a reference for the purposes of this application.**I verify that all professional staff and other health services staff who deliver direct services to our clients are current and in good-standing with their respective licensing and/or certifying board or agency. I also verify that those employees, who do not yet have their license and/or certification, have a plan and are working to obtain the appropriate license and/or certification. I also verify relevant legal background checks were made as well as educational credentials.**I understand that any contractual relationship with Bay-Arenac Behavioral Health Authority, may be subject to termination if I fail to comply with any of the regulations or policies specified.***Declaring that the statements made in this application are true, I hereby make application and request to become a part of the board’s provider network:** |
|  |
| Signature of Applicant | Date |

Return all pages and supporting materials via to elewis@babha.org, via fax to (989) 497-1531, or mail to:

 **Bay-Arenac Behavioral Health**

 **Attn: Contract Department**

 **201 Mulholland**

 **Bay City, MI 48708**