**Provider Network Application Form**

|  |  |  |
| --- | --- | --- |
| 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: | |  | |

|  |
| --- |
| 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*

|  |  |  |  |
| --- | --- | --- | --- |
| **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)* | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: | | | | |  | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Third Party Reimbursement Provider Numbers (if applicable):**  *Please list any third party reimbursement numbers* | | | | | | | | | | |
| Type: | Medicare  Medicaid | | | *Provider Number:*  *Provider Number:* | |  | | | | |
|  | | | | |
|  | | | | |
| List of Third Party /  Commercial Insurances Accepted: | | | | | |  | | | | |
|  | | | | |
|  | | | | | |  | | | | |
| **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:** | |  |
|  | | | | |  |
|  | | | | |  |
|  | | | | |  |
| **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).* | | | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 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 Management  Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Proposed Rate |
|| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **TREATMENT CAPACITY** **(Indicate how many treatment or service “slots” are available):** | \_\_\_\_\_\_ |
| **Additional Comments:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | |
|  | |

|  |  |  |
| --- | --- | --- |
| **Alternative Language resources:**  *Please identify any staff persons fluent in a non-English language* | | |
| **Name & Title:** | **Language(s) spoken:** |  |
|  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  | | | | | | |
|  | | | | | |  | | | | | | |
|  | | | | | |  | | | | | | |
|  | | | | | |  | | | | | | |
| **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)*** | | | | | | | |  | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **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)*** | | |  |

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 of  conviction(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,* ***preferably CMH Boards*** *(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](mailto: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**