SHIAWASSEE COUNTY COMMUNITY
Mental Health Authority

PROVIDER NETWORK APPLICATION FORM

Organization type:

- ☐ INPATIENT PSYCHIATRIC SERVICES
- ☐ COMMUNITY LIVING SUPPORTS/SIH
- ☐ SPECIALIZED RESIDENTIAL (GROUP HOME)
- ☐ SUBSTANCE USE DISORDERS
- ☐ INDIVIDUAL
- ☐ LICENSED INDEPENDENT PRACTITIONERS
- ☐ PRIMARY CARE
- ☐ SPECIALIZED RESIDENTIAL (INDIV. PLACEMENT)
- ☐ VOCATIONAL SERVICES

LEGAL NAME OF ORGANIZATION/INDIVIDUAL: _____

Mailing/Billing Address: _____

_____

Phone Number: _____ Fax: _____

National Provider Identifier (NPI) Number: _____

Federal Tax ID Number: _____

Are you exempt from Federal Income Tax?

☐Yes ☐No

If Yes, please attach copy of tax exempt certificate

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: _____

Shiawassee County Community Mental Health
PO Box 428, Owosso, Michigan 48867
Phone 989.723.6791
Fax 989.725.5061

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:
Please indicate services offered and proposed rate (specify per unit or per event)

☐Applied Behavioral Service Monitoring Proposed Rate Proposed Rate

Services Provided at
this Location:

- ☐ Assertive Community Treatment (ACT) _____
- ☐ CLS/Housing Assistance _____
- ☐ CLS/Medical Supplies _____
- ☐ CLS/Support Staff _____
- ☐ Crisis Intervention _____
- ☐ Crisis Residential _____
- ☐ Crisis Stabilization _____
- ☐ CSM Face to Face Contact _____
- ☐ Enhanced Dental _____
- ☐ Enhanced Health Services _____
- ☐ Family Skills Development _____
- ☐ Group Therapy _____
- ☐ Health Assessment _____
- ☐ Health Services _____
- ☐ Home Based Contact _____
- ☐ Individual Therapy _____
- ☐ Inpatient Hospital Day _____
- ☐ Interpreter _____
- ☐ Lab Services _____
- ☐ Medication Administration _____
- ☐ Medical Certification _____
- ☐ Medication Review _____
- ☐ Nutritional Services _____
- ☐ Occupational Therapy _____
- ☐ Partial Hospital _____
- ☐ Peer Directed and Operated Services _____
- ☐ Person Centered Planning _____
- ☐ Physical Therapy _____
- ☐ Prevention _____
- ☐ Psychiatric Assessment on a Medical Floor _____
- ☐ Psychiatric Evaluation _____
- ☐ Psychiatric Follow Up and Subsequent Care _____

_____

- ☐ Psychological Testing _____
- ☐ Psychotropic Pharmacy _____
- ☐ Residential-Adult _____
- ☐ Residential-Child _____
- ☐ Respite _____
- ☐ Skill Building Assistance _____
- ☐ Speech Therapy _____
- ☐ Supported Independent Housing _____
- ☐ Transportation _____
- ☐ Wraparound _____
- ☐ Supports Coordination _____
- ☐ Supported Employment _____

_____

Substance Abuse: _____

- ☐ Assessment _____
- ☐ Group Outpatient _____
- ☐ Individual Outpatient _____
- ☐ Intensive Outpatient _____
- ☐ Long Term Residential _____
- ☐ Methadone-Pharmacologic _____
- ☐ Residential Detox _____
- ☐ Screening/Eligibility _____
- ☐ Short Term Residential _____
- ☐ Case Management _____

_____

Other: _____

- ☐ _____ _____
- ☐ _____ _____
- ☐ _____ _____
- ☐ _____ _____
- ☐ _____ _____
- ☐ _____ _____
- ☐ _____ _____
- ☐ _____ _____

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:**

THIRD PARTY REIMBURSEMENT PROVIDER NUMBERS (IF APPLICABLE):
Please list any third party reimbursement numbers

Type: ☐ Medicare *Provider Number:* _____
☐ Medicaid *Provider Number:* _____

List of Third Party /
Commercial Insurances Accepted: _____

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**	**Hearing Impaired**
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)

SANCTIONS:
Has the organization/individual 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

Additional Information:

Organizations: Complete Appendix A
Individuals: Complete Appendix B

I fully understand that any misstatements in, or omissions from, this application may constitute cause for denial of membership to the provider network of Shiawassee County Community Mental Health Authority. 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 Shiawassee County Community Mental 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/Title Date

Appendix A

ORGANIZATION INFORMATION

CORPORATE CONTACT DATA:

NAME OF CEO: _____
TITLE: _____
PHONE NUMBER: _____

NAME OF BILLING PERSON: _____
TITLE: _____
PHONE NUMBER: _____

NAME OF CONTRACT MANAGER: _____
TITLE: _____
PHONE NUMBER: _____
EMAIL ADDRESS: _____

-

CREDENTIALING / PRIVILEGING

Please attach copies of the organization's credentialing and privileging policies and procedures (if applicable). Attach Employee Roster with credentials and privileges granted by your organization

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)(i.e. CARF, JHACO, COA,CHAP etc)

CERTIFIED OR ACCREDITED BY:		**EXPIRATION DATE:**	
	_____		_____
	_____		_____
	_____		_____

MEDICAL DIRECTOR PROFILE:

Name: _____
Hospital Affiliations: _____
Medical Training: _____
Board Certification: _____

RECIPIENT RIGHTS ADVISOR NAME: _____

Appendix B
INDIVIDUAL INFORMATION

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		

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
2. Have you ever refused membership on a hospital medical or allied health staff?	☐ Yes	☐ No
3. Has your request for any specific privileges ever been suspended, diminished, revoked or voluntarily or involuntarily not renewed?	☐ Yes	☐ No
4. Have your privileges at any hospital ever been suspended, diminished, revoked or voluntarily or involuntarily not removed?	☐ Yes	☐ No
5. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	☐ Yes	☐ No
6. Are you currently engaged in the use of illegal controlled substances?	☐ Yes	☐ No
7. 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
8. Have you ever been convicted of a crime (felony or misdemeanor)? If Yes, please explain and give dates of conviction(s):	☐ Yes	☐ No
9. Do you have any felony charges pending against you? If Yes, please explain:	☐ Yes	☐ No

Criminal background checks may be conducted on prospective providers of Shiawassee County Community Mental Health. New providers may not be added to the provider network until Verification is received through primary source of information.

Photo ID verified by _____

REFERENCES:
List three references (include full name, address and phone number)

1. _____

2. _____

3. _____

APPROVED FOR FY 2008/FY 2009