



SHIAWASSEE COUNTY COMMUNITY
Mental Health Authority

PROVIDER NETWORK APPLICATION FORM

- Organization type:
- | | |
|---|---|
| <input type="checkbox"/> INPATIENT PSYCHIATRIC SERVICES | <input type="checkbox"/> LICENSED INDEPENDENT PRACTITIONERS |
| <input type="checkbox"/> COMMUNITY LIVING SUPPORTS/SIH | <input type="checkbox"/> PRIMARY CARE |
| <input type="checkbox"/> SPECIALIZED RESIDENTIAL (GROUP HOME) | <input type="checkbox"/> SPECIALIZED RESIDENTIAL (INDIV. PLACEMENT) |
| <input type="checkbox"/> SUBSTANCE USE DISORDERS | <input type="checkbox"/> VOCATIONAL SERVICES |
| <input type="checkbox"/> INDIVIDUAL | |

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: _____

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)

<input type="checkbox"/> Applied Behavioral Service Monitoring	Proposed Rate	Proposed Rate
Services Provided at this Location:	_____	_____

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	Developmentally 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)***

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