



PROVIDER NETWORK APPLICATION FORM

- Organization type:
- | | |
|---|---|
| <input type="checkbox"/> INPATIENT PSYCHIATRIC SERVICES | <input type="checkbox"/> LICENSED INDEPENDENT PRACTITIONERS |
| <input type="checkbox"/> COMMUNITY LIVING SUPPORTS NON-LICENSED | <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: _____

ADDITIONAL COMMENTS: _____

SERVICES PROVIDED:

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

<input type="checkbox"/> Applied Behavioral Service Monitoring	Proposed Rate	<input type="checkbox"/> Psychological Testing	Proposed Rate
<input type="checkbox"/> Assertive Community Treatment (ACT)	_____	<input type="checkbox"/> Psychotropic Pharmacy	_____
<input type="checkbox"/> CLS/Housing Assistance	_____	<input type="checkbox"/> Residential-Adult	_____
<input type="checkbox"/> CLS/Medical Supplies	_____	<input type="checkbox"/> Residential-Child	_____
<input type="checkbox"/> CLS/Support Staff	_____	<input type="checkbox"/> Respite	_____
<input type="checkbox"/> Crisis Intervention	_____	<input type="checkbox"/> Skill Building Assistance	_____
<input type="checkbox"/> Crisis Residential	_____	<input type="checkbox"/> Speech Therapy	_____
<input type="checkbox"/> Crisis Stabilization	_____	<input type="checkbox"/> Supported Independent Housing	_____
<input type="checkbox"/> CSM Face to Face Contact	_____	<input type="checkbox"/> Transportation	_____
<input type="checkbox"/> Enhanced Dental	_____	<input type="checkbox"/> Wraparound	_____
<input type="checkbox"/> Enhanced Health Services	_____	<input type="checkbox"/> Supports Coordination	_____
<input type="checkbox"/> Family Skills Development	_____	<input type="checkbox"/> Supported Employment	_____
<input type="checkbox"/> Group Therapy	_____		
<input type="checkbox"/> Health Assessment	_____	Substance Abuse:	
<input type="checkbox"/> Health Services	_____	<input type="checkbox"/> Assessment	_____
<input type="checkbox"/> Home Based Contact	_____	<input type="checkbox"/> Group Outpatient	_____
<input type="checkbox"/> Individual Therapy	_____	<input type="checkbox"/> Individual Outpatient	_____
<input type="checkbox"/> Inpatient Hospital Day	_____	<input type="checkbox"/> Intensive Outpatient	_____
<input type="checkbox"/> Interpreter	_____	<input type="checkbox"/> Long Term Residential	_____
<input type="checkbox"/> Lab Services	_____	<input type="checkbox"/> Methadone-Pharmacologic	_____
<input type="checkbox"/> Medication Administration	_____	<input type="checkbox"/> Residential Detox	_____
<input type="checkbox"/> Medical Certification	_____	<input type="checkbox"/> Screening/Eligibility	_____
<input type="checkbox"/> Medication Review	_____	<input type="checkbox"/> Short Term Residential	_____
<input type="checkbox"/> Nutritional Services	_____	<input type="checkbox"/> Case Management	_____
<input type="checkbox"/> Occupational Therapy	_____		
<input type="checkbox"/> Partial Hospital	_____	Other:	
<input type="checkbox"/> Peer Directed and Operated Services	_____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> Person Centered Planning	_____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> Physical Therapy	_____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> Prevention	_____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> Psychiatric Assessment on a Medical Floor	_____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> Psychiatric Evaluation	_____	<input type="checkbox"/> _____	_____
<input type="checkbox"/> Psychiatric Follow Up and Subsequent Care	_____	<input type="checkbox"/> _____	_____
	_____	<input type="checkbox"/> _____	_____
	_____	<input type="checkbox"/> _____	_____

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)							

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 will be conducted on prospective providers of Shiawassee County Community Mental Health.

Photo ID verified by _____

REFERENCES:

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

1. _____
2. _____
3. _____