SHIAWASSEE
Health & Wellness

# PROVIDER NETWORK APPLICATION FORM

Organization type:

- ☐ INPATIENT PSYCHIATRIC SERVICES
- ☐ COMMUNITY LIVING SUPPORTS NON-LICENSED
- ☐ 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 Health and Wellness
1555 Industrial Drive
Owosso, Michigan 48867
Phone 989.723.6791 Fax 989.725.5061

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

| | Proposed Rate | | Proposed Rate |
|---|---|---|---|
| ☐ Applied Behavioral Service Monitoring | | ☐ Psychological Testing | |
| ☐ Assertive Community Treatment (ACT) | | ☐ Psychotropic Pharmacy | |
| ☐ CLS/Housing Assistance | | ☐ Residential-Adult | |
| ☐ CLS/Medical Supplies | | ☐ Residential-Child | |
| ☐ CLS/Support Staff | | ☐ Respite | |
| ☐ Crisis Intervention | | ☐ Skill Building Assistance | |
| ☐ Crisis Residential | | ☐ Speech Therapy | |
| ☐ Crisis Stabilization | | ☐ Supported Independent Housing | |
| ☐ CSM Face to Face Contact | | ☐ Transportation | |
| ☐ Enhanced Dental | | ☐ Wraparound | |
| ☐ Enhanced Health Services | | ☐ Supports Coordination | |
| ☐ Family Skills Development | | ☐ Supported Employment | |
| ☐ Group Therapy | | | |
| ☐ Health Assessment | | **Substance Abuse:** | |
| ☐ Health Services | | ☐ Assessment | |
| ☐ Home Based Contact | | ☐ Group Outpatient | |
| ☐ Individual Therapy | | ☐ Individual Outpatient | |
| ☐ Inpatient Hospital Day | | ☐ Intensive Outpatient | |
| ☐ Interpreter | | ☐ Long Term Residential | |
| ☐ Lab Services | | ☐ Methadone-Pharmacologic | |
| ☐ Medication Administration | | ☐ Residential Detox | |
| ☐ Medical Certification | | ☐ Screening/Eligibility | |
| ☐ Medication Review | | ☐ Short Term Residential | |
| ☐ Nutritional Services | | ☐ Case Management | |
| ☐ Occupational Therapy | | Other: | |
| ☐ 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 | | ☐ _____ | |

**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:**

*Attach a copy of the current certificate of insurance*

**GENERAL LIABILITY INSURANCE**

*Attach a copy of the current certificate of insurance*

**WORKER'S COMPENSATION INSURANCE**

*Attach a copy of the current certificate of insurance*

**AUTOMOBILE INSURANCE (IF TRANSPORTING CONSUMERS)**

*Attach a copy of the current certificate of insurance*

**PROPERTY INSURANCE (IF A RESIDENTIAL PROVIDER):**

*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

**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:

**NAME OF SECURITY OFFICER:**
TITLE:
PHONE NUMBER:
EMAIL ADDRESS:

**NAME OF HIPAA OFFICER:**
TITLE:
PHONE NUMBER:
EMAIL ADDRESS:

**NAME OF RECIPIENT RIGHTS ADVISOR**
TITLE:
PHONE NUMBER:
EMAIL ADDRESS:

**MEDICAL DIRECTOR PROFILE:**
Name:
Hospital Affiliations:
Medical Training:
Board Certification:

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**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. (I.e.; CARF, TJC, COA, CHAP etc.)*

**CERTIFIED OR ACCREDITED BY:**

**EXPIRATION DATE:**

*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.*

*Any changes to the information provided in this application will be conveyed to Shiawassee County Community Mental Health Authority at least thirty days before the intended effective date of change.*

*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