



PROVIDER PANEL APPLICATION

INITIAL ANNUAL

(To be used for single service program/license and updated at time of change or every two years at minimum.)

CORPORATE/BUSINESS INFORMATION *Submit copy of filed paperwork.*

Corporate/Legal Name:		
Owner:	Email Address:	
Mailing Address:		
Billing Address (if different than mailing):		
Telephone #:	Fax #:	E-Mail:

ADMINISTRATIVE INFORMATION

Program Manager:	Email Address:
Phone:	
Mailing Address:	
Most Recent Independent Audit:	Auditor:
Tax Identification Number (TIN):	Payee:
Medicaid #: (if applicable)	Medicare #: (if applicable)
NPI # (s): (if applicable) <i>(attach verification form from website)</i>	
Primary Contact for Application:	Contact #:
Credentialing Contact, if applicable:	Contact #:
Compliance Officer:	Contact #:

TYPE OF ORGANIZATION *(Please check one)* **(Submit copy of filed paperwork.)**

<input type="checkbox"/> Federal	<input type="checkbox"/> State	<input type="checkbox"/> City	<input type="checkbox"/> County
<input type="checkbox"/> Privately Owned	<input type="checkbox"/> Private Non-Profit	<input type="checkbox"/> For Profit	<input type="checkbox"/> Other:

LICENSURE/CERTIFICATION - *Attach a copy of your license, most recent licensing report and any plan of correction that was required.*

Is the organization licensed/certified in the State of Michigan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Type _____ License # _____ Exp. Date _____			
How many people / beds are you licensed to serve?	If applicable.		
Attach a copy of your license, most recent licensing report and any plan of correction that was required.			

ACCREDITATION **(Attach copy of most recent report and Plan of Correction, if applicable.)**

Is the organization/facility accredited?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, by:
	<input type="checkbox"/> MDCH	<input type="checkbox"/> CARF	<input type="checkbox"/> JCAHO
	<input type="checkbox"/> NCQA	<input type="checkbox"/> URAC	<input type="checkbox"/> OTHER:
Date of most recent accreditation cycle – From _____ to _____			
Program(s) accredited:			

LIABILITY/INSURANCE INFORMATION **(Attach copy of insurance documents.)**

Company name of liability carrier: _____
Policy number: _____

LIMITS:	Per Occurrence: _____ Aggregate: _____
DATES:	Effective Date: _____ Expiration Date: _____

WORKERS COMPENSATION INFORMATION - *Please attach a current copy of the policy face sheet with limits and expiration dates listing coverage for all facility sites: ALL ADDRESSES must be listed.*

Company name: _____
Policy number: _____
LIMITS: Per Occurrence: _____ Aggregate: _____
DATES: Effective Date: _____ Expiration Date: _____

ORGANIZATIONAL PROFILE - *Please complete the following sections in their entirety. Responses need to cover the past five (5) years to the present.*

	Yes	No	N/A
Has the organization's state license/certification ever been revoked, suspended, or limited?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there action pending to suspend, revoke, or limit the organization's license/certification?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the organization ever had its accreditation revoked, suspended or limited?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there action pending to revoke, suspend, or limit the organization's accreditation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the organization ever had sanctions imposed by Medicaid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the organization ever had sanctions imposed by Medicare?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the organization ever been denied professional liability insurance or has its insurance ever been canceled or denied renewal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the organization ever been a defendant in any lawsuit in regard to the practice of mental health or substance abuse treatment where there has been an award or payment of \$50,000 or more?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the organization had any malpractice claims in regard to the practice of mental health or substance abuse treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "YES" to any of the above questions, please provide the current status and details on a separate sheet of paper. Include the following: description of incident, correspondence with state licensing boards, and/or a detailed description of any litigation, including settlements, court awards, etc. Please feel free to include a personal summary of the events; however, your application cannot be processed without the necessary official documentation.

PROGRAM PROFILE – *Check all that apply.*

<input type="checkbox"/> Assertive Community Treatment	<input type="checkbox"/> Outpatient Clinic – Individual/Group Therapy
<input type="checkbox"/> Assistance w/Challenging Behavior	<input type="checkbox"/> Peer Delivered or Operated Services
<input type="checkbox"/> Targeted Case Management	<input type="checkbox"/> Psycho-Social Rehabilitation Program
<input type="checkbox"/> Supports Coordination	<input type="checkbox"/> Respite Care
<input type="checkbox"/> Community Living Supports:	<input type="checkbox"/> Skill Building: <input type="checkbox"/> MI <input type="checkbox"/> DD
<input type="checkbox"/> MI <input type="checkbox"/> DD	<input type="checkbox"/> Nursing
<input type="checkbox"/> CLS Supervised Apartments:	<input type="checkbox"/> Medication Management
<input type="checkbox"/> MI <input type="checkbox"/> DD	<input type="checkbox"/> Other – Specify _____
<input type="checkbox"/> Children's Model Waiver	
<input type="checkbox"/> Children's Residential	<input type="checkbox"/> Crisis Residential Services
<input type="checkbox"/> Family Support Services: <input type="checkbox"/> MI <input type="checkbox"/> DD	<input type="checkbox"/> Inpatient Psychiatric Hospital
<input type="checkbox"/> Home Based (MDCH Certification Required)	<input type="checkbox"/> Partial Hospital Program
<input type="checkbox"/> CLS - Licensed Residential Setting	<input type="checkbox"/> SA Outpatient Program
<input type="checkbox"/> Personal Care – Lic. Residential Setting	<input type="checkbox"/> SA Residential Services
<input type="checkbox"/> Supported Employment	<input type="checkbox"/> SA Detoxification Services
<input type="checkbox"/> Ancillary:	<input type="checkbox"/> SA Methadone Services
<input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech <input type="checkbox"/> Dietary	<input type="checkbox"/> Co-occurring Residential
	<input type="checkbox"/> Co-occurring Outpatient

AGE GROUP AND GENDER SERVED - *Please indicate the age groups for which this program provides treatment.*

Age Group	Male (√)	Female (√)
Child (6-12)	<input type="checkbox"/>	<input type="checkbox"/>
Adolescent (13-17)	<input type="checkbox"/>	<input type="checkbox"/>
Adult (18-64)	<input type="checkbox"/>	<input type="checkbox"/>
Senior (65 & up)	<input type="checkbox"/>	<input type="checkbox"/>

Please respond to the following questions regarding the program/license:

	Yes	No
Does this service address comply with ADA regulations?	<input type="checkbox"/>	<input type="checkbox"/>
Is this service address accessible by public transportation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you accept Medicaid?	<input type="checkbox"/>	<input type="checkbox"/>
Do you accept Medicare?	<input type="checkbox"/>	<input type="checkbox"/>
Are you CHAMPUS authorized at this address?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a provider agreement with BCBS for this address?	<input type="checkbox"/>	<input type="checkbox"/>
List all HMOs with which you have a provider agreement:		
Please list any other provider agreements for this address:		

HOURS OF OPERATION

MON	TUES	WED	THUR	FRI	SAT	SUN

LANGUAGE COMPETENCE - In addition to English, please list the languages in which the program conducts treatment.

--

SPECIAL ACCOMMODATIONS

Please indicate if you have the capability to treat the following. Check all that apply. <input type="checkbox"/> Hearing-Impaired <input type="checkbox"/> Visually Impaired <input type="checkbox"/> Speech Impaired <input type="checkbox"/> Other (Specify): _____

PROGRAM/LICENSEE STAFF ROSTER – List all owners, operators, and employees. Attached additional page(s) if necessary.

Name Last, First	Degree	Licensure Exp. Date	Job Title

CLS and Licensed Residential Care Providers Only Not applicable

Community Living Supports (CLS)/Personal Care in Licensed Setting: Provide enhanced staffing patterns per home.

Day of Week	1 st Shift	2 nd Shift	3 rd Shift
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			
Total FTE Staffing:			

Staff Training: Please provide a description of how your organization evaluates initial and ongoing competency of your staff including types of training, frequency required, and curriculum resources.

Training Contact Person: _____ **Contact #:** _____

Certification, Release, and Signature

I hereby certify that all information contained in this application, and all its attachments, are accurate, complete, and true.

I understand that in making this application to NorthCare Network, the facility agrees:

- (a) That any information contained in this application which subsequently is found to be false could result in denial of my application or termination of participation in NorthCare’s Provider Network;
- (b) That it is the facility’s responsibility to promptly advise NorthCare Network, of any changes or additions to the information contained in this application;
- (c) That all information contained in this application or its attachments is subject to NorthCare Network’s investigation and review; and
- (d) That this is an application only and that submission of this application does not automatically result in participation in the NorthCare Provider Network.
- (e) That this application may be shared with any or all Member CMHSPs in the NorthCare Network.

We hereby authorize NorthCare Provider Network to consult with administrators and members of the facility and/or institutions which the agency has been or is currently associated with, and others, including past and present malpractice carriers, who may have information bearing on professional competence, character, and ethical qualifications. We further consent to the inspection by representatives of NorthCare Provider Network of all documents that may be material to an evaluation of the facility’s professional competence, character, and ethical qualifications.

WE HEREBY RELEASE FROM LIABILITY ALL REPRESENTATIVES OF NORTHCARE NETWORK, FOR THEIR ACTS PERFORMED IN GOOD FAITH AND WITHOUT MALICE IN CONNECTION WITH EVALUATING THIS APPLICATION, CREDENTIALS, AND QUALIFICATIONS, AND WE RELEASE FROM ANY LIABILITY ANY AND ALL INDIVIDUALS AND ORGANIZATIONS WHO PROVIDE INFORMATION TO NORTHCARE NETWORK, IN GOOD FAITH AND WITHOUT MALICE CONCERNING PROFESSIONAL COMPETENCE, CHARACTER, AND ETHICS. WE HEREBY CONSENT TO THE RELEASE AND EXCHANGE OF INFORMATION RELATING TO ANY DISCIPLINARY ACTION, SUSPENSION, OR CURTAILMENT OF PROFESSIONAL CLINICAL APPOINTMENTS AND/OR CLINICAL SERVICES TO NORTHCARE NETWORK.

All applications for participation in the NorthCare Provider Network shall be reviewed by NorthCare Network. NorthCare Network has final authority for membership in the Provider Network. In the event that the agency, facility, or institution is accepted for participation in the NorthCare Provider Network, we hereby consent to NorthCare Network’s inspection of the records of mutually served individuals as necessary for its quality, peer and utilization review processes.

It is understood that we (I) abide by applicable by-laws, rules and regulations, policies and procedures of the NorthCare Network as in force at the time of this application and as amended, and agree to be bound by the terms thereof in all matters related to the consideration of this application.

It is understood that failure to comply with the agreements specified above or providing inaccurate, incorrect, or withholding information on this application will automatically terminate appointment as a provider of behavioral service in the NorthCare Provider Network.

By signing this application, the facility gives consent for verification of the information provided in this application.

Signature of Facility CEO or Designated Representative

Date

A PHOTOCOPY OF THIS DOCUMENT SHALL BE EFFECTIVE AS THE ORIGINAL.