NORTHCARE NETWORK

PROVIDER PANEL and CREDENTIALING APPLICATION

☐ INITIAL ☐ UPDATE

(To be used by Organizations w/multiple service programs/licenses and updated at time of change or every two years at minimum.)

CORPORATE/BUSINESS INFORMATION

Corporate/Legal Name:		
Organization/DBA Name:		
Mailing Address:		
City:	State:	Zip Code:
Billing Address (if different than mailing):		
City:	State:	Zip Code:
Telephone #:	Fax #:	E-Mail:

ADMINISTRATIVE INFORMATION

Chief Executive Officer:	
Chief Financial Officer:	
Chief Operating Officer:	
Medical Director:	
Clinical Director:	
Business Manager:	
Recipient Rights Officer:	Contact #:
Compliance Officer:	Contact #:
Quality Improvement Officer:	Contact #:
Primary Contact for Application:	Contact #:
Secondary Contact for Application:	Contact #:
Credentialing Contact:	Contact #:

TYPE AND OWNERSHIP - ***Important Note:*** *All programs listed in this application must correspond to the TIN and Payee listed below. If there is more than one TIN, an additional application must be completed.*

Parent Corporation or Owner of Organization:			
Address if Different Than Above:		State:	Zip Code:
Most Recent Independent Audit:	Auditor:		
TIN:	Payee:		
Medicaid #: (if applicable)	Provider Type:		
Medicare #: (if applicable)			
NPI # (s): (if applicable) (attach verification form from website)			

TYPE OF ORGANIZATION (*Please check one)*

☐ Federal ☐ State ☐ City ☐ County
☐ Privately Owned ☐ Private Non-Profit ☐ For Profit ☐ 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? Yes ☐ No ☐ N/A ☐
Type _____License # _____ Exp. Date _____

ACCREDITATION

Is the organization/facility accredited? ☐ Yes ☐ No If yes, by:
☐ MDCH ☐ CARF ☐ JCAHO ☐ NCQA ☐ URAC ☐ OTHER:_____

Date of most recent accreditation cycle - From_____ to _____
Program(s) accredited:_____
_____

LIABILITY/INSURANCE INFORMATION

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?	☐	☐	☐
Is there action pending to suspend, revoke, or limit the organization's license/certification?	☐	☐	☐
Has the organization ever had its accreditation revoked, suspended or limited?	☐	☐	☐
Is there action pending to revoke, suspend, or limit the organization's accreditation?	☐	☐	☐
Has the organization ever had sanctions imposed by Medicaid?	☐	☐	☐
Has the organization ever had sanctions imposed by Medicare?	☐	☐	☐
Has the organization ever been denied professional liability insurance or has its insurance ever been canceled or denied renewal?	☐	☐	☐
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?	☐	☐	☐
Has the organization had any malpractice claims in regard to the practice of mental health or substance abuse treatment?	☐	☐	☐

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 - ***If your organization is applying to provide more than one of the identified program types listed below, a Program Profile needs to be completed for each program/licensed service.*** *Please copy this entire section for programs that apply. (A separate profile should be completed for each license residential setting if under one Corporate/Business licensed name.)*

PROGRAM/LICENSE NAME/LOCATION/TYPE

Name	Address	City	State	Zip Code
Phone number	**Fax number**			

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

TYPE OF PROGRAM/LICENSE (*Please check one*)

☐ Partial Hospitalization - free standing	☐ Psychiatric Hospital
☐ Partial Hospitalization - hospital based	☐ SUD Detoxification Tx Center
☐ Specialized Residential	☐ Other, please specify
☐ SUD Residential TX Center	
☐ SUD Outpatient Service Facility/Clinic	
☐ General Hospital with psychiatric unit	

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

Age Group	Male (√)	Female (√)
Child (6-12)	☐	☐
Adolescent (13-17)	☐	☐
Adult (18-64)	☐	☐
Senior (65 & up)	☐	☐

PROGRAM DIRECTOR, LOCATION, AFFILIATION, AND CERTIFICATION

Program Director: _____Clinical Contact: _____

LICENSURE/CERTIFICATION

Is the Program licensed/certified in the State of Michigan? Yes ☐ No ☐ 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

Is the Program accredited? ☐ Yes ☐ No If yes, by:
☐ MDCH ☐ CARF ☐ JCAHO ☐ NCQA ☐ URAC ☐ OTHER:_____

Date of most recent accreditation cycle - From_____ to _____

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

	Yes	No
Does this service address comply with ADA regulations?	☐	☐
Is this service address accessible by public transportation?	☐	☐
Do you accept Medicaid?	☐	☐
Do you accept Medicare?	☐	☐
Are you CHAMPUS authorized at this address?	☐	☐
Do you have a provider agreement with BCBS for this address?	☐	☐
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.
☐ Hearing-Impaired ☐ Visually Impaired ☐Speech Impaired ☐ Other (Specify): _____

PROGRAM/LICENSEE STAFF ROSTER – 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	1st Shift	2nd Shift	3rd 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.