Behavioral Health Facility/Agency – Credentialing Application

<u>ATTACHMENTS NEEDED</u> please include with your completed application the following items for each location.

- ☐ W-9 Form completed, signed and dated
- ☐ Disclosure of Ownership Form completed, signed and dated
- ☐ Copy of current State License/State approval (as applicable)
- ☐ Copy of Medicare/Medicaid Participation Certification (as applicable)
- ☐ Copy of Certifications and/or Accreditation Certificates (e.g. Medicare, etc.)
- ☐ Copy of CLIA certification (as applicable)
- ☐ Copy of State certification for atypical, non BCBA autism providers(if applicable)
- ☐ Letter of documentation for 1000 hours or treatment for atypical, non BCBA autism providers
- ☐ Copy of Declaration Sheet and/or Certificate of Insurance
  - **For facilities/programs with an acute inpatient component:** Professional/general liability $1,000,000/$3,000,000 minimum coverage
  - **For facilities/programs without an acute inpatient component:** Professional liability $1,000,000/$3,000,000 minimum coverage Comprehensive general liability $1,000,000/$3,000,000 minimum coverage

Please note:

- ☐ All applications must complete <u>all</u> questions (unless otherwise noted)
- ☐ Please check the N/A box if not applicable
- ☐ Applications that do not include all requested documents and responses to questions will not be able to be processed.
- ☐ Please return all documents via the method below:
  - Sunflower/Cenpatico: Attn: Credentialing, 12515-8 Research Blvd, Suite 400, Austin, TX 78759
  - UnitedHealthcare/Optum: Please return this application along with your contract to the address provided on your cover letter or directly to your assigned UnitedHealthcare/Optum Contractor.
  - Amerigroup:
    - If FedEx / UPS: Amerigroup, ATTN: Angela Pimentel, 1801 Sara Drive, Ste. H, Chesapeake, VA 23320
    - If regular mail: Amerigroup, ATTN: Angela Pimentel, PO Box 62509, Virginia Beach, VA 23466

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1. **Facility / Provider Name & Address: Note: legal name and DBA name must match W-9.**

Legal Name: ______________________________

DBA Name: ______________________________

Corporate Name (if different): ______________________________

Identify what best describes the organization (check)

MH	SA		MH	SA	
		Freestanding Day Treatment			Detox
		Freestanding IOP			Psychiatric Residential Treatment Facility
		General Hospital			Outpatient Clinic
		Federally Qualified Heath Center			Rural Health Center
		Psychiatric Hospital			Peer Support
		Methadone Maintenance			Tribe/Tribal Organization/Urban Indian Organization
		Community Mental Health Center			Residential Treatment Center

2. **Services Provided:**

Substance Use Facility Services (if applicable, check all that apply)

Level I - Outpatient	**Adult**	**Geri**	**Adol**	**Child**
Individual Counseling				
Group Counseling				
Level II - Intensive Outpatient Treatment/Partial Hospitalization	**Adult**	**Geri**	**Adol**	**Child**
Intensive Outpatient				
Partial Hospitalization				
Level III - Residential/Inpatient Treatment	**Adult**	**Geri**	**Adol**	**Child**
Reintegration				
Intermediate				
Acute detoxification				
Auxiliary Services	**Adult**	**Geri**	**Adol**	**Child**
Assessment/Referral				
Medicaid Case Management				
Peer Support				
Crisis Intervention				

Mental Health Facility Services (if applicable, check all that apply)

Outpatient Therapy and Medication Management Services	**Adult**	**Geri**	**Adol**	**Child**
Evaluation and Assessment				
Testing				
Individual Therapy				
Family Therapy				
Group Therapy				
Medication Management				
Medication Administration				
Case Consultation				
Rehabilitation Services	**Adult**	**Geri**	**Adol**	**Child**
Community Psychiatric Support and Treatment				
Psychosocial Rehabilitation				
Peer Support				
Crisis Intervention				

Targeted Case Management	Adult	Geri	Adol	Child
Targeted Case Management for the SPMI/SED populations				
Kan-be-Healthy	**Adult**	**Geri**	**Adol**	**Child**
Evaluation and Assessment				
Other	**Adult**	**Geri**	**Adol**	**Child**
Inpatient				
Emergency Room Services				
Intensive Outpatient				
Partial Hospitalization				
HCBS SED Waiver Services			**Adol**	**Child**
Parent Support and Training				
Short Term Respite Care				
Professional Resource Family Care				
Independent Living/Skill Building				
Wrap around Facilitation				
Attendant Care				

Federal Tax ID Number: ______________________ Is this Tax ID used for all locations? ☐ Yes ☐ No

NPI ______________________ Is this for all locations? ☐ Yes ☐ No

Taxonomy ______________________ Is this NPI used for all locations? ☐ Yes ☐ No

*If No, please list on a separate sheet of paper all numbers and the Legal Name for each

Primary Address: ____

City County ______________________

HANDICAP ACCESSIBLE	YES	NO	N/A
ADA Compliant	YES	NO	N/A

State ______________ Zip ____________

Phone (____) _____ - ______ Ext: ________ Fax: (_____) _____ - ______

Are in-home services offered? Yes No

Office Hours ☐ Open 24 hours - or complete hours of operations below

MON	TUES	WED	THU	FRI	SAT	SUN
What are your after hour arrangements?						

Credentialing Contact / Office Manager ______________________________

Phone (__) ___ - _____ Ext: _______ Fax: (___) ___ - _

E-Mail Address:

Billing Address: **Same as Primary** ☐ Yes ☐ No **If same as primary, do not complete this section**

Please indicate all billing addresses used, and include zip plus four if used.

Address ______________________________

City __ State ___ Zip __________

Phone (_____) ___ - ____ Ext: _____ Fax: (____) _ - _

Mailing Address: **Same as Primary** ☐ Yes ☐ No **If same as primary, do not complete this section**

Address ______________________________

City __ State ___ Zip __________

Phone (_____) ___ - ____ Ext: _____ Fax: (____) _ - _

CORPORATE/SYSTEM OWNER (as provided on W-9): ☐ **N/A**

Name: ______________________________

DBA Name: ______________________________

Address: ______________________________

City __ State . Zip __________

Phone (_____) ____ - ____ Ext: ___ Fax: (___) ___ - ___

4. **ADDITIONAL PRACTICE / OFFICE LOCATIONS?** ☐ Yes ☐ No **If yes, lease list other practice/office addresses.**

If additional space is needed, please attach a separate page.

STREET

CITY | COUNTY | ST | ZIP

PHONE | FAX

HANDICAP ACCESSIBLE ☐ YES ☐ NO ☐ N/A

ADA COMPLIANT ☐ YES ☐ NO ☐ N/A

What are your after hour arrangements?

☐ Open 24 hours - or complete hours of operations below

MON	TUES	WED	THU	FRI	SAT	SUN

STREET

CITY | COUNTY | ST | ZIP

PHONE | FAX

HANDICAP ACCESSIBLE ☐ YES ☐ NO ☐ N/A

ADA COMPLIANT ☐ YES ☐ NO ☐ N/A

What are your after hour arrangements?

☐ Open 24 hours - or complete hours of operations below

MON	TUES	WED	THU	FRI	SAT	SUN

STREET

CITY | COUNTY | ST | ZIP

☐ Open 24 hours - or complete hours of operations below

MON	TUES	WED	THU	FRI	SAT	SUN

PHONE | FAX

HANDICAP ACCESSIBLE ☐ YES ☐ NO ☐ N/A

ADA COMPLIANT ☐ YES ☐ NO ☐ N/A

What are your after hour arrangements?

5. **SERVICE COUNTIES** Check all counties you will be providing the above checked services

****If you provide different services in different counties, please attach explanation**

☐ Allen	Coffey	Geary	Johnson	Miami	Pratt	Sherman
☐ Anderson	Comanche	Gove	Kearny	Mitchell	Rawlins	Smith
☐ Atchison	Cowley	Graham	Kingman	Montgomery	Reno	Stafford
☐ Barber	Crawford	Grant	Kiowa	Morris	Republic	Stanton
☐ Barton	Decatur	Gray	Labette	Morton	Rice	Stevens
☐ Bourbon	Dickinson	Greeley	Lane	Nemaha	Riley	Sumner
☐ Brown	Doniphan	Greenwood	Leavenworth	Neosho	Rooks	Thomas
☐ Butler	Douglas	Hamilton	Lincoln	Ness	Rush	Trego
☐ Chase	Edwards	Harper	Linn	Norton	Russell	Wabaunse
☐ Chautauqua	Elk	Harvey	Logan	Osage	Saline	Wallace
☐ Cherokee	Ellis	Haskell	Lyon	Osborne	Scott	Washingtc
☐ Cheyenne	Ellsworth	Hodgeman	Marion	Ottawa	Sedgwick	Wichita
☐ Clark	Finney	Jackson	Marshall	Pawnee	Seward	Wilson
☐ Clay	Ford	Jefferson	McPherson	Phillips	Shawnee	Woodson
☐ Cloud	Franklin	Jewell	Meade	Pottawatomie	Sheridan	Wyandotte

6. **LICENSURE/CERTIFICATIONS**

Medicare Certified: ☐ **YES** ☐ **NO** (If YES, attach a copy CMS letter indicating Medicare # & effective date)

Medicare Numbers: ________ ________ ________ ________

Medicaid Certified: ☐ **YES** ☐ **NO** (If YES, attach a copy State letter indicating Medicaid # & effective date)

Medicaid Numbers: ________ ________ ________ ________

7. INSURANCE

Professional Liability/Malpractice Liability

Name of Corporate Entity on Declaration Sheet and/or Certificate of Insurance: ______________________

Name of Carrier	Eff. Date	Exp. Date	Coverage Amount Per Occurrence	Coverage Amount Aggregate	

1. Has the license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed? ☐ YES ☐ NO
2. Has the business been denied participation, suspended from or denied renewal from Medicare or Medicaid? ☐ YES ☐ NO
3. Has the business ever had its professional liability coverage cancelled but not renewed? ☐ YES ☐ NO
4. Has the business been denied accreditation by its selected accrediting body (e.g. JCAHO), or had its accreditation status reduced, suspended, revoked or in any way revised by the accrediting body? ☐ YES ☐ NO ☐ N/A
5. During the past five years, has the business entered into a settlement disposition of $100,000 or more for any malpractice claim? ☐ YES ☐ NO
6. Are there any malpractice claims pending against the business? ☐ YES ☐ NO

8. Accreditation Status

Check all that apply AND attach certificate of accreditation

☐ JCAHO/ TJC ☐ AOA ☐ AAAHC ☐ HFAP ☐ ACHC ☐ CHAP ☐ DNV ☐ COA ☐ CAH ☐ DNV

☐ CARF ☐ ABPCO ☐ NCQA ☐ URAC

☐ Other: ________________

Not Accredited:

Has provider had an on-site survey by CMS or State agency? ☐ Yes ☐ No Date of last State survey: ____/____/____
If no, successful completion of a health plan onsite visit will be required to complete credentialing. You will be contacted by the Health Plan to schedule the visit.

Non accredited providers must provide a copy of their most recent government agency survey (may not be older than 36 months) along with your Corrective Action Plan (if deficiencies were cited), OR attach letter from government agency stating Facility is in substantial compliance with most recent survey standards. Facilities who don't meet the requirements above require an onsite visit before network status may be granted. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.

Component Attestation/Consent & Release Form

☐ **Decline Sunflower State Health Plan**

I hereby understand that as a prospective/current Sunflower State Health Plan provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to Sunflower State Health Plan Credentials Committee for their review and approval, and, absent such affirmative approval, Sunflower State Health Plan members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from Sunflower State Health Plan. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Sunflower State Health Plan in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Sunflower State Health Plan credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

☐ **Decline UnitedHealthcare/Optum**

ANY ALTERATION OR FAILURE TO SIGN AND DATE THIS FORM WILL RESULT IN THE DELAY OF PROCESSING THIS APPLICATION

By signing below, I attest that I am the duly authorized representative of the Component, that all information on the Application pertains to the above-named Component, and that such information is current, complete and correct.

Your signature is required to complete this application. Stamped signatures are NOT acceptable.

☐ **Decline Amerigroup**

All information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify Amerigroup of any changes thereto. I understand that this application does not entitle me to participation in Amerigroup. By applying for appointment as an Amerigroup Participating Provider, I authorize the Plan, its medical director and appropriate representatives to consult with administrators and members of other institutions where I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by Amerigroup, its medical director and appropriate representatives of all records and documents, excluding medical records of non-members of Amerigroup's Plans, that may be material to an evaluation of any professional qualifications and competence to carry out the requested duties, as well as my moral and ethical qualifications for Participating Provider status with Amerigroup. I consent and agree that Amerigroup will complete a criminal history background check to determine if I or any Subcontracted Providers have any history of felony convictions, including adjudication withheld on a felony, plea or nolo contendere to a felony or entry into a pretrial for a felony. I agree to obtain any consents or approvals required for my Subcontracted Providers to undergo such background checks. I hereby release Amerigroup and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release any individuals and organizations from any liability that provide information to Amerigroup or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the Ancillary Agreement between me or my group and Amerigroup, as such terms may be applicable to me.

I understand that as an applicant for participation in Amerigroup, I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from Amerigroup, I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the Credentialing Committee, if they so request. I further understand that I may appeal the Committee's decision either in writing or by appearance before the Credentialing Committee, if they so request.

Business Name: ______________________________

Authorized Representative Name (Print or Type) ______________________________

Title: ______________________________

Signature: ______________________________

Date:

Non-Program Based Agency Data:

Please fill in the following information: Expertise, Language(s), Ethnicity(ies), and Population Treated for Primary Practice Address

Practice Address # 1 (Primary) ______________________ City ____________________ State _____ Zip ____________

Provider Name	**Check if Applicable**	**Special Interest**
		Schizophrenia and Schizoaffective
		Bipolar Disorders
		Depressive Disorders
		Anxiety Disorders
		PTSD
		ADHS
		Personality Disorders
Please write in any additional certifications in evidence based practices		
Provider Name	**Check if Applicable**	**Special Interest**
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		Depressive Disorders
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		Depressive Disorders
		Anxiety Disorders
		PTSD
		ADHS
		Personality Disorders
Please write in any additional certifications in evidence based practices		

Language(s) spoken by clinicians within Agency (write in): ______________________

Ethnicity(ies) of clinicians (write in): ______________________

Gender(s): Male ☐ Female ☐

Age Range Served

Geriatric (65 yrs or more)	☐ Yes	☐ No
Adult (18 – 64 years)	☐ Yes	☐ No
Adolescent (13 – 17 years)	☐ Yes	☐ No
Child (12 yrs or less)	☐ Yes	☐ No

Indicate any additional services that you provide (other than traditional outpatient services):

Staff Roster Data

Please provide the following information for independently licensed staff (or state approved non-independent licensed providers) who will be submitting claims. We do not require a copy of their license or certification. Non-licensed staff are not loaded individually and should not be included.

Provider Name	SSN	DOB	Degree	TIN	License	DEA	NPI#	Medicaid # -if Required	Taxonomy	Specialty	Primary Address & phone	Remit Address