**Macomb County Community Mental Health**

**Provider Profile Application**

**ALL INFORMATION SUBJECT TO VERIFICATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CORPORATE**  **INFORMATION** | Corporate/Legal Name: | | | |
| Organization/DBA Name: | | | |
| Organization Mailing Address: | | | |
| City: | State: | Zip + 4 code: | |
| Billing Address (if different than mailing) | | | |
| Tel.:( ) | Fax:( ) | | E-Mail: |

|  |  |  |
| --- | --- | --- |
| **ADMINISTRATIVE**  **INFORMATION** | Chief Administrative Officer: | |
| Chief Financial Officer: | |
| Chief Medical Officer: | |
| Chief Clinical Manager: | |
| Respondent for Recipient Rights Complaints: | |
| Business Manager: | |
|  | Primary Contact Person: | E-mail: |
|  | Secondary Contact Person: | E-Mail: |
| **PLEASE ATTACH A LISTING OF THE PROGRAM’S CURRENT BOARD OF DIRECTORS (specifying number of primary and secondary consumers on Board)** | | |

|  |  |  |
| --- | --- | --- |
| **TYPE OF PROGRAM**  ***(Please check***  ***ALL that apply)*** | \_\_\_ Assertive Community Treatment  \_\_\_ Assistance w/Challenging Behavior  \_\_\_ Children’s Model Waiver  \_\_\_ Children’s Residential  \_\_\_ Case Management Services  \_\_\_ Community Living Supports ( \_\_\_ MI or \_\_\_ DD)  \_\_\_ Crisis Residential (Adult or Child)  \_\_\_ Day Programs  \_\_\_ Emergency/Crisis Unit – hospital based  \_\_\_ Family Support Services ( \_\_\_ MI or \_\_\_ DD)  \_\_\_ General Hospital  \_\_\_ Hab Waiver Services  \_\_\_ Home Based Services  \_\_\_ Intensive Crisis Stabilization Services | \_\_\_ O.T. \_\_\_ P.T. \_\_\_ SP & L  \_\_\_ Out of County Case Management Services  \_\_\_ Out of County Outpatient Services  \_\_\_ Out of County Residential Services  \_\_\_ Outpatient Clinic Mental Health Services  \_\_\_ Peer Delivered or Operated Services  \_\_\_ Psychiatric Hospital (Adult or Child)  \_\_\_ Psycho-Social Rehabilitation Programs  \_\_\_ Residential Group Home  \_\_\_ Respite Care  \_\_\_ Skill Building Services ( \_\_\_ MI or \_\_\_ DD)  \_\_\_ Supported Indep. Program (SIP)  \_\_\_ Wrap Around Services  \_\_\_ Other (specify): |

**TYPE OF ORGANIZATION** *(Please check one)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \_\_\_ Federal  \_\_\_ State  \_\_\_ County | \_\_\_ City  \_\_\_ Private Non-profit  \_\_\_ Privately Owned | | \_\_\_ Corporation  Partnership  LLC/LLP | |
| Parent Corporation or Owner of Organization: | | | | |
| Street Address: | | | | |
| City: | | State: | | Zipcode: |
| Telephone: ( ) | | Fax: ( ) | | |
| Name and Title of Corporate Executive Officer: | | | | |

***Important Note:*** *All programs listed in this application must correspond to the Tax Identification Number (TIN) and Payee listed below. If there is more than one TIN, an additional application must be completed.* ***Providers need to submit copy of Federal W-9.***

|  |  |  |
| --- | --- | --- |
| **TAX ID** | **TIN:** | **Payee:** |
| Medicaid # (if applicable): | Agency NPI # (if applicable): |
| Medicare # (if applicable): | |

**LICENSOR/CERTIFICATION AND/OR ACCREDITATION**

Is the organization state licensed/certified: \_\_\_\_\_ Yes *(If yes, complete the following license information*

\_\_\_\_\_ No *and attach a copy)*

|  |  |  |
| --- | --- | --- |
| Type: | License #: | Exp. Date: |
| Type: | License #: | Exp. Date: |
| Type: | License #: | Exp. Date: |
| Type: | License #: | Exp. Date: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | **Yes** | **No** | **N/A** | **Exp. Date** |
| **ACCREDITATION/CERTIFICATION** | Has the organization been reviewed and accredited by JCAHO? |  |  |  |  |
| Has the organization been reviewed and accredited by CARF? |  |  |  |  |
| Has the organization been certified by COA? |  |  |  |  |
| Has the organization been reviewed and accredited by DCH? |  |  |  |  |
| Has the organization been approved or certified by Medicaid? |  |  |  |  |
| Has the organization been approved or certified by Medicare? |  |  |  |  |
| Please indicate any other accreditation/certifications: | | | | |

***(Please attach a current copy of all Accreditation Award Letters or Certificates)***

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| **LIABILITY/INSURANCE**  **INFORMATION** | Company Name of Liability Carrier: | | |
| Policy Number: | | |
| LIMITS: | Per Occurrence: | Aggregate: |
| DATES: | Effective Date: | Expiration Date: |
| Company Name of Liability Carrier: | | |
| Policy Number: | | |
| LIMITS: | Per Occurrence: | Aggregate: |
| DATES: | Effective Date: | Expiration Date: |

*(Please attach a current copy of the policy face sheet with limits and expiration dates listing coverage for organization sites.* ***ALL ADDRESSES*** *must be listed.)*

**CERTIFICATION, RELEASE, AND SIGNATURE**

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

**I understand that in making this application to Macomb County Community Mental Health (CMH), the organization agrees to the following:**

1. any information contained in this application which subsequently is found to be false could result in denial of my application or termination of participation with MCCMH:
2. it is the organization’s responsibility to promptly advise CMH of any changes or additions to the information contained in this application;
3. all the information contained in this application or its attachments is subject to CMH investigation and review;
4. this is an application only and that submission of this application does not automatically result in participation in the CMH Provider Network; and
5. the information contained in this document provides a basis for monitoring of the contractual requirements between this agency and MCCMH. Information provided could result in adverse contract action including sanction, suspension or termination.
6. Except for what is noted on a separate attached sheet, there is no relationship between the contracting entity’s principal officers and board members and any member of MCCMHS (to include staff employees, Board members, and principal Directors). Disclosure must also be made regarding the contracting entity’s relationship with any member of the Macomb County Board of Commissioners, any Macomb County Department Head, or any member of the Office of the Macomb County Executive.

We hereby authorize the Macomb CMH to consult with administrators and members of the organization 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 Macomb CMH of all documents that may be material to an evaluation of the organization’s professional competence, character, and ethical qualifications.

WE HEREBY RELEASE FROM LIABILITY ALL REPRESENTATIVES OF MACOMB CMH 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 MACOMB CMH 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 PRIVILEGES AND/OR CLINICAL SERVICES TO THE MACOMB CMH PROVIDER NETWORK.

A. All applications for participation in the CMH Provider Network shall be reviewed by the CMH Business Management Division. Recommendations for CMH Provider Network participation will be forwarded to the CMH Board, or designee for approval.

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

B. In the event that the agency, organization, or institution is accepted for participation in the CMH Provider Network, we consent to CMH inspection of our patient records relating to consumers as necessary for its peer and utilization review process.

We understand that if this application is rejected for reasons relating to professional conduct or competence, CMH may report the rejection to the appropriate State licensing board and/or the National Practitioner Data Bank.

* 1. To abide by applicable bylaws, rules and regulations, policies and procedures of the CMH Provider Network as in force at the time of this application, and agree to be bound by the terms thereof in all matters related to the consideration of this application.
  2. Acknowledge the organization’s obligation to provide continuous care and supervision to all for whom we have responsibility, and that the organization will seek clinical consultation as necessary to insure the highest quality of consumer care.
  3. That the organization, or designee will be willing to appear before any appropriate committee of CMH with regard to 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 health service working with MCCMH.

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Signature of Organization CEO or Designated Representative Date

***A PHOTOCOPY OF THIS DOCUMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.***Rev. 09/03/11