**FORM A**

**Macomb County Community Mental Health - Office of Substance Abuse (MCOSA)**

**Provider Profile Application**

***ALL INFORMATION SUBJECT TO VERIFICATION***

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| **CORPORATE****INFORMATION** | Corporate/Legal Name: |
| Organization/DBA Name: |
| Organization Mailing Address: |
| City: | State: | Zip + 4 code: |
| Billing Address (if different than mailing) |
| Phone:( )  | Fax:( ) | Email: |

|  |  |
| --- | --- |
| **ADMINISTRATIVE****INFORMATION** | Chief Administrative Officer: |
| Chief Financial Officer: |
| Chief Medical Officer: |
| Chief Clinical Manager: |
| Respondent for Recipient Rights Complaints: |
| Business Manager: |
|  | Primary Contact Person: | Email: |
|  | Secondary Contact Person: | Email: |

**ORGANIZATION TYPE**

|  |  |  |
| --- | --- | --- |
| \_\_\_ Faith Based \_\_\_ Private Non-profit\_\_\_ Privately Owned | \_\_\_ Corporation Partnership LLC/LLP  | \_\_\_ Public\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Parent Corporation or Owner of Organization: |
| Street Address: |
| City: | State: | Zip Code: |
| 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. Submit copy of Federal W-9.*

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

|  |  |
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|  **LIABILITY/INSURANCE/BONDING** **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.)*

**ACCREDITATION**

|  |  |
| --- | --- |
| Accredited by: | Expiration Date: |
| List accredited service categories: |

**ORGANIZATION PROFILE**

*Please complete this section in its entirety, covering the past five (5) calendar years plus current year to date.*

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| --- | --- | --- | --- |
|  | **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 any other certification/accreditation revoked, suspended, or limited? |  |  |  |
| Is there action pending to revoke, suspend, or limit the other certification/accreditation? |  |  |  |
| Has the organization ever had sanctions imposed by Medicare and/or Medicaid? |  |  |  |
| 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 use disorder treatment? |  |  |  |
| \* Note: If you have answered “yes” to any of the above questions, please provide the current status and details on a separate sheet of paper. Please 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. |

**CORPORATE COMPLIANCE**

*Identify the following staff as related to Compliance requirements:*

|  |  |  |  |
| --- | --- | --- | --- |
| **Staff Person** | **Compliance Officer** | **HIPAA Privacy Officer** | **HIPAA Security Officer** |
|  **Name** |  |  |  |
|  **Phone** |  |  |  |

**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 (PIHP), 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 in the PIHP Provider Network;
2. it is the organization’s responsibility to promptly advise PIHP 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 PIHP investigation and review;
4. this is an application only and that submission of this application does not automatically result in participation in the PIHP Provider Network; and
5. the information contained in this document provides a basis for monitoring of the contractual requirements between this agency and MCPIHP. 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 the PIHP (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 PIHP 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 PIHP 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 PIHP 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 PIHP 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 PIHP PROVIDER NETWORK.

A. All applications for participation in the PIHP Provider Network shall be reviewed by the PIHP Office of Substance Abuse (MCOSA). Recommendations for PIHP Provider Network participation will be forwarded to the PIHP 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 PIHP Provider Network, we consent to PIHP 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, PIHP 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 PIHP 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 ensure the highest quality of consumer care.
	3. That the organization, or designee will be willing to appear before any appropriate committee of PIHP 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 in the PIHP Provider Network.

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Signature of Organization CEO or Designated Representative Date

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

**SITE SPECIFIC INFORMATION**

*(Complete a separate form for each service site)*

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| --- | --- |
| Agency: |  |
| Location: |  | License Number: |  |
| Telephone Number: |  | Fax Number: |  |

**Licensed/Certified Services and Levels of Care**- Check all that apply:

[x]  Prevention [ ]  Early Intervention

[ ]  Outpatient [ ]  Intensive Outpatient

[ ]  Opioid Health Home [ ]  Medication for Opioid Use Disorder

[ ]  Withdrawal Management [ ]  Residential

[ ]  Peer Recovery Supports [ ]  Recovery Home [ ]  Other:

[ ]  **Co-Occurring Capable***:* Staff address the interaction of the substance related and mental health disorders in assessing the client’s readiness to change, relapse risk and recovery environment. Psychiatric services are provided directly or coordinated through referral.

[ ]  **Co-Occurring Enhanced**: Co-occurring treatment groups are regularly provided on site; motivational enhancement therapies are utilized to address co-occurring treatment issues; psychiatric services are provided on site as part of the integrated treatment plan.

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| **Age Group & Gender -** Indicate the groups served - Check all that apply: |
| **Child/Adolescent (0 -17)** | **Adult (18 - 59)** | **Senior (60 and up)** |
| [ ] Males [ ] Females | [ ] Males [ ] Females | [ ] Males [ ] Females |

**Specialty Services** – Indicate any of the specialty services provided below:

[ ]  **Adolescent Specialty** – Program is licensed and accredited, as required, to provide SUD programming specific to meet the needs of individuals under the age of 18, including an emphasis on family engagement. The program minimally is able to provide co-occurring capable services. Clinical staff have a minimum of 15 semester hours/2080 treatment hours providing supervised services to adolescents.

[ ]  **Women’s Specialty** *–*Provided to pregnant women, women with dependent children or women seeking to regain custody of dependent children (see BSAAS Policy #12, Women’s Treatment Services, for complete details). *Specify type:*

[ ]  Gender Competent: Provides gender specific services and treatment groups that focus on the specific needs and issues of the women served. Clinical staff have or are working towards possessing: 1) a minimum of 8 semester hours or equivalent of gender specific substance use disorder training 2) or 1040 hours of supervised gender specific substance use disorder training.

[ ]  Gender Responsive/Women’s Designated Program: All services provided to women are gender specific and provides services that address and meet the needs of challenges women face. Directly or through referral, the program provides case management, transportation, primary medical care for women and their children and therapeutic interventions for children of women served. Clinical staff have or are working towards possessing: 1) a minimum of 12 semester hours or equivalent of gender specific substance use disorder training 2) or 2040 hours of supervised gender specific substance use disorder training.

*Site Specific Information Continued*

**Treatment Agency: Location:**

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| --- |
| **Languages Spoken (other than English)** – Indicate other languages spoken and the name of staff members that can provide services in languages other than English,including American Sign Language: |
| Name/Position |  | Language |  |
| Name/Position |  | Language |  |

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| --- |
| **SPECIAL POPULATIONS** - Indicate if you have any resource/expertise to service the following populations. Check all that apply.\_\_ Hearing impaired Visually impaired Speech impaired Other (specify): |

|  |  |  |
| --- | --- | --- |
| **Please respond to the following questions regarding the service site:** | **Yes** | **No** |
| Does this service address comply with ADA (Americans w/Disabilities Act) regulations? |  |  |
| Is this service address accessible by public transportation (within 0.5 mile)? |  |  |
| Is program able to respond to urgent cases within 24-hours of contact from the client/AMS? |  |  |
| Able to provide routine appointments within seven days of initial contact? |  |  |
| Does the program have 24-hour on-call availability? |  |  |
| Do you accept Medicaid? |  |  |
| Do you accept Medicare? |  |  |
| Do you have a provider agreement with BC/BS for this address? |  |  |
| List all HMOs, other health insurance organizations and other related entities with which you have a provider agreement and/or are able to bill for Substance Use Disorder Services (attach additional pages if necessary). Please list Health Program Name, Effective date and Expiration date for each agreement.  |
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| **Site Contact Information:** | **Name** | **Phone #** | **Email** |
| Site Director |  |  |  |
| Clinical |  |  |  |
| Financial |  |  |  |
| Billing |  |  |  |
| Data/EMR |  |  |  |
| Prevention |  |  |  |