Macomb County Community Mental Health
Provider Profile Application

ALL INFORMATION IS REQUIRED TO BE COMPLETED AND IS 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)		
	Phone:( )	Fax:( )	E-Mail:

ADMINISTRATIVE INFORMATION	Chief Administrative Officer:	
	Chief Financial Officer:	
	Chief Medical Officer:	
	Chief Clinical Manager:	
	Respondent for Recipient Rights Complaints:	
	Business Manager:	
	Contract Primary Contact Person:	E-mail:
		Phone:
	Contract Secondary Contact Person:	E-mail:
		Phone:
	Clinical Director/Supervisor:	E-mail:
	Location :	Phone:
	Clinical Director/Supervisor:	*E-mail:*
	Location:	Phone:
	Clinical Director/Supervisor:	E-mail:
	Location:	Phone:

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) ___ GeneralHospital ___HabilitativeWaiver Services ___ Home Based Services ___ Intensive Crisis Stabilization Services	___ O.T. ___ P.T. ___ SP & L ___ Out of CountyCase Management Services ___ Out of CountyOutpatient 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 ___ SkillBuilding Services (___ MI or ___ DD) ___ Supported Independent 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:	Zip code:
Telephone: ( )	Fax: ( )	
Name and Title of Corporate Executive Officer:		

TAX ID

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):	

LICENSE/CERTIFICATES

Is the organization state licensed/certified: _____ Yes _____ No

(Please attach a current copy of all Licenses and Certificates)

Type:	License/Certification #:	Exp. Date:
Type:	License/Certification #:	Exp. Date:
Type:	License/Certification #:	Exp. Date:
Type:	License/Certification #:	Exp. Date:

ACCREDITATION/CERTIFICATION

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

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

INSURANCE

(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.)*

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:

ORGANIZATION PROFILE

(Please complete this section. Your responses need to cover the past five (5) calendar years plus current year to the present. If a question does not apply to your organization, you may check "N/A" (Not Applicable.)

	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 state license/certification?			
Has the organization's accreditation status ever been revoked, suspended, or limited?			
Is there action pending to revoke, suspend, or limit the organization's accreditation status?			
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 abuse 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.*			

ADMITTING PRIVILEGES FOR PSYCHIATRIC HOSPITALIZATION (if applicable)

Please list all Physicians/Psychiatrists who have admitting privileges at your organization. _____N/A

Provider Last Name	**Provider First Name**	**License**

PROGRAM PROFILE

Your organization may have more than one location identified on page one of this application. If so, please photocopy this page (page THREE), plus pages FOUR and FIVE, and complete for <u>each</u> program service.

HOURS OF OPERATION (e.g., 8:30 am - 8:00 pm)	Mon.	Tue.	Wed.	Thur.	Fri.	Sat.	Sun.

TREATMENT STAFF ROSTER – CREDENTIALS
Please complete the attached Credential Verification Form.

Please identify the person in your organization responsible for ensuring staff have and maintain appropriate credentials:

Staff Responsible for Credentialing	Phone Number

AGE GROUP AND GENDER
Please check (✓) the groups for which this program provides services.

Child/Adolescent (0 -17)	Adult (18 - 59)	Senior (60 and over)
___ Female ___ Male	___ Female ___ Male	___ Female ___ Male

Please respond to the following questions regarding the service address(es):	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)?		
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 Mental health Services (attach additional pages if necessary). Please list Health Program Name, Effective date and Expiration date for each agreement.		

PROGRAM AND SERVICE INFORMATION
Please provide a list of all services unique to the service site.

Component	Capacity

OUTCOME STUDIES	
	Does the program conduct Outcome Studies? ___ Yes ___ No *(If yes, briefly describe and include examples.)*

LANGUAGE COMPETENCE

In addition to English, please identify the languages in which the program offers service (including American Sign Language):

FOCUS OF SUPPORT SERVICES

(The following information is for internal Macomb CMH use only. Each consumer's benefit plan will determine if a problem area or service is reimbursable.)Check all that apply.

	Adjustment Disorders		Elimination Disorders		Mood Disorders		Somatoform Disorders
	Anxiety Disorders		Factitious Disorders		Motor Skill Disorders		Substance Related Disorders
	Attention Deficit & Disruptive Behavioral Disorders		Forensic Evaluation		Personality Disorders		Tic Disorders
	Communication Disorders		Impulse-Control Disorders NOS		Schizophrenia & Other Psychotic Disorders		Others (specify):
	Delirium, Dementia, and other Cognitive Disorders		Learning Disorders		Sexual & Gender Identity Disorders		
	Dissociative Disorders		Mental Disorders due to a General Medical Condition		Physical/Sexual Abuse		
	Eating Disorders		Developmental Disabilities		Sleep Disorders		

SPECIAL POPULATIONS

Please indicate if you have any resource/expertise to service the following populations. Check all that apply.

___ Hearing impaired ___ Visually impaired ___ Speech impaired ___ Other (specify below):

AFTERCARE

Does the program offer aftercare? ___ Yes ___ No If yes, please complete this section.

Type of Program	Duration in Weeks	# Sessions per Week	Duration of Session

QUALITY IMPROVEMENT

Please attach a copy of the Organization's current Quality Improvement Plan and most recent report of Quality Improvement activities.

Identify the person responsible for Quality Improvement activities:

Responsible Quality Improvement Staff	Phone Number

CORPORATE COMPLIANCE
Please upload on the Provider Portal a copy of the organization's current Corporate Compliance Plan and most recent report of Compliance activity.

Identify the following staff as related to Compliance requirements:

Staff Person	Compliance Officer	HIPAA Privacy Officer	HIPAA Security Officer
Name			
Phone			

STAFF TRAINING
Please upload on the Provider Portal, the Provider Training Transcript and Criminal Background Check form.

Please identify the person in your organization responsible for staff training.

Staff Responsible for Staff Training	Phone Number

CRIMINAL BACKGROUND CHECKS
Please upload on the Provider Portal, the Provider Training Transcript and Criminal Background Check form.

Please identify the person in your organization responsible for criminal background checks.

Staff Responsible for Criminal Background Checks	Phone Number

DELEGATED FUNCTIONS
Certain functions, as identified in the provider contract, have been delegated to the agency.

Please describe below how the organization ensures that functions that have been delegated are being completed and monitored. Please identify the person(s) responsible for monitoring the completion of delegated functions.

Delegated Function(s)	***Staff Responsible***

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:

(a) 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 CMH Provider Network.
(b) It is the organization's responsibility to promptly advise CMH of any changes or additions to the information contained in this application.
(c) All the information contained in this application or its attachments is subject to CMH investigation and review;
(d) This is an application only and that submission of this application does not automatically result in participation in the CMH Provider Network.
(e) 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.
(f) 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 MCCMH (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.
(g) The Provider Disclosure Information Request Form (Disclosure of Ownership & Controlling Interest and Statement Attestation of Criminal convictions, Sanctions, Exclusions, Debarment or Termination) is attached to this application and will be updated upon execution of the Agreement; during re-contracting; within 35 days of a change in ownership; or within 30 days of a request by CMH.

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 in the CMH Provider Network.

_____

Signature of Organization CEO or Designated Representative **Date**