MACOMB COUNTY COMMUNITY MENTAL HEALTH

Provider Profile Application

ALL INFORMATION IS REQUIRED TO BE COMPLETED AND IS SUBJECT TO VERIFICATION
(If any fields are left blank this document will be sent back for completion)

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:
Type	___ Federal ___ State ___ County	___ City ___ Private Non-profit ___ Privately Owned	___ Corporation Partnership LLC/LLP

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 a copy of Federal W-9.*

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

ADMINISTRATIVE INFORMATION	Chief Executive Officer / Executive Director:	
	Chief Financial Officer:	
	Chief Medical Officer:	
	Clinical Director:	
	Respondent for Recipient Rights Complaints:	
	Staff Responsible for Credentialing:	
	Lead Quality Staff Name:	E-mail:
	Title:	Phone:
	Compliance Officer	E-mail:
	Title:	Phone:
	Name	E-mail:
	Biller (Needs EMR Access):	E-mail:
	Location:	Phone:

TYPE OF PROGRAM ***(Please check ALL that apply)***	___ Applied Behavioral Analysis ___ Assertive Community Treatment ___ Behavioral Services ___ Campership ___ Children's Residential ___ Case Management Services ___ Community Living Supports ___ Crisis Residential (Adult) ___ Crisis Residential (Children) ___ Home Based Services ___ Intensive Crisis Stabilization Services ___ Occupational Therapy ___ Physical Therapy ___ Speech Therapy	___ Music Therapy ___ Art Therapy ___ Recreation Therapy. ___ Massage Therapy ___ Peer Support Services ___ Private Duty Nursing ___ Psychiatric Hospital (Adult or Child) ___ Psycho-Social Rehabilitation Programs ___ Respite Services ___ Skill Building Services) ___ Specialized Residential Services ___ Wrap Around Services

LICENSE

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

(Please attach a current copy of all Licenses)

Type:	License #:	Exp. Date:
Type:	License #:	Exp. Date:
Type:	License #:	Exp. Date:
Type:	License #:	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/ INSURAN	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 the 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.

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 (American's w/Disabilities Act) regulations? *Provide documentation to support response. Examples Accreditation, License etc.*		
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

LANGUAGE COMPETENCE

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

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):

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, 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 MCCMH Provider Network.
(b) It is the organization's responsibility to promptly advise MCCMH of any changes to the information contained in this application by completing/returning an updated Attachment A Provider Profile Application to MCCMH. This application is due at the onset of each Fiscal Year.
(c) All the information contained in this application or its attachments is subject to MCCMH investigation and review;
(d) This is an application only and that submission of this application does not automatically result in participation in the MCCMH Provider Network.
(e) The information contained in this document provides a basis for monitoring of the contractual requirements between this agency and the COUNTY. 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 the COUNTY (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 the COUNTY.

We hereby authorize the COUNTY 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 the COUNTY 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 the county 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 the county 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 MCCMH provider network.

A. All applications for participation in the MCCMH Provider Network shall be reviewed by MCCMH. Recommendations for MCCMH Provider Network participation will be forwarded to the MCCMH Board, or designee for recommendation of approval to Macomb County.

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 MCCMH Provider Network, we consent to MCCMH inspection of our patient records relating to individuals served 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, MCCMH 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 MCCMH 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 care.

3. That the organization, or designee will be willing to appear before any appropriate committee of the COUNTY 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

MCCMH Provider Network.

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

A PHOTOCOPY OF THIS DOCUMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL. Rev. 6.8.23