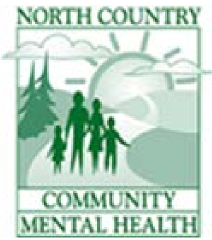

NORTH COUNTRY COMMUNITY MENTAL HEALTH AUTHORITY

CONTRACT PROVIDER APPLICATION

1) PROVIDER IDENTIFICATION/INFORMATION

Contracted Provider Name:

D/B/A's (if none, write none):

Federal Tax ID/SSN:

Provider website/URL:

Provider Legal Entity Type - Check one of the following:

- Sole Proprietors and partnerships: Individual providers including practitioners who file taxes on the 1040 series of tax forms
- For-profit corporations: Those companies that typically file a tax form 1120 with the IRS.
- Governmental units: Includes transportation authorities, intermediate school districts, public universities and community colleges.
- Non-Profit organizations or corporations: Typically, those organizations that have 501(c)3 status and report on the IRS 990 form.

2) SERVICES PROVIDED

Check all general categories of services that you are qualified to provide, regardless of whether or not those services are included in your NCCMH contract:

- ❍ Licensed Residential
- ❍ Personal Residential Home
- ❍ Professional Services (Therapy, Doctor, etc.)
- ❍ Other:
- ❍ Respite/Respite Camp
- ❍ Day Programs
- ❍ InPatient Hospital

National Provider Identifier (NPI) #, if applicable:

Medicaid ID #, if applicable:

Are you registered in CHAMPS: YES NO **Are you accepting New Enrollees?** YES NO

Cultural Competency is required training for our staff: YES NO

Do you have Linguistic Capabilities: YES NO

Specify any secondary language capabilities:

ADA Compliance: Are all of your Office/Facility, Retail outlets, Exam Rooms, Equipment able to accommodate persons with disabilities? YES NO

Method of Personal Intervention: We DO DO NOT **train on and solely use the CPI Method.**

We (also or alternatively) use the following methods of personal intervention:

Note: If you do not SOLELY utilize the CPI form of intervention in facilities where NCCMH clients are placed, you are required to request written approval from NCCMH Behavior Treatment Committee on the use of other forms of Non-Violent Crisis Intervention other than CPI. Alternative methods must be approved by written contract addendum. Please contact the NCCMH Contract Manager at providerrelations@norcocmh.org for information.

3) CONTACT INFORMATION

Corporate/Legal Address:

Physical Address:

City: State: Zip:

Mailing Address:

City: State: Zip:

Authorized Person to sign & modify contracts:

Contract Signee:
Title:
Phone:
Cell:
Fax:
Email:

Primary Contact for Client Placement:

Business Name: __ ____
Primary Contact:
Address:
City: State: Zip:
Phone:
Fax:
Cell:
Email:

Primary Contact for Finance:

Business Name: __
Primary Contact:
Address:
City: State: Zip:
Phone:
Fax:
Cell:
Email:

PLEASE ATTACH ADDITIONAL INFORMATION AS NEEDED FOR EACH SPECIFIC MAIN LOCATION/CONTACT.

PLEASE ATTACH LISTING OF HOMES, LICENSES AND CONTACT INFORMATION FOR EACH LICENSED/SPECIALIZED OR OTHER HOME TYPE.

4) ACCREDITATION, LICENSES

Are you licensed or accredited? Yes No If yes, list below:

Accreditation/License Entity Name: Expiration:

Accreditation/License Entity Name: Expiration:

Accreditation/License Entity Name: Expiration:

If no, do you have plans to become accredited? YES NO

PLEASE ATTACH COPY OF ACCREDITATION OR LICENSES.

5) ATTESTATION

I fully understand that any misstatements in, or omissions from, this application may constitute cause for disqualification or termination of provider participation with North Country Community Mental Health Authority. All information submitted in this application is true to the best of my knowledge and belief.

I verify that all professional staff and other health services staff who deliver direct services to our consumers are current and in good-standing with their respective training, licensing and/or certifying board or agency. I also verify that those employees who do not yet have their required training, license and/or certification, have a plan and are working to obtain the appropriate license and/or certification. I also verify relevant legal background checks as well as educational credentials were verified or completed prior to hire and rechecked on any frequency required by Medicaid or by contract with North Country Community Mental Health Authority.

I understand that any contractual relationship with North Country Community Mental Health Authority may be subject to termination if I fail to comply with any of the regulations or policies specified in the contract or by Medicaid regulation.

DECLARING THAT THE STATEMENTS MADE IN THIS APPLICATION ARE TRUE, I HEREBY MAKE APPLICATION AND REQUEST TO BECOME OR REMAIN A PART OF THE NCCMH PROVIDER NETWORK:

____
Name of Contractor's Authorized Representative Title

____
Signature of Authorized Representative Date
(INK OR CERTIFIED DIGITAL SIGNATURE REQUIRED)