NORTH COUNTRY
COMMUNITY MENTAL HEALTH

CONTRACT PROVIDER APPLICATION

PROVIDER IDENTIFICATION/INFORMATION

Provider Name:_____ Website: _____

Physical Address: _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____

SERVICES INFORMATION

Check all categories that you are qualified to provide, regardless of whether those services will be included in your NCCMH contract.

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

Registered in CHAMPS	Yes □	No □	Accepting New Enrollees	Yes □	No □
Cultural Competency	Yes □	No □	Telehealth Offered	Yes □	No □
Linguistic Capabilities	Yes □	No □	Interpretation Services	Yes □	No □

Secondary language capabilities: _____

Accreditation(s): _____

Physical Accommodations Offered

Accessible parking or vehicles	☐ Yes	☐ No
Adaptive technology or equipment	☐ Yes	☐ No
Automatic or push button doors	☐ Yes	☐ No
Barrier free shower or toilet or sink/counter	☐ Yes	☐ No
Braille or large print or visual alarms	☐ Yes	☐ No
Community based services	☐ Yes	☐ No
Handrails or grab bars	☐ Yes	☐ No
Loaner equipment available	☐ Yes	☐ No
Ramps or elevators	☐ Yes	☐ No
Transfer aids	☐ Yes	☐ No
Wide doorways	☐ Yes	☐ No

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Method of Personal Intervention MANDT ☐ Other ☐

Note: NCCMH uses the MANDT system for behavioral intervention, if you use a different non-violent crisis intervention method, you must seek approval from NCCMH. Alternative methods must be approved by written contract addendum. Please contact the NCCMH Contract Manager at providerrelations@norcocmh.org for information.

PROVIDER CONTACTS

Authorized Signer of Contracts and/or Addendums:

Name: _____ Title: _____

Phone: _____ Email: _____

Placements

Name: _____ Title: _____

Phone: _____ Email: _____

Finance

Name: _____ Title: _____

Phone: _____ Email: _____

LOCATIONS: Please attach a list of all locations including:

- Name, Address, and Phone number for each location.
- Copies of ALL location licenses
- Copies of ALL location accreditations

ATTESTATION

I affirm that all information provided in this application is accurate to the best of my knowledge. I understand that any false statements or omissions may result in disqualification or termination of provider status with North Country Community Mental Health Authority. I confirm that all staff delivering direct services are properly trained, licensed, or certified, and in good standing. Those not yet fully credentialed are actively working toward compliance. Legal background checks and educational verifications were completed prior to hire and are maintained per Medicaid and NCCMH requirements. I acknowledge that failure to comply with NCCMH policies or Medicaid regulations may result in contract termination.

I hereby apply to join or continue as a provider in the NCCMH network, affirming the truth of the above statements.

_____ _____

Authorized Representative Name Title

_____ _____

Authorized Representative Signature Date