NORTH COUNTRY COMMUNITY MENTAL HEALTH AUTHORITY

FY20 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.)
❍ Respite/Respite Camp
❍ Day Programs
❍ InPatient Hospital
❍ Other: ____

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

What, if any, Non-Violent Crisis Intervention protocol do you use?

❍ <u>CPI is our standard for **ALL** facilities/homes</u> ❍ CPI is **<u>used in some but not all</u>** of our facilities/homes

<u>Other Non-Violet Crisis Intervention protocols used</u> if any: ______________________________________

As applicable, have you received approval from NCCMH Behavior Treatment Committee on the use of other forms of Non-Violent Crisis Intervention other than CPI: ❍ Yes ❍ No

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:

Accreditation/License Entity Name: ________________________________ Expiration: _________________

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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 Date