



# SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

## **FY10 Service Provider Application** **WWW.SCCMHA.ORG**

### **Instructions for Provider**

Please print legibly and return all pages to:

SCCMHA- Contracts & Properties Manager  
500 Hancock  
Saginaw, MI, 48602  
Or Fax to 989-498-4219

A SCCMHA Provider Application must be completed or renewed by the provider for each SCCMHA fiscal year and must be on file for contract initiation, continuation or revision. The attached application is provided to maintain accurate provider demographics, secure signed releases for annual background checks, and provide an opportunity for you or your organization to make SCCMHA aware of current information regarding your services being offered.

Please complete the following list of 22 items. If your organization has multiple provider sites listed within your contract, please attach additional site information pertaining to question #7 to the end of this application. If you need extra space, please feel free to attach another sheet or additional literature such as brochures that would assist SCCMHA to further understand your service(s) being offered.

If changes occur during the fiscal year in legal name, addresses, staffing ratios, or key contact information, these changes **MUST** be reported with written notice to SCCMHA Contracts & Properties Manager, in a timely manner.

**1. Provider Information:**

Provider Legal Name: \_\_\_\_\_

D/B/A: \_\_\_\_\_

Federal Tax ID/SSN: \_\_\_\_\_

National Provider Identifier (NPI) #, if applicable: \_\_\_\_\_

Provider Legal Entity Type: Check one of the following:

- Sole Proprietors and partnerships: Individual providers including practitioners who file taxes on the 140 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 501c.3 status and report on the IRS 990 form.

**2. Corporate/Legal Mailing Address:**

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**3. Authorized Person to sign & modify Contracts:**

Contract Signee: \_\_\_\_\_

Title: \_\_\_\_\_

**4. Contract Manager or designee to facilitate contract documents:**

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**5. Professional Providers (Individuals):**

Are you licensed to operate in the State of Michigan and compliant with applicable state and/or federal requirements?

Yes \_\_\_\_\_ No \_\_\_\_\_

Professional License # \_\_\_\_\_ Specialty: \_\_\_\_\_

**6. COB: (Coordination of Benefits) Is this section applicable to your service delivery?:**

Yes \_\_\_\_\_ No \_\_\_\_\_ Inpatient, Case Management, Outpatient, and Enhanced Health Providers: Please select approved insurances you are qualified to bill:

Medicare \_\_\_\_\_ Blue Care Network \_\_\_\_\_ Saginaw Qualified Health Plans: \_\_\_\_\_  
BCBS \_\_\_\_\_ Health Plus Commercial: \_\_\_\_\_ Other: \_\_\_\_\_

**7. Are you currently capable of billing electronically (i.e. 837P or 837I compliant)? Y\_\_\_ N\_\_\_**  
**Provider Site Primary Contact (Individual/Non-Residential Agency):**

**\*Note: attach additional sheets for each specific site location**

Provider Site Name: \_\_\_\_\_

Primary Contact: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Handicap Accessible: Yes \_\_\_\_\_ No \_\_\_\_\_ Bus Route: Yes \_\_\_\_\_ No \_\_\_\_\_

Service Hours of Operation & explanation of 24 hour on-call procedures:

\_\_\_\_\_  
\_\_\_\_\_

**8. Billing Address/Contact:**

Corporate Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Would you like your letters of authorization sent to your billing address: Yes \_\_\_\_\_ No \_\_\_\_\_

If you have multiple provider sites, would you like all site's payments & remittances rolled together? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Billing Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**9. Auditing Contact:**

Who should be contacted to schedule & coordinate an SCCMHA audit?

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**10. Training Contact:**

Who is responsible for monitoring and scheduling continuing education training requirements?

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Mail your training transcripts to corporate address: \_\_\_\_\_ or provider site address(s): \_\_\_\_\_

**11. Licensed Residential Providers (AFC/CFC): Is this section applicable to your service delivery?:**

Yes \_\_\_\_\_ No \_\_\_\_\_

Home Manager or Lead Staff Name: \_\_\_\_\_

License #: \_\_\_\_\_ # of Beds Licensed: \_\_\_\_\_

License Certification Type: MI: \_\_\_\_\_ DD: \_\_\_\_\_ Both: \_\_\_\_\_

Home Gender: Male: \_\_\_\_\_ Female: \_\_\_\_\_ Mixed: \_\_\_\_\_

Wheelchair Accessible: Yes: \_\_\_\_\_ No: \_\_\_\_\_

**Home Staffing Pattern:**

FTE's 1st Shift: \_\_\_\_\_

FTE's 2nd Shift: \_\_\_\_\_

FTE's 3rd Shift: \_\_\_\_\_

Other Direct Care or Professional Staff: \_\_\_\_\_

Total weekly hours of direct care staffing: \_\_\_\_\_

(Clarification: Providers for non SCCMHA owned homes may consider up to 40 weekly hours of home manager/lead staff time to be direct care and 100% of assistant manager time to be direct care if he/she is providing daily face to face resident care. Providers for SCCMHA owned homes will have set direct care FTE staffing requirements listed within their contract)

**Does your agency run a Behavioral Management Committee (BMC) to monitor treatment plans that include restrictive, aversive, and/or intrusive interventions?:** Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please describe committee, frequency of meetings, composition of professional staff, etc...

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**12. Non-Licensed Residential Providers (Supported Independent Programs): Is this section applicable to your service delivery?:** Yes \_\_\_\_\_ No \_\_\_\_\_

Home Manager or Lead Staff Name: \_\_\_\_\_

# of Rental Units: \_\_\_\_\_ Monthly Rent Charged: \_\_\_\_\_

List Landlord/Provider paid utilities: \_\_\_\_\_

Total # of Beds: \_\_\_\_\_ Home Gender: Male: \_\_\_\_\_ Female: \_\_\_\_\_ Mixed: \_\_\_\_\_

Wheelchair Accessible: Yes: \_\_\_\_\_ No: \_\_\_\_\_

**Average daily hours of Staffing Assistance/Supervision provided:**

1-3 hours: \_\_\_\_\_ 4-6 hours: \_\_\_\_\_ 7-12 hours: \_\_\_\_\_ 13-23 hours: \_\_\_\_\_

**13. Description of Organization's Mission and Scope:**

(If more convenient, feel free to attach a hard copy or brochure(s))

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**14. What is your current payor mix of funding/revenue sources?**

Payor name/entity	% of total funding
SCCMHA	

**15. How many primary or secondary consumers do you or your organization employ, have stakeholders, or leadership roles of which are SCCMHA consumers?**

<u>Role/Title:</u>	<u>Diversity Information:</u>	<u>Population Type:</u>	<u>% of FTE:</u>	<u>Paid Employment Y/N:</u>
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**Note: Please maintain a list of such consumers to be made available to SCCMHA upon request for State reporting purposes only.**

**16. Type of Accreditation for Organization/Programs: Is this section applicable to your service delivery?: Yes \_\_\_\_\_ No \_\_\_\_\_, If yes, attach copy of current accreditation certificate.**

Accreditation Entity Name: \_\_\_\_\_ Expiration: \_\_\_\_\_

**17. Type of Licensure for Organization/Programs: Is this section applicable to your service delivery?: Yes \_\_\_\_\_ No \_\_\_\_\_, If yes, attach copy of current licensure certificate.**

Licensing Entity Name: \_\_\_\_\_ Expiration: \_\_\_\_\_

**18. Please attach a statement of declaration of any known potential or real conflicts of interests with SCCMHA.**

None known at this time: \_\_\_\_\_ OR Statement of declaration attached:  
 Does your organization employ or contract with any SCCMHA employee? Yes: \_\_\_\_ No: \_\_\_\_  
 If yes, full name of person(s): \_\_\_\_\_

**19. If incorporated, please list all board members: Is this section applicable to your service delivery?**

Yes \_\_\_\_\_ No \_\_\_\_\_

Composition of Board of Directors			
Name:	Position:	Current or past consumer? Y or N :	Term:

**20a. Provider verifies that all officers, directors, partners, significant purchasers, and board members are in good standing. Such individuals have not been disbarred, or sanctioned by Medicaid, Medicare or the Office of the Inspector General. Provider has also verified their good standing from the following web site: <http://epls.arnet.gov>.**

Verification Complete: \_\_\_\_\_ Verification Incomplete: \_\_\_\_\_

Have judgments or settlements been made in the last five (5) years against you in professional liability cases or are there any pending? No \_\_\_\_ Yes \_\_\_\_

Litigation:	Outcome/Status:

**20b. Credentialing:** (Organizations): Provider verifies compliance with SCCMHA credentialing policy and procedure as listed within the SCCMHA FY10 Network Services Provider Manual Section 09.04.04.10, including direct source verification of license, background checks, and references; and maintains such documentation on file subject to SCCMHA or MDCH review:

Verification Complete: \_\_\_\_\_ Verification Incomplete: \_\_\_\_\_

**21. Attachments:**

<b><u>Copies of the following should be attached to this application:</u></b>	<b><u>Included (Y/N):</u></b>
Organizational Chart	
Tax Status, and any IRS Tax Exempt Letter if applicable	
Annual Report	
Professional, Gen. Liab., WC, Auto Insurance Certificate(s), if applicable	
Accreditation Certificates	
Professional License	
Signed W-9: go to <a href="http://www.irs.gov/">http://www.irs.gov/</a> to obtain form	
TB Test (if an individual provider)	

**22. Authorized Contract Signee or Residential Licensee:**

I hereby give authorization to SCCMHA to check my Recipient Rights history, criminal background history, drivers license record, and references to verify my eligibility to become a participating provider.

The following information will be used solely by SCCMHA for State Police background check purposes only.

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Gender: Male: \_\_\_\_\_ Female: \_\_\_\_\_

Race: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

\_\_\_\_\_  
Provider/Licensee Print Name

\_\_\_\_\_  
Provider/Licensee Signature

\_\_\_\_\_  
Date

## **Provider Pre-Contract Notice**

- \* Consumer Appeals & Grievance**
- \* Customer Service Complaints**
- \* Pre-Contract Delegation**

Included in the SCCMHA Network Services Provider Manual, which is a contract attachment of varied SCCMHA requirements, is the policy, “Appeals & Grievances”. Federal regulations require that SCCMHA, as the PIHP, provide information about the grievance system for Medicaid enrollees to all providers and subcontractors at the time of entering into a contract. SCCMHA requires Grievance & Appeals training of providers.

All consumers who are recipients of SCCMHA services have certain Grievance and Appeal rights, including the following:

*Advance Notice must be given to any consumer as soon as possible, but at least 12 days prior to the proposed date action is to take place, if existing services are being reduced, suspended or terminated. Adequate Action notices must be given to any consumer that is denied a service and the notice must be given at the time of the denial.*

*A Grievance (or Customer Service Complaint) may be filed for any dissatisfaction with services, such as a concern about quality of service or a relationship problem. The complaint will be handled as an ‘appeal’ if it involves an action of denial, reduction, suspension or termination of services. Some Grievances may be referred to the Recipient Rights office if the complaint rises to the level of a potential recipient rights violation.*

*SCCMHA will provide assistance to consumers with the filing of any Customer Service Complaint.*

*The toll-free number for the filing of a Customer Service Complaint must be made readily available to consumers by SCCMHA and all providers. (1-800-258-8678)*

*Customer Service Complaints may be made in writing or filed orally.*

*Customer Service Complaints that are Grievances must be resolved within 60 calendar days.*

Providers should contact the SCCMHA Director of Customer Services & Recipient Rights for questions or guidance on any of these matters.

Per SCCMHA policy for standards and procedures, all providers have delegated responsibilities of credentialing, at minimum where applicable. Some providers may have additional delegated responsibilities, which will be documented in a pre-contract assessment.

I fully understand that any misstatements in, or omissions from, this application may constitute cause for disqualification or termination of provider participation with Saginaw County 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 clients are current and in good-standing with their respective licensing and/or certifying board or agency. I also verify that those employees, who do not yet have their 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 were made as well as educational credentials.

I understand that any contractual relationship with Saginaw County Community Mental Health Authority may be subject to termination if I fail to comply with any of the regulations or policies specified.

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

\_\_\_\_\_  
Signature of Applicant / Title:

\_\_\_\_\_  
Date:

**AUTHORITY USE ONLY**

Are Provider services being offered needed? Y\_\_\_\_\_ Initiate contract by verifying following items:

N\_\_\_\_\_ Notify Provider and hold on file

Confirmation of the following:	Status:	Staff initials:
Is application fully completed		
Agency Status		
Insurance(s) Verification		
License Verification		
Accreditation Status		
Site Visit (if new provider)		
Review of sanction provider websites-federal & state		
Background Check Verification		
Recipient Rights Verification		