SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

FY19 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/monthly OIG and sanctioned provider lists, and provide an opportunity for you or your organization to make SCCMHA aware of current information regarding services being offered. All responses are subject to an audit by SCCMHA.

Please complete the following list of 23 items. If your organization has multiple provider sites listed within your contract, please attach additional site information pertaining to questions #6-8 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) and/or service sites being offered.

For provider's under contract: If changes occur during the fiscal year in legal name, tax identification, NPI, addresses, staffing, 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's (if none, write none): _____
Federal Tax ID/: _____
National Provider Identifier (NPI) #, if applicable: _____
Medicaid ID #, 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.

Note: All Providers which are not Non-Profit please attach copy of your most recent Federal filed tax form.

2. **Corporate/Legal mailing address: (No P.O. Box numbers please)**

Address: _____
City: _____ State: ____ Zip: _____

3. **Authorized person to sign & modify contracts:**

Contract Signee: _____
Title: _____
Email: _____

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

Name: _____
Title: _____
Phone: _____
Fax: _____
Email: _____

5. **HIPAA privacy officer to be notified of SCCMHA electronic medical record (EMR) access / logon requests:**

Name: _____
Title: _____
Phone: _____
Email: _____

6. Provider Site Primary Contact :

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

Provider Site Name: _____

Primary Contact for this site: _____

Address: _____

City: _____ State: ___ Zip: _____

Phone: _____

Fax: _____

Cell: _____

Email: _____

Handicap Accessible: Yes ____ No ____ Bus Route: Yes ____ No ____

7. Are you a Licensed Residential Provider (AFC/CFC/CCI)? :

Yes_____ No_____ If no, then skip to next section. If yes, then answer the following:

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

Home Manager or Lead Staff Name: _____

License #: _____ # of Beds Licensed: _____

License Certification Type: MI: _____ DD: _____ Both: _____ Other: _____

Home/residential phone: _____ Home/residential fax: _____

Home/residential email: _____

Home Gender: Male: _____ Female: _____ Mixed: _____

Wheelchair Accessible: Yes: _____ No: _____

Total weekly hours of direct care staffing required (based on full occupancy): _____

Average Direct Care hourly wage including benefits: $_____

8. Billing Office Address/Contact:

Corporate Billing Address: _____

City: _____ State: _____ Zip: _____

Would you like letters of authorization sent to your billing office address: Yes ____ No ____

If you have multiple provider sites, would you like all site's payments & remittances rolled together?

Yes_____ No_____ N/A_____

Are you currently capable of submitting claims electronically (i.e. 837P or 837I compliant)?

Y_____ N_____

Claims Contact: _____

Phone: _____ Fax: _____Email:_____

COB: (Coordination of Benefits) for Inpatient, Case management, Outpatient Clinic, Autism, & Enhanced Health Disciplines (OT/PT/Nursing/Speech/Dietary/Psychology), are you approved to bill commercial insurances?

Yes_____ No_____: If yes, then please select approved insurances you are qualified to bill:

Medicare ____ Saginaw Medicaid Health Plans: _____

BCBS ____ Other: _____

9. Auditing Contact:

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

Name: _____

Title: _____Phone: _____

Fax: _____

Email: _____

10. Training Contact:

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

Name: _____

Title: _____

Phone: _____

Fax: _____ Email: _____

Mail your training transcripts to corporate address: ____ or provider site address(s):_____ or both: ____

11. Description of Organization's Mission and Scope: (If more convenient, feel free to attach a hard copy of brochure(s) or policy)

_____

_____

_____

_____

_____

12. What is your organization's current payor mix of funding/revenue sources?

Payor name/entity	% of total funding
SCCMHA	

13. Does your organization employ or offer leadership roles to any primary or secondary consumers?
Y_____ N_____ If yes, please list below.

Role/Title:	Diversity Information:	Population Type:	% of FTE:	Paid Employment Y/N:

Note: Please maintain a list of consumers to be made available to SCCMHA upon request for State reporting purposes only.

14. **Type of Accreditation for Service Programs:** Is this section applicable to your service delivery even if not required by SCCMHA? Yes _____ No _____ If yes, attach copy of current accreditation certificate.

Accreditation Entity Name:_____ Expiration: _____

15. **Type of Licensure for Service Programs:** Is this section applicable to your service delivery?

Yes_____ No_____ If yes, attach copy of current licensure certificate.

Licensing Entity Name: _____ Expiration: _____

16. **Do you employ or are you able to accommodate persons with limited English proficiency (translation or interpretation)?** Yes_____ No_____ If yes, please describe:

_____

17. **Please attach a statement of declaration of any known potential or real conflicts of interests with SCCMHA (organizational or individual):**

None known at this time: _____ OR Description attached: _____

Does your organization employ or contract with any known SCCMHA employee(s)? Yes: ____ No: ____

If yes, full name of person(s): _____

18. **If incorporated, please list all board members: Is this section applicable to your service delivery? If yes, attach additional information as necessary**

Yes _____ No _____

Composition of Board of Directors			
Name:	**Position:**	**Primary or secondary consumer representative? Y or N**	**Term:**

19. 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 federal databases: **SAM (System for Award Management, LEIE (List of Excluded Individuals/Entities), EPLS (General Services Administration's Excluded Parties List System), MDHHS Sanctioned Provider List**

Verifications Complete: _____

Have legal 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:

20. Credentialing: Provider verifies compliance with SCCMHA credentialing policy and procedure as listed within the SCCMHA Network Services Provider Manual Section 09.04.03.01, including direct source verification of license and education, prior to hire and annual background checks, NPI, registration in CHAMPS, monthly sanction checks as noted above,and references; and maintains such documentation on file subject to SCCMHA, MSHN or MDHHS review of all persons involved in SCCMHA service delivery:

Verification Complete: _____

21. Attachments:

Copies of the following should be attached to this application:	Included (Y/N):
Organizational Chart (including all individuals involved in SCCMHA service delivery)	
Tax Status, and any IRS tax exempt letter if applicable	
Professional, general liability, workers comp, auto insurance certificates, if applicable	
Accreditation certificates, if applicable	
Signed W-9: go to http://www.irs.gov to obtain form	

22. Authorized Contract Signee or Residential Licensee:

I hereby give authorization to SCCMHA to check my Recipient Rights history, criminal background history, driver's license record, OIG and sanctioned provider lists, 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: _____ Gender: Male: _____ Female: _____

Race: _____

_____
Provider/Licensee: Print Full Name (include any aliases)

_____ _____
Provider/Licensee Signature Date

23. <u>For new applicants please provide three references who can speak to your experience providing care for persons with special needs, developmental disabilities or mental illness:</u>

Name	Address	Phone
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Consumer Appeals & Grievance
Customer Service Complaints
Pre-Contract Notice / Delegation

Included in the SCCMHA Network Services Provider Manual, which is a contract attachment of varied SCCMHA requirements, is the policy are three policies, "Appeals & Grievances" Medicaid Appeals, Customer Service Grievance, and Local Appeals. Federal regulations require that SCCMHA, as a provider for Mid-State Health Network also known as MSHN, as and 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 primary 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. Adequate Action Notices must be given to consumers at the time of their Person Centered Plan.

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. (989)797-3452 or (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.

Provider Affirmation:

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

consumers 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 OR REMAIN A PART OF THE SCCMHA PROVIDER NETWORK:

_____ _____

Signature of Applicant / Title: Date: