SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

FY19 Service Provider Application
(Individual Licensed Providers, Sole Proprietors)
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 checks, and provide an opportunity for you to make SCCMHA aware of current information regarding your services being offered. All responses are subject to an audit by SCCMHA.

Please complete the following list of 10 items. 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 being offered.

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

1. **Provider Specific Information:**

Provider Legal Name: _____

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

Federal Tax ID/SSN: _____

National Provider Identifier (NPI) #, if applicable: _____

Medicaid ID#, if applicable: _____

2. Private Practitioners/Individuals Only:

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

Yes ____ No ____ N/A_____

Professional License # _____ Specialty: _____

Professional License # _____ Specialty: _____

3. Practice Site Information:

Practice Site Location: _____
Primary Contact: _____
Address: _____ (**No P.O. Box numbers please**)
City: _____ State: ___ Zip: _____
Phone: _____
Fax: _____
Cell: _____
Email: _____
Handicap Accessible: Yes ____ No ____ Bus Route: Yes ____ No ____
Are you accepting new patients? Yes_____ No_____
Service Hours of Operation & explanation of 24 hour on-call procedures:

_____
_____
_____

4. Billing Office Address/Contact:

Billing Address: _____ (**No P.O. Box numbers please**)
City: _____ State: _____ Zip: _____
Would you like letters of authorization sent to your billing office address: Yes ____ No ____
Are you currently capable of submitting claims electronically (i.e. 837P compliant)? Y_____ N_____
Claims Contact: _____
Phone: _____ Fax: _____Email:_____

COB: (Coordination of Benefits) 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 ____ HAP ____ Other: _____

5. Description of service experience:

_____
_____
_____
_____
_____
_____

6. **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 you or your organization employ or contract with any known SCCMHA employee(s)?

Yes: ____ No: ____ If yes, full name of person(s): _____

7. **Provider verifies that they are in good standing and 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 databases: SAM (System for Award Management, LEIE (List of Excluded Individuals/Entities), EPLS (General Services Administration's Excluded Parties List System, MDHHS Sanctioned Providers 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:**

8. **Attachments:**

Copies of the following should be attached to this application:	**Included (Y/N):**
Tax Status, and any IRS Tax Exempt Letter if applicable	
Professional, Gen. Liab., Auto Insurance Certificate(s), if applicable	
Professional License(s)	
Signed W-9: go to http://www.irs.gov/ to obtain form	
Resume, inclusive of previous work history	

9. Background Check:

I hereby give authorization to SCCMHA to check my Recipient Rights history, criminal background history, driver's license record, OIG, and references to verify my eligibility in becoming or maintaining active status as a participating provider.

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

DOB: _____ Gender: Male: _____ Female: _____

Race: _____

_____
Print Full Name (include any aliases)

_____ _____
Signature Date

10. 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:

Name	Address	Telephone(s)
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 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 / Credentials: Date: