



FY21 Service Provider Application

www.sccmha.org

Instructions for Provider

Please print legibly and return all pages to:

SCCMHA- Director of Contracts & Procurement
500 Hancock
Saginaw, MI, 48602
Or Fax to 989-498-4219

A SCCMHA Provider Application must be completed or renewed by each 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 audit by SCCMHA.

Please complete the following list of 24 items. If your organization has multiple provider sites listed within your contract, please attach additional site information pertaining to questions #7-9 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 timely with written notice to SCCMHA Contracts & Properties Manager.

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 contact/officer to be notified of SCCMHA electronic medical record (EMR) access / logon requests:

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

6. Recipient Rights Contact:

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

7. 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 ____

8. 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 licensed 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 (based on full occupancy): _____

Average Direct Care staff hourly wage including benefits: \$ _____

9. 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, Outpatient Clinic(s)-Therapy/psychology/psychiatry, 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 Plan(s): _____

BCBS _____ Other: _____

10. Auditing Contact:

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

Name: _____

Title: _____ Phone: _____

Fax: _____

Email: _____

11. 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: _____

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

13. What is your organization’s current payor mix of significant funding/revenue sources?

Payor name/entity	% of total funding
SCCMHA	

14. Does your organization employ or offer leadership roles to any primary or secondary consumers?

Y_____ N_____ If yes, please list below.

Paid

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

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

15. Type of Accreditation for Service Programs (Case Management, Supports Coordination, and Outpatient Clinics Only): Please attach copy of current accreditation certificate.

Accreditation Entity Name:_____ Expiration: _____

16. Type of Licensure for Service Programs: Attach copy of current licensure certificate.

Licensing Entity Name: _____ Expiration: _____

17. Do you employ or are you able to accommodate persons with limited English proficiency (translation or interpretation)? Yes _____ No _____ If yes, please describe:

18. 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): _____

19. If incorporated, please attach a listing of all board members which includes the following grid information:

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

20. 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:

Initial such verifications have been completed: _____

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

Litigation:	Outcome/Status:

21. 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 and CHAMPS enrollment/registration, OIG monthly sanction checks, and maintains such documentation on file subject to SCCMHA, MSHN or MDHHS review of all persons involved in SCCMHA service delivery:

Initial such verifications are completed timely: _____

22. 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, as applicable	
Accreditation certificates, if applicable	
Signed W-9: go to http://www.irs.gov to obtain form	

23. Authorized Contract Signee or Residential Licensee:

I hereby give authorization for 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 or remain a participating provider.

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

DOB: _____ Gender: Male: _____ Female: _____

Race: _____

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

Provider/Licensee Signature

Date

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

	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: