Advanced Behavioral Health, Inc.

Organization Credentialing Application Form

SECTION A: General Application Information

Application Type (Please check only ONE)

- ☐ New Application
- ☐ Additional Service

Service Classification (Please check all that apply)

- ☐ Clinical
- ☐ Non-Clinical

Name of Individual Completing Application:
Telephone Number: ( ) -

Note: If additional space is needed to complete any of the fields indicated on this application, please submit on an additional 81/2 x 11 inch sheet of paper.

SECTION B: General Agency Information

Agency/Provider Name:	
DBA (if applicable)	
Mailing Address (Address where correspondences and contracts are mailed)	
Address 1:	
Address 2:	
City: , State: , Zip:	
Phone Number ( ) -	Fax Number ( ) -
Email Address:	
Website:	
Has your agency been credentialed for other services by ABH, Inc in the last three years?	

☐ No ☐ Yes	If yes, Date Last Credentialed: / / under Program Name:

SECTION C: Billing Address (Address where payments are mailed)

Legal Name of Organization	
DBA (if applicable)	
Billing Contact Person:	
Address 1:	
Address 2:	
City: , State: , Zip	
Phone Number ( ) -	Fax Number ( ) -
Email Address:	

SECTION D: General Business Information

Type of Ownership:	☐ Private ☐ Public ☐ State Operated Program Other:		
Status:	☐ For-Profit ☐ Not-For-Profit Other:		
Tax ID Number/EIN:	NPI:	Medicaid Provider ID:	501c3 ID:
State Tax ID Number:			
What percentage of the organization's fee-for-service business is billed electronically? %			

***** Please enclose a copy of a completed W9 with this application *****

SECTION E: Primary Service Location Information Please complete all that apply.

Address 1:
Address 2:
City, State, Zip: Handicap Accessible: ☐ Yes ☐ No

Phone Number ( ) -	Fax Number ( ) -
Email Address:	

SECTION F: Additional Service Location Information Please complete all that apply.

Additional Service Location 1:

Contact Person:	
Address 1:	
Address 2:	
City, State, Zip:	Handicap Accessible: ☐ Yes ☐ No
Phone Number ( ) -	Fax Number ( ) -
Email Address:	

Additional Service Location 2:

Contact Person:	
Address 1:	
Address 2:	
City, State, Zip:	Handicap Accessible: ☐ Yes ☐ No
Phone Number ( ) -	Fax Number ( ) -
Email Address:	

Additional Service Location 3:

Contact Person:	
Address 1:	
Address 2:	
City, State, Zip:	Handicap Accessible: ☐ Yes ☐ No
Phone Number ( ) -	Fax Number ( ) -
Email Address:	

Additional Service Location 4:

Address 1:	
Address 2:	
City, State, Zip:	Handicap Accessible: ☐ Yes ☐ No

Phone Number ( ) -	Fax Number ( ) -
Email Address:	

SECTION G: Key Facility Personnel

Chief Executive Officer

Name:	Email Address:
Phone Number ( ) - ext	Fax Number ( ) -

Chief Financial Officer

Name:	Email Address:
Phone Number ( ) - ext	Fax Number ( ) -

Chief Medical Director

Name:	Email Address:
Phone Number ( ) - ext	Fax Number ( ) -

Chief Clinical Director

Name:	Email Address:
Phone Number ( ) - ext	Fax Number ( ) -

Contact Person

Name:	Email Address:
Phone Number ( ) - ext	Fax Number ( ) -

SECTION H: Licensure/Certification/Registration Please attach a current copy of the applicable license.

Regulatory Agency	Type and Classification	Certificate Number:	Expiration Date: / /
Regulatory Agency	Type and Classification	Certificate Number:	Expiration Date: / /
Regulatory Agency	Type and Classification	Certificate Number:	Expiration Date: / /
Regulatory Agency	Type and Classification	Certificate Number:	Expiration Date: / /
Regulatory Agency	Type and Classification	Certificate Number:	Expiration Date: / /

Are there any conditions that have been place on the above Licensure/Certification/Registration?

☐ Yes ☐ No

If your answer is YES, please provide a detailed explanation on a separate sheet of paper and attach to this application.

SECTION I: Professional Liability Insurance Information

Name of Liability Carrier:	
Address:	
City: , State: , Zip	
Limits of Professional Liability: $ M Per Occurrence $ M Per Aggregate	
Insurance Effective Date: / / Insurance Expiration: / /	
Type of Policy: ☐ Claims Made ☐ Occurrence ☐ Self-Insured Trust	
Are you covered by any Trust or other professional liability arrangement wherein the government limits liability in any medical malpractice action? ☐ Yes ☐ No	
Are all Clinical personnel covered by this policy? ☐ Yes ☐ No	

***** Please enclose a copy of your current certificate of liability insurance with application *****

SECTION J: General Liability Insurance Information

Name of Liability Carrier:	
Address:	
City: , State: , Zip	
Limits of General Liability: $ M Per Occurrence $ M Per Aggregate	
Insurance Effective Date: / / Insurance Expiration: / /	
Type of Policy:	

☐ Claims Made ☐ Occurrence ☐ Self-Insured Trust

***** Please enclose a copy of your current certificate of liability insurance with application *****

SECTION K: Language Competence

In addition to English, please identify the languages available to participants:

☐ American Sign Language	☐ Greek	☐ Norwegian	☐ Yiddish
☐ Arabic	☐ Hebrew	☐ Polish	☐ Other:
☐ Armenian	☐ Hindi	☐ Portuguese	☐ Other:
☐ Chinese	☐ Hungarian	☐ Russian	
☐ Dutch	☐ Italian	☐ Spanish	☐ Other:
☐ Farsi	☐ Japanese	☐ Swedish	
☐ French	☐ Korean	☐ Tagalog	
☐ German	☐ Laotian	☐ Vietnamese	

SECTION L: History of Agency Sanctions, Malpractice Claims and/or Adverse Events

Please complete this section in its entirety. If a question does not apply to your facility, you may check Not Applicable (N/A). If you have answered '**Yes**' to any of the below questions, please complete the form **SECTION M: Agency Malpractice Claim Information Worksheet** by providing the current status and details. Please include the following: description of incident, including correspondence with state licensing boards, and/or a detailed description of any litigation, including settlements, court awards, etc. Please feel free to include a personal summary of the events; however, your application cannot be processed without the necessary official documentation.

	In the last five years:	**Yes**	**No**	**N/A**
1	Has the organization been named in any malpractice action?	☐	☐	☐
2	Has the organization had, or currently have pending, any malpractice legal action?	☐	☐	☐
3	Has the Organization had professional liability insurance refused, revoked, declined or accepted on special terms?	☐	☐	☐
4	Has any payor (including but not limited to any federal, state, or private insurance) investigated, suspended, revoked or taken other action against the Organization's contract, Provider Agreement, and/or license to conduct business?	☐	☐	☐
5	Have any memberships in professional organizations been revoked, reduced, denied, or suspended by others or voluntarily given up by the Organization, or are any actions now under way, which may lead to such sanctions?	☐	☐	☐
6	Has any license, certification, or accreditation been revoked, denied or suspended by others or voluntarily given up by the Organization, or are any actions now under way, which may lead to such sanctions?	☐	☐	☐
7	Have any owners, officers or shareholders of the Organization been convicted of a crime, excluding misdemeanors?	☐	☐	☐
8	Has the Organization been assessed a penalty, conviction, suspension, or other Sanction; or is the Organization currently under investigation by Medicare or Medicaid Programs?	☐	☐	☐

9	Has the Organization ever been a defendant in any lawsuit with regard to the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000.00 (fifty thousand dollars) or more?	☐	☐	☐
10	Has any claim or suit for alleged malpractice been brought against the facility/ program, or are you aware of any circumstances that might lead to such a claim or suit against the facility/program?	☐	☐	☐

SECTION L: Continued

		Yes	No	N/A
11	Has the agency had any malpractice claims regarding the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000 or more?	☐	☐	☐
12	Has any officer, owner, or executive staff of this Organization done business with the Department of Mental Health and Addiction Services (DMHAS), Department of Children and Families (DCF), or Advanced Behavioral Health (ABH) under a different name?	☐	☐	☐
13	Has the organization had monies recouped by DMHAS, DCF or ABH?	☐	☐	☐
14	Has the organization ever had a contract terminated by DMHAS, DCF or ABH?	☐	☐	☐
15	Has the organization ever received an unfavorable finding or corrective action by DMHAS, DCF or ABH?	☐	☐	☐

Number of Claims:

☐ 0 ☐ 1 ☐ 2 ☐ More

My signature certifies that I have answered all questions accurately, completely and to the best of my ability. I understand that any misrepresentation or false statement can result in my being withdrawn from the list of providers as well as possible recourse through the State and/or Federal agencies.

Printed Name:

Completed and signed by:_____ Date: / /
(All signatures must be original)

Title:

SECTION M: Agency Malpractice Claim Information Worksheet

This form is only completed if you answered "Yes" to any item listed on Section L of this application.

Name of Claimant:	
Date of Alleged Incident: / /	Date Lawsuit Filed: / /
Court:	Case Number:
Allegations:	

Status of Case:

- ☐ Pending before Malpractice Panel
- ☐ Pending in Court
- ☐ Closed without Payment
- ☐ Pre-trial Settlement (include dollar amount):
  Date of Settlement: / / $ 0.00
- ☐ Verdict for Defendant
- ☐ Verdict for Plaintiff

What was/is the agency's status:

- ☐ Sole defendant ☐ Co-defendant
- ☐ Other (please describe):

Name and phone number of Insurance Carrier:

Name and Phone Number of Defense Attorney:

Name and Phone Number of Plaintiff's Attorney:

Provide name and phone numbers of others that could furnish additional information regarding the claim/suit:

Provide, in detail, the nature of the allegation of wrongdoing/negligence: (attach separate page, if necessary)

**** The information above applies to # Section L ****

Name:

Signature:_____ (All signatures must be original)

Date: / /

SECTION N: Program Specific Requirements

You may be required to submit additional documentation with this application in relation to the program you are applying for. Please refer to the Program Documentation Grid for a complete listing of all required documentation.

SECTION O: Certification and Authorization Page

For purposes of making this application to remain or become a participating Provider, the Applicant certifies that all information provided is true and correct to the best of the Applicant's knowledge and belief. The Applicant agrees to notify ABH promptly if there are any material changes in the information provided, whether prior to or after acceptance as a provider. The Applicant understands and agrees that if DCF, DMHAS or ABH determines that this application contains any significant misstatements, misrepresentations or omissions, acceptance of this application for participation and any subsequent participating provider agreement with the Applicant may be voidable at DCF, DMHAS', or ABH's discretion.

The Applicant hereby authorizes the release to DCF/DMHAS or ABH of any information held by any person, entity or governmental agency which DCF/DMHAS or ABH determines may have relevant information for purposes of evaluating this original application or any re-credentialing information. The Applicant agrees to hold any such person, entity or governmental agency providing information to DCF/DMHAS or ABH harmless from any liability for providing such information.

The Applicant hereby further authorizes DCF/DMHAS or ABH to release any and all information related in any way to the Applicant's professional practice to any person, entity or governmental agency which: (a) provides DCF/DMHAS or (BH with an authorization signed by the Organization; or (b) has a legal right to know under any state or federal law. The Applicant agrees to hold DCF/DMHAS and ABH harmless from any liability for providing such information as specified herein.

The Applicant understands and agrees that the certifications, authorizations, and other provisions contained herein shall remain in force for as long as this application is pending and, if accepted for participation, for as long as the Applicant's provider agreement with DCF/DMHAS/ABH remains in force.

The Applicant further understands and agrees that (a) the Applicant has the burden of producing all information required or requested by DCF/DMHAS or ABH in connection with this application; and (b) DCF/DMHAS or ABH is under no obligation to complete the processing of this application until such information is provided by the Organization.

Date: / / _____

Signature **(All signatures must be original)**

Name of Applicant:

Title:

Date of Birth: / /

Social Security Number:

Advanced Behavioral Health, Inc.