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**WISE – Provider Contact Form**

*Where applicable, please add in the appropriate contact.*

**Agency Name:**

***Waiver Services***

**(ALS) Assisted Living Services Contact:**

|  |  |
| --- | --- |
| Name: |       |
| Telephone #: |       |
| Fax #: |       |
| Email:  |       |

**(BES) Brief Episode Stabilization Contact:**

|  |  |
| --- | --- |
| Name: |       |
| Telephone #: |       |
| Fax #: |       |
| Email:  |       |

**(CSP) Community Support Program Contact:**

|  |  |
| --- | --- |
| Name: |  |
| Telephone #: |  |
| Fax #: |  |
| Email:  |  |

 **(PS) Peer Support Contact:**

|  |  |
| --- | --- |
| Name: |       |
| Telephone #: |       |
| Fax #: |       |
| Email:  |       |

**(RA) Recovery Assistant Contact:**

|  |  |
| --- | --- |
| Name: |       |
| Telephone #: |       |
| Fax #: |       |
| Email:  |       |

**(SE) Supported Employment Contact:**

|  |  |
| --- | --- |
| Name: |       |
| Telephone #: |       |
| Fax #: |       |
| Email:  |       |

**(TCM) Transitional Case Management Contact:**

|  |  |
| --- | --- |
| Name: |  |
| Telephone #: |  |
| Fax #: |  |
| Email:  |  |

***General Contacts***

**Agency CEO:**

|  |  |
| --- | --- |
| Name: |  |
| Telephone #: |  |
| Fax #: |  |
| Email:  |  |

**Referrals / Authorizations Contact:**

(Person DMHAS would send the authorizations, recovery plans to)

|  |  |
| --- | --- |
| Name: |  |
| Telephone #: |  |
| Fax #: |  |
| Email:  |  |

**Program Contact:**

(Responsible for maintaining agency credentialing requirements and **receives Provider Alert Emails**)

|  |  |
| --- | --- |
| Name: |  |
| Telephone #: |  |
| Fax #: |  |
| Email:  |  |

**Chief Clinical Officer:**

(APRN, LCSW, LMFT, LPC, MD, PhD, Psy. D. and RN)

|  |  |
| --- | --- |
| Name: |  |
| Telephone #: |  |
| Fax #: |  |
| Email:  |  |

**Billing Contact:**

|  |  |
| --- | --- |
| Name: |  |
| Telephone #: |  |
| Fax #: |  |
| Email:  |  |

**Filled out by:**

**Date:**