Advanced Behavioral Health, Inc.

Organization Credentialing Application Form



**SECTION A: General Application Information**

**Application Type (Please check only ONE)**

* New Application
* Additional Service
* Re-credentialing

**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:       |
|  |

**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?    %  |
| Has your agency been credentialed for other services by ABH, Inc. in the last three years? € No € YesIf yes, Date Last Credentialed:    /   /    under Program Name:       |
| Please check any Medicaid Waiver your agency is currently or previously been a provider: € CHCPE € ABI € PCA € DSS |
| Please list any other Medicaid funded services your agency currently provides:       |

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

|  |
| --- |
| Address 1:      |
| Address 2:      |
| City:      , State:   , Zip       |
| Phone Number (   )    -      Fax Number (   )    -      |
| City,      State,   Zip:       Handicap Accessible: € Yes € No |

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

**Additional Service Location 1:**

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

**Additional Service Location 2:**

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

**Additional Service Location 3:**

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

**Additional Service Location 4:**

|  |
| --- |
| Address 1:      |
| Address 2:      |
| City:      , State:   , Zip       |
| Phone Number (   )    -      Fax Number (   )    -      |
| City,      State,   Zip:       Handicap Accessible: € Yes € No |

**SECTION G: Key Facility Personnel**

**Chief Executive Officer**

|  |
| --- |
| Name:       Email Address:      |
| Social Security Number:      Date of Birth:    /   /    |
| Phone Number (   )    -      ext.     Fax Number (   )    -      |

**Chief Financial Officer**

|  |
| --- |
| Name:       Email Address:      |
| Social Security Number:      Date of Birth:    /   /    |
| Phone Number (   )    -      ext.     Fax Number (   )    -      |

**Chief Medical Director**

|  |
| --- |
| Name:       Email Address:      |
| Social Security Number:      Date of Birth:    /   /    |
| Phone Number (   )    -      ext.     Fax Number (   )    -      |

**Chief Clinical Director**

|  |
| --- |
| Name:       Email Address:      |
| Social Security Number:      Date of Birth:    /   /    |
| Phone Number (   )    -      ext.     Fax Number (   )    -      |

**Contact Person**

|  |
| --- |
| Name:       Email Address:      |
| Social Security Number:      Date of Birth:    /   /    |
| 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 € NoIf 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 |  | German |  | Korean |  | Swedish |
|  | Arabic |  | Greek |  | Laotian |  | Tagalog (Philippines)  |
|  | Armenian |  | Hebrew |  | Norwegian  |  | Vietnamese  |
|  | Chinese |  | Hindi  |  | Polish  |  | Yiddish  |
|  | Dutch |  | Hungarian  |  | Portuguese  |  | Other: |
|  | Farsi |  | Italian  |  | Russian  |  | Other:  |
|  | French |  | Japanese |  | Spanish  |  | Other: |

**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 government agency investigated, suspended, revoked or taken other action against the Organization’s license to conduct business? (Include Medicaid/Medicare)  | [ ]  | [ ]  | [ ]  |
|  |  |  |  |  |
| 5 | Have any memberships in professional organizations been revoked, reduced, denied, or suspended by others or voluntarily given up by the Organization, orare any actions now under way, which may lead to such sanctions?  | [ ]  | [ ]  | [ ]  |
|  |  |  |  |  |
| 6 | Has any license, certification, or accreditation been revoked, denied or suspendedby 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 convictedof a crime, excluding misdemeanors?  | [ ]  | [ ]  | [ ]  |
|  |  |  |  |  |
| 8 | Has the Organization been assessed a penalty, conviction, suspension, or otherSanction; or is the Organization currently under investigation by Medicare orMedicaid Programs?  | [ ]  | [ ]  | [ ]  |
|  |  |  |  |  |
| 9 | Has the Organization ever been a defendant in any lawsuit with regard to thepractice of mental health or substance abuse treatment where there has been anaward 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:

[ ] 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: Chief Clinical Officer Information**

**Page 10 and 11 is to be completed by the Chief Clinical Officer, who must be a licensed clinician; for the agency.**

**Demographic Information:**

Last Name:      First Name:      MI

**Social Security Number**: **(For identification purposes only)**:       -     -

**Date of Birth:     /     /**

Is Chief Clinical Officer for the agency [ ]  Employed by Agency or [ ]  Under Contract with Agency

**Primary Practice Office Address State of Primary Practice**:

 Street City/Town State Zip Code

|  |  |  |  |
| --- | --- | --- | --- |
|       |       |       |       |

Office Telephone Number: Fax Number:

|  |  |  |
| --- | --- | --- |
|        |  |       |

**E-mail Address**:\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION N: Continued**

**Licensure/Certification**

Indicate the discipline under which you are LICENSED and/or CERTIFIED at the highest level to practice independently:

Complete the following license information for ALL states in which you are currently licensed.

|  |  |  |  |
| --- | --- | --- | --- |
| State | License Type(e.g., Psychologist, etc.) | License # | Expiration Date(Month/Day/Year) |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

**Please attach a current copy of all licenses.**

Indicate current applicable Certifications

|  |  |  |
| --- | --- | --- |
| Certification TypeDrug Enforcement Agency (DEA) Certificate (MD, APRN) | Certification # | Expiration Date(Month/Day/Year) |
|  |       |       |
|  |  |  |

***Please attach a current copy of all certifications.***

**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:





**SECTION P: Certification and Authorization Page**

**The following information/documentation is mandatory to complete the**

 **Credentialing process:**

1. Copy of Current Agency License **along with previous expired agency license-** to demonstrate that the agency has been in business for at least a year,
2. Copy of current Accreditation Certification- CARF ( Commission on Accreditation of Rehabilitative Services) , The Joint Commission, COA or other DMHAS approved accreditations. If applying for Recovery Assistant Services only, accreditation certificate is not needed.
3. **Copy of any other nationally recognized Accreditations**
4. Copy of Insurance Cover page for Malpractice/ Professional Liability and General Liability
	* 1. Limit coverage’s must be at least $1,000,000 per occurrence/$3,000,000 in the annual aggregate
		2. All addresses for all sites/locations covered by the policy
		3. ABH must be added to the policy as a Certificate Holder

**SECTION Q: Waiver Services**

|  |
| --- |
| **Return all requested material to:****Advanced Behavioral Health, Inc.****213 Court Street****Middletown, CT 06457****Attn: Mental Health Waiver*****Please remember to make a copy of all documentation submitted.*** |

 **The Agency is Applying for Participation to Provide the Following Services**:

*Check all that apply:*

 [ ]  Assisted Living Agency Services

[ ]  Brief Episode Stabilization

[ ]  Community Support Program

[ ]  Recovery Assistant (Individual, Group, and Overnight)

[ ]  Peer Support

[ ]  Supported Employment

[ ]  Transitional Case Management

[ ]  Adult Day Health

[ ]  Home Delivered Meals

* The specific service applications are on the following pages. Prior to each service application is a description of the service, including the DMHAS qualifications.
* Complete only those service applications which your agency plans to provide.
* Service Reimbursement Schedules can be found on the DMHAS website: **http://www.ct.gov/dmhas/site/default.asp**