Louisiana Facility and Ancillary Credentialing Application

Legal Name: _____

d/b/a: _____

☐ Initial Credentialing ☐ Recredentialing ☐ Addition of a new site to a current contract

Please enclose the following with your completed Facility & Ancillary Provider Application:

- ☐ Initial Credentialing: A list of current professional Mental Health/Chemical Dependency staff privileged to admit and/or treat patients in your facility, (include license type, address, telephone numbers, and social security numbers) that you would recommend that we contact for membership on our Individual Provider Panel.
- ☐ Initial and Re-Credentialing: A copy of your TJC/CARF/COA/or AOA accreditation letter with dates of accreditation. If you are not accredited, please submit a copy of a state site survey approval letter with the date the site survey was completed and approved.
- ☐ Initial and Re-Credentialing: A copy of the state or local license(s) and/or certificate(s) under which your facility operates.
- ☐ Initial and Re-Credentialing: A copy of your CLIA license (If applicable).
- ☐ Initial and Re-Credentialing: A copy of your Pharmacy license (If applicable).
- ☐ Initial and Re-Credentialing: A copy of your DEA or CDS (If applicable).
- ☐ Initial and Re-Credentialing: A copy of your professional and general liability insurance policy with the limits of coverage per occurrence and in aggregate, name of liability carrier, and insurance effective date and expiration date (Month/Day/Year).
- ☐ Initial and Re-Credentialing: Listing of satellite locations and services offered at each location (include copies of accreditation, license, Insurance, CLIA, and Pharmacy if applicable).
- ☐ Initial and Re-Credentialing: A copy of your NDMS agreement. (If applicable)
- ☐ A copy of your state or local fire/health certificate (Non-accredited facilities only)
- ☐ A copy of your Quality Assurance Plan (Non accredited facilities only)
- ☐ Description of Aftercare or Follow up Program (Non-accredited facilities only)
- ☐ Current copy of your Louisiana Office of Behavioral Health (OBH) Certification Letter
- ☐ Initial and Re-Credentialing: Disclosure of Ownership and Control Interest Statement

Please Note: A <u>separate</u> Facility & Ancillary Credentialing Application must be completed for each facility with a unique Federal Tax ID.

Legal Name: _____

d/b/a: _____

Facility Certification Type

- ☐ Hospital (acute care, Free standing, state)
- ☐ Intensive Family Intervention
- ☐ Adult Living Facility
- ☐ Home Health Agency
- ☐ Psychiatric Residential(children only)
- ☐ Detox Residential
- ☐ Detox Inpatient
- ☐ Psychosocial Rehab (adult only)
- ☐ Mobile Crisis
- ☐ Short Term Respite (children only)
- ☐ Detox Inpatient
- ☐ Independent Living/skills building (children)
- ☐ Case Conference (children only)
- ☐ Multi-Systemic Therapy (children only)
- ☐ Community Mental Health Center
- ☐ Mental Health Rehabilitation Center (OP)
- ☐ Assisted Long-Term Care Facility
- ☐ Outpatient Clinic
- ☐ Substance Abuse Residential
- ☐ Crisis Residential
- ☐ Intensive Case Management (adult only)
- ☐ Crisis Intervention
- ☐ Emergency Room
- ☐ Functional Therapy (children only)
- ☐ Therapeutic Group Home (children only)
- ☐ Wrap Around Facilitation (children only)
- ☐ Parent/Youth Suppports/Training (children only)
- ☐ ECT
- ☐ Suboxone (please include staff certification to administer suboxone)
- ☐ Other: _____

Note: Copy of state certification is ***required*** for each service checked above.

I. Ownership/Management

President/CEO Name: _____ Phone: _____

Vice President Name/COO_____ Phone: _____

Managed Care Contact:_____ Phone: _____

II. Facility Information

Federal Tax ID #: _____

National Provider ID # (NPI): _____ Taxonomy: _____

Additional NPI/ Taxonomy information:_____

Medicare Provider #:_____ Expiration Date:_____

Medicaid Provider #:_____Expiration Date:_____

License Number: _____ Expiration Date:___

CLIA Certificate	Yes ☐	No ☐	N/A ☐	(Provide Current Copy)
Pharmacy Certificate	Yes ☐	No ☐	N/A ☐	(Provide Current Copy)
DEA Certificate	Yes ☐	No ☐	N/A ☐	(Provide Current Copy)

Have your facility been certified by the Louisiana Office of Behavioral Health (OBH)? ☐ Yes ☐ No

If no, please discontinue the credentialing application process and contact the OBH to obtain certification.

If yes, please check all the services your facility is certified to perform below:

Behavioral Health Services Provided (please check all that apply)			
☐	*Inpatient*: Ages Served: _____	☐	*Day Treatment Program* (check one or both) *Substance Abuse* ☐ *Mental Health* ☐ Ages Served: _____
☐	*Detox* Ages Served: _____	☐	*Electroconvulsive Therapy* (ECT) (check one or both) *Inpatient* ☐ *Outpatient* ☐
☐	*23-hour Observation / Crisis Stabilization*	☐	*Traditional Outpatient*
☐	*Intensive Outpatient Program (IOP)* (check one or both) *Substance Abuse* ☐ *Mental Health* ☐ Ages Served: _____	☐	*Partial Hospitalization Program (PHP)* (check one or both) *Substance Abuse* ☐ *Mental Health* ☐ Ages Served: _____

Other Services Not Listed Above:

_____

_____

Physical Location (If you have more than one physical location, please list each location on a separate sheet and complete the information requested below.)

Facility/Clinic Name:____

Address: _____

City: _____ State:_ Zip: _____ County:_

Phone:__ Fax: _____ Website: _____

Office Manager: _____ Email: _____

Credentialing Contact:_____ Email: _____

Language(s) spoken at this location:

- ☐ English
- ☐ Spanish
- ☐ Haitian Creole
- ☐ Laotian / Hmong
- ☐ Polish
- ☐ Vietnamese
- ☐ Cambodian
- ☐ Russian
- ☐ French
- ☐ Other _____

Hours of Operation: ☐ 24-hours, or

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
___to___	___to___	___to___	___to___	___to___	___to___	___to___

Is the facility open at least five (5) days per week? Yes ☐ No ☐

Age Groups Treated:

☐ 0-12 yrs ☐ 13-17 yrs ☐ 18-64 yrs ☐ 65+ yrs ☐ All ages ☐ Other _____

Are PAs, APNP's and/or Nurse Practitioners used? Yes ☐ No ☐

Is the facility disabled accessible? Yes ☐ No ☐

Billing Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Fax: _____

Email Address: _____

Is your facility affiliated with any other health care organization(s) through corporate linkage or other formal arrangement? If so, please provide the following information: (*List additional affiliations on a separate page.*)

Affiliated Name: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Fax: _____ Federal Tax ID#: _____

III. *Accreditation and/or Certification*

Is the facility accredited? Yes ☐ No ☐ If yes: Expiration Date:_____ (Month/Day/Year)

Agency Name	*Acronym*	*Applied Date*	*Expiration Date*
Accreditation Commission for Health Care, Inc.	ACHC		
American Association of Ambulatory Health Centers	AAAHC		
American Osteopathic Hospital Association	AOHA		

Commission on Accreditation for Rehab Facilities	CARF		
Community Health Accreditation Program	CHAP		
Healthcare Quality Association on Accreditation	HQAA		
Joint Commission on Accreditation of Healthcare Organizations	JCAHO		
National Committee for Quality Assurance	NCQA		
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc	URAC		
State Facility Operating License	N/A		
Others (please list)			

Please provide a copy of these documents as applicable, including the results of the survey and a report that shows the effective date of accreditation or certification, deficiencies and approved plan for corrective action.

IV. *Insurance Coverage – (Attach copy of declaration pages)*

Current Professional Carrier: _____

Amount per Occurrence:_____ Amount per Aggregate:_____

Dates of Coverage: From: _____ To: _____

Current Worker's Compensation Carrier: _____

Dates of Coverage: From: _____ To: _____

V. *Sanctions – If any question below is responded to with a "yes", please provide an explanation on a separate sheet, and attach to this Application.*

1. Have there been or are there currently pending any malpractice claims, suits, settlements or proceedings involving the facility? Yes ☐ No ☐

2. Has the facility ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? Yes ☐ No ☐

3. Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to professional conduct? Yes ☐ No ☐

4. Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer, or a Regulatory Agency (CLIA, OSHA, etc.) Yes ☐ No ☐

5. Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended, or revoked for any reason? Yes ☐ No ☐

6. Has an officer ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense? Yes ☐ No ☐

7. Has the corporation, an officer or a board member ever been convicted of a felony?
   Yes ☐ No ☐

VI. Facility Responsibility Form

I hereby understand that as a prospective/current ***Cenpatico*** provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Cenpatico in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Cenpatico credentialing/recredentialing requirements for all such individuals associated with my practice.

By applying for participation with Cenpatico, I hereby fully understand that the information submitted in this application shall be held confidential by the Cenpatico and provided only to individuals connected with the Plan on a need to know basis. Not withstanding the foregoing, I agree to the following:

- Participation in the credentialing review functions of Cenpatico.
- Authorize Cenpatico and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, or other State or Federal regulatory agencies.
- Consent to an inspection by Cenpatico and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- Consent to the release of such information for credentialing purposes.
- Release from liability all representatives of Cenpatico for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

In order to evaluate this application for participation in and/or continued participation with Cenpatico, the Facility hereby gives permission to Cenpatico to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that Cenpatico will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of Cenpatico.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility is selected or retained, after such selection or retention, the Facility agrees to inform Cenpatico in writing within 10 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by Cenpatico on its own behalf and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Cenpatico programs or any program until such time as this Facility receives notice of participation.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. A photo copy shall have the same force and effect as the signed original.

Signature of Facility CEO (or authorized designee): _____

Title: _____

Name (Print): _____

Date: _____

ATTACHMENT A: Additional Service Sites Covered by the Agreement:

Additional Site #1: _____

Street Address: _____

Suite/Building/P.O. Box: _____

Phone number (for patient use): _____ Fax: _____

Type of services offered: _____

Additional Site #2: _____

Street Address: _____

Suite/Building/P.O. Box: _____

Phone number (for patient use): _____ Fax: _____

Type of services offered: _____

_____

_____

Additional Site #3: _____

Street Address: _____

Suite/Building/P.O. Box: _____

Phone number (for patient use): _____ Fax: _____

Type of services offered: _____

_____

_____

Additional Site #4: _____

Street Address: _____

Suite/Building/P.O. Box: _____

Phone number (for patient use): _____ Fax: _____

Type of services offered: _____

_____

_____