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## BEHAVIORAL ORGANIZATIONAL CREDENTIALING APPLICATION

Please complete and return this application as soon as possible. Sign and date the application/release and include copies of all requested documents listed.

### WHP Credentialing Application Checklist

- Completed Application
- Signed and Dated Attestation/Release of Information page
- Copy of all facility licenses
- Copy of JCAHO, NCQA, CARF, COA or CHAP accreditation certificate
- State/CMS Survey Results

**\*If Not Accredited\* Please include the following:**

- **\*Policy & Procedure ensuring staff is qualified for their current position**
- **Roster of Licensed Staff with license numbers, DEA number if applicable, Medicare numbers, NPI, SS#, Date of Birth, Practitioner type, Clinic Location**
- **\*Roster of non-licensed staff with Practitioner type, Clinic location, Date of Birth, SS# and Medicare # if applicable**
- **\*Quality Assurance Policy**

- Copy of Hospital Admissions Policy
- Copy of any State Mental Health Services Designation Certificates
- Current Certificate of Professional and General Liability Insurance
- Brief Summaries for any malpractice claims over \$100,000 during the last 5 years
- W-9

**Non-Delegated Organizations that are not accredited will be asked to submit copies of a minimum of five random applications for a desktop review as part of the credentialing process.**

**Equal Employment Commitment:** It is the policy of Windsor Health Plan to adhere to all applicable federal, state and local fair employment practice laws, orders and regulations. WHP contracts and credentials without regard to race, color, religion, sex, national origin, veteran status, disability (provided that the organization/individual is able to perform the essential functions of the job with or without accommodation), or age. Decisions regarding credentialing are based upon valid job-related requirements.

Windsor Health Plan considers all credentialing information to be confidential and protects the confidentiality and integrity of its credentialing files.



**WHP BHO FACILITY CREDENTIALING APPLICATION**

**Initial Credentialing**     **Recredentialing**     **Additional Site**

**FACILITY INFORMATION (PLEASE PRINT CLEARLY):**

Corporate Name \_\_\_\_\_

Facility/Program Name (dba) \_\_\_\_\_

Physical Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

County \_\_\_\_\_

Contact Person for Credentialing \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

President/CEO  
Name \_\_\_\_\_ Title \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Medical Director  
Name \_\_\_\_\_ Title \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

**Billing Information:**

Tax ID # \_\_\_\_\_ NPI # \_\_\_\_\_  
(Required as of May 2007; contact CMS for more info)

Billing Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Contact Person for Billing \_\_\_\_\_

Billing Telephone# (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Billing Fax # (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Hours of Operation (including evening and weekend): \_\_\_\_\_

On-Call/Hospital Admissions Policy: \_\_\_\_\_

***Please attach copy of On- Call/Hospital admissions policy with application***

**Type of Facility- Please check all that apply– please submit any Certificates for Mental Health Services**

- |   |  |
|---|--|
| <input type="checkbox"/> Community Mental Health Center                       | <input type="checkbox"/> Adult Foster Care Licensed Residential Crisis                             |
| <input type="checkbox"/> Community Mental Health Clinic                       | <input type="checkbox"/> Mental Health Day Treatment   |
| <input type="checkbox"/> Residential Treatment Center (RTC)                   | <input type="checkbox"/> Mental Health Partial Psych/Partial Hospitalization                       |
| <input type="checkbox"/> Alcohol and Drug Treatment Center                    | <input type="checkbox"/> Mental Health Residential/Inpatient Treatment, IRTS or Residential Crisis |
| <input type="checkbox"/> 24-hour Behavioral Health Unit in a General Hospital |  |
| <input type="checkbox"/> Psychiatric Hospital                                 | <input type="checkbox"/> Other _____   |

**Licensure**

Please list all state and Federal Licenses for the facility. If there is a license for each service location, please indicate. Attach a copy of each license

<i>State</i>	<i>Type</i>	<i>Number</i>	<i>Date Issued</i>	<i>Expiration Date</i>	<i>Status</i>

**Medicare Certification - Please check the appropriate box**

Attach a copy of the last certification report for each site. Include the plan of correction to address any identified deficiencies

Is the Facility Medicare/Medicaid Certified? Yes  No

Date of last site survey? \_\_\_\_\_ Plan of Correction Accepted? Yes  No

Medicare # \_\_\_\_\_

**Accreditation – Please check the appropriate box**

Has the Facility been approved by an accrediting body? Yes  No

If yes, please select the accrediting body below and enter information in the table below

If pending, please indicate the date of survey or application date

JCAHO\_\_\_ URAC\_\_\_ CARF\_\_\_ CHAP\_\_\_ NCQA\_\_\_

OTHER\_\_\_ Please specify \_\_\_\_\_

Will require approval by Medical Advisory Committee (MAC)

**In order to comply with NCOA standards, Windsor Health Plan will conduct an onsite review of all organizations that are not accredited or have not received a CMS/State Site Survey**

**Staff Qualifications**

**If your organization is NOT currently accredited, attach a copy of the Policy & Procedure or documented process used to ensure that direct care providers are legally and professionally qualified for the position to which they are appointed and for the performance of the privileges granted**

**To your knowledge, has any member of your organization’s medical/clinical staff ever been the subject of disciplinary proceedings by any state or licensing board? Yes  No**

If “yes” is checked, please explain fully on a separate sheet.

**Background Investigations**

**The organization’s Executive Director, Medical Director or Clinical Director must sign the following:**

I attest that this organization conducts background investigations on all employees, interns, volunteers, and contract agents having contact with clients, consisting of at least the following, prior to hire:

1. A name search through the appropriate State Bureau of Investigation
2. Primary Source Verification from the licensing board for licensed persons
3. A check of the Central Registry of Child Abuse for persons having unsupervised contact with clients under age 18
4. A check of references of former employees for clinical staff

The organization has written criteria for evaluating which convictions or complaints make an applicant unacceptable for hire or a person unacceptable for retention.

\_\_\_\_\_  
 Signature Title Date

**Professional and/or General Liability Coverage**

Attach a copy of the declaration sheet of your current policy showing policy limits, coverage limitations and policy period

Carrier \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_  
 City State Zip Code

Telephone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

<b>Effective Date:</b>	<b>Expiration Date:</b>	<b>Retroactive Date:</b>
<b>Policy #</b>		
<b>Limit Per Occurrence:</b>	<b>Aggregate Limit:</b>	

**Has your professional liability insurance coverage ever been denied, cancelled, non-rewarded, or initially refused upon application? Yes  No  If “yes” is checked; please explain fully on a separate sheet.**

**All facilities are required to carry liability insurance in the amount of \$1million per occurrence and \$3 million aggregate.**

Accredited organizations are not required to submit claims history.

**Practice Information**

Identify the approximate percentage of practice time dedicated to the following client population:

Population	Young Child 0-5	Child 6-12	Adolescent 13-17	Adult 18-64	Older Adult 65+
Percentage					

Are there any specific populations that your organization does not serve? Yes  No   
 If yes, please list: \_\_\_\_\_

**Specialized Training/Experience**

Check all that apply

**Specialized Training in Treatment Modalities:**

- |                       |                          |                                |                          |                          |                          |
|-----------------------|--------------------------|--------------------------------|--------------------------|--------------------------|--------------------------|
| Individual Therapy    | <input type="checkbox"/> | Brief/Solution Focused Therapy | <input type="checkbox"/> | Rehab/Vocational Therapy | <input type="checkbox"/> |
| Couples Therapy       | <input type="checkbox"/> | Cognitive-Behavioral Therapy   | <input type="checkbox"/> | Art/Music/Dance Therapy  | <input type="checkbox"/> |
| Family Therapy        | <input type="checkbox"/> | Dialectical Behavior Training  | <input type="checkbox"/> | Recreation Therapy       | <input type="checkbox"/> |
| Group Therapy         | <input type="checkbox"/> | EMDR: Level _____              | <input type="checkbox"/> | Experiential Therapy     | <input type="checkbox"/> |
| Child Play Therapy    | <input type="checkbox"/> | Biofeedback                    | <input type="checkbox"/> | Psychodrama              | <input type="checkbox"/> |
| Medication Management | <input type="checkbox"/> | ECT                            | <input type="checkbox"/> |                          |                          |

Faith-based Therapy: *specify:* \_\_\_\_\_

Other: *specify:* \_\_\_\_\_

**Clinical Specialties with Training and Experience of 1 year:**

- |                                |                          |                                    |                          |                            |                          |
|--------------------------------|--------------------------|------------------------------------|--------------------------|----------------------------|--------------------------|
| Initial Assessment/Evaluation  | <input type="checkbox"/> | Personality/Character Disorders    | <input type="checkbox"/> | Grief/Loss                 | <input type="checkbox"/> |
| Psychological Testing          | <input type="checkbox"/> | Post Traumatic Stress Disorder     | <input type="checkbox"/> | Gay/Lesbian Issues         | <input type="checkbox"/> |
| Neuropsychological Testing     | <input type="checkbox"/> | Schizophrenia/Psychotic Disorders  | <input type="checkbox"/> | Adjustment Issues          | <input type="checkbox"/> |
| Crisis Intervention            | <input type="checkbox"/> | Severe & Persistent Mental Illness | <input type="checkbox"/> | Anger Management           | <input type="checkbox"/> |
| Critical Incident Debriefing   | <input type="checkbox"/> | Sexual Dysfunctions                | <input type="checkbox"/> | Stress Management          | <input type="checkbox"/> |
| Psychopharmacology             | <input type="checkbox"/> | Sleep Disorders                    | <input type="checkbox"/> | Developmental Disabilities | <input type="checkbox"/> |
| Chemical Dependency/Abuse      | <input type="checkbox"/> | Somatoform Disorders               | <input type="checkbox"/> | Physical Disabilities      | <input type="checkbox"/> |
| Anxiety/Panic/Phobia Disorders | <input type="checkbox"/> | Marriage                           | <input type="checkbox"/> | Medical Stress             | <input type="checkbox"/> |
| Attention Deficit Disorders    | <input type="checkbox"/> | Divorce                            | <input type="checkbox"/> | Head Trauma / OBS          | <input type="checkbox"/> |
| Bipolar Disorders              | <input type="checkbox"/> | Domestic Violence                  | <input type="checkbox"/> | Chronic Pain               | <input type="checkbox"/> |
| Depressive Disorders           | <input type="checkbox"/> | Parent/Child Problems              | <input type="checkbox"/> | Chronic / Terminal Illness | <input type="checkbox"/> |
| Dissociative Identity Disorder | <input type="checkbox"/> | Adoption Issues                    | <input type="checkbox"/> | Physical Abuse             | <input type="checkbox"/> |
| Eating Disorders               | <input type="checkbox"/> | Blended Families                   | <input type="checkbox"/> | Sexual Abuse               | <input type="checkbox"/> |
| Gender Identity Issues         | <input type="checkbox"/> | Foster Family Issues               | <input type="checkbox"/> | Other Trauma               | <input type="checkbox"/> |
| Impulse Control Disorders      | <input type="checkbox"/> | Caregiver Support                  | <input type="checkbox"/> | Victims Issues             | <input type="checkbox"/> |
| Obsessive/Compulsive Disorders | <input type="checkbox"/> | School Problems                    | <input type="checkbox"/> | Forensics                  | <input type="checkbox"/> |

Specify cultural/ethnic specialties:  
 \_\_\_\_\_

Languages spoken and/or translators:  
 \_\_\_\_\_

Please list any other category not listed above:  
 \_\_\_\_\_

**Clinical Staffing**

Specify the number of full-time (FT) and part-time (PT) staff in each category

	MD/DO	Licensed PhD/PsyD/EdD	LCSW	LPC	RN/BSN/ LPN	CNS/NP	Nurses w Prescriptive Authority	CAC I,II,III	Unlicensed Doctoral or Master	Bachelor Degree	Para-professionals
<b>FT</b>											
<b>PT</b>											

**ATTESTATION QUESTIONS and RELEASE INFORMATION**

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet. Please sign and date each additional sheet.

- 1. Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State Health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service? Yes  No
- 2. Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service? Yes  No
- 3. Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions under Federal or State law, relating to the interference or obstruction of any investigation into any criminal offense as described in Title 42- Code of Federal Regulations Section 1001.1001 or 1001.201? Yes  No
- 4. Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance? Yes  No
- 5. Has this provider, under any current or former name or business identity, ever had licensure to provide health care by any State licensing authority revoked, suspended or been issued a conditional license? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority. Yes  No
- 6. Has this provider, under any current or former name or business identity, ever had accreditation revoked or suspended? Yes  No
- 7. Has this provider, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by, a Federal or State health care program, or any disbarment from participation in any Federal Executive Branch procurement or non-procurement program? Yes  No
- 8. Is this provider, under any current or former name or business identity, currently suspended from Medicare or Medicaid payment under any Medicare or Medicaid billing number? Yes  No

**I, the undersigned authorized agent, hereby attest and certify that all statements on this entire Application are true, accurate, and complete to the best of my knowledge. I fully understand that any falsification of information or omissions from this Application may be grounds for denial of this Application as a Health Plan participating provider or cause for summary dismissal from the Health Plan. Further, I understand that acceptance of this Application does not constitute approval or acceptance of participating status with the Health Plan and grants this provider no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued by the Health Plan.**

**I attest and certify that the medical and/or clinical staff (direct service providers) are provided licensed clinical supervision and are legally and professional qualified for the positions to which they are appointed and for the performance of privileges granted.**

**I hereby release from any liability all individuals who submit information at the request of the organizations indicated on the page one from whom credentialing is being requested, or their designee(s), to facilitate the assessment of the qualifications for this facility or affiliation. I release from liability and hold harmless Windsor Health Group as applicable, its designee(s), their directors, employees, or agents for acts in good faith and without malice in connection with the evaluation of this facility.**

**I understand, as an authorized agent of the applicant, that I and the organization have the burden of producing adequate information for proper evaluation of the organization's competence, character, and ethics and for resolving doubts about such qualifications.**

\_\_\_\_\_  
Executive/Medical/Clinical Director Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

**PROVIDER SUMMARY BY LOCATION:**

**PLEASE COMPLETE THE FOLLOWING FOR EACH LICENSED SITE THAT USES THE TAX I.D. NUMBER SHOWN ON THE APPLICATION. IF ADDITIONAL SPACE IS NEEDED, ADD A SEPARATE PAGE.**

A. Site Name: \_\_\_\_\_  
Physical Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Services: \_\_\_\_\_  
NPI: \_\_\_\_\_  
Accreditation Yes  No  On-Call Hours \_\_\_\_\_

B. Site Name: \_\_\_\_\_  
Physical Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Services: \_\_\_\_\_  
NPI: \_\_\_\_\_  
Accreditation Yes  No  On-Call Hours \_\_\_\_\_

C. Site Name: \_\_\_\_\_  
Physical Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Services: \_\_\_\_\_  
NPI: \_\_\_\_\_  
Accreditation Yes  No  On-Call Hours \_\_\_\_\_

D. Site Name: \_\_\_\_\_  
Physical Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Services: \_\_\_\_\_  
NPI: \_\_\_\_\_  
Accreditation Yes  No  On-Call Hours \_\_\_\_\_