



Organization Profile and Credentialing Application

Initial Profile and Application

Re-credentialing Application and Profile Review

I. Certification, Licensure and Accreditation Information

Name: _____

Address (for billing and payment purposes): _____

City: _____ State: _____ Zip Code: _____

Federal Tax Identification Number: _____ Nonprofit For Profit

State Licensure Number: _____ Hospital CMHC Agency Group Practice

Medicare Certification Number: _____

Medicaid Certification Number: _____

National Provider Identifier Number _____

Group National Provider Identifier Number _____

CLIA Number (If applicable) _____

Taxonomy Codes: Group Multi-Specialty-193200000X Single Specialty-193400000X

Group IHCP Number (Medicaid #): _____

Chief Executive Officer: _____ Phone: _____

Chief Clinical Officer: _____ Phone: _____

Controlled Substance Registration Certificate # _____ Effective Dates _____ to _____

Drug Enforcement Registration # _____ Effective Dates _____ to _____

Contact name and number to be used by InteCare during daytime hours regarding billing or administrative issues:

Contact Name: _____ Title: _____

Phone #: () _____ - _____ Fax # () _____ - _____

Contact for Compliments & Complaints

Contact Name: _____ Title _____

Phone #: () _____ - _____ Fax #: () _____ - _____

Current Accreditation by one or more of the following national accrediting organizations? (Please check all that apply)

JCAHO CARF HFAP COA Other: _____

Contact for Accreditation: _____ Phone: _____

Accreditation #1: _____ Accreditation Type: _____

Accreditation Status: _____ Date of Most Recent Survey: _____

Date of Accreditation Expiration: _____

Accreditation #2: _____ Accreditation Type: _____

Accreditation Status: _____ Date of Most Recent Survey: _____

Date of Accreditation Expiration: _____

Accreditation #3: _____ Accreditation Type: _____

Accreditation Status: _____ Date of Most Recent Survey: _____

Date of Accreditation Expiration: _____

II. Access and General Information

I. Inpatient facility? Yes No If No, list all hospitals used: _____

II. From the time of call to your facility, what is the average amount of time it takes for consumers to be seen for their first **routine** appointment? _____ Days (Please use data for the last 3 months)

Organizations accredited by JCAHO, CARF, COA, & HFAP do not need to fill out the following information.

III. Does your organization have 24 hour life threatening emergency coverage? Yes No
 If yes, please describe coverage: _____

A. Crisis Appointments: Contact Name(s): _____
 Phone Number(s): _____

Please write in the steps for crisis access in the space below:

IV. Does your practice offer urgent care appointments within 48 hours? Yes No

A. Urgent Appointments:
 Contact Name(s): _____
 Phone Number(s): _____

Please write in the steps for crisis access in the space below:

V. Do all locations have handicapped accessibility? Yes No

VI. Do all locations have well lit waiting rooms and treatment rooms? Yes No

VII. Do all locations have an adequate amount of seating for patients? Yes No

VIII. Do all locations have posted office hours? Yes No

IX. Do you have a centralized single point of access? Yes No Please describe your 24/7 emergency services:

X. Intake Process: (Please check all that apply for your organization)

<input type="checkbox"/> Centralized Telephone Access	<input type="checkbox"/> Initial Assessment – Community Assessment
<input type="checkbox"/> 24/7 In Person Access	<input type="checkbox"/> Initial Assessment – Office Based
<input type="checkbox"/> M-F In Person Access	<input type="checkbox"/> Initial Assessment by Intake Clinician
<input type="checkbox"/> M-F Site Based Intake	<input type="checkbox"/> Initial Assessment by Program
<input type="checkbox"/> Telephonic Financial Process	<input type="checkbox"/> Treatment Assignment at Initial Assessment
<input type="checkbox"/> In Person Financial Process	<input type="checkbox"/> Treatment Assignment Following Review
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

XI. Currently, how many active consumers do you have? _____
How many consumers do you serve per year? _____

XII. Please indicate all languages spoken by employees of your organization

XIII. Please list the names, addresses, hours of operation and access contact person at each location associated with your organization on the following, copying as many pages as needed. Please be sure to list any schools that your organization provides services to:

If your organization has more office sites please copy this page and add additional address locations as needed.

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number: () _____ - _____

Population: Adult Child 0-5 Child 6 –12 Adolescent Older Adult Addictions Special: _____

Does this office have any age restrictions? _____

Services: Outpatient Group Case Management IOP/Partial Residential Vocational Inpatient

Access Contact Name: _____ Phone Number :() _____ - _____

Fax Number: () _____

24-hour Emergency Number: () _____ - _____ # providers at this site: _____

County _____

Office hours:

Mon. _____ Tue. _____ Wed. _____ Thurs. _____ Fri. _____ Sat. _____ Sun. _____

Is this site near public transportation lines (excluding Medicaid transport.)? _____

Is this site ADA accessible? _____

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number: () _____ - _____

Population: Adult Child 0-5 Child 6 –12 Adolescent Older Adult Addictions Special: _____

Does this office have any age restrictions? _____

Services: Outpatient Group Case Management IOP/Partial Residential Vocational Inpatient

Fax Number: () _____ - _____

Office hours:

Mon. _____ Tue. _____ Wed. _____ Thurs. _____ Fri. _____ Sat. _____ Sun. _____

Access Contact Name: _____ Phone Number :() _____ - _____

24-hour Emergency Number: () _____ - _____ # providers at this site: _____

County _____

Is this site near public transportation lines (excluding Medicaid transport.)? _____

Is this site ADA accessible? _____

III. Credentialing & Recredentialing Information			
Element	Our Organization conducts Primary Source Verification for this Element	Our Organization conducts Secondary Source Verification for this Element	Our Organization requests this information from the provider, and is kept on file
A.) Current Drug Enforcement Administration Certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.) State Controlled Substance License	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.) Proof of Liability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.) History of Sanctions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.) Professional Liability Claims History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F.) State Licensure Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.) Board Certification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H.) Psychiatry Residency Certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I.) Hospital Privileges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J.) Resume	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K.) License and/or HSPP Certificate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L.) Signed Permission Regarding Criminal History Check	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M.) Signed Release of Information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N.) Completed Criminal History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O.) Signed W-9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P.) Professional References	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q.) Work History (10 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R.) Advanced Practice Nurse Collaborative Agreements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S.) Copy of highest relevant educational transcript	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>S.) Our organization includes the following licensures in our credentialing verification program: (Check all that apply)</p> <p><input type="checkbox"/> MD/DO <input type="checkbox"/> HSPP <input type="checkbox"/> Advanced Practice Nurses <input type="checkbox"/> LCSW, LMFT, LMHC</p> <p><input type="checkbox"/> Other: _____</p>			
<p>T.) Please describe your organization's primary verification process: (feel free to use additional pages as needed)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>			
<p>U.) Please describe your organization's secondary verification process: (feel free to use additional pages as needed)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>			

V.) How often do you recredential your providers?

- Annually
 Every Two Years
 Every Three Years
 Organization does not recredential providers

IV. Liability Insurance and Information:

Liability Insurance: Company Name	Policy Number	Expiration Date	Limits: Occurrence	Limits: Aggregate

Please provide your previous malpractice carrier if you have been insured for less than five years with your current carrier.

Name _____
 Address _____
 Phone _____
 Policy Number _____

If the response is "yes" to any of the following questions, please attach explanation including the following information (whether open or closed and regardless of payment. Questions or concerns related to the scope of this disclosure may be directed to the InteCare Clinical Director, who may consult Corporate Counsel.

Liability Questions:	Yes	No
1. Has the organization ever been sanctioned by a professional or licensing association for ethical violations?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your organization ever entered into a settlement or had a malpractice judgment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the organization ever been denied malpractice insurance or has your insurance ever been canceled or renewal refused?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has there ever been any punitive or voluntary surrender action relating to your:	<input type="checkbox"/>	<input type="checkbox"/>
a. State License	<input type="checkbox"/>	<input type="checkbox"/>
b. Certification	<input type="checkbox"/>	<input type="checkbox"/>
5. To the best of your knowledge, is your organization involved in any malpractice or punitive action at the time of this application?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the organization been expelled or suspended from receiving payment under the Medicare or Medicaid Program?	<input type="checkbox"/>	<input type="checkbox"/>
7. Is there any reason why your facility would not be able to perform the functions required as an InteCare participating provider?	<input type="checkbox"/>	<input type="checkbox"/>

V. Provider Manual Requirements

Please note that by signing the application in section VII, you attest that you have read and will comply with the requirements of the Provider Manual. The InteCare Provider Manual may be accessed at www.intecare.org/providers.

VI. Submission and Completion of Requested Information Checklist

1. Copy of current Accreditation Certificate (s) along with the most recent written report of survey findings. (JCAHO; CARF; etc.)
2. Copy of current state licensure. (Copy of current national certificate(s). e.g. copy of current Division of Mental Health and Addiction Certificate(s))
3. Copy of Medicare & Medicaid Certification (or) letters from agency verifying organization eligibility.
4. Copy of the facility's policies and procedures re: confidentiality as it relates to medical records and information systems; complaint and quality of care; standard urgent and emergent access; appointment availability standards and/or availability policies and procedures.
5. Completed Organizational Profile and Credentialing Application Form with signature and date. Must include all site locations with applicable contact numbers and address. (Organizations may submit this information on separate sheets instead of completing this section on the application)
6. Copy of current insurance declaration page. If selected employees are dedicated to participate in the Network, the insurance sheet must include their names on it, (or) must have an attestation attached on corporate letterhead stating that all employees are covered under the current policy.
7. Two (2) signed Provider Participation Agreements.
8. Copy of current DEA if applicable.
9. Signed and Dated Release of Information
10. Copy of current agency customer satisfaction report.

VII. Provider Attestation

The applicant hereby certifies that all information supplied to InteCare, Inc. including licensure, insurance and malpractice history, is accurate and complete. The applicant understands that any information entered into this application, which is subsequently found to be inaccurate or false, may result in punitive action up to and including exclusion from contracting with InteCare, Inc.

The Organization understands that continuing participation, as a provider for InteCare, Inc. is dependent upon successful completion of the credentialing process.

Organization Name: _____

Authorized Signature: _____ Date _____

Print Name and Title: _____

Provider Organization/Facility Application Checklist

The following information is included in the Organization Application for InteCare Network

Participation:

- Completed Organization Profile and Credentialing Application Form with Signature and date. Must include all site locations with applicable contact numbers and addresses. (Organizations can submit this information on separate sheets instead of completing that section on the application form)
- Copy of Current Insurance Binder. If selected employees are dedicated to participate in the Network, the insurance binder must include their names on it, (or) must have an attestation attached on corporate letterhead stating that all employees are covered under the current binder.
- Proof of Organizational/Facility payment into the Indiana Patient's Compensation Fund.
- Copy of Current National Accreditation Certificate(s) and most recent written report of survey findings- (JCAHO; CARF; Etc.)
- Copy of State or National Certificate(s) - (e.g. Division of Mental Health and Addictions Certificates)
- Copy of Medicare & Medicaid Certification (or) letters from each agency verifying organization eligibility
- Copy of the Organization/Facility confidentiality policies and procedures as it relates to medical records and information systems
- Copy of the Organization/Facility Client complaint and quality of care policies and procedures
- Copy of the Organization/Facility appointment availability standards and/or policy and procedures; standard urgent and emergent access standards
- Copy of Covered Individual Rights and Responsibilities
- List of all eligible employees that organization has designated to participate in the InteCare Network. (The actual application packet for each employee is usually submitted after the on-site audit has been completed)
- Two (2) signed and dated Provider Participation Agreements and two (2) signed and dated applicable Exhibits
- Copy of current agency customer satisfaction report
- Copy of current DEA if applicable
- Signed and dated Release of Information