Additional Practice Addendum

Please complete the following for each company or location in which you practice. You may copy additional sheets if necessary.

Please provide your billing address below:

Name: _____________________________ Address_____________________________________

City: ____________ State: ____ Zip Code: ________ County: ____________________

Phone: ( ) _____-__ Fax: ( ) ___-___ Email_________________________________

Billing Tax Identification #_________________ Group NPI #_______________________

Group Medicaid # (Group IHCP #) ____

Please check one: Are you an Employee __________ or Contractor_________________________?

Please provide your physical address below:

Name: _____________________________ Address_____________________________________

City: ____________ State: ____ Zip Code: ________ County: ____________________

Phone: ( ) _____-__ Fax: ( ) ___-___

Your weekly hours at this location: ____

What are your office hours?

Mon.____________Tue.__________Wed.__________Thurs.________Fri.________Sat.________Sun._____

Is this location near public transportation lines?

____

Are facilities at this site ADA Accessible?

____

Please provide your mailing address below:

Name: _____________________________ Address_____________________________________

City: ____________ State: ____ Zip Code: ________ County: ____________________

Phone: ( ) _____-__ Fax: ( ) ___-______________

Please provide your address for tax purposes below:

Name: _________________ Address: ____

City: ________________ State: ______ Zip Code: _________________ County: _____________________

Additional Practice Addendum

IV. Clinical Services: (List those that you provide)		
Outpatient Clinical Services		
❒ Outpatient Psychiatric Treatment _ Geriatric _ Adult _ Adolescent _ Children	❒ Outpatient Substance Use Disorder Treatment _ Geriatric _ Adult _ Adolescent _ Children	
❒ Outpatient Medication Management	❒ Medication Assisted Treatment (MAT)	
❒ Crisis Evaluation/Intervention	❒ Outpatient Detoxification Alcohol and Other Drugs	
❒ Critical Incident Debriefing	❒ Assertive Community Treatment (ACT)	
❒ Employee Assistance Program (EAP)	❒ Social Skills Training	
❒ Applied Behavioral Analysis	❒ Case Management	
❒ Psychological Evaluation	❒ Vocational/Supportive Employment	
❒ Substance Use Disorder Evaluation	❒ Therapeutic Foster Care	
❒ Psychiatric Evaluation	❒ Supervised Living	
❒ Electroconvulsive Therapy (ECT)	❒ Other:	
❒ Psychological/Neuropsychological Testing	❒ Other:	
Higher Levels of Care		
❒ Inpatient	❒ Residential	❒ Intensive Outpatient
❒ Sub Acute	❒ Partial Hospitalization	❒ Other:

VI. Population Served at this location:	
❒ Mental Health Adults: Ages18-65	❒ Hispanic/Latino
❒ MH Child & Adolescents: ❒ 0-6 ❒ 7-12 ❒ 13-17	❒ Developmentally Delayed/MR
❒ Substance Use Disorder Adults: Ages 18-65	❒ Deaf/Hearing Impaired
❒ Substance Use Disorder Child & Adolescents	❒ Blind/Sight Impaired
❒ Mental Health Older Adults	❒ Learning Disabled
❒ Substance Use Disorder Older Adults	❒ Other:
❒ Mental Health Adults: Ages18-65 **Do you have any age restrictions? (Please describe)**	

Additional Practice Addendum

Access Information

I. From the time of call to your practice, 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)

A. Routine Appointments:
Contact Name(s):____

Phone Number(s):____

Please write in the steps for routine access in the space below:
____
____
____

II. Does your practice 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:
____
____
____

III. 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:
____
____
____

IV. Do all locations where you practice have handicapped accessibility? ❒ Yes ❒ No
If not, please attach an explanation.

V. Do all locations where you practice have well lit waiting rooms and treatment rooms? ❒ Yes ❒ No

VI. Do all locations where you practice have adequate seating? ❒ Yes ❒ No

VII. Do all locations where you practice have posted office hours? ❒ Yes ❒ No