Organization Profile and Credentialing Application

❒ **Initial Profile and Application** ❒ **Re-credentialing Application and Profile Review**

Mark all areas of the application NA for any item not applicable

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

DMHA Certification(s)_____Effective Date_____to_____

CLIA Number (If applicable) _____Effective Date_____to_____

Group Taxonomy Code (s): _____

Chief Executive Officer: _____ Phone: _____

Email Address_____

Chief Clinical Officer: _____ Phone: _____

Email Address_____

Controlled Substance Registration Certificate #_____Effective Date _____to_____

Drug Enforcement Registration #_____ Effective Date _____to _____

State Dep. Of Health Hospital License_____Effective Date_____to_____

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

Contact Name: _____ Title: _____

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

Email Address_____

Contact for Compliments & Complaints
Contact Name:_____ Title_____

Phone #. ( ) _____-_____ Fax #. ( )_____-_____

Email Address_____

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: _____

Email Address_____

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) Standard is within 10 days

III. Does your organization have 24 hour life threatening emergency coverage? ❒Yes ❒No
Please describe (If not, do you have an answering service or voice mail that directs callers to go to the ER or dial 911. Must have contact within 15 minutes and face to face within one hour:_____
_____
_____

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
Please describe (If not do you have an answering service or voice mail that directs callers to go to the ER or dial 911?):_____
_____
_____

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

Phone Number(s):_____

V. Do all locations have well lit waiting rooms and treatment rooms? ❒Yes ❒No
VI. Do all locations have an adequate amount of seating for patients? ❒Yes ❒No
VII. Do all locations have posted office hours? ❒Yes ❒No
VIII. Do you have a centralized single point of access for all locations? ❒Yes ❒No If no, please fill out page four under each office location.

Local Telephone Number _____

Toll Free Number_____

Telephone Number for 24/7 Crisis_____

Please indicate all languages spoken by employees of your organization
_____
_____
_____

III. Physical Service Locations

Please list the names, addresses, hours of operation and access contact person at each location associated with your organization.

Name: _____Address: _____

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

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? _____

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

Does this office have any age restrictions? _____

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

Fax Number: ( )_____ 24-hour Emergency Number: ( )_____-_____

Group NPI Number(s)_____

Group Medicaid (IHCP) Number(s)_____ Alpha Location _____

Group Medicare Number(s)_____

Populations and Services Provided: Please mark all that apply to this location

- Outpatient Medication Management
- Outpatient Detoxification Alcohol and Other Drugs
- Medication Assisted Treatment (MAT)
- Crisis Evaluation/Intervention
- Critical Incident Debriefing
- Employee Assistance Program (EAP)
- Applied Behavioral Analysis
- Psychological/Neuropsychological Testing
- Case Management
- Peer Support
- Assertive Community Treatment (ACT)
- Social Skills Training
- Vocational/Supportive Employment
- Therapeutic Foster Care
- Supervised Living
- Other:

❒ Outpatient Psychiatric Treatment
- Geriatric
- Adult
- Adolescent
- Children

❒ Outpatient Substance Use Disorder Treatment
- Geriatric
- Adult
- Adolescent
- Children

❒ Intensive Outpatient Psychiatric Treatment
- Geriatric
- Adult
- Adolescent
- Children

❒ Intensive Outpatient Substance Use Disorder Treatment
- Geriatric
- Adult
- Adolescent
- Children

❒ Partial Hospitalization Psychiatric Treatment
- Geriatric
- Adult
- Adolescent
- Children

❒ Partial Hospitalization Substance Use Disorder Treatment
- Geriatric
- Adult
- Adolescent
- Children

❒ Residential Psychiatric Treatment
- Geriatric
- Adult
- Adolescent
- Children

❒ Residential Substance Use Disorder Treatment
- Geriatric
- Adult
- Adolescent
- Children

❒ Sub Acute Inpatient Psychiatric Treatment
- Geriatric
- Adult
- Adolescent
- Children

❒ Residential Detoxification Alcohol and Other Drugs
- Geriatric
- Adult
- Adolescent
- Children

❒ Acute Inpatient Psychiatric Treatment
- Geriatric
- Adult
- Adolescent
- Children

❒ Acute Inpatient Substance Use Disorder Rehabilitation
- Geriatric
- Adult
- Adolescent
- Children

❒ Eating Disorder Treatment
- Acute Inpatient
- Residential
- Partial Hospitalization
- Intensive Outpatient

Other:

If your organization has more office sites please copy additional pages as needed (pgs. 5&6) and provide each address location along with populations and services provided.

Name: _____Address: _____

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

County_____

Office hours:

Mon._____Tue._____Wed._____Thurs._____Fri._____Sat._____Sun._____

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

Does this office have any age restrictions? _____

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

Is this site ADA accessible? _____

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

Fax Number: ( )_____ 24-hour Emergency Number: ( )_____-_____

Group NPI Number(s)_____

_ Outpatient Medication Management _ Outpatient Detoxification Alcohol and Other Drugs _ Medication Assisted Treatment (MAT) _ Crisis Evaluation/Intervention _ Critical Incident Debriefing _ Employee Assistance Program (EAP) _ Applied Behavioral Analysis _ Psychological/Neuropsychological Testing	_ Case Management _ Peer Support _ Assertive Community Treatment (ACT) _ Social Skills Training _ Vocational/Supportive Employment _ Therapeutic Foster Care _ Supervised Living _ Other:
❒ **Outpatient Psychiatric Treatment** = Geriatric = Adult = Adolescent = Children	❒ **Outpatient Substance Use Disorder Treatment** = Geriatric = Adult = Adolescent = Children
❒ **Intensive Outpatient Psychiatric Treatment** = Geriatric = Adult = Adolescent = Children	❒ **Intensive Outpatient Substance Use Disorder Treatment** = Geriatric = Adult = Adolescent = Children
❒ **Partial Hospitalization Psychiatric Treatment** = Geriatric = Adult = Adolescent = Children	❒ **Partial Hospitalization Substance Use Disorder Treatment** = Geriatric = Adult = Adolescent = Children

❒ **Residential Psychiatric Treatment**

- ___ Geriatric
- ___ Adult
- ___ Adolescent
- ___ Children

❒ **Sub Acute Inpatient Psychiatric Treatment**

- ___ Geriatric
- ___ Adult
- ___ Adolescent
- ___ Children

❒ **Acute Inpatient Psychiatric Treatment**

- ___ Geriatric
- ___ Adult
- ___ Adolescent
- ___ Children

❒ **Eating Disorder Treatment**

- ___ Acute Inpatient
- ___ Residential
- ___ Partial Hospitalization
- ___ Intensive Outpatient

❒ **Residential Substance Use Disorder Treatment**

- ___ Geriatric
- ___ Adult
- ___ Adolescent
- ___ Children

❒ **Residential Detoxification Alcohol and Other Drugs**

- ___ Geriatric
- ___ Adult
- ___ Adolescent
- ___ Children

❒ **Acute Inpatient Substance Use Disorder Rehabilitation**

- ___ Geriatric
- ___ Adult
- ___ Adolescent
- ___ Children

Other:

***IV. General Liability Insurance and Information*: Please provide $1M per occurrence/$3M aggregate limits for General Liability. Please provide a copy of the declaration page.**

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_____

***V. Professional Liability Insurance and Information*: Please provide $1M per occurrence/$3M aggregate limits for Professional Liability or Proof of Participation in the Indiana Patient's Compensation Fund. Please provide a copy of the declaration page showing the employees who are covered under the policy on the insurer's letterhead.**

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_____

VI. Liability Questions

If the response if "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?	❒	❒
2. Has your organization ever entered into a settlement or had a malpractice judgment?	❒	❒
3. Has the organization ever been denied malpractice insurance or has your insurance ever been canceled or renewal refused?	❒	❒
4. Has there ever been any punitive or voluntary surrender action relating to your:	❒	❒
a. State License	❒	❒
b. Certification	❒	❒
5. To the best of your knowledge, is your organization involved in any malpractice or punitive action at the time of this application?	❒	❒
6. Has the organization been expelled or suspended from receiving payment under the Medicare or Medicaid Program?	❒	❒
7. Is there any reason why your facility would not be able to perform the functions required as an InteCare participating provider?	❒	❒

VII. 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.

VIII. 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 Certificate. Must include coverage for General and Professional Liability. Must have covered of $1M per occurrence and $3M aggregate or participate in the IN Patient's Compensation Fund. If you do not have $1M/$3M limits for general liability then you must have an excess liability policy or an umbrella that makes up the difference. For an FQHC must show proof of deeming through HRSA.

☐Copy of Current National Accreditation Certificate(s) or letter of approval. - (JCAHO, CARF, COA, AOA (HFAP.)

☐Copy of State or National Certificate(s) - (e.g. Division of Mental Health and Addictions Certificates)

☐Two (2) signed and dated InteCare Participating Provider Agreements and two (2) signed and dated Exhibits and Addendum, if applicable.

☐Copy of current DEA if applicable

☐Signed and dated Release of Information

☐W-9

☐Copy of CLIA Certificate if applicable

☐Primary Contact Information Form

☐ Hospital License, if applicable