

CareLink and ConsumerLink Networks Provider Application

Rev 12/09

Select the Network you are interested in applying for:

CareLink - MI

ConsumerLink – DD

Both

COMPLETION OF THIS APPLICATION DOES NOT GUARANTEE A CONTRACT WITH CARELINK OR CONSUMERLINK

How did you receive your application: Mail Fax Pick Up E-Mail Internet

Instructions: Please complete one application for each organization, and include unique service information for each site where care will be provided. Please print or type the information on the application. Incomplete applications will be returned. If you have additional questions or concerns, please call a Provider Relations Representative at 313-656-0000.

Please attach the following documents with each application:

- Copy of all current accreditations (NCQA, JCAHO, CARF, AOA, COA, other); if none indicate. Include accreditation letter.
- Copy of current state licenses and certificates
- Copy of FEP (Fair Employment Practices) application / certificate(s).
- Copy of state site visit report for non-accredited agencies or organizations
- Copy of **general** and **professional** (where applicable) liability insurance (minimum of \$1mil/\$3mil is required)
- Signed Direct Care Wage Attestation Form, if appropriate.
- Copy of organizational chart
- Staff Roster (page 8 – all information must be entered)
- Number of FTE's (Full Time Employees) _____
- Resume of Licensee/Provider –residential facilities only (Resumes of Direct Care Workers not required)
- Completed W-9 form- can also be obtained on IRS web site
- For Free Standing Psychiatric Hospitals Only – copy of the Agreement for Provision of Medical Care Services

How many CareLink clients are you currently providing services for? _____

How many ConsumerLink clients are you currently providing services for? _____

Are you willing to accept General (SSI) clients: Yes No **If yes, how many?** _____

Does anyone in your organization speak other languages fluently? No _____ Yes: please list _____

A. General Information (please print or type)

Corporation: _____

Mailing/Billing Address: _____

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

Telephone #: () _____ Alt. Telephone #: () _____

Facsimile #: () _____ E-mail Address: _____

Have you ever contracted with another Network? Yes No

If so, was contract terminated? Yes No Reason: _____

If so, which site? _____

Address to where checks are to be mailed: _____

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List addresses for ALL sites you are applying for, including the License information.
(If additional space is needed, this page may be copied.)

1. Site Name: _____
Site Address: _____ Cross Streets: _____
City: _____ State: _____ Zip Code: _____ County: _____
Site Telephone #: () _____ Site Facsimile #: () _____
Site Contact Person: _____ Title: _____
Capacity _____ Vacancy _____ Style of home (ranch, colonial, etc.): _____
Are any languages other than English spoken in the facility? Yes No If Yes, what language(s)? _____
Barrier Free? Yes No First floor bedroom? Yes No
Transportation provided to clients? Yes No Family Live-In? Yes No
Willing to accept: Age range _____ Rate range _____
 Male Female Both
of CareLink clients at this facility _____ # of ConsumerLink clients at this facility _____
Total Number of MI clients at this site* _____ Total Number of DD clients at this site* _____
* please include all consumers from all networks

2. Site Name: _____
Site Address: _____ Cross Streets: _____
City: _____ State: _____ Zip Code: _____ County: _____
Site Telephone #: () _____ Site Facsimile #: () _____
Site Contact Person: _____ Title: _____
Capacity _____ Vacancy _____ Style of home (ranch, colonial, etc.): _____
Are any languages other than English spoken in the facility? Yes No If Yes, what language(s)? _____
Barrier Free? Yes No First floor bedroom? Yes No
Transportation provided to clients? Yes No Family Live-In? Yes No
Willing to accept: Age range _____ Rate range _____
 Male Female Both
of CareLink clients at this facility _____ # of ConsumerLink clients at this facility _____
Total Number of MI clients at this site* _____ Total Number of DD clients at this site* _____
* please include all consumers from all networks

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B. Contact Person(s):

1. Primary Contact: _____ Telephone #: _____
Title: _____ Alternate #: _____
2. Alternate Contact: _____ Telephone #: _____
Title: _____ Alternate #: _____
3. President/CEO/Owner: _____ Telephone #: _____
4. Billing Contact: _____ Telephone #: _____
5. Person Completing Application: _____ Telephone #: _____

C. Classification of Business (all that apply): Private Public For Profit Not-for-profit Non-profit

Tax ID#: _____ NPI # _____

D. If facility / program is a subsidiary of, in partnership with, or administratively organizationally linked with another program or health system please identify and indicate below; if no other affiliations check box .

Corporate Name: _____

DBA/Trade Name: _____

Primary Mailing Address: _____

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

Telephone #: () Facsimile #: () E-Mail: _____

E. Accreditation/Certification (check all that apply); attach copy of certificate:

NCQA Accreditation: Yes No N/A If Yes, indicate Expiration Date: _____

JCAHO Accreditation: Yes No N/A If Yes, indicate Expiration Date: _____

CARF Accreditation: Yes No N/A If Yes, indicate Expiration Date: _____

AOA Accreditation: Yes No N/A If Yes, indicate Expiration Date: _____

COA Accreditation: Yes No N/A If Yes, indicate Expiration Date: _____

Medicaid Certified: Yes No N/A Number: _____ Expiration Date: _____

Medicare Certified: Yes No N/A Number: _____ Expiration Date: _____

F. Legal Description of Program / Facility:

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G. Liability/Insurance Information; attach copy of certificate:

Name of Liability Carrier: _____

Policy Number: _____ Effective Date: _____ Expiration Date: _____

Professional Liability Limits: Per Occurrence: \$ _____ Aggregate: \$ _____

General Liability Limits: Per Occurrence: \$ _____ Aggregate: \$ _____

H. General Liability History:

This information will be reviewed in order to determine acceptance or denial of this application for credentialing or re-credentialing. If you respond “yes” to any of the questions below, please submit a detailed explanation of the situation or event involved (specific client names may be deleted), and the actions taken, including pending status. Such documentation should include, but is not limited to the following:

- Sanction letters and/or related documents from any licensing, certifying or credentialing entity
- Settlement agreements, petitions, complaints, responses and letters of demand concerning malpractice claims that name the organization or specific program
- Claim history from your insurance company for the last three years
- Description of relevant quality improvement activities or changes resulting from the sanction, lawsuit, settlement, etc.

1. Has the facility/program been named in any malpractice action over the last **five** years? Yes No
2. Has the facility/program been named in any currently pending legal actions? Yes No
3. Has any government agency investigated, suspended, revoked or taken other action against the facility/programs license to conduct business within the last **five** years? Yes No
4. Has the facility/program had professional liability insurance revoked, suspended, declined, or accepted on special terms over the last **five** years? Yes No
5. Has the facility/program members or staff been removed, sanctioned or suspended from membership in a professional association for violation(s) of its ethical code of practice within the last **five** years? Yes No
6. Has the facility/program, members of the program, or staff been penalized, expelled or suspended from receiving payment under the Medicaid or Medicare programs within the last five years? Yes No
7. Have any facility/program owners, officers, or staff been convicted of a crime excluding misdemeanors? Yes No
8. Have any facility/program owners, officers ever had or have an IRS levy instituted? Yes No

I. Fiscal Stability

1. Provide a copy of the organization’s most recent financial statement, along with the name, address, telephone number of the preparer.
2. List the name and address of any CareLink/ConsumerLink Network board member or employee with whom a staff member or director of the organization has had a substantial financial relationship within the past twelve (12) months on page 7. If not applicable, indicate on the attachment.
3. List all debts owed to or loans obtained from a CareLink/ConsumerLink Network board member or employee by a staff member or director of the organization on page 7. If not applicable, indicate on the attachment.

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J. Provider Services & Proposed Fee Schedules:

Please select the service(s) that your agency is willing to provide by marking an “x” in the box to the left of the service description. Also indicate in the appropriate box the expected rate of remuneration.

Selection	Service Description	Current Contracted Fee
<input type="checkbox"/>	ACT (must be approved by MDCH)	\$
<input type="checkbox"/>	Assessment/Evaluation	\$
<input type="checkbox"/>	Case Management	\$
<input type="checkbox"/>	Club House/Peer Directed/Consumer Run	\$
<input type="checkbox"/>	Community Employment Services	\$
<input type="checkbox"/>	Community Living/Training Support	\$
<input type="checkbox"/>	Community Services Coordination	\$
<input type="checkbox"/>	Crisis Residential (must be approved by MDCH)	\$
<input type="checkbox"/>	Emergency Services	\$
<input type="checkbox"/>	Enhanced Health Services	\$
<input type="checkbox"/>	Ext. Observation Beds (MI) (must be approved by MDCH)	\$
<input type="checkbox"/>	Family Skills Development	\$
<input type="checkbox"/>	Fiduciary/Financial Services	\$
<input type="checkbox"/>	Home-Based Services (must be approved by MDCH)	\$
<input type="checkbox"/>	Housing Assistance	\$
<input type="checkbox"/>	Independent Living	\$
<input type="checkbox"/>	Inpatient Mental Health	\$
<input type="checkbox"/>	Intensive Crisis Stabilization (must be approved by MDCH)	\$
<input type="checkbox"/>	Medication Administration	\$
<input type="checkbox"/>	Medication Monitoring	\$
<input type="checkbox"/>	Mental Health Therapy/Counseling	\$
<input type="checkbox"/>	Occupational Therapy	\$
<input type="checkbox"/>	Organization Employment Services	\$
<input type="checkbox"/>	Outpatient Mental Health Services	\$
<input type="checkbox"/>	Outpatient Partial Hospital Services (must be approved by MDCH)	\$
<input type="checkbox"/>	Person Centered Planning	\$
<input type="checkbox"/>	Physical Therapy	\$
<input type="checkbox"/>	Psychosocial Rehabilitation (must be approved by MDCH)	\$
<input type="checkbox"/>	Respite Care Services	\$
<input type="checkbox"/>	Self-Determination	\$
<input type="checkbox"/>	Semi – Independent Living	\$
<input type="checkbox"/>	Skill Building	\$
<input type="checkbox"/>	Specialized Residential (As Authorized)	\$
<input type="checkbox"/>	Speech/Language Therapy	\$
<input type="checkbox"/>	Support Coordination	\$
<input type="checkbox"/>	Support/Integrated Employment Services	\$
<input type="checkbox"/>	Supported Independent Living	\$
<input type="checkbox"/>	Wraparound Services	\$

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K. Provider Services & Proposed Fee Schedules (continued)

If other, please specify

Selection	Service Description	Current Contracted Fee
<input type="checkbox"/>		\$
<input type="checkbox"/>		\$
<input type="checkbox"/>		\$
<input type="checkbox"/>		\$
<input type="checkbox"/>		\$
<input type="checkbox"/>		\$
<input type="checkbox"/>		\$
<input type="checkbox"/>		\$
<input type="checkbox"/>		\$
<input type="checkbox"/>		\$

Please Note: the rate amount submitted on your application does not necessarily carry over to the contract. The approved rate will be determined based on individual need at the time the authorization is issued.

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Name of Organization: _____

List of CareLink/ConsumerLink Network, board member(s), staff or affiliates with whom a member of the applicant's organization has had a financial relationship within the past twelve (12) months:

Name	Address	Organizational Position
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

List of all debts owed to, or loans obtained from a CareLink/ConsumerLink Network board member or employee by a staff member or director of the organization:

Name	Organizational Position	Debt Owed/Loans Obtained
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

CareLink/ConsumerLink Network Affiliates:	CareLink Network Board of Directors:	ConsumerLink Network Board of Directors
Development Centers, Inc.	Dr. Robert Shaw	Ed Forry
Hegira Programs, Inc.	Carmen McIntyre, M.D.	Sheilah Clay
Neighborhood Services Organization	Roberta Sanders	Melvin Houston
Northeast Guidance Center	Cheryl Coleman	John VanCamp
Southwest Solutions	Patrick O'Neil	Doug Rich
The Children's Center	Debora Matthews	Mike Lott
The Guidance Center	Joseph Tardella	Barbara Lea Jones
New Center Community Mental Health Svcs	Marvin T. Cato	Yuself Seegars
	Sarah Clark	LeKisha Franklin-Shorter
	Judith Chapman	Stratford Johnson
	Eric De La Rosa	Shawnese Laury-Johnson
	Bessie Tyler	
	Braunwynn Franklin	
	Phil Cavanagh	
	Dr. Marsha Foster Boyd	

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Staff Roster – for residential only

If additional space is needed, this page may be copied.

1. Staff Name: _____ FTE: Y N Date of Hire: _____
City: _____ State: _____ Zip Code: _____ County: _____
Criminal Background Check Conducted: Yes No Date: _____
Most recent dates for: Direct Care Worker training _____ Medication training _____
Recipient Rights training _____ First Aid training _____
CPR training _____ TB Test _____
Credentials, certifications or other trainings
(Substance Abuse Training, Blood Borne Pathogen Training, etc.): _____

Location(s) staff is employed: _____

2. Staff Name: _____ FTE: Y N Date of Hire: _____
City: _____ State: _____ Zip Code: _____ County: _____
Criminal Background Check Conducted: Yes No Date: _____
Most recent dates for: Direct Care Worker training _____ Medication training _____
Recipient Rights training _____ First Aid training _____
CPR training _____ TB Test _____
Credentials, certifications or other trainings
(Substance Abuse Training, Blood Borne Pathogen Training, etc.): _____

Location(s) staff is employed: _____

3. Staff Name: _____ FTE: Y N Date of Hire: _____
City: _____ State: _____ Zip Code: _____ County: _____
Criminal Background Check Conducted: Yes No Date: _____
Most recent dates for: Direct Care Worker training _____ Medication training _____
Recipient Rights training _____ First Aid training _____
CPR training _____ TB Test _____
Credentials, certifications or other trainings
(Substance Abuse Training, Blood Borne Pathogen Training, etc.): _____

Location(s) staff is employed: _____

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Provider Application for Credentialing

Release Authorization and Ethical Commitment

The Applicant hereby has submitted an application for appointment to the Provider Panel of CareLink/ConsumerLink Network. The Applicant certifies that the information provided is true, complete and correct. The Applicant further understands that any information entered into this document that is subsequently found to be false, could result in removal from the provider network. The Applicant agrees to maintain general and professional liability coverage as stated in this document.

The Applicant authorizes CareLink/ConsumerLink Network or its designee to obtain and verify information contained on the application and consents to release all persons, organizations, including other networks or other entities of liability in any respect because of having furnished information as a result of this application.

The Applicant authorizes investigation of all statements contained in this application and specifically authorizes CareLink/ConsumerLink Network to investigate any and all information that may be reasonably relevant to an evaluation of including, but not limited to the organization's ability to render clinical services, character and moral and ethical qualifications. The Applicant releases CareLink/ConsumerLink Network and its designees from any liability for any reports, records, recommendations, claims information and claims history, or any other information given in good faith and related to the credentialing process. The Applicant further understands that participation as a provider for CareLink/ConsumerLink Network is dependent upon successful completion of the credentialing process. A photocopy of this authorization shall be deemed equivalent to the original. The Applicant understands and agrees that misrepresentation or omission of facts called for is grounds for termination from the Provider Panel.

I certify that I am authorized to make the above warranties, representations and releases on behalf of this provider organization and to sign this application on behalf of this organization.

Criminal background checks must be done on all new hires and annually thereafter. Signing this form confirms this process is completed by the organization.

Name of Provider Organization (Print)

Name of Authorized Representative (Print)

Date

Signature of Authorized Representative

RETAIN A COPY OF THIS APPLICATION FOR YOUR FILES

Return this Application to: BHPI – Provider Relations
Attn: Leona Gaines
1333 Brewery Park, Suite 300
Detroit, MI 48207