

# CareLink Network Provider Application

Revised 03/2004

This section to be completed by CareLink Network ONLY:

Date Reviewed: \_\_\_\_\_ Date Approved: \_\_\_\_\_ Provider ID: \_\_\_\_\_

## Instructions:

Please complete one application for **each** organization, and include unique service information for **each** site where care will be provided. Please print the information requested using black ink, or type the information on the application. Incomplete applications will not be processed.

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 *(N/A for Residential)*
- Copy of current state licenses and certificates
- Copy of state site visit report for non-accredited agencies or organizations
- Verification of professional liability insurance (minimum of \$1mil/\$3 mil is required) *(N/A for General AFC)*
- Verification of general liability insurance
- Staff Roster with Credentials or Certifications *(Attach current training certificates for Recipient Rights, CPR and First Aid)* and documentation of Criminal Background Check (Attachment A.3)
- Tax ID (see page 3, section E) or completed W-9 form
- Description of QA/QI *(N/A for Residential)*
- Description of MIS Capabilities *(N/A for Residential)*
- Description of Clinical Program Inventory/Program Statement
- Copy of Recipient Rights Policy, Procedure, History, and Access to Recipient Rights Agent

How many CareLink clients are you currently providing services for? \_\_\_\_\_

## A. General Information (Please Print or Type)

1. Legal Name of Facility/Program: \_\_\_\_\_

2. DBA/Trade Name: \_\_\_\_\_

3. Primary Mailing Address: \_\_\_\_\_  
Street

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Telephone #: ( ) \_\_\_\_\_ Alt. Telephone #: ( ) \_\_\_\_\_

Facsimile # ( ) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

License #: \_\_\_\_\_ License Expiration Date \_\_\_\_\_

4. Preferred Mailing Address: \_\_\_\_\_  
(If different than Primary Address) Street

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

# CareLink Network Provider Application

Revised 03/2004

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

1. Name of Facility: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Street  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Telephone #: ( ) \_\_\_\_\_ Facsimile #: ( ) \_\_\_\_\_  
Contact Person: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
License #: \_\_\_\_\_ License Expiration Date \_\_\_\_\_

2. Name of Facility: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Street  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Telephone #: ( ) \_\_\_\_\_ Facsimile #: ( ) \_\_\_\_\_  
Contact Person: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
License #: \_\_\_\_\_ License Expiration Date \_\_\_\_\_

3. Name of Facility: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Street  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Telephone #: ( ) \_\_\_\_\_ Facsimile #: ( ) \_\_\_\_\_  
Contact Person: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
License #: \_\_\_\_\_ License Expiration Date \_\_\_\_\_

4. Name of Facility: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Street  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Telephone #: ( ) \_\_\_\_\_ Facsimile #: ( ) \_\_\_\_\_  
Contact Person: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
License #: \_\_\_\_\_ License Expiration Date \_\_\_\_\_

# CareLink Network Provider Application

Revised 03/2004

B. Primary Contact Person(s):

1. Name: \_\_\_\_\_ Title: \_\_\_\_\_ Telephone #: \_\_\_\_\_
2. Name: \_\_\_\_\_ Title: \_\_\_\_\_ Telephone #: \_\_\_\_\_
3. Person Completing Application: \_\_\_\_\_ Telephone #: \_\_\_\_\_
4. President/CEO/Owner: \_\_\_\_\_ Telephone #: \_\_\_\_\_
5. Recipient Rights Officer: \_\_\_\_\_  
Telephone # ( ) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

C. Classification of Business (Check All That Apply):  Private  Public  For Profit  Non-profit

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 skip this section.

1. Corporate Name: \_\_\_\_\_  
DBA/Trade Name: \_\_\_\_\_  
Primary Mailing Address: \_\_\_\_\_  
Street  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Telephone #: ( ) \_\_\_\_\_ Facsimile #: ( ) \_\_\_\_\_ E-Mail: \_\_\_\_\_

E. Billing Address: \_\_\_\_\_  
Street

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Tax ID #: \_\_\_\_\_

F. Accreditation/Certification (Check All That Apply):

- 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: \_\_\_\_\_

G. Legal Description of Program / Facility:

---

---

---

# CareLink Network Provider Application

Revised 03/2004

## H. Liability/Insurance Information:

Name of Liability Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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

## I. 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

## J. Tax Reports and Payments Certification

Check those boxes below that apply. If box number four (4) is checked, provide the additional information as requested.

1.  a. Has filed City, County, State and Federal tax reports for Fiscal Year for the most recent fiscal year ended.  
b. Indicate the last fiscal year reported: \_\_\_\_\_.
2.  a. Is delinquent in filing the following City, County, State, and/or Federal tax reports for the most recent fiscal year ended.  
b. Indicate the last fiscal year reported: \_\_\_\_\_.
3.  Has paid all taxes due as of the date of this application.

# CareLink Network Provider Application

Revised 03/2004

**J. Tax Reports and Payments Certification (continued)**

Check those boxes below that apply. If box number four (4) is checked, provide the additional information as requested.

4.  Has not paid the following taxes as of the date of this application. Indicate the years taxes not paid, including the current fiscal year.

Type of Tax	Payable To:	Due Date	Projected Date of Payment
a. _____	_____	_____	_____
b. _____	_____	_____	_____
c. _____	_____	_____	_____
d. _____	_____	_____	_____

**K. Fiscal Stability**

1. Provide a copy of the organizations' most recent certified financial audit, along with the name, address, telephone number and contact person for the auditing firm. Include a copy of the Independent Auditor's Report on the Internal Control Structure. (This is typically a companion report issued by the auditors at the same time and for the same audit periods as the report on the financial statements)
2. Provide a copy of the engagement letter with the auditing firm that will perform the next Fiscal Year audit.
3. Attach copies of the tax returns filed with the Internal Revenue for the last fiscal year.
4. Attach a copy of the organizations' most recent internal quarterly financial report. Include the organizations' budget, profit/loss statement and/or revenue and expenditure report.
5. Attach a report of the organization's current outstanding indebtedness and loan history.
6. Provide a financial or business plan for the organization that includes the following:
  - a. Means of obtaining (or maintaining) positive cash flow.
  - b. Plans to retire existing or projected debt.
  - c. Provisions for a dedicated cash reserve for working capital. If the organization does not have a dedicated cash reserve, the plan must include how the organization will fund such a reserve by \_\_\_\_/\_\_\_\_/\_\_\_\_.
7. Provide a list of current internal control structure policies and procedures. Provide a copy of the policies and procedures governing:
  - a. Cash receipts, including the accrual of revenue and obligations due from third parties.
  - b. Cash disbursements, including the accrual of expenditures and obligations due to third parties.
  - c. The determination of residential costs and allocation of costs (both direct and indirect) to service settings.
8. List the name and address of any CareLink 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 Attachment A.1. If not applicable, indicate on the attachment.
9. List all debts owed to or loans obtained from a CareLink Network board member or employee by a staff member or director of the organization on Attachment A.2. If not applicable, indicate on the attachment.
10. Provide a list of all assets owned or leased property, equipment, etc.

# CareLink Network Provider Application

Revised 03/2004

L. 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 right of the service description, and indicate in the appropriate box the expected rate of remuneration:

Selection	Service Description	Requested Fee for Service
<input type="checkbox"/>	ACT	\$
<input type="checkbox"/>	Assessment/Evaluation	\$
<input type="checkbox"/>	Case Management	\$
<input type="checkbox"/>	Clerical Aide Training/Job Placement	\$
<input type="checkbox"/>	Club House	\$
<input type="checkbox"/>	Community Employment Services	\$
<input type="checkbox"/>	Community Inpatient	\$
<input type="checkbox"/>	Community Living/Training Support	\$
<input type="checkbox"/>	Community Services Coordination	\$
<input type="checkbox"/>	Consumer Run	\$
<input type="checkbox"/>	Crisis Residential	\$
<input type="checkbox"/>	Day Programs	\$
<input type="checkbox"/>	DD Case Management	\$
<input type="checkbox"/>	DD Substance Abuse	\$
<input type="checkbox"/>	Detox Treatment	\$
<input type="checkbox"/>	Domestic Viol. Counseling	\$
<input type="checkbox"/>	Emergency	\$
<input type="checkbox"/>	Emergency Services (MI)	\$
<input type="checkbox"/>	Emergency Shelter	\$
<input type="checkbox"/>	Employment Services Coordination	\$
<input type="checkbox"/>	Enhanced Health Services	\$
<input type="checkbox"/>	Epilepsy Support/Health Services	\$
<input type="checkbox"/>	Ext. Observation Beds (MI)	\$
<input type="checkbox"/>	Family Skills Development	\$
<input type="checkbox"/>	Fiduciary Services	\$
<input type="checkbox"/>	Financial Services	\$
<input type="checkbox"/>	Home-Based Services	\$
<input type="checkbox"/>	Housing Assistance	\$
<input type="checkbox"/>	Housing Development	\$
<input type="checkbox"/>	Independent Living	\$
<input type="checkbox"/>	Inpatient	\$
<input type="checkbox"/>	Intensive Crisis Stabilization	\$
<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	\$
<input type="checkbox"/>	Outpatient Partial Hospital Services	\$
<input type="checkbox"/>	PCP	\$

# CareLink Network Provider Application

Revised 03/2004

L. Provider Services & Proposed Fee Schedules (**continued**)

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

Selection	Service Description	Requested Fee for Service
<input type="checkbox"/>	Peer Delivered/Operated Support	\$
<input type="checkbox"/>	Personal Social Services.	\$
<input type="checkbox"/>	Physical Therapy	\$
<input type="checkbox"/>	Psychosocial Rehabilitation	\$
<input type="checkbox"/>	Respite Care Services	\$
<input type="checkbox"/>	S.E.P.	\$
<input type="checkbox"/>	Self-Determination	\$
<input type="checkbox"/>	Sex Offender Treatment	\$
<input type="checkbox"/>	Sexual Abuse Counseling	\$
<input type="checkbox"/>	Skill Building	\$
<input type="checkbox"/>	Specialized Residential	\$
<input type="checkbox"/>	Specialized Services	\$
<input type="checkbox"/>	Speech/Language Therapy	\$
<input type="checkbox"/>	State Hospital Services	\$
<input type="checkbox"/>	Substance Abuse Prevention Outpatient Treatment	\$
<input type="checkbox"/>	Substance Abuse Treatment	\$
<input type="checkbox"/>	Support Coordination	\$
<input type="checkbox"/>	Support/Integrated Employment Services	\$
<input type="checkbox"/>	Supported Independent Living	\$
<input type="checkbox"/>	Wraparound Services	\$

# CareLink Network Provider Application

Revised 03/2004

Attachment A.1

Name of Organization: \_\_\_\_\_

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

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

**CareLink Network Affiliates:**

Development Centers, Inc.  
Hegira Programs, Inc.  
North East Guidance Center  
Neighborhood Service Organization  
New Center Community Mental Health, Inc.  
Southwest Development Center  
The Children's Center  
The Guidance Center

**CareLink Network Board of Directors:**

Robert Shaw  
Ed Forry  
Cheryl Coleman  
Sheilah Clay  
Roberta Sanders  
John VanCamp  
Ted Lewis  
Michael Lott

# CareLink Network Provider Application

Revised 03/2004

Attachment A.2

List of all debts owed to, or loans obtained from a CareLink 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 Network Affiliates:**

Development Centers, Inc.  
Hegira Programs, Inc.  
North East Guidance Center  
Neighborhood Service Organization  
New Center Community Mental Health, Inc.  
Southwest Development Center  
The Children's Center  
The Guidance Center

**CareLink Network Board of Directors:**

Robert Shaw  
Ed Fory  
Cheryl Coleman  
Sheilah Clay  
Roberta Sanders  
John VanCamp  
Ted Lewis  
Michael Lott

# CareLink Network Provider Application

Revised 03/2004

Attachment A.3

## Staff Roster

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

**Criminal Background checks are conducted for all new hires**  Yes  No **Initial** \_\_\_\_\_

1. Staff Name: \_\_\_\_\_ Date of Hire: \_\_\_\_\_  
Criminal Background Check Conducted:  Yes  No  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Credentials and/or Training:: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Staff Name: \_\_\_\_\_ Date of Hire: \_\_\_\_\_  
Criminal Background Check Conducted:  Yes  No  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Credentials and/or Training:: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Staff Name: \_\_\_\_\_ Date of Hire: \_\_\_\_\_  
Criminal Background Check Conducted:  Yes  No  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Credentials and/or Training:: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Staff Name: \_\_\_\_\_ Date of Hire: \_\_\_\_\_  
Criminal Background Check Conducted:  Yes  No  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_  
Credentials and/or Training:: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# CareLink Network

## Provider Application for Credentialing

### Release Authorization and Ethical Commitment

The Applicant hereby has submitted an application for appointment to the Provider Panel of CareLink 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 Network or its designee to obtain and verify information contained on the application and consents to release all persons, organizations 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 authorize CareLink Network to investigate any 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 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 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.

\_\_\_\_\_  
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: CareLink Network  
Attn: Laura Layou  
BHPI  
Provider Relations  
1333 Brewery Park, Suite 300  
Detroit, MI 48207