

ConsumerLink Network Provider Application

Revised 03/2004

This section to be completed by ConsumerLink 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 or applications with more than one service location listed 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 ConsumerLink 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: _____

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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 _____

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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:

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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.

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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 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 Attachment A.1. If not applicable, indicate on the attachment.
9. List all debts owed to or loans obtained from a ConsumerLink 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.

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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	\$

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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	\$

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Attachment A.1

Name of Organization: _____

List of ConsumerLink 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. _____	_____	_____

ConsumerLink 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

ConsumerLink Network Board of Directors:

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

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Attachment A.2

List of all debts owed to, or loans obtained from a 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. _____	_____	_____

ConsumerLink Network Affiliates:

Development Centers, Inc.
Hegira Programs, Inc.
North East Guidance Center
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Robert Shaw
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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:: _____

