

**CENTERPOINT HUMAN SERVICES
APPLICATION FOR NEW PROVIDERS**

Instructions: (*Fill in ALL blanks*)

1. **Complete Section I** to describe your **agency** and the **service(s)** that you are proposing.
2. **Complete Section II** to describe the location and service(s) your agency proposes to deliver. Provide facility information on **each** facility that your agency operates.

Section I. Agency Information **Date Submitted:** _____

1. Contact Information

Corporate Name: _____

Physical Address: (Not P.O. Box) _____

City _____ State _____ ZIP _____ County _____

.....
Mailing Address: (If Different) _____

City _____ State _____ ZIP _____ County _____

.....
Mailing Address for Checks: _____

City _____ State _____ ZIP _____ County _____

.....
Facility Name: (If Different) _____

City _____ State _____ ZIP _____ County _____

.....
Telephone: Office: _____ Office Hours: _____

Fax: _____ Office Manager: _____

Cell: _____ Pager: _____

.....
Recommended Primary Contact: _____

Primary Contact E-mail Address: _____

Executive Director/CEO: (Name) _____ (Title) _____

Clinical/Medical Director/Qualified Professionals: _____

.....
2. Authority: List name of person(s) in agency who has authority to negotiate a contract:

3. Agency Legal Entity Type: (As listed with IRS)

- C-Corporation General Partnership Cooperative
 S-Corporation Sole Proprietorship Not for Profit Corporation
 Limited Liability Corporation Limited Liability Partnership

4. Agency Federal Tax ID #: _____ **or Social Security #:** _____

5. Ownership: List the name(s) and SSN# for individuals who own at least 5% interest in the business. (Percentage ownership is non-applicable, if non-profit corporation)

Name	Social Security Number	Percentage Ownership

6. Is your agency staffed and equipped to serve:

- Physically Handicapped? Yes No Deaf/Hard of Hearing? Yes No
 Blind/Visually Impaired? Yes No Behaviorally Disruptive? Yes No
 Sexually Aggressive? Yes No
 Foreign Languages? (Specify) _____

7. Insurance coverage and Professional Liability

A) Have you ever had a claim against you? Yes No

If "Yes", please list the name and amounts of the insurance and disposition.

B) Are there any current, unsettled claims? Yes No

C) Have you ever had your coverage cancelled? Yes No

D) Has there ever been any action or investigation against you or any owner or qualified professional in your agency relating to:

- 1) License? Yes No
 2) Certification? Yes No
 3) Registration? Yes No
 4) Privileges? Yes No
 5) Billing practices? Yes No

E) Have you or any owners ever been convicted of a crime, including, but not limited to, crimes involving children, fraud, or narcotics other than minor traffic violations? Yes No

If "Yes", please list charge, disposition and dates.

F) Have any adverse actions been filed against you by

- 1) Medicaid? Yes No
 2) Medicare? Yes No
 3) Other Insurance? Yes No

G) Have you or has anyone in your company who has an ownership, managerial or clinical role ever been sanctioned by any professional organization or government agency? Yes No

H) Have you ever had a contract cancelled by another Area Program/LME in North Carolina or similar entity in another state? Yes No

** If you answered “yes” to any of the above questions, please explain in an attachment.*

8) Please list all relevant contracts your agency or owners currently have and/or have had for the past two (2) years with any LME. (Skip to number 9 if you have no contracts.)

Please include for each:

- A) Contracting Agency/Area Program/LME
 - Contact name
 - Phone number
 - Email address
- B) What services are/were provided?
- C) Beginning and ending dates.
- D) Dollar amount of contract.

9. Have you ever provided MH/DD/SA services under another agency name?

Yes No If yes, specify the name(s): _____

10. Please check the service(s) you wish to provide for each population you wish to support.

Population(s) Requesting to Service	Adult	Child / Adolescent
	MI <input type="checkbox"/>	MI <input type="checkbox"/>
	SA <input type="checkbox"/>	SA <input type="checkbox"/>
	DD <input type="checkbox"/>	DD <input type="checkbox"/>
Service Type		
1) Enhanced		
a) Community Support Services - Child/Adolescents	<input type="checkbox"/>	<input type="checkbox"/>
b) Community Support Services – Adult	<input type="checkbox"/>	<input type="checkbox"/>
c) Community Support Team	<input type="checkbox"/>	<input type="checkbox"/>
d) Diagnostic Assessment	<input type="checkbox"/>	<input type="checkbox"/>
e) Multi-Systemic Therapy	<input type="checkbox"/>	<input type="checkbox"/>
f) Mobile Crisis Management	<input type="checkbox"/>	<input type="checkbox"/>
g) Intensive In-Home Services	<input type="checkbox"/>	<input type="checkbox"/>
h) Assertive Community Treatment Team	<input type="checkbox"/>	<input type="checkbox"/>
i) Substance Abuse Comprehensive Outpatient Treatment	<input type="checkbox"/>	<input type="checkbox"/>
j) Targeted Case Management	<input type="checkbox"/>	<input type="checkbox"/>

k) Outpatient Opioid Treatment (OTP)	<input type="checkbox"/>	<input type="checkbox"/>
l) Substance Abuse Non-Medical Community Residential Treatment	<input type="checkbox"/>	<input type="checkbox"/>
m) Substance Abuse Medically Monitored Community Residential Treatment	<input type="checkbox"/>	<input type="checkbox"/>
n) Facility Based Crisis Programs	<input type="checkbox"/>	<input type="checkbox"/>
2) Day / Night		
a) PH	<input type="checkbox"/>	<input type="checkbox"/>
b) PSR	<input type="checkbox"/>	<input type="checkbox"/>
c) MH/SA Day Treatment – Child / Adolescents	<input type="checkbox"/>	<input type="checkbox"/>
d) Vocational	<input type="checkbox"/>	<input type="checkbox"/>
e) Respite	<input type="checkbox"/>	<input type="checkbox"/>
3) Residential		
a) Supervised Living - II, III, IV, V, VI	<input type="checkbox"/>	<input type="checkbox"/>
b) Group Living (Low, Moderate, High)	<input type="checkbox"/>	<input type="checkbox"/>
c) Level II – Therapeutic Foster Care – Family Type	<input type="checkbox"/>	<input type="checkbox"/>
d) Level II – Therapeutic Home	<input type="checkbox"/>	<input type="checkbox"/>
e) Level III	<input type="checkbox"/>	<input type="checkbox"/>
f) Level IV	<input type="checkbox"/>	<input type="checkbox"/>
4) CAP-MR/DD Services	<input type="checkbox"/>	<input type="checkbox"/>

11. Is your agency directly enrolled with the Division of Medical Assistance (DMA)?

Yes No (Attach Proof of Enrollment)

12. Check the counties in which you provide services:

Forsyth Stokes Davie Other _____

13. List agency days and hours of operation. _____

14. Please list agency clinical specialties and specify age group (child/adolescent, adults):

Forsyth: _____

Stokes: _____

Davie: _____

15. Accredited Services Available: Please list and attach proof of national accreditation or certification for each service(s).

16. If your agency has not had any contracts for services within the past 2 years, describe the experience and resources key personnel have had in providing requested services for adults and /or child/adolescent consumers.

Section II: Facility Information – A facility is identified as a service site.
(If your agency operates more than one facility, copy and complete this section for each facility.)

Facility Name: _____

Facility Address: _____

City _____ State _____ ZIP _____ County _____

Facility Telephone: Main _____ Fax _____

Facility Days / Hours of Operation: _____

Information about the Facility Director/Manager:

Facility Director/Mgr.'s Name	
Facility Director/Mgr.'s Experience	
Facility Director/Mgr.'s Education	
Facility Director/Mgr.'s Credentials	

This facility provides services in the following category (ies):

Service Categories	Yes	Staff/Client Ratio	Capacity	No
Residential (24-hour care)				
Day/Night Services (More than 3 hours/day)				
Periodic Services (Hourly services)				

List the specific services delivered at this facility, the lead staff and their credentials:

Service(s) Offered at this Facility	Lead Staff Associated	Credential(s)

Population(s) served at this facility:

Age Range Served (Check all that apply)	Disabilities Served (Check all that apply)	Gender(s) Served
0 – 5 years	Mental Health (MH)	Male
6 – 12 years	Substance Abuse (SA)	Female
13 – 17 years	Developmental Disabilities (DD)	
18 – 21 years	MH/SA	
22 – 59 years	MH/DD	
60+ years	Other:	