Facility/ancillary/long-term care provider application

Provider identification	
Legal business name:	
Doing business as (if applicable):	
Credentialing Contact:	Credentialing Contact Email:
Credentialing Contact Phone:	Secure Fax:
Alternative Contact:	Alternative Contact Phone:
TIN:	NPI:
Taxonomy:	EMR:
API:	
Long-term care vendor number:	
DADS/DARS Contract #:	

Primary office/service address (Please submit Additional Locations Addendum for all other locations.)			
Practice location name:			
Medicaid Number/TPI:	Medicare ID:		
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Preferred):	County:
Phone:	Fax:	Primary contact:	
Administrator (full name):			
Does provider bill from this address? ☐ Yes ☐ No			

Billing information (if different than above)			
Billing name:			
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Optional):	County:

Facility/ancillary/long-term care provider application

Correspondence Address			
Billing name:			
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Optional):	County:

Primary office	Office Hours (AM-PM)
Monday:	
Tuesday:	
Wednesday:	
Thursday:	
Friday:	
Saturday:	
Sunday:	

Age of patients served:

- ☐ Newborn
- ☐ Preschool (3 to 5 years)
- ☐ Children (6-12 years)
- ☐ Adolescents (13-18 years)
- ☐ Adults
- ☐ Geriatrics (65+ years)

Please indicate any age limitations: _____

Patient program/population served:

- ☐ Serves intellectual or developmental disability (IDD) population
- ☐ Services pediatric population

Please indicate any gender limitations: _____

Does this office meet American Disabilities Act (ADA) accessibility requirements? ☐ Yes ☐ No ☐ N/A

Check all that apply:

Handicap accessible: ☐ Building ☐ Parking ☐ Restroom

Services for the disabled: ☐ Text telephone ☐ American Sign Language ☐ Mental/physical imp.

Accessible by public transportation: ☐ Bus/Taxi ☐ Subway ☐ Regional train

Do you use Electronic Health Records? ☐ Yes ☐ No ☐ N/A

If No, when might you start? _____

Electronic Claim Submission? ☐ Yes ☐ No ☐ N/A

Does business have internet access? ☐ Yes ☐ No ☐ N/A

If Yes, please check all that apply: ☐ Sign Language ☐ TTD/TTY ☐ None

Identify any foreign language(s) that are spoken other than English: ☐ Arabic ☐ Hindi ☐ Russian ☐ Chinese ☐ Italian ☐ Spanish ☐ Farsi ☐ Japanese ☐ Sign Language ☐ French ☐ Korean ☐ Tagalog ☐ German ☐ Laotian ☐ Vietnamese ☐ Hebrew ☐ Portuguese ☐ Other (specify) _____

Other Information. If entry is not applicable please enter "N/A" (not applicable).

Do you have Emergency Room Capabilities? ☐ Yes ☐ No ☐ N/A

Facility/ancillary/long-term care provider application

Average case load per day _____ ☐ N/A

Maximum capacity caseloads per day _____ ☐ N/A

What is your occupancy rate? _____ ☐ N/A

Unique Services you currently offer to your Medicaid patients: _____

_____

After hours coverage yes/no, If yes:

Answering Service ☐ Yes ☐ No

Automated Message ☐ Yes ☐ No

On-Call Staff ☐ Yes ☐ No

Provider type

- ☐ Adaptive Aids/Medical Equipment (LTSS)
- ☐ Adaptive Assistance Devices
- ☐ Adult Day Care
- ☐ Adult Foster Care
- ☐ Allied Health Professional Group
- ☐ Ambulance Service/Transportation Company
- ☐ Ambulatory Surgical Center (ASC)-Freestanding/Independent
- ☐ Ambulatory Surgical Center (ASC)-Hospital Based
- ☐ Amputee Center
- ☐ Assisted Living
- ☐ Audiology/Hearing Center
- ☐ Biological Products Manufacturer
- ☐ Birthing Center
- ☐ Blood Bank
- ☐ Cardiac Diagnostic Center
- ☐ Cardiac Rehab Center
- ☐ Case Management
- ☐ Certified Registered Nurse Anesthesia (CRNA) Group
- ☐ Chiropractic Group/Practice
- ☐ Chore Service
- ☐ Companion Services
- ☐ Comprehensive Care Program (CCP)
- ☐ Comprehensive Health Center (CHC)
- ☐ Comprehensive Outpatient Rehab Facility (CORF)
- ☐ Congregate Care Facility
- ☐ Convalescent Facility
- ☐ County Indigent Health Care Program (CIHCP)
- ☐ Day Habilitation (LTSS)
- ☐ Dental Group/Practice
- ☐ Diabetes Education Center
- ☐ Diagnostic and Treatment Center
- ☐ Dialysis Center
- ☐ Dispensing Optical Company
- ☐ Drug and Department Stores
- ☐ Durable Medical Equipment
- ☐ Early Childhood Intervention (ECI)
- ☐ Early Intervention Provider Agency
- ☐ Emergency Response Service/System
- ☐ Employment Assistance
- ☐ End Stage Renal Disease Facility (ESRD)
- ☐ Endoscopy Facility
- ☐ Family Counseling and Training
- ☐ Family Planning Clinic
- ☐ Federal Qualified Health Center (FQHC)
- ☐ Financial Management Service Agency
- ☐ Free Standing Emergency Room
- ☐ Habilitation (LTSS)
- ☐ Hearing Aid Equipment

Facility/ancillary/long-term care provider application

Provider type (continued)

- ☐ Hemophilia Treatment Center
- ☐ Home and Community Support Services
- ☐ Home Health Agency
- ☐ Home Infusion
- ☐ Homemaker Service
- ☐ Hospice
- ☐ Hospital Long Term, Limited or Specialized Care
- ☐ Hospital, Acute Care
- ☐ Hospital, Military
- ☐ Hospital, Pedatric
- ☐ Hospital, Private, Full Care
- ☐ Hospital, Rehabilitation
- ☐ Independent Lab/Privately Owned Lab
- ☐ Infertility Center
- ☐ Infusion Therapy Clinic
- ☐ Laboratory
- ☐ Lithotripsy Center
- ☐ Local Health Department
- ☐ Magnetic Resonance Imaging (MRI)
- ☐ Maternity Service Clinic
- ☐ Meals, Home Delivered Meals
- ☐ Minor Home Modification
- ☐ Mobile X-Ray/Mobile Diagnostic Provider
- ☐ Multi Specialty Group
- ☐ Non-Emergent Transportation Services
- ☐ Nursing Home
- ☐ Nursing/Health Care Staffing Service
- ☐ Nutritional Counseling
- ☐ Occupational Therapy Group/Clinic
- ☐ Optometric Group/Practice
- ☐ Oral and Maxillofacial Surgery Clinic
- ☐ Organ Procurement Organization
- ☐ Orthodontist Group
- ☐ Orthotics/Prosthetics
- ☐ Oxygen Supplier
- ☐ Pediatric Day Health Care
- ☐ Personal Assistance Services Agency
- ☐ Personal Care Services
- ☐ Pest Control
- ☐ Pharmacist Group
- ☐ Pharmacy
- ☐ Pharmacy-Chain
- ☐ Pharmacy-Close Operation
- ☐ Pharmacy-Home Health IV LTC
- ☐ Pharmacy-Hospital Class C
- ☐ Pharmacy-Independent
- ☐ Pharmacy-Out of State Contracted
- ☐ Pharmacy-Out of State Non-contracted
- ☐ Pharmacy-Out of State TMHCN
- ☐ Physical Therapy Group/Clinic
- ☐ Physician Group
- ☐ Podiatric Group/Practice
- ☐ Prescribed Pediatric Extended Care Centers (PPECC)
- ☐ Public Health Agency
- ☐ Radiation / Cancer Treatment Centers
- ☐ Respiratory Therapy
- ☐ Retail Clinic
- ☐ Rural Health Clinic-Freestanding/Independent
- ☐ Rural Health Clinic-Hospital Based
- ☐ Skilled Nursing Facility
- ☐ Sleep Medicine Center
- ☐ Supported Employment/Employment Assistance
- ☐ Transition Assistance Services (LTSS)
- ☐ Tuberculosis (TB) Clinic-Group
- ☐ Urgent Care Center
- ☐ Vehicle Modification (LTSS)

Facility/ancillary/long-term care provider application

Response to these questions is required only if your facility type is listed below

Federally Qualified Health Center (FQHC) centers — Please confirm you currently meet and will continue to meet Medicare conditions of coverage as defined in the Social Security Act §1861(aa)? ☐ Yes ☐ No
If no, attach an explanation of any deficiencies.

Comprehensive Outpatient Rehabilitation Facility (CORF), End-Stage Renal Dialysis (ESRD) Center, Outpatient Physical Therapy (PT), Outpatient Speech Rehabilitation facility, end-stage renal dialysis center, outpatient physical therapy, outpatient speech athology and Rural Health Center (RHC)rural health centers: Please confirm you currently meet and will continue to comply with all Centers for Medicare & Medicaid Services or state survey requirements. ☐ Yes ☐ No
If no, attach an explanation of any deficiencies.

STAR Kids Providers Must Answer the Following:

All questions must be answered with a checked "yes" or "no". Do not mark N/A for any questions.

Do you participate in the Medically Dependent Children Program (MDCP)? ☐ Yes ☐ No

Do you participate in the Community First Choice Program (CFC)? ☐ Yes ☐ No

Are you a Home and Community Support Service Agency (HCSSA) Provider? ☐ Yes ☐ No

Are you a Community Living Assistance and Support Services (CLASS) Provider? ☐ Yes ☐ No

Do you participate in the Deaf, Blind, & Multiple Disabilities (DBMD) Program? ☐ Yes ☐ No

Are you a Youth Empowerment Services (YES) Provider? ☐ Yes ☐ No

Are you recognized as a NCQA Patient-Centered Medical Home? ☐ Yes ☐ No

If yes, what level? _____

Do you offer Telemedicine Services? ☐ Yes ☐ No

Do you offer Telehealth Services? ☐ Yes ☐ No

Do you offer Telemonitoring Services? ☐ Yes ☐ No

Please give a list of where telemedicine services are provided if in addition to services locations

_____

_____

Do you participate in an Electronic Visit Verification Program (EVV)? ☐ Yes ☐ No

If yes, name of vendor used _____

Do you have experience in treating any of the following:

Children with Post-Traumatic Stress Disorder? ☐ Yes ☐ No

Children and sexual abuse? ☐ Yes ☐ No

Children with physical abuse? ☐ Yes ☐ No

Children with developmental disabilities? ☐ Yes ☐ No

Children with special needs and disabilities? ☐ Yes ☐ No

Facility/ancillary/long-term care provider application

Customer Service/Quality Improvement Initiatives

1. Does your organization provide any patient advocacy services? ☐ Yes ☐ No

Explain: _____

_____

2. Is the facility involved in a Quality Improvement Program (QIP)? ☐ Yes ☐ No

If YES, name of contact person: _____

To whom should questions regarding employee complaints, bills, estimates, or potential high cost surgeries, etc. be addressed?

Name:	
Phone:	Email:

Licensure & Certificates (attach a copy of current licensure and Clinical Laboratory Improvements Amendment [CLIA] certification, if applicable)

Type of License: State:	License issuance date:	License number:	Expiration date:
Type of License: State:	License issuance date:	License number:	Expiration date:
Type of License: State:	License issuance date:	License number:	Expiration date:
Radiology Certificate #:		Radiology Expiration Date:	
CLIA Certificate #:		CLIA Expiration Date:	

Accreditation/certification (attach a copy of current accreditation, certificate or survey)

A.

☐ Accreditation Association of Ambulatory Health Care (AAAHC)

☐ Accreditation Commission for Health Care (ACHC)American

☐ Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

☐ American Board for Certification in Orthotics & Prosthetics

☐ American College of Radiology (ACR)

☐ American College of Radiology

☐ Board of Certification

☐ Center for Improvement in Healthcare Quality

☐ Clinical Laboratory Improvement Amendments (CLIA)

☐ CMS

☐ Commission on Accreditation of Rehabilitation Facilities (CARF)

Note: Continuing Care Accreditation Commission (CCAC) and CARF have merged, so CCAC not included separately

☐ Commission on Office Laboratory Accreditation (COLA)

☐ Community Health Action Partnership (CHAP)

☐ Council on Accreditations (COA)

☐ Det Norske Veritas Healthcare, Inc (DNV)

☐ Healthcare Facility Accreditation Program (HFAP)

☐ Healthcare Quality Association on Accreditation

☐ Intersocietal Accreditation Commission (IAC)

☐ Joint Commission for the Accreditation of HealthCare Organization (TJC or JCAHO)

☐ National Association of Boards of Pharmacy (NABP)

Facility/ancillary/long-term care provider application

Accreditation/certification (continued)

- ☐ National Board of Accreditation for Orthotic Suppliers
- ☐ RadSite
- ☐ Texas Department of Aging and Disability Services (Tx DADS)
- ☐ The Compliance Team
- ☐ Utilization Review Accreditation Commission (URAC)

Accrediting Body:	Initial accreditation date (mm/dd/yyyy):	Date of last survey (mm/dd/yyyy):
Accrediting Body:	Initial accreditation date (mm/dd/yyyy):	Date of last survey (mm/dd/yyyy):
Accrediting Body:	Initial accreditation date (mm/dd/yyyy):	Date of last survey (mm/dd/yyyy):

☐ Not accredited — Expected date of accreditation (mm/dd/yyyy): _____

B. Site Survey — Visit May Be Required

Nonaccredited providers must provide a copy of:

- **Most recent government agency survey (may not be older than 36 months),**
- **Corrective action plan (if deficiencies were cited), and attach the proof from the government agency stating facility is in substantial compliance with most recent survey standards.**

Facilities that don't meet the requirements above require an onsite visit before network status may be granted. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.

Has the provider had an on-site survey by CMS or state agency? ☐ Yes ☐ No

(YES) Date of most recent full survey _____

(NO) Successful completion of a health plan onsite visit will be required to complete credentialing.

General and professional liability insurance – Please submit a copy of your certificate of insurance.	
General liability coverage	
Current carrier name:	
Policy number:	Coverage type: ◯ Occurence-based ◯ Claims-based
Effective date:	Expiration date:
Per incident: $	Aggregate: $
Professional/Malpractice liability coverage – Please submit a copy of your certificate of insurance.	
Current carrier name:	
Policy number:	Coverage type: ◯ Occurence-based ◯ Claims-based
Effective date:	Expiration date:
Per incident: $	Aggregate: $

Facility/ancillary/long-term care provider application

Workers Compensation Insurance – Please submit a copy of your certificate of insurance. (Don't enforce for all types)	
Current carrier name:	
Policy number:	Coverage type: ◯ Occurence-based ◯ Claims-based
Effective date:	Expiration date:
Per incident: $	Aggregate: $

Automobile Insurance
Are you required to carry automobile insurance? ☐ Yes ☐ No (If yes, submit a copy of your certificate.)

Advance Directive Policy

Do you have an Advance Directive policy? ☐ Yes ☐ No

Hospital, nursing homes, home health care agency, and skilled nursing facility: If you responded No, please include a copy of the specific section of your policy/process, which addresses that you do not maintain Advance Directive policies. You do not have to include the complete policy.

Professional Disclosure Questions

Please include an explanation on a separate sheet for any question(s) answered Yes.

1. Has the organization ever been reprimanded, fined by any state agency that disciplines allied health professionals or health organizations? ☐ Yes ☐ No

Has the organization's license to practice or operate in any jurisdiction (state or county) ever been denied, revoked, suspended, sanctioned or subject to probation or any conditions or limitations? ☐ Yes ☐ No

2. Have any disciplinary proceedings ever been instituted against the organization by any medical organization or medical institute? ☐ Yes ☐ No
3. Has the organization ever been convicted of a felony? ☐ Yes ☐ No
4. Have any malpractice suits, arbitration or other proceeding ever been instituted against the organization (regardless of outcome)? ☐ Yes ☐ No
5. Has the organization ever been investigated, reprimanded, censured, excluded, suspended or disqualified by Medicare or Medicaid program? ☐ Yes ☐ No
6. Has the organization's liability insurance policy ever been canceled? ☐ Yes ☐ No
7. Has the organization ever been denied renewal of the liability insurance policy or had any limitations placed on the scope of coverage? ☐ Yes ☐ No

Note: This impacts the section called "Enclosures."

Explanation of "Yes" answers to attestation questions Credentialing Questionnaire

Facility/ancillary/long-term care provider application

Attestation Consent and Release

All information provided in this, or in connection with this application, is complete and accurate to the best of my knowledge, and I shall immediately notify the Plan(s) of any changes thereto. I understand that this application does not entitle me to participation in the Plan(s) network. By applying for appointment as an _____ participating provider, I authorize the Plan(s) plan, its medical director, and appropriate representatives to consult with administrators and members of other institutions where I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to the inspection by the Plan(s), and their representatives, its medical director and appropriate representatives, of all records and documents, excluding medical records of nonmembers of _____ plans, that may be material to an evaluation of any professional qualifications and competence to carry out the requested duties, as well as my moral and ethical qualifications for participating provider status with the Plan(s) _____. I consent and agree that _____ will complete a criminal history background check to determine if I, or any subcontracted providers, have any history of felony convictions, including adjudication withheld on a felony, plea or nolo contendere to a felony or entry into a pretrial for a felony. I agree to obtain any consents or approvals required for my subcontracted providers to undergo such background checks.

I hereby release the Plan(s) and its representatives, including TAHP and Aperture Credentialing, LLC, from any liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I hereby release any individuals and organizations from any liability that provide information to the Plan(s) and its representatives or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the ancillary agreement between me or my group and the Plan(s), as such terms may be applicable to me.

I understand that as an applicant for participation in the Plan(s), I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from the Plan(s), I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the credentialing committee, if they so request. I further understand that I may appeal the committee's decision either in writing or by appearance before the credentialing committee, if they so request.

By signing below, I attest that I have reviewed and understand all terms and conditions contained in this Attestation/Consent & Release. I agree that my electronic signature is equivalent to my hand-written signature.

Type or Print Name _____

Title _____

Signature _____

Date _____

Enclosures

Please submit all applicable documents from the list below with your completed and signed application. Failure to provide this information will prohibit completion of your credentialing and/or contracting process. Please submit enclosures for each location.

- ☐ Copy of all federal, state and/or local licenses required to operate as a health care facility (by location)
- ☐ Copy of accreditation certificate or letter
- ☐ Copy of most recent CMS or state survey, including your corrective action plan if deficiencies were cited or cover letter from CMS/state agency stating facility is in substantial compliance
- ☐ Copy of CLIA certificate for each location, as applicable
- ☐ Copy of current DEA certificate (if applicable);
- ☐ Current TDH Radiology certificate for each location (if applicable);
- ☐ Evidence of Texas Mental Health and Mental Retardation certification (REQUIRED for community mental health centers)
- ☐ Evidence of Medicare certification (REQUIRED for institutional centers)
- ☐ Professional/Malpractice liability/Workers Compensation Certificate of Insurance (AS REQUIRED ABOVE);
- ☐ Copy of TMHP Medicaid Letter (when applicable)

Facility/ancillary/long-term care provider application

Enclosures (continued)

- ☐ Evidence of an Agreement with HHSC [REQUIRED for CORF providers]
- ☐ Facility Organizational Chart
- ☐ Medical Director's or Administrator's Curriculum Vitae/ Resume
- ☐ Medical Staff / Allied Health Professional Roster
- ☐ Explanation of "Yes" answers to attestation questions
- ☐ Company brochure (if available)
- ☐ Current Signed W-9
- ☐ Auto (professional/general/WC/ Auto) Insurance

Attachment B - Hospital Facilities

Hospital - part of multi-hospital system? ☐ Yes ☐ No

Are you considered an Essential Community Provider as defined by CMS? ☐ Yes ☐ No

Hospital Services/Treatment Levels:

- ☐ Adult acute care
- ☐ Level 1 trauma
- ☐ Level 2 trauma
- ☐ Level 3 trauma
- ☐ Level 4 trauma
- ☐ Children's Hospital — [CMS Designated
- ☐ Designated Childrens Unit/Wing
- ☐ Specializes in Pediatric Services

Are you a member of the American Hospital Association? ☐ Yes ☐ No

Number of Certified Beds _____

NICU Level _____ Certification Date _____

Medicare - Certified Acute Inpatient Facility Information

Medicare Certified Bed Count: _____ ICU Bed Count(excluding Neonatology): _____

Skilled Nursing or Swing Bed Count: _____ Inpatient Psychiatric Bed Count: _____

- ☐ Acute Inpatient Rehab Services
- ☐ Cardiac Catheterization Services
- ☐ Outpatient Occupational Therapy
- ☐ Cardiac Surgery Program
- ☐ Outpatient Physical Therapy
- ☐ Critical Care Services– Intensive Care Unit (ICU)
- ☐ Outpatient Speech Therapy
- ☐ Diagnostic Radiology
- ☐ Skilled Nursing Unit
- ☐ Durable Medical Equipment
- ☐ Surgical Services (Outpatient or ASC)
- ☐ Inpatient Psychiatric Facility Services
- ☐ Mammography
- ☐ Orthotics and Prosthetics
- ☐ Outpatient Dialysis
- ☐ Outpatient Infusion/Chemotherapy

Medicare-Approved Transplant Programs

- ☐ Heart/Lung
- ☐ Heart
- ☐ Intestinal
- ☐ Kidney
- ☐ Liver
- ☐ Lung
- ☐ Pancreas
- ☐ Other _____

Facility/ancillary/long-term care provider application

Attachment C - Texas Long-Term Services and Supports

Provider type Services Details			
Personal assistance service direct: ☐ Consumer-directed block grant model ☐ Consumer-directed service (CDS) model ☐ Consumer-delegated agency model ☐ Financial management/ CDS ☐ Rate enhancement program Department of Aging and Disability Services (DADS) participant contract number: _____ List level: _____	Day activity/health services: ☐ Rate enhancement program Department of Aging and Disability Services (DADS) participant contract number: _____ List level: _____	Residential care/assisted living facility: ☐ Rate enhancement program Department of Aging and Disability Services (DADS) participant contract number: _____ List level: _____	☐ Transition/relocation services

Long-term Care Provider Knowledge of state requirements:

The rendering service practitioner must be knowledgeable of the following:

a. Acts that constitute abuse, neglect or exploitation of a member, as defined in 40 TAC Chapter 705, Subchapter A

b. Reports suspected abuse, neglect or exploitation, as instructed

Adheres to applicable state laws when providing transportation

May not be a spouse, legally responsible for person or employment supervisor of the member who receives the service

FOR SUPERIOR HEALTH PLAN AND COMMUNITY FIRST ONLY

Counties Served: Please select the ones in which services can be provided or check here ☐ STATEWIDE [servicing all counties]

☐ Andrews	☐ Aransas	☐ Archer	☐ Armstrong	☐ Atascosa
☐ Austin	☐ Bailey	☐ Bandera	☐ Bastrop	☐ Baylor
☐ Bee	☐ Bell	☐ Bexar	☐ Blanco	☐ Borden
☐ Bosque	☐ Brazoria	☐ Brazos	☐ Brewster	☐ Briscoe
☐ Brooks	☐ Brown	☐ Burleson	☐ Burnet	☐ Caldwell
☐ Calhoun	☐ Callahan	☐ Cameron	☐ Carson	☐ Castro
☐ Chambers	☐ Childress	☐ Clay	☐ Cochran	☐ Coke
☐ Coleman	☐ Collin	☐ Collingsworth	☐ Colorado	☐ Comal
☐ Comanche	☐ Concho	☐ Coryell	☐ Cottle	☐ Crane
☐ Crockett	☐ Crosby	☐ Culberson	☐ Dallam	☐ Dallas
☐ Dawson	☐ Deaf Smith	☐ Denton	☐ DeWitt	☐ Dickens
☐ Dimmit	☐ Donley	☐ Duval	☐ Eastland	☐ Ector

Facility/ancillary/long-term care provider application

Counties Served (continued)

☐ Edwards	☐ El Paso	☐ Ellis	☐ Falls	☐ Fayette
☐ Fisher	☐ Floyd	☐ Foard	☐ Fort Bend	☐ Freestone
☐ Frio	☐ Gaines	☐ Galveston	☐ Garza	☐ Gillespie
☐ Glasscock	☐ Goliad	☐ Gonzales	☐ Gray	☐ Grimes
☐ Guadalupe	☐ Hale	☐ Hall	☐ Hamilton	☐ Hansford
☐ Hardeman	☐ Hardin	☐ Harris	☐ Hartley	☐ Haskell
☐ Hays	☐ Hemphill	☐ Hidalgo	☐ Hill	☐ Hockley
☐ Hood	☐ Howard	☐ Hudspeth	☐ Hunt	☐ Hutchinson
☐ Irion	☐ Jack	☐ Jackson	☐ Jasper	☐ Jeff Davis
☐ Jefferson	☐ Jim Hogg	☐ Jim Wells	☐ Johnson	☐ Jones
☐ Karnes	☐ Kaufman	☐ Kendall	☐ Kenedy	☐ Kent
☐ Kerr	☐ Kimble	☐ King	☐ Kinney	☐ Kleberg
☐ Knox	☐ La Salle	☐ Lamb	☐ Lampasas	☐ Lavaca
☐ Lee	☐ Leon	☐ Liberty	☐ Limestone	☐ Lipscomb
☐ Live Oak	☐ Llano	☐ Loving	☐ Lubbock	☐ Lynn
☐ Madison	☐ Martin	☐ Mason	☐ Matagorda	☐ Maverick
☐ McCulloch	☐ McLennan	☐ McMullen	☐ Medina	☐ Menard
☐ Midland	☐ Milam	☐ Mills	☐ Mitchell	☐ Montgomery
☐ Moore	☐ Motley	☐ Navarro	☐ Newton	☐ Nolan
☐ Nueces	☐ Ochiltree	☐ Oldham	☐ Orange	☐ Palo
☐ Parker	☐ Parmer	☐ Pecos	☐ Pinto	☐ Polk
☐ Potter	☐ Presidio	☐ Randall	☐ Reagan	☐ Real
☐ Reeves	☐ Refugio	☐ Roberts	☐ Robertson	☐ Rockwall
☐ Runnels	☐ San Saba	☐ San Jacinto	☐ San Patricio	☐ Schleicher
☐ Scurry	☐ Shackelford	☐ Sherman	☐ Somervell	☐ Starr
☐ Stephens	☐ Sterling	☐ Stonewall	☐ Sutton	☐ Swisher
☐ Tarrant	☐ Taylor	☐ Terrell	☐ Terry	☐ Throckmorton
☐ Tom Green	☐ Travis	☐ Tyler	☐ Upton	☐ Uvalde
☐ Val Verde	☐ Victoria	☐ Walker	☐ Waller	☐ Ward
☐ Washington	☐ Webb	☐ Wharton	☐ Wheeler	☐ Wichita
☐ Wilbarger	☐ Willacy	☐ Williamson	☐ Wilson	☐ Winkler
☐ Wise	☐ Yoakum	☐ Young	☐ Zapata	☐ Zavala

Facility/ancillary/long-term care provider application

Attachment D - Behavioral Health Facilities/Providers

Specialty Service Identified (examples ECT, Eating Disorders, Ambulatory Detox….)

Place of service location for each program/service _____

Secure fax number for each place of service address _____

Bed Counts for inpatient Mental Health or Substance Use Disorder _____

Behavioral health (BH):

- ☐ Behavioral Health (MH) Rehabilitation
- ☐ Behavioral Health Facility
- ☐ Behavioral Health Intensive Outpatient
- ☐ Behavioral Health Partial Hospitalization
- ☐ Behavioral Health Residential Treatment
- ☐ Behavioral Health Unit
- ☐ Chemical Dependency Intensive Outpatient
- ☐ Chemical Dependency Partial Hospitalization
- ☐ Develop/Behavioral Pediatric
- ☐ Hospital, Behavioral Health
- ☐ Local Behavioral Health Authority (LMHA)
- ☐ Mental Retardation Diagnostic Services (MRDA)
- ☐ Outpatient Behavioral Health
- ☐ OUTPATIENT DIAG/TREATMENT CTR
- ☐ Physiological-Independent Diagnostic Testing Facilities (IDTF)
- ☐ Psychiatric Clinic
- ☐ Psychology Group
- ☐ Residential Treatment Facility/Program
- ☐ Residential-Based Supported Community Living Services
- ☐ Substance Abuse Treatment Center
- ☐ Adolescent & Children Behavioral Health
- ☐ DUI/DWI Education Program
- ☐ Intensive Family Intervention Adult Living Facility
- ☐ Rehabilitative Behavioral Health Services (RBHS) Assisted Long-Term Care Facility
- ☐ Statewide Inpatient Psychiatric Program
- ☐ Psychiatric Residential Treatment Facility

Facility/ancillary/long-term care provider application

Identify specialty services offered	Available	Not Available	Location(s)	Comments/Descriptions
Eating Disorder Treatment — Inpatient	☐	☐		
Eating Disorder Treatment – Outpatient	☐	☐		
Electro-convulsive Therapy (ECT) - Inpatient	☐	☐		
Electro-convulsive Therapy (ECT) – Outpatient	☐	☐		
Dual Diagnosis Services	☐	☐		
Continuing Day Treatment	☐	☐		
LBGT services	☐	☐		
Domiciliary Services in an IOP or PHP setting (program must be formally approved by UBH)	☐	☐		
Chronically Mentally Ill Services (CMI)/ Severely Mentally Ill Services (SMI)	☐	☐		
Respite Care Services	☐	☐		
Emergency Room Services (assessment only)	☐	☐		
Twenty-three (23) Hour Crisis Observation	☐	☐		
Mobile Crisis Stabilization	☐	☐		
MHSA Outpatient Clinics in a hospital	☐	☐		
Ambulatory Detox - Drug	☐	☐		
Ambulatory Detox - Alcohol	☐	☐		
Medication Assisted Treatment (MAT) - in an Detox, IOP or PHP setting ☐ Methadone ☐ Suboxone ☐ Buprenorphine ☐ Naltrexone (i.e. vivitrol)	☐	☐		
	☐	☐		
Sober Living/Supervised Living				
Halfway House				
Group Home				
Therapeutic Foster Care				
ASAM Residential Services				☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7
Bridge on Discharge (aftercare planning immediately post IP discharge)				☐ Geriatric ☐ Adult ☐ Adol. ☐ Child

Facility Type:

- ☐ Hospital
- ☐ Intensive Family Intervention Adult Living Facility
- ☐ Home Health Agency
- ☐ Rehabilitation Center
- ☐ Rehabilitative Behavioral Health Services (RBHS) Assisted Long-Term Care Facility
- ☐ Substance Use Treatment Facility
- ☐ Statewide Inpatient Psychiatric Program
- ☐ Psychiatric Residential Treatment Facility

Facility/ancillary/long-term care provider application

Facility Practice Locations and Levels of Care per location															
Facility Locations	Age Category	Mental Heatlh						Substance Abuse							
		Inpatient	Partial	IOP	Residential	Observation		I/P Detox	I/P Rehab	Partial	IOP	Residential	Ambulatory Detox		
Location #1															
Address:	Child														
	Adol.														
Phone:	Adult														
Secure Fax:	Geriatric														
NPI:		ECT	☐ I/P		☐ O/P				☐ Methadone			☐ Suboxone			
Taxonomy:	# of I/P Beds (MH):	# of Medicare I/P Beds (MH):						# of I/P Beds (SA):							
Location #2															
Address:	Child														
	Adol.														
Phone:	Adult														
Secure Fax:	Geriatric														
NPI:		ECT	☐ I/P		☐ O/P				☐ Methadone			☐ Suboxone			
Taxonomy:	# of I/P Beds (MH):	# of Medicare I/P Beds (MH):						# of I/P Beds (SA):							
Location #3															
Address:	Child														
	Adol.														
Phone:	Adult														
Secure Fax:	Geriatric														
NPI:		ECT	☐ I/P		☐ O/P				☐ Methadone			☐ Suboxone			
Taxonomy:	# of I/P Beds (MH):	# of Medicare I/P Beds (MH):						# of I/P Beds (SA):							
Location #4															
Address:	Child														
	Adol.														
Phone:	Adult														
Secure Fax:	Geriatric														
NPI:		ECT	☐ I/P		☐ O/P				☐ Methadone			☐ Suboxone			
Taxonomy:	# of I/P Beds (MH):	# of Medicare I/P Beds (MH):						# of I/P Beds (SA):							
Location #5															
Address:	Child														
	Adol.														
Phone:	Adult														
Secure Fax:	Geriatric														
NPI:		ECT	☐ I/P		☐ O/P				☐ Methadone			☐ Suboxone			
Taxonomy:	# of I/P Beds (MH):	# of Medicare I/P Beds (MH):						# of I/P Beds (SA):							

Facility/ancillary/long-term care provider application

Abuse, Neglect, and Exploitation Attestation

Provider must be knowledgeable of acts that constitute Abuse or Neglect and Abuse, Neglect, or Exploitation of a Member. The Department of Family and Protective Services oversee Child Protective Services (CPS) and Adult Protective Services (APS).

Abuse is defined as "the negligent or willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical or emotional harm or pain by the person's caretaker, family member, or other individual who has an ongoing relationship with the person" and includes, but is not limited to:

- Scratches, cuts, bruises, and burns
- Welts, scalp injury, and gag marks
- Sprains, punctures, broken bones, and bedsores
- Confinement
- Rape and other forms of sexual abuse
- Verbal and psychological abuse

Neglect is defined as "the failure to provide for one's self the goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain, or the failure of a caretaker to provide such goods or services" and includes, but is not limited to:

- Malnourishment and dehydration
- Too much or too little medication
- Lack of heat, running water, or electricity
- Unsanitary living conditions
- Lack of medical care
- Lack of personal hygiene or clothes

Exploitation is defined as "the illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with an elderly or disabled person that involves using, or attempting to use, the resources of the elderly or disabled person, including the person's social security number or other identifying information, for monetary or personal benefit, profit, or gain without the informed consent of the elderly or disabled person" and includes, but is not limited to:

- Taking Social Security or Supplemental Security Income (SSI) checks
- Abusing joint checking accounts
- Taking property and other resources

To Report Abuse for APS or CPS contact them at the following:

- By Phone: 1-800-252-5400
- Online: https://www.dfps.state.tx.us/Contact_Us/report_abuse.asp

The Abuse Hotline toll-free 24 hours a day, 7 days a week, nationwide, or report with our secure website and get a response within 24 hours.

By my signature below, I attest that the Provider represents and warrants they are knowledgeable of acts that constitute Abuse or Neglect (CPS) and Abuse, Neglect, or Exploitation (APS) of a Member. Provider

Type or Print Name _____

Title _____

Signature _____

Date _____