

**Salish Behavioral Health Administrative Services Organization**

Serving Clallam, Jefferson, and Kitsap Counties

PROVIDER FACILITY APPLICATION

 [ ] Initial or [ ] Recredential

|  |
| --- |
| **I. INSTRUCTIONS AND CHECKLIST** |
| This form should be typed or legibly printed in ink. Copies of all documents must be current. If more space is needed than provided, attach additional sheets and reference the questions being answered.**Current copies of the following documents must be submitted with this application as is applicable:** [ ] State Business License [ ]  State Behavioral Health Agency License for each location providing contracted services. [ ] A completed W-9 [ ]  Evidence of current National Accreditation OR Results of the most recent DOH Audit/Survey within 36 months[ ] Face Sheet of Commercial Liability Policy or ACCORD Certificate (Salish BH-ASO must be named in the policy)[ ] Disclosure of Ownership Form (DOO) – Verified, signed, and dated <https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/27-094.pdf>[ ] Proof of Exclusions/Debarment verifications for each individual listed on DOO (initialed and dated within one (1) week of application submission (to include OIG, SAM, and Washington State exclusion checks for HCA and DSHS)[ ] Agency Organizational Chart**For Inpatient Psychiatric or Secure Withdrawal Management Facilities:**[ ] Credentialing Policy and Procedure[ ] Medical Staff Executive Committee Membership |
| **II. FACILITY INFORMATION** |
| Legal Business Name: (As listed on W9)       |
| Doing Business As: (if applicable)       |
| Contact Person:       | Email:       |
| Tax ID(s):       |
| **III. PRIMARY SERVICE ADDRESS** |
| Facility Location Name:       |
| Address Line 1:       |
| Address Line 2:       |
| City:       | State:       | ZIP:       | County:       |
| Phone:       | Fax:       | Primary Contact:       |

|  |
| --- |
| Does this location meet ADA accessibility requirements? [ ]  Yes [ ]  No |
| Check all that apply:Handicap Accessible: [ ]  Building [ ]  Parking [ ]  RestroomServices for Disabled: [ ]  Text Telephone [ ]  American Sign Language [ ]  Mental/Physical Impairment Accessible by Public Transportation: [ ]  Yes [ ]  No |

|  |
| --- |
| **IV. SECONDARY SERVICE ADDRESS (Attach separate sheet for additional Facility locations)** |
| Facility Location Name:       |
| Address Line 1:       |
| Address Line 2:       |
| City:       | State:       | ZIP:       | County:       |
| Phone:       | Fax:       |  | Primary Contact:       |
| Does this office meet ADA accessibility requirements? [ ] Yes [ ]  No |
| Check all that apply:Handicap Accessible: [ ]  Building [ ] Parking [ ] RestroomServices for Disabled: [ ] Text Telephone [ ] American Sign Language [ ]  Mental/Physical Impairment Accessible by Public Transportation: [ ] Yes [ ]  No |

|  |
| --- |
| **V. NATIONAL PROVIDER IDENTIFIER (NPI) (Attach a separate sheet for multiple NPIs)** |
| Name:       |
| Service Address:       |
| Tax ID/EIN:       | NPI#:       |
| Taxonomy Code(s):       |

|  |
| --- |
| **VI. LICENSURE (Attach a separate sheet for additional licensure information, if applicable)** |
| State:       | Issue Date:       | License Number:       | Expiration Date:       |
| State:       | Issue Date:       | License Number:       | Expiration Date:       |
| State:       | Issue Date:       | License Number:       | Expiration Date:       |
| State:       | Issue Date:       | License Number:       | Expiration Date:       |
| State:       | Issue Date:       | License Number:       | Expiration Date:       |
| State:       | Issue Date:       | License Number:       | Expiration Date:       |

|  |
| --- |
| **VII. GENERAL AND PROFESSIONAL LIABILITY INSURANCE** |
| **General Liability Coverage** |
| Current Carrier Name:       |
| Policy Number:       | Coverage Type:[ ]  Occurrence Based [ ]  Claims Based |
| Effective Date:       | Expiration Date:       |
| Per Incident: $      | Aggregate: $      |
| **Professional Liability Coverage** |
| Current Carrier Name:       |
| Policy Number:       | Coverage Type: [ ]  Occurrence Based [ ]  Claims Based |
| Effective Date:       | Expiration Date:       |
| Per Incident: $      | Aggregate: $      |

|  |
| --- |
| **VIII. ATTESTATION QUESTIONS** |
| **If your answer is “yes” to any of the following questions, please provide complete details and any pertinent documents on a separate sheet of paper. Be sure to include dates and status or outcome of each action. Please provide the specific nature of allegations/events that led to an affirmative response to the below questions.** |
| Has your organization ever been disciplined by any state licensing or other authorizing agency, or by any Professional Conduct Board, or has it been reprimanded, or fined by a state agency that disciplines your specific provider type?  |  [ ] Yes [ ]  No |
| Has your organization ever been reprimanded, censured, excluded, suspended, or disqualified by the Medicare or Medicaid program? |  [ ] Yes [ ]  No |
| Have any malpractice suits, arbitration, or other legal proceedings been instituted, active, or settled that involved your organization (including all entities/individuals listed in the DOO) within the last 3 years? |  [ ] Yes [ ]  No |

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omission from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

I certify that the appropriate state license or certification source is checked for all new employees or contracted service providers prior to the first provision of service. I certify that the appropriate state license or certification source is checked at least annually for existing and contracted service providers in order to ensure that every licensed individual providing services as a representative of the applicant holds a current license or certification to provide services. I certify that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service. I certify the applicant does not employ or contract with any individual convicted of a felony for a health-care related crime, including but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispensing of controlled substance.

**I certify that the on-line exclusion lists for the Health and Human Services Office of Inspector General (OIG) (**<http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp>**), the System for Award Management (SAM) (**<https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf>**), and the Washington State Health Care Authority (HCA)**

Provider Terminations (<https://www.hca.wa.gov/billers-providers-partners/apple-health-medicaid-providers/provider-termination-and-exclusion-list>) are checked for all new employees and contracted service providers prior to the first provision of service. I certify that the on-line exclusion lists for the OIG, SAM, and Washington State Exclusion checks (both HCA and DSHS) are checked on a monthly basis for all existing employees and contracted service providers to ensure that no state or federally or Washington State excluded individuals perform any function related to any State or federal health care program. I certify that I will remove any employee or contracted service provider found on one of the above referenced exclusion lists from any functions related to a State or federal health care program.

The individual executing this attestation has the proper authority and authorization and does so with the intent to fully bind the applicant to the truthfulness of its answers.

**Organization**

**Printed Name**

SBHASO Personnel Only:

Received Date and Initials:

**Title**

**Signature (Stamp not acceptable)**

**Date**

614 Division St., Port Orchard, Washington 98366 360.337.7050 T | 800.525.5637 | 360.337.5721 Fax

Additional Pages

|  |
| --- |
|  **ADDITIONAL SERVICE ADDRESS (Attach separate sheet for additional Facility locations)** |
| Facility Location Name:       |
| Address Line 1:       |
| Address Line 2:       |
| City:       | State:       | ZIP:       | County:       |
| Phone:       | Fax:       |  | Primary Contact:       |
| Does this office meet ADA accessibility requirements? [ ] Yes [ ]  No |
| Check all that apply:Handicap Accessible: [ ]  Building [ ] Parking [ ] RestroomServices for Disabled: [ ] Text Telephone [ ] American Sign Language [ ]  Mental/Physical Impairment Accessible by Public Transportation: [ ] Yes [ ]  No |