Children Come First
RISE Wisconsin, Inc.
Provider Network

PROVIDER APPLICATION

Application Information and Requirements:

1. All information requested on the attached application must be submitted. Providers not completing the application in its entirety or not submitting all information requested will not be considered for participation as a Provider in this program.

2. This application needs to be filled out in its entirety by each Provider if they intend to provide any of the services listed. Additional pages may be added as needed. The Services to Be Provided section must be filled out in detail for each category of service the agency intends to provide. Additional services may be requested throughout the year by completing a revised application.

3. Send the completed application to:
   Children Come First
   RISE Wisconsin, Inc.
   Attn: Provider Network Coordinator
   1334 Dewey Court
   Madison, WI 53703

4. It is the Provider’s responsibility to keep all information current. Any change in the ability of the Provider to provide services must be reported to the Provider Network Coordinator. Failure to provide such notice may result in the cancellation of their approval to participate in the Provider Network. Children Come First reserves the right to remove a Provider from the program at any time.

5. No eligible client will be unlawfully denied services or be subjected to discrimination because of age, race, religion, color, national origin, sex, sexual orientation, location, disability, physical condition or developmental disability as defined in 51.01 (s) Wisconsin Statues.
6. Participation in Children Come First constitutes the Provider’s approval to allow authorized representatives of the Children Come First to have access to all records necessary to confirm the provision of services by the Provider. Providers will comply with periodic scheduled audits as required. Failure on the part of the Provider to provide such access, comply with reporting requirements or meet any other program requirements may result in withholding or forfeiture of any payments due.

7. The programs served by the Provider Network are unable to guarantee the volume of referrals to the Provider.

8. For most network services, a unit rate has been established for the service. Children Come First pays vendors based on the Provider’s actual invoice. Children Come First customarily will not use a Provider whose rate for the service exceeds the established rate. Rates submitted and approved will be in effect this calendar year and/or until amended and approved by the Provider Network Coordinator. Rates are effective upon receipt of notification of approval to provide services by Children Come First. Providers may not bill retroactively.

9. The Provider certifies to the best of its knowledge and belief that it and its principals: (1) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal or State department or agency; (2) have not within a three-year period preceding this agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (3) are not presently indicted for or otherwise criminally charged by a government entity (Federal, State or local) with commission of any of the offenses enumerated in (2) of this certification; and (4) have not within a three-year period preceding this contract had one or more public transaction (Federal, State or local) terminated for cause or default.

10. The Provider certifies that it has completed Caregiver Background checks for all direct service providers within the last 4 years. Background checks must include: 1) Background Information Disclosure Form; 2) Criminal History Record Request Form indicating “No Record Found”; 3) Response to Caregiver Background Check letter from the Department of Health and Family Services (DHFS) that reports administrative finding or licensing restriction Status; 4) Out-of-State conviction records from any State or other US jurisdiction for direct service providers who resided outside of Wisconsin at any time during the 3 preceding years. Background checks that show a criminal record and/or license denial or revocations are to be forwarded to the CCF Provider Network Coordinator for review prior to acceptance of the Application.

11. CCF requires that all Providers contracted for a community-based service have an agency policy prohibiting staff from carrying or concealing a weapon while in the presence of a client during working hours. All required Providers must submit a
copy of their Weapons policy at the time of application into the network in order to be considered for contracting.

12. First-time applications are reviewed by the Provider Network Coordinator to determine whether the services are appropriate for the Provider Network. No services may be provided by prospective vendors without the written approval by the Provider Network Coordinator of the services to be provided by the vendor. A letter will be mailed to the vendor announcing the acceptance or rejection of the vendor into the Provider Network, along with a Fee for Service Agreement, the services the vendor is authorized or not authorized to provide and rates for the services to be provided by the vendor. Vendors providing services outside of this approval will not be paid. The effective date of the Fee-for-Service Agreement between the Vendor and Children Come First will be stated in the letter of approval.

13. For additional information, contact Brianna Vejvoda, Provider Network Coordinator, at 608-210-0106 or providernetwork@risewisconsin.org.
Children Come First  
RISE Wisconsin, Inc.  
Provider Network

PROVIDER APPLICATION

☐ In Network  ☐ Out of Network

GENERAL INFORMATION

☐ Individual Credentialed Provider  ☐ Partnership  ☐ Corporation
☐ Service Corporation  ☐ Profit  ☐ Non-Profit  ☐ Other

Agency Name: __________________________________________

Agency Director: _________________________________________

Contact Person for Billing  Phone: _________________________

Preferred Email Address for CCF Correspondence:  

Is your agency required to be in compliance with the Health Insurance Portability and Accountability Act (HIPAA)?  ☐ Yes  ☐ No

Name of Compliance Officer:  

For Tax Purposes, please provide Tax ID here:  

Page 4 of 9
OFFICES: List all practice sites, identify primary, mailing and billing address

Office #1 Please list additional offices on a separate sheet

Office Name ___________________________________________ Check all applicable boxes:

☐ Primary Office
☐ Secondary Office
☐ Mailing Address
☐ Billing Address

Address: ______________________________________________________

City: __________________ State: __________ Zip: __________

Telephone Number: __________________ Fax Number: __________________

PROGRAM/FACILITY ACCESSIBILITY

Hours Available

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<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<tbody>
<tr>
<td>a.m.</td>
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<td>p.m.</td>
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Providers must ensure that medically necessary services are available 24 hours a day.

Communications Available:

☐ TTY – Teletypewriter ☐ Sign Language
☐ Non-English Languages

Spoken:

Handicapped Parking: ☐ Yes ☐ No
On Bus Line: ☐ Yes ☐ No

Minority or Disadvantaged Vendor:

☐ Yes ☐ No

(Check all that apply)

Minority Vendor
☐ At least 51% of Board of Directors are minorities
☐ Organization is owned and operated by at least 51% minorities

Disadvantaged Vendor
☐ At least 51% of Board of Directors are women
☐ Organization is owned and operated by at least 51% women
SERVICES TO BE PROVIDED

( per attached Covered Services document)

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Rate</th>
<th>Covered Service</th>
<th>Rate</th>
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Please indicate any non-traditional therapeutic services offered:

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

PROFESSIONAL LIABILITY INSURANCE

Current Liability Carrier

Name of Company: ________________________________  Start Date: __________
Complete Address: ________________________________  Policy Number: __________
Phone Number: ________________________________  Fax Number: ________________
Email: ________________________________  Coverage Amounts: ________________

*Please attach a copy of your current Certificate of Liability Insurance Declaration page

AGENCY EVIDENCED BASED-GUIDELINES

Does the agency have Practice Guidelines: □Yes □No

If yes, submit copy along with application

If yes, please describe how the agency implements the Practice Guidelines:

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

If agency has not adopted its own Practice Guidelines and Standards, agency must adopt and adhere to those of the Children Come First Program
TRAUMA-INFORMED CARE PRACTICES

Does the agency practice trauma-informed care: ☐ Yes ☐ No
If yes, please describe how the agency demonstrates trauma-informed care in its work:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Does the agency offer any trauma-specific therapies (TF-CBT, EMDR, etc.): ☐ Yes ☐ No
Please list:

_____________________________________________________________________
_____________________________________________________________________

Does the agency use (or be willing to use) a trauma screener or assessment if requested? ☐ Yes ☐ No
If yes, which ones:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Our agency is not currently doing this but would be interested in learning more: ☐ Yes ☐ No
CLINICIAN/PRACTITIONER  
Copy and complete this page for each staff member that is to be added to the network

Name: ____________________________  Covered Service(s): ____________________________

Degree: ____________________________  Discipline: ____________________________

Specialties: ___________________________________________________________________

Languages Spoken: ___________________________________________________________________

<p>| ID NUMBERS |
|-----------------|-----------------|-----------------|
| <strong>State License:</strong> List all current and past state licenses |</p>
<table>
<thead>
<tr>
<th>State of Licensure</th>
<th>Number</th>
<th>Type</th>
<th>Expiration Date</th>
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<tbody>
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</table>

<p>| OTHER ID NUMBERS |
|--------------------|-----------------|-----------------|</p>
<table>
<thead>
<tr>
<th><strong>Type of Number</strong></th>
<th><strong>Number</strong></th>
<th><strong>Expiration Date</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>MA Provider Number</td>
<td></td>
<td></td>
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<tr>
<td>National Provider ID Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
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</tbody>
</table>

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<thead>
<tr>
<th>INSURANCES ACCEPTED</th>
<th>Please include insurances and other funding sources for your services</th>
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<tr>
<th>ADDITIONAL DOCUMENTATION NEEDED</th>
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<tr>
<td>For each staff member, please include a copy of the following items:</td>
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<tr>
<td>• Resume</td>
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<tr>
<td>• Diploma of highest degree earned (if not licensed)</td>
</tr>
<tr>
<td>• Verification of relevant licensure (if applicable)</td>
</tr>
</tbody>
</table>

Has the above clinician/practitioner been excluded from providing services for Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act:  
[ ] Yes  [ ] No

Background checks have been completed on the above clinician/practitioner within the last 4 years and are available upon request at the above agency. Submit Wisconsin State Dept. of Justice and/or Dept. Regulation and Licensing report to Children Come First for review if criminal record, denial, or revocation is noted.

Signature: ____________________________  Date ____________________________
Consent to Release Information

Verification of Professional Liability Insurance

Copy and complete this form for each Insurance Carrier used in the last 5 years.

<table>
<thead>
<tr>
<th>Name of Insurance Carrier</th>
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<tbody>
<tr>
<td>Street Address</td>
</tr>
<tr>
<td>City</td>
</tr>
<tr>
<td>Policy Number</td>
</tr>
</tbody>
</table>

I understand that this Consent to Release Information is made in connection with Physician/Practitioner contracting, credentialing, or recredentialing activity conducted by RISE on behalf of the Children Come First Program.

I hereby authorize RISE and it representatives to contact and consult with the Insurance Carrier identified below with which I have affiliated, have used for liability insurance or who may have information relevant to my professional liability insurance and/or malpractice insurance claims history.

I release and hold harmless from liability all persons, entities, and institutions when in good faith and without malice for acts performed in gathering or exchanging information related to this credentialing or recredentialing process. This release and hold harmless provision applies to all person, entities and institutions that provide and/or receive information as part of the RISE – Children Come First Program credentialing or recredentialing process.

I, the undersigned, authorize

Print Practitioner Name: 

Practitioner Signature: ___________________________ Date: _______________