Children Come First
RISE Wisconsin, Inc.
Provider Network

Rev 03/21/2016

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 Program Development Manager. 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. 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.

12. If Provider is accepted into the Provider Network, the Provider Network Coordinator will arrange for a site visit within 3 months of the signed contract.

13. For additional information, contact Brianna Vejvoda, Provider Network Coordinator, at 608-210-0106

RISE
Helping Community & Family Thrive

DANE COUNTY
DEPARTMENT OF HUMAN SERVICES

Children Come First
RISE Wisconsin, Inc.
Provider Network

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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: _____

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

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
a.m.							
p.m.							

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)			
Covered Service	Rate	Covered Service	Rate

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 <u>each</u> staff member that is to be added to the network

Name: _____ Covered Service(s): _____

Degree: _____ Discipline: _____

Specialties: _____

Languages Spoken: _____

ID NUMBERS			
State License: *List all current and past state licenses*			
State of Licensure	**Number**	**Type**	**Expiration Date**

OTHER ID NUMBERS		
Type of Number	**Number**	**Expiration Date**
MA Provider Number		
National Provider ID Number		
Other:		

INSURANCES ACCEPTED	**Please include insurances and other funding sources for your services**

ADDITIONAL DOCUMENTATION NEEDED

For each staff member, please include a copy of the following items:

- Resume
- Diploma of highest degree earned (if not licensed)
- Verification of relevant licensure (if applicable)

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.

Consent to Release Information

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

_____

Name of Insurance Carrier

_____

Street Address

_____

City State Zip Code

_____

Policy Number

to send verification of my professional liability coverage, to include dates of coverage, amounts of coverage and any limitations in coverage to RISE – Children Come First Program who will hereinafter be a Certificate Holder and as such is to be notified of the amount of my current and any future coverage and/or changes to my insurance status.

Print Practitioner Name: _____

Practitioner Signature: _____ Date: _____