



Children Come First RISE Wisconsin, Inc. Provider Network

Rev 1/1/2020

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 and Quality Care Specialist
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 and Quality Care Specialist. 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 Statutes.

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 and Quality Care Specialist. 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 and Quality Care Specialist 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 and Quality Care Specialist 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 Elizabeth Park-Floyd, Provider Network and Quality Care Specialist, at 608-210-0150 or providernetwork@risewisconsin.org.



**Children Come First
RISE Wisconsin, Inc.
Provider Network**

Rev 1/1/2018

PROVIDER APPLICATION

In Network

Out of Network

GENERAL INFORMATION					
<input type="checkbox"/>	Individual Credentialed Provider	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	Corporation
<input type="checkbox"/>	Service Corporation	<input type="checkbox"/>	Profit	<input type="checkbox"/>	Non-Profit
		<input type="checkbox"/>		<input type="checkbox"/>	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 _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Check all applicable boxes:
 Primary Office
 Secondary Office
 Mailing Address
 Billing Address

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 <i>Covered Services</i> 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
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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
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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
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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 its 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: _____