

# Alamance-Caswell Local Management Entity Network Provider-Application for Enrollment

PLEASE COMPLETE ALL SECTIONS OF THE APPLICATION COMPLETELY. If you are applying to provide an enhanced benefit requiring endorsement within Alamance or Caswell counties, you must also submit a correct and complete Division of Medicaid Assistance Community Intervention Services Provider Enrollment Package, or other appropriate package (NC DMA Application for Community Alternative Programs for CAP-MR/DD or the Residential Services Provider Enrollment Application for Child Residential programs/services). The submission of a complete application package does not constitute enrollment/endorsement. Admission into the AC LME Provider Network is contingent on the identified needs of the community and the current capacity within the provider network. Additionally, each application is subject to internal review and credentialing processes prior to any decision/award. Incomplete application packages will not be processed.

## Contact Information

Business/Organization Name: \_\_\_\_\_ FEIN#: \_\_\_\_\_

Application Contact Person:

Last Name	First Name	Middle Name	Social Security Number
( ) - Ext.	( ) -		
Office Telephone		Office Fax	E-Mail

Mailing Address: \_\_\_\_\_  
 PO Box/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Physical Address: \_\_\_\_\_  
 PO Box/Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

## Medicaid Enrollment

Are you enrolled with the NC Division of Medical Assistance (DMA) to receive direct reimbursement for Medicaid clients?

Yes If yes, provide Medicaid Provider Number(s) (include all & specify, if multiple numbers have been assigned): \_\_\_\_\_

What is your current capacity to serve Medicaid consumers? \_\_\_\_\_

No If not, when do you plan to be directly enrolled? \_\_\_\_\_

## Certification/Licensure

Type(s): \_\_\_\_\_ States: \_\_\_\_\_

Certification/License #s: \_\_\_\_\_

Year(s) Obtained: \_\_\_\_\_ Expiration Date(s): \_\_\_\_\_

## Additional Business/Organization Information

For each question, place an "X" in one box only. Provide additional information as indicated.

1. How long has the organization been in business under its current name? \_\_\_\_\_
2. Does the organization currently or in the past operate under a different name:  Yes  No
  - a. If yes, please specify: \_\_\_\_\_
3. Please indicate status of your agency:  For profit  Non profit

4. Has the organization had a compliance verification review or DHSR survey reflecting full compliance of the services you wish to provide?  Yes  No
  - a. If yes, please specify: \_\_\_\_\_
5. Has the organization ever been subject to a license revocation, endorsement withdrawal, regulatory (DHSR, DSS, LME, DMA, etc...) investigation?  Yes  No
  - a. If yes, please specify: \_\_\_\_\_
6. Has the organization ever had a contract terminated for cause?  Yes  No
  - a. If yes, please specify: \_\_\_\_\_
7. Does the organization currently have any outstanding tax debts (NCGS 143C-6-23(c))?  Yes  No
  - a. If yes, please specify: \_\_\_\_\_
8. Please list all organizations with whom you currently contract and/or have contracted within the last 12 months (Please include Agency Name, Contact Name, Address, Phone Number): \_\_\_\_\_
9. Please list other provider organizations with which formal alliances are in place (i.e. administrative cost sharing, direct referrals, etc.) Provide Agency Name, Contact Name, Address, Phone Number, & nature of the alliance: \_\_\_\_\_
10. Is the organization nationally accredited?  Yes  No
  - a. If yes, by which accrediting body? \_\_\_\_\_ Date of Accreditation? \_\_\_\_\_ Term? \_\_\_\_\_ years
  - b. If no, what is your plan for becoming accredited (if applicable)? \_\_\_\_\_

### Education (Independent Practitioners Only)

Highest Clinical Degree: \_\_\_\_\_

Date: \_\_\_\_\_

Program: \_\_\_\_\_

College: \_\_\_\_\_

List additional relevant training to the treatment of children and adolescents: \_\_\_\_\_

Number of years in which you have been involved in counseling or evaluation to children and adolescent: \_\_\_\_\_

### Service Information

1. Please list the services that you wish to provide. (Be specific as to the type of service and disability group [age/disability group] and expected capacity to service in a 12 month period). \_\_\_\_\_
2. Number of first appointment slots available on a weekly basis? \_\_\_\_\_ Day(s)/Times(s): \_\_\_\_\_
3. Is your office space handicapped accessible?  Yes  No
4. Are bilingual services available?  Yes  No
  - i. If yes, please specify: \_\_\_\_\_
5. Please specify other special populations served by your agency: \_\_\_\_\_

Place an "X" in the box indicating the diagnostic areas treated by the organization:

	Child	Adol.	Adult		Child	Adol	Adult
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disability Determination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct D/O	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stress-Related Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotic D/O	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reactive Attachment D/O	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating D/O	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bi-Polar D/O	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PTSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuro-psychological D/O	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Reactive (pre-adol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forensic Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Reactive (adolescent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Offender (specify type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Place an "X" in the box indicating the approaches used in your work:

<input type="checkbox"/>	Cog. Beh. Therapy	<input type="checkbox"/>	Brief Therapy	<input type="checkbox"/>	Ecological	<input type="checkbox"/>	Biofeedback
<input type="checkbox"/>	Behavioral Therapy	<input type="checkbox"/>	Psychodynamic	<input type="checkbox"/>	EMDR	<input type="checkbox"/>	Social Skills Training
<input type="checkbox"/>	Reality Therapy	<input type="checkbox"/>	Strategic Therapy	<input type="checkbox"/>	Family Systems	<input type="checkbox"/>	Parent Training
<input type="checkbox"/>	Eclectic	<input type="checkbox"/>	Psychological Testing	<input type="checkbox"/>	DBT	<input type="checkbox"/>	Other, please specify: _____
<input type="checkbox"/>	Play Therapy	<input type="checkbox"/>	Forensic Services	<input type="checkbox"/>	Stress Management	<input type="checkbox"/>	Other, please specify: _____

**Emergency Coverage**

Place an X in the corresponding box to indicate the arrangements you have made to cover your practice in the following situations:

	Nights	Weekends	Holidays	Vacations
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24 Hour Beeper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24 Hour Answering Service Can Reach Me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Answering Machine with Emergency #	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Member of Practice with 24 Hour Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colleague Covers Practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Staffing**

1. Do you have psychiatric capacity within your organization?  Yes  No      Tele-psychiatry?  Yes  No

If yes, please provide the names and credentials of the psychiatrists: \_\_\_\_\_

If no, indicate what arrangements you have made or are planning to make your practice for clients who need psychiatric evaluation and/or medication: \_\_\_\_\_

2. List the staff positions for the services being provided (include credentials, brief description of responsibilities): \_\_\_\_\_

3. Are there any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the practitioner's ability to provide care according to accepted standards of professional performance or pose a threat to the health and safety of patients?  Yes  No

If yes, please provide more information: \_\_\_\_\_

**Liability Insurance Coverage**

Carrier Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Amount of Coverage \$ \_\_\_\_\_ per Occurrence      Aggregate \$: \_\_\_\_\_      Expiration Date: \_\_\_\_\_

1. Has any professional liability claim or suit ever been made against you in the past ten years?  Yes  No
2. Are you aware of any circumstance that may result in a professional liability claim or suit?  Yes  No
3. Have you ever been convicted of a crime – other than a minor traffic offense – in any state or country?  Yes  No
4. Have you ever been charged with a crime – other than a minor traffic offense – in any state or country, the disposition of which was other than acquittal or dismissal?  Yes  No

*If you responded "Yes" to any of the questions in this section, please provide a detailed narrative as an attachment to the application.*

## Program Policy and Procedures

Please answer the following questions in detail. You may attach copies of the organizations Policy and Procedures as a substitute. If an attachment is provided, please indicate by writing "see attached [NAME OF DOCUMENT]"

1. What is your agency's mission statement or service philosophy (Program Description may be attached as a substitute)? \_\_\_\_\_
2. Do you currently have, or anticipate having, the ability to transmit claims electronically?  Yes  No
3. List community supportive resources that you routinely interface with or to which you refer clients. \_\_\_\_\_
4. List the supportive services (transportation, community outings, etc.) that you include as a part of each service level that you wish to provide for us. Please be concise and specific. \_\_\_\_\_
5. List the community outreach activities that will be provided, and how often will these activities take place? \_\_\_\_\_
6. Please attach Policies and Procedures that address the following:
  - a. Consumer Intake/Enrollment
  - b. Service Planning/Documentation
  - c. Staff Credentialing, Training, & Supervision
  - d. Monitoring of Regulatory Compliance
  - e. Monitoring of Consumer Progress
  - f. Conflict of Interest (NCGS 143C-6-23 (b))
  - g. Consumer Rights Protection

## Attached Documentation

Please place an X in the box to indicate the required documentation has been submitted with your completed Provider Profile.

- Certificate of Liability Insurance coverage
- Copy of approved Medicaid provider enrollment agreement, if applicable
- W9 Form
- Resume (independent practitioners)
- Copy of each certification and/or license, if applicable
- Proof of Financial Solvency: Established Provider Agencies-Copy of most recent annual financial audit  
Established Independent Practitioner-Attachment C from most recent tax return  
New Providers-Business Plan w/projected budget including revenues and expenses
- Notification of Endorsement Action letter, if applicable
- NC Criminal Records Check that is no more than 3 months old
- DEA certificate or state controlled substance certificate, if applicable
- Two letters of professional reference
- DMA Enrollment Application, if applicable

## Signature

By signing below I attest to the following:

- AC LME has my consent/authorization to collect any information necessary to verify the information in the Application for Enrollment.

- The information submitted with the Application for Enrollment is true and correct to the best of my knowledge.
- No dissolution, revocation, or revenue suspension is currently, or has been attached within the past six (6) months, to this provider entity.
- The submission of the completed Application for Enrollment and required supporting documentation constitutes my request for approval to participate in the Alamance-Caswell Local Management Entity's Provider Network.

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Print Name

Signature

Date

**AC LME  
PROVIDER DIRECTORY INFORMATION**

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The information you provide will be used by AC LME's Screening/Triage/Referral department to refer consumers to your company and will be made available in the LME's provider directory available to the public via the AC LME's website. *(IF YOU HAVE A STATE FUNDED CONTRACT WITH AC LME AND HAVE MORE THAN ONE SITE, PLEASE COMPLETE A SEPARATE FORM FOR EACH SITE).*

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**Agency Name:** \_\_\_\_\_

**Physical Address:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**TTY #:** \_\_\_\_\_

**Hotline/First Responder #:** \_\_\_\_\_

**Website:** \_\_\_\_\_

**Program Director/Phone/E-Mail Address:** \_\_\_\_\_

**Referral Contact/Phone/E-Mail Address:** \_\_\_\_\_

**Program History/Philosophy:** \_\_\_\_\_ (may attach agency brochure)

**Service(s) Provided:** \_\_\_\_\_

**Population(s) Served:**  Child Mental Health       Adult Mental Health  
 Child Dev. Disability       Adult Dev. Disability  
 Child Substance Abuse       Adult Substance Abuse

**Professional Specialties (i.e. language capacity, specialty therapies, etc.):** \_\_\_\_\_

**Hours of Operation:** \_\_\_\_\_

**Licensing/Accreditation:** \_\_\_\_\_

**Insurance(s) Accepted:**       AC LME IPRS Contract       Medicaid       NC Health Choice  
 Medicare       Private Insurance (specify): \_\_\_\_\_