Provider Application Service Location Form

A service location is defined as each facility-based location where members will be able to go to for services; or for in-home services, each location that will receive referrals for service. The Service Locations Form coincides with the Provider Application Form if more than one service location is needed.

***Service Location Name:**

*Street Address: ______________________________
City: ______________________________ State: _____ Zip Code: ____________________
County of Location: ______________________________
General Phone Number: ____________________ General Fax Number: ____________________

Medicaid Certification, if applicable, State: Number:

Medicare Certification, if applicable, Number:

*If a residential service, indicate staffing pattern of service location:	

*If a ***residential service***, please mark all of the following that apply:

- ☐ Location has overnight awake staff
- ☐ Location has semi-awake overnight Staff
- ☐ Location is fully accessible on exterior (no steps or ramped)
- ☐ Location is fully accessible on interior (no steps)
- ☐ Location has specialized programming for challenging behaviors
- ☐ Location has specialized programming for moderate to severe Alzheimer's/dementia
- ☐ Location serves persons with intellectual disability
- ☐ Location serves persons with physical disabilities
- ☐ Location serves aging/frail adults
- ☐ Location has specialized programming to serve individuals with criminal/sex offender issues
- ☐ Location has other specialized programming, please describe: ____________________
- ☐ Other information specific to location:

*If service is based at a provider operated facility or office, is location Wheelchair Accessible? ☐ Yes ☐ No

*If licensed or regulated by the State of authority, has service location been issued any citations or statements of deficiency within the last 3 years? ☐ Yes ☐ No
If yes, please provide a description and current status: ______________________________
____

Service Location Contacts- (if different from agency contacts listed above)

*Program/Facility Manager Name: ______________________________
(main point of contact for program or department questions, information)

Phone: ____________________ Fax: ____________________

Email Address: ____________________

Notifications to receive from Inclusa: ☐ Applicable Inclusa Notices ☐ Insurance Renewal Notices ☐ Credentialing Notices ☐ Member Rate Agreement

*Service Referral Recipient Name: ______________________________ ☐ Same as Program Manager

Phone: ____________________ Fax: ____________________

Email Address: ____________________

Notifications to receive from Inclusa: ☐ Applicable Inclusa Notices ☐ Insurance Renewal Notices ☐ Credentialing Notices ☐ Member Rate Agreement

Name: ____ ☐ Same as Program Manager

Phone: ________________ Fax: ______________

Email Address: _____________

Notifications to receive from Inclusa: ☐ Applicable Inclusa Notices ☐ Insurance Renewal Notices ☐ Credentialing Notices ☐ Member Rate Agreement

***Hours of Operation or Availability, if NOT a residential service**

☐ Operations Available 24/7

Monday	_____	to	_____	☐ Closed
Tuesday	_____	to	_____	☐ Closed
Wednesday	_____	to	_____	☐ Closed
Thursday	_____	to	_____	☐ Closed
Friday	_____	to	_____	☐ Closed
Saturday	_____	to	_____	☐ Closed
Sunday	_____	to	_____	☐ Closed

Holiday Schedules for providers with annual Holiday Schedules when business is closed, please submit a current Holiday calendar with this application.