INSTRUCTIONS: Type or print information on this application. Fields with a * indicate it is a required field.

SECTION I – CORPORATE / AGENCY INFORMATION

***Legal Business Name** (as it appears on your W-9 Form)**:**	
DBA name (if applicable)**:**	
***Address** (as appears on W-9 Form)**:** **City, State Zip Code:**	***County:**
Website Address:	
Number of Employees:	**NPI** (if applicable)**:**
Provides Interpreter Service: ☐ for languages other than English	☐ for Hearing Impaired

Agency Contacts	Notification Preference	Types of notices to receive (check all that apply)
*__Contract Administrator__ Name: _____ Title: _____ Email Address: _____ Phone: _____ Fax : _____ ☐ Authorized to sign contract and rate agreement documents	☐ Mail ☐ Email ☐ Fax	☐ Contract ☐ Documents ☐ Contract Notices ☐ Applicable Inclusa Notices ☐ Member Rate ☐ Agreements ☐ Insurance Renewal ☐ Notices ☐ Credentialing ☐ Notices
***Payment & Billing__ Name: _____ Title: _____ Email Address: _____ Phone: _____ Fax: _____ Address: _____ (if different above) ☐ Authorized to sign contract and rate agreement documents	☐ Mail ☐ Email ☐ Fax	☐ Contract ☐ Documents ☐ Contract ☐ Notices ☐ Applicable Inclusa Notices ☐ Member Rate ☐ Agreements ☐ Insurance Renewal ☐ Notices ☐ Credentialing Notices
***Service Referral Contact:__ Name: _____ Title: _____ Email Address: _____ Phone: _____ Fax: _____ Address: _____ (if different above) ☐ Authorized to sign contract and rate agreement documents	☐ Mail ☐ Email ☐ Fax	☐ Contract Documents ☐ Contract Notices ☐ Applicable Inclusa Notices ☐ Member Rate Agreements ☐ Insurance Renewal Notices ☐ Credentialing Notices

Agency Contacts continued	Notification Preference	Types of notices to receive (check all that apply)
Credentialing Contact Name: _____ Title: _____ Email Address: _____ Phone: _____ Fax: _____ Address: _____ (if different above)	☐ Mail ☐ Email ☐ Fax	☐ Contract Documents ☐ Contract Notices ☐ Applicable Inclusa Notices ☐ Member Rate ☐ Agreements ☐ Insurance Renewal Notices ☐ Credentialing Notices
Quality Contact Name: _____ Title: _____ Email Address: _____ Phone: _____ Fax: _____ Address: _____ (if different above)	☐ Mail ☐ Email ☐ Fax	☐ Contract Documents ☐ Contract Notices ☐ Applicable Inclusa Notices ☐ Member Rate Agreements ☐ Insurance Renewal Notices ☐ Credentialing Notices

SECTION II - SERVICES

Indicate services in the Family Care Benefit you are applying to provide as a subcontractor for Inclusa

☐	Adaptive Aids - General	☐	Home Delivered Meals
☐	Adaptive Aids – Vehicles	☐	Home Health Agency (licensed)
☐	Adaptive Aids - Service Dog	☐	Home Modifications- Environmental Accessibility Adaptations
☐	Adult Day Care (licensed)	☐	Independent/Private Nursing Services
☐	Alcohol & Other Drug Abuse	☐	Medical Supplies - disposable and specialized
☐	Communication Aids or Interpreter Service	☐	Mental Health Services
☐	Community Support Program (licensed)	☐	Occupational, Physical and/or Speech Therapy-Outpatient
☐	Community Supported Living	☐	Personal Care Agency
☐	Counseling & Therapeutic Resources- Massage (licensed)	☐	Personal Emergency Response Service (PERS)
☐	Consumer Education	☐	Prevocational Services
☐	Counseling & Therapeutic Resources- Foot Care	☐	Respite Care- in home or facility
☐	Counseling & Therapeutic Resources- General	☐	Skilled Nursing Facility (licensed)
☐	Daily Living Skills Training	☐	Supported Employment
☐	Day Habilitation Services	☐	Supportive Home Care- chore, lawn, and/or snow service
☐	Day Treatment	☐	Supportive Home Care- general
☐	Durable Medical Equipment (no hearing aids or prosthetics)	☐	Transportation Services
☐	Financial Management Services	☐	Vocational Future Planning Service
Residential Services			
☐	Adult Family Home (certified 1-2 bed)	☐	Adult Family Home (licensed 3-4 bed)
☐	Community Based Residential Facility (CBRF)- (licensed)	☐	Residential Care Apartment Complex (RCAC)- must be state certified

Briefly describe your program/services:

_____

_____

_____

_____

SECTION III – SERVICE LOCATIONS

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. An Additional Service Location Form is available on the website 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
- ☐ Credentialing Notices
- ☐ Insurance Renewal Notices
- ☐ Member Rate Agreement

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

*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		Friday	____ to ____	☐ Closed	
Tuesday	____ to ____	☐ Closed		Saturday	____ to ____	☐ Closed	
Wednesday	____ to ____	☐ Closed		Sunday	____ to ____	☐ Closed	
Thursday	____ to ____	☐ Closed					

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

SECTION IV - ATTESTATION AND SIGNATURE

Signature of this application acknowledges applicant attests to the following statements:

Provider is not barred from State or Federal funding or from doing business under State or Federal Funding.

For any provider with direct care to Inclusa members, Provider meets requirements for Criminal and Caregiver Background Checks as established by the Wisconsin Department of Health Services, Division of Quality Assurance (http://www.dhs.wisconsin.gov/caregiver/index.htm).

Provider assures for quality, competency and fiscal soundness in provision of services.

Provider will comply with subcontract requirements. Services to Inclusa members may not be performed without a signed subcontract and prior authorization from Inclusa.

In receiving this application, Inclusa relies on the truth of the following statement:

All information entered in all sections of this Provider Application is accurate and complete. If any of information changes, Provider will notify Inclusa immediately of any such change.

Authorized Signature and Title_____ **Date** _____

NOTIFICATION OF CHANGES: You must inform Inclusa of any changes in licensure, certification, group affiliation, corporate name, ownership, and physical service location or payee address prior to the change occurring.

Submission Instructions: All fields with a ***** must be completed. The application and other documents (such as W9, copy of license, etc.) can be submitted to Inclusa in one of the following methods:

- Email: ProviderDevelopment@inclusa.org
- Fax: 608-785-5336, Attn: CR/PR Provider Development
- Mail: Attn: CR/PR Provider Development, Inclusa, 1407 Saint Andrew Street, Ste. 100, La Crosse WI 54603