INSTRUCTIONS: Type or print information on this application. Fields with a * indicate 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 it appears on W-9 Form):	
***City, State, Zip:**	***County:**
***Number of Employees:**	**Website:**
***Tax ID** (EIN/SSN):	**NPI** (if applicable):
Interpreter Service Provided: ☐ for languages other than English	☐ for Hearing Impaired

Agency Contacts	Types of notices to receive (check all that apply)
***Contract Administrator** Name: ____________ Phone: ____________ Title: ____________ Fax: ____________ Email Address: ____________ Mailing Address: ____________ (if different from Corp./Agency) ____________ ☐ Authorized to sign contract and rate agreement documents	☐ Contract Documents ☐ Contract Notices ☐ General Inclusa Notices ☐ Service Referrals ☐ Member Rate Agreements ☐ Disenrollment Notices ☐ Insurance Renewal Notices ☐ Credentialing Notices
***Payment Address & Billing Contact** ☐ Same as Contract Administrator Name: ____________ Phone: ____________ Title: ____________ Fax: ____________ Email Address: ____________ Mailing Address: ____________ (if different from Corp./Agency) ____________ ☐ Authorized to sign contract and rate agreement documents	☐ General Inclusa Notices ☐ Billing-Related Notices ☐ Service Referrals ☐ Member Rate Agreements ☐ Disenrollment Notices ☐ Other (list):
***Service Referral Contact** ☐ Same as Contract Administrator Name: ____________ Phone: ____________ Title: ____________ Fax: ____________ Email Address: ____________ Mailing Address: ____________ (if different from Corp./Agency) ____________ ☐ Authorized to sign contract and rate agreement documents	☐ General Inclusa Notices ☐ Service Referrals ☐ Member Rate Agreements ☐ Disenrollment Notices ☐ Other (list):

Agency Contacts (continued)	Types of notices to receive (check all that apply)
Credentialing Contact ☐ Same as Contract Administrator Name: ______ Phone: ______ Title: ______ Fax: ______ Email Address: ______ Mailing Address: ______ (if different from Corp./Agency) ______	☐ General Inclusa Notices ☐ Insurance Renewal Notices ☐ Credentialing Notices ☐ Other (list):
Quality Contact ☐ Same as Contract Administrator Name: ______ Phone: ______ Title: ______ Fax: ______ Email Address: ______ Mailing Address: ______ (if different from Corp./Agency) ______	☐ General Inclusa Notices ☐ Quality-Related Notices and Inquiries ☐ Other (list):

SECTION II – SERVICES

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

- ☐ Adaptive Aids (general, vehicle, service dog)
- ☐ Adult Day Care (licensed)
- ☐ Alcohol & Other Drug Abuse Services (AODA)
- ☐ Assistive Technology/Communication Aids (includes interpreter services)
- ☐ Community Support Program (CSP) (licensed)
- ☐ Community Supported Living
- ☐ Consultative Clinical & Therapeutic Services for Caregivers (CCTS) (training for paid and unpaid caregivers)
- ☐ Consumer Education and Training (including mental health peer specialists)
- ☐ Counseling & Therapeutic Resources (licensed, non-Medicaid-certified therapies)
- ☐ Daily Living Skills Training
- ☐ Day Habilitation Services
- ☐ Day Treatment Services – AODA
- ☐ Day Treatment Services – Medical/Behavioral
- ☐ Disposable Medical Supplies (including OTC)
- ☐ Durable Medical Equipment (except hearing aids or prosthetics)
- ☐ Environmental Accessibility Adaptations (home modifications)
- ☐ Financial Management Services (fiscal intermediary for SDS)
- ☐ Financial Management Services (organizational rep payee)
- ☐ Home Delivered Meals
- ☐ Home Health Agency (licensed and Medicaid certified; Medicare may also be required depending on service)
- ☐ Housing Counseling
- ☐ Mental Health Services
- ☐ Nursing Facility (licensed)
- ☐ Nursing Services (independent/private)
- ☐ Occupational and Physical Therapy Services (outpatient)
- ☐ Personal Care Agency (Wisconsin Medicaid certified)
- ☐ Personal Emergency Response Service (PERS)
- ☐ Prevocational Services
- ☐ Respite Care (in member's home)
- ☐ Respite Care (in substitute living facility)
- ☐ Speech & Language Pathology Services (outpatient)
- ☐ Supported Employment
- ☐ Supportive Home Care (chore services)
- ☐ Supportive Home Care (general; including non-medical personal care)
- ☐ Transportation Services
- ☐ Vocational Futures Planning & Support

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)

☐ Other (list):

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 for services; or for in-home services, each location that will receive referrals for service. If more than one service location is included in this application, please complete a Provider Application Service Location Form for each additional location. The form is available on the Inclusa website Providers/Contracting page.

***Service Location Name:**	
***Address:**	
***City, State, Zip:**	***County:**
***Tax ID** (EIN/SSN):	**NPI** (if applicable):
General Phone Number:	**General Fax Number:**
Medicaid Certification Number (if applicable):	**Certifying State:**
Medicare Certification Number (if applicable):	
Website:	
***Family Care Target Groups Served** ☐ Frail older adults ☐ People with physical disabilities ☐ People with intellectual/developmental disabilities	**Specialized Programming** Describe other information specific to this location, e.g., programming for dementia or challenging behaviors.
***Wheelchair Accessible** (if service is based at a provider-operated facility or office): ☐ Yes ☐ No	

Service Location Contacts	Types of notices to receive (check all that apply)
***Program/Facility Manager** ☐ Same as Contract Administrator (main point of contact for program or department questions, information) Name: ______ Phone: ______ Title: ______ Fax: ______ Email Address: ______ Mailing Address: ______ (if different from Corp./Agency) ______	☐ General Inclusa Notices ☐ Referral Notices ☐ Disenrollment Notices ☐ Insurance Renewal Notices ☐ Credentialing Notices ☐ Other (list):
Service Referral Recipient ☐ Same as Corp./Agency Referral Contact Name: ______ Phone: ______ Title: ______ Fax: ______ Email Address: ______ Mailing Address: ______ (if different from Service Location) ______	☐ General Inclusa Notices ☐ Service Referrals ☐ Disenrollment Notices ☐ Other (list):

Service Location Contacts (continued)	**Types of notices to receive (check all that apply)**
***Residential Rate Agreement Recipient** (**AFH/CBRF/RCAC** Only – Required) Name: ______________________ Phone: ______________ Title: ____________________ Fax: ________________ Email Address: ______________________________ Mailing Address: ______________________________ (if different from Service Location) ______________________________	☐ General Inclusa Notices ☐ Residential Rate Agreements Service Referrals ☐ Disenrollment Notices ☐ Other (list):

***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 on 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 (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. Provision of 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 this information changes, Provider will notify Inclusa immediately of any such change.

Authorized Signature ______________________________ **Date** ____________________

Title ________________________

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 W-9, copy of license, etc.) can be submitted to Inclusa by 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, 2615 East Avenue South, Ste. 103, La Crosse WI 54601