Provider Application Form

Instructions: All fields with a * must be completed. Please type or print. Application form and other documents (such as W-9, copy of license, service location forms, etc.) may be submitted by one of the following methods:

Email: ProviderDevelopment@inclusa.org **Fax**: 608-785-5336, Attn: CR/PR Provider Development

Mail: Inclusa, Attn: CR/PR Provider Development, 3349 Church St. Ste 1, Stevens Point, WI 54481

***Person Completing This Form**		
Name:	Phone:	Email:

SECTION I – COMPANY / 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):
***General Phone Number:**	**General Fax Number:**

SECTION II – SERVICES

***Indicate which Family Care Benefit Package services 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

  Residential Services:
  - ☐ Adult Family Home 1-2 Bed (AFH)
  - ☐ Adult Family Home 3-4 Bed (AFH)
  - ☐ Community Based Residential Facility (CBRF)
  - ☐ Residential Care Apartment Complex (RCAC)
- ☐ 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
- ☐ Other (list):

Briefly describe your program/services:

SECTION III – MINORITY BUSINESS

**** PLEASE CHECK ALL THAT APPLY:**

☐ **Disabled Veteran Business**	☐ **Disadvantaged Business Enterprise**	☐ **Minority Owned Business**
☐ **Small Business Enterprise**	☐ **Women Owned Business**	

SECTION IV – SERVICE LOCATION INFORMATION

A **service location** is defined as a place where members reside or access facility-based services, or a location that receives referrals for services provided in a member's home.

***Number of service locations included in this application**: ____

Please complete the information below for one location. **If more than one service location is included in this application**, 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:**
Provider Agency ID (*for personal care and supportive home care providers who are not Medicaid certified, to enable Electronic Visit Verification/EVV):	
Medicare Certification Number (*if applicable):	**Website:**
Wheelchair Accessible (*if service is based at a provider-operated facility or office): ☐ Yes ☐ No	
Interpreter Service Provided: ☐ for languages other than English ☐ for Hearing Impaired	

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.

*Services: List Family Care Benefit Package service(s) provided at this location as shown above in Section II.	
***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.

SECTION V – CONTACT INFORMATION

Business contacts from providers in our network are used in a variety of roles in our business system, both at the **Company/Agency** and **Service Location** level. Some contact types can be **at Service Location and/or Company/Agency** level. Please refer to the *Provider Contact Information and Updates* document on our website Providers/Resources page for details.

Instructions: List applicable contact names in the following table, then provide contact information for each person in the Contact Details section that follows. Required contacts are marked with: *.

Company/Agency Contacts	(apply to all Service Locations)
***Required Company/Agency Contact**	**List One Name Per Role**
Contract	
Credentialing	
Directory	
Payment/Remittance	
***Required Company/Agency and/or Service Location Contact**	**List at Least One Name Per Role** (here and/or under Service Location)
Disenrollment	
Notifications	
Quality	
Vacancy Reporting - AFH, CBRF, or RCAC (Company/Agency level preferred)	
Optional Contacts	**List Name(s) as Appropriate**
Billing	
Medical Records	
Supervising RN	

Service Location Contacts	(apply to Service Location above)
*Required Service Location Contacts	List One Name Per Role
Program/Facility	
Rate Agreement (AFH, CBRF, or RCAC)	
Referral (may have more than one)	
*Required Company/Agency and/or Service Location Contact	List at Least One Name Per Role (here and/or under Company/Agency)
Disenrollment	
Notifications	
Quality	
Vacancy Reporting - AFH, CBRF, or RCAC (Company/Agency level preferred)	
Optional Contacts	**List Name(s) as Appropriate**
Billing	
Medical Records	
Supervising RN	
1-2 Bed AFH Certification/Re-Cert. (list 1)	

Contact Details

* Provide direct contact information here **for each person named above**. Attach additional sheets as needed.

Contact Name:		**Title**:
Phone:	**Fax**:	**Email**:
Postal Address:		
Contact Name:		**Title**:
Phone:	**Fax**:	**Email**:
Postal Address:		
Contact Name:		**Title**:
Phone:	**Fax**:	**Email**:
Postal Address:		
Contact Name:		**Title**:
Phone:	**Fax**:	**Email**:
Postal Address:		
Contact Name:		**Title**:
Phone:	**Fax**:	**Email**:
Postal Address:		

SECTION VI – 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** _____

Type or Print Name _____

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.