



# 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](mailto:ProviderDevelopment@inclusa.org) **Fax:** 608-785-5336, Attn: Provider Relations

**Mail:** Inclusa, Attn: Provider Relations, 2801 Hoover Rd, Unit 3, Stevens Point, WI 54481

<b>*Person Completing This Form</b>		
Name:	Phone:	Email:

## SECTION I – COMPANY / AGENCY INFORMATION

<b>*Legal Business Name</b> (as it appears on your W-9 Form):	
DBA name (if applicable):	
<b>*Address</b> (as it appears on W-9 Form):	
<b>*City, State, Zip:</b>	<b>*County:</b>
<b>*Number of Employees:</b>	<b>*Website:</b>
<b>*Tax ID</b> (EIN/SSN):	<b>NPI</b> (if applicable):
<b>*General Phone Number:</b>	<b>General Fax Number:</b>

## SECTION II – SERVICES

<p><b>*Indicate which Family Care Benefit Package services you are applying to provide as a subcontractor for Inclusa:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Adaptive Aids (general, vehicle, service dog)</li> <li><input type="checkbox"/> Adult Day Care (licensed)</li> <li><input type="checkbox"/> Alcohol &amp; Other Drug Abuse Services (AODA)</li> <li><input type="checkbox"/> Assistive Technology/Communication Aids (includes interpreter services)</li> <li><input type="checkbox"/> Community Support Program (CSP) (licensed)</li> <li><input type="checkbox"/> Community Supported Living</li> <li><input type="checkbox"/> Consultative Clinical &amp; Therapeutic Services for Caregivers (CCTS) (training for paid and unpaid caregivers)</li> <li><input type="checkbox"/> Consumer Education and Training (including mental health peer specialists)</li> <li><input type="checkbox"/> Counseling &amp; Therapeutic Resources (licensed, non-Medicaid-certified therapies)</li> <li><input type="checkbox"/> Daily Living Skills Training</li> <li><input type="checkbox"/> Day Habilitation Services</li> <li><input type="checkbox"/> Day Treatment Services – AODA</li> <li><input type="checkbox"/> Day Treatment Services – Medical/Behavioral</li> <li><input type="checkbox"/> Disposable Medical Supplies (including OTC)</li> <li><input type="checkbox"/> Durable Medical Equipment (except hearing aids or prosthetics)</li> <li><input type="checkbox"/> Environmental Accessibility Adaptations (home modifications)</li> <li><input type="checkbox"/> Financial Management Services (fiscal intermediary for SDS)</li> <li><input type="checkbox"/> Financial Management Services (organizational rep payee)</li> <li><input type="checkbox"/> Home Delivered Meals</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Home Health Agency (licensed and Medicaid certified; Medicare may also be required depending on service)</li> <li><input type="checkbox"/> Housing Counseling</li> <li><input type="checkbox"/> Mental Health Services</li> <li><input type="checkbox"/> Nursing Facility (licensed)</li> <li><input type="checkbox"/> Nursing Services (independent/private)</li> <li><input type="checkbox"/> Occupational and Physical Therapy Services (outpatient)</li> <li><input type="checkbox"/> Personal Care Agency (Wisconsin Medicaid certified)</li> <li><input type="checkbox"/> Personal Emergency Response Service (PERS)</li> <li><input type="checkbox"/> Prevocational Services</li> <li>Residential Services: <ul style="list-style-type: none"> <li><input type="checkbox"/> Adult Family Home 1-2 Bed (AFH)</li> <li><input type="checkbox"/> Adult Family Home 3-4 Bed (AFH)</li> <li><input type="checkbox"/> Community Based Residential Facility (CBRF)</li> <li><input type="checkbox"/> Residential Care Apartment Complex (RCAC)</li> </ul> </li> <li><input type="checkbox"/> Respite Care (in member’s home)</li> <li><input type="checkbox"/> Respite Care (in substitute living facility)</li> <li><input type="checkbox"/> Speech &amp; Language Pathology Services (outpatient)</li> <li><input type="checkbox"/> Supported Employment</li> <li><input type="checkbox"/> Supportive Home Care (chore services)</li> <li><input type="checkbox"/> Supportive Home Care (general; including non-medical personal care)</li> <li><input type="checkbox"/> Transportation Services</li> <li><input type="checkbox"/> Vocational Futures Planning &amp; Support</li> <li><input type="checkbox"/> Other (list):</li> </ul>
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Briefly describe your program/services:

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### SECTION III – MINORITY BUSINESS

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

<input type="checkbox"/> <b>Disabled Veteran Business</b>	<input type="checkbox"/> <b>Disadvantaged Business Enterprise</b>	<input type="checkbox"/> <b>Minority Owned Business</b>
<input type="checkbox"/> <b>Small Business Enterprise</b>	<input type="checkbox"/> <b>Women Owned Business</b>	

### 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.

<b>*Service Location Name:</b>	
<b>*Address:</b>	
<b>*City, State, Zip:</b>	<b>*County:</b>
<b>*Tax ID (EIN/SSN):</b>	<b>NPI (*if applicable):</b>
<b>*General Phone Number:</b>	<b>General Fax Number:</b>
<b>Medicaid Certification Number (*if applicable):</b>	<b>Certifying State:</b>
<b>Provider Agency ID (*for personal care and supportive home care providers who are not Medicaid certified, to enable Electronic Visit Verification/EVV):</b>	
<b>Medicare Certification Number (*if applicable):</b>	<b>Website:</b>
<b>Wheelchair Accessible (*if service is based at a provider-operated facility or office):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Interpreter Service Provided:</b> <input type="checkbox"/> for languages other than English <input type="checkbox"/> for Hearing Impaired	
<b>Hours of Operation or Availability (*if not a residential service)</b>	
<input type="checkbox"/> Operations Available 24/7	
Monday    _____    to    _____ <input type="checkbox"/> Closed	Friday    _____    to    _____ <input type="checkbox"/> Closed
Tuesday    _____    to    _____ <input type="checkbox"/> Closed	Saturday    _____    to    _____ <input type="checkbox"/> Closed
Wednesday    _____    to    _____ <input type="checkbox"/> Closed	Sunday    _____    to    _____ <input type="checkbox"/> Closed
Thursday    _____    to    _____ <input type="checkbox"/> Closed	
<b>Holiday Schedules:</b> 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)
<b>*Required Company/Agency Contact</b>	<b>List One Name Per Role</b>
<b>Contract</b>	
<b>Credentialing</b>	
<b>Directory</b>	
<b>Payment/Remittance</b>	
<b>*Required Company/Agency and/or Service Location Contact</b>	<b>List at Least One Name Per Role (here and/or under Service Location)</b>
<b>Disenrollment</b>	
<b>Notifications</b>	
<b>Quality</b>	
<b>Vacancy Reporting - AFH, CBRF, or RCAC (Company/Agency level preferred)</b>	
<b>Optional Contacts</b>	<b>List Name(s) as Appropriate</b>
Billing	
Medical Records	
Supervising RN	

Service Location Contacts	(apply to Service Location above)
<b>*Required Service Location Contacts</b>	<b>List One Name Per Role</b>
Program/Facility	
Rate Agreement (AFH, CBRF, or RCAC)	
Referral (may have more than one)	
<b>*Required Company/Agency and/or Service Location Contact</b>	<b>List at Least One Name Per Role (here and/or under Company/Agency)</b>
Disenrollment	
Notifications	
Quality	
Vacancy Reporting - AFH, CBRF, or RCAC (Company/Agency level preferred)	
<b>Optional Contacts</b>	<b>List Name(s) as Appropriate</b>
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](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. 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.

<b>Authorized Signature</b> _____	<b>Date</b> _____
<b>Type or Print Name</b> _____	
<b>Title</b> _____	

**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.