



# Provider Application – Service Location Form

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.

This form is used to provide information for additional locations when submitting the Inclusa [Provider Application Form](#), or for adding new services or a new location to an existing contract.

**Instructions:** Use a separate form for each location. All fields with a \* must be completed. Please type or print. Submit by one of the following methods:

**Email:** [ProviderDevelopment@inclusa.org](mailto:ProviderDevelopment@inclusa.org) **Fax:** 608-785-5336, Attn: Provider Development

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

<b>*Person Completing This Form</b>		
Name:	Phone:	Email:
<b>*Submission Reason:</b> (select one)		
<input type="checkbox"/> Additional information for new provider application	<input type="checkbox"/> Add location to existing contract	
	<input type="checkbox"/> Add service(s) to existing contracted location	

## 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>*Tax ID</b> (EIN/SSN):	NPI (if applicable):	
<b>*General Phone Number:</b>	General Fax Number:	
<b>*Minority Business Type - Please check any/all that apply:</b>		
<input type="checkbox"/> Disabled Veteran Business	<input type="checkbox"/> Disadvantaged Business Enterprise	<input type="checkbox"/> Minority Owned Business
<input type="checkbox"/> Small Business Enterprise	<input type="checkbox"/> Women Owned Business	

## SECTION II – SERVICE LOCATION INFORMATION

<b>*Service Location Name:</b>		
<b>*Address:</b>		
<b>*City, State, Zip:</b>		<b>*County:</b>
<b>*Tax ID</b> (EIN/SSN):	NPI (*if applicable):	
<b>*General Phone Number:</b>	General Fax Number:	
Medicaid Certification Number (*if applicable):		Certifying State:
HCBS Compliance <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, list Service(s) that are compliant <a href="#">Click or tap here to enter text.</a>		
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  
Please list languages: [Click or tap here to enter text.](#)  
  
 for Hearing Impaired

**Hours of Operation or Availability** (\*if not a residential service)

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					

**Holiday Schedules:** For providers with annual holiday schedules when business is closed, please submit a current holiday calendar with this application.

**\*Services**  
Indicate below *all* Family Care Benefit Package services you wish to provide at or from this location.  
(Include both current and potential new services if this is a request to add services to an existing location.)

- |  |  |
|--|--|
| <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><li><input type="checkbox"/> Home Health Agency (licensed and Medicaid certified, Medicare may also be required depending on service)</li></ul> | <ul style="list-style-type: none"><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> |
|--|--|

**New services for existing locations**

List any services checked above that you are requesting to add for an existing contracted location:

**\*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 IV – 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 for this location in the following table, then provide contact information for each person in the Contact Details section that follows. Required contacts are marked with: \*.

*Note for currently contracted providers:* This form requests Service Location contact information only. For information about your existing contacts at the Company/Agency level, or Service Location contacts for other contracted locations, please contact us at [ProviderRelations@inclusa.org](mailto:ProviderRelations@inclusa.org) or call 877-622-6700 (press 2 then press 3).

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

<b>Contact Name:</b>		<b>Title:</b>
<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>
<b>Postal Address:</b>		
<b>Contact Name:</b>		<b>Title:</b>
<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>
<b>Postal Address:</b>		
<b>Contact Name:</b>		<b>Title:</b>
<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>
<b>Postal Address:</b>		

<b>Contact Name:</b>		<b>Title:</b>
<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>
<b>Postal Address:</b>		
<b>Contact Name:</b>		<b>Title:</b>
<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>
<b>Postal Address:</b>		

**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](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.