Texas Facility/Ancillary/Long-term Care Credentialing Application Instructions

- Applications should be typed or legibly printed in black or dark blue ink. If more space is needed, attach additional sheets and reference the question being answered. ALL fields are required to be completed unless otherwise directed.
- Modification to the wording or format of the application will invalidate the application.
- **If any of your locations has a unique license, unique NPI and/or a unique Tax ID number, a separate credentialing event and application will be required.** If you have multiple locations that bill under the same license/NPI/Tax ID, please complete the Secondary Locations Excel Template.
- A Secondary Locations Addendum is required for EACH practice location and for each provider type.
- Mark questions as N/A if they are not applicable.
- Ensure all enclosures listed on pages 7-8 are attached.
- Ensure the Attestation on page 7 is signed and dated.

Provider Groups: Complete pages 1-7

Ancillaries/Clinics: Complete pages 1-7

Hospitals: Complete pages 1-7 and Attachment A

LTSS Providers/Nursing Facilities: Complete pages 1-7 and Attachment B

Behavioral Health Providers: Complete pages 1-7 and Attachment C

(Select your Behavioral Health provider type on pg. 4)

Facility/Ancillary/Long-term Care Provider Credentialing Application

Provider identification			
Legal Business Name:			
Doing Business As (if applicable):			
Credentialing Contact:		Credentialing Contact Email:	
Credentialing Contact Phone:		Secure Fax:	
Alternative Contact:		Alternative Contact Phone:	
Taxpayer Identification Number:		National Provider Identifier (NPI):	
Taxonomy:	Atypical Provider Identifier (API):	Name of Medical Director:	

Location/Service Address to be Credentialed (Please note: if any of your locations has a unique license, unique NPI and/or a unique Tax ID number, a separate credentialing event and application will be required. If you have multiple locations that bill under the same license/NPI/Tax ID, please complete the Secondary Locations Excel Template. This practice location should agree with the location reflected on the letter you received from Verisys.)			
Practice location name:			
Medicaid Number/TPI:	Medicare ID:		
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Preferred):	County:
Phone:	Fax:	Primary contact:	

Billing information (if different than above)			
Billing name:			
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Optional):	County:

Credentialing Address (Please Note: Verisys will send credentialing correspondence to this address.)			
Credentialing Contact:			
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Optional):	County:

Facility/Ancillary/Long-term Care Provider Credentialing Application

Primary Office Hours

Mon	Tue	Wed	Thur	Fri	Sat	Sun

Required After-hours coverage: ☐ Answering Service ☐ Voicemail with Instructions

Age of patients served:

- ☐ Newborn
- ☐ Preschool (3 to 5 years)
- ☐ Children (6-12 years)
- ☐ Adolescents (13-18 years)
- ☐ Adults
- ☐ Geriatrics (65+ years)
- ☐ None

Patient program/population served:

- ☐ Serves Intellectual & Developmental Disabilities (IDD) population
- ☐ Services pediatric population
- ☐ None

Please indicate any age limitations: _____ Please indicate any gender limitations: _____

Do you offer the following services:

Telemedicine Services ☐ Yes ☐ No Telehealth Services ☐ Yes ☐ No Telemonitoring Services ☐ Yes ☐ No

ADA Requirements

Access & Availability ☐ Yes ☐ No Appropriate Equipment Available ☐ Yes ☐ No

Languages Spoken

Languages Spoken By Provider Staff Other Than English:

- ☐ Spanish
- ☐ American Sign Language
- ☐ Vietnamese
- ☐ Other:_____

Provider Type (Only one provider type should be reflected for the location to be credentialed.)

- ☐ Adaptive Aids/Medical Equipment (LTSS)
- ☐ Adult Day Care
- ☐ Adult Foster Care
- ☐ Ambulance Service/Transportation Company
- ☐ Ambulatory Surgical Center
- ☐ Assisted Living
- ☐ Audiology/Hearing Center
- ☐ Biological Products Manufacturer
- ☐ Birthing Center
- ☐ Blood Bank
- ☐ Cardiac Rehab Center
- ☐ Clinic/Group Practice
- ☐ Comprehensive Care Program (CCP)
- ☐ Comprehensive Health Center (CHC)
- ☐ Comprehensive Outpatient Rehab Facility (CORF)
- ☐ Congregate Care Facility
- ☐ Convalescent Facility
- ☐ County Indigent Health Care Program (CIHCP)
- ☐ Day Habilitation (LTSS)
- ☐ Diabetes Education Center
- ☐ Diagnostic and Treatment Center
- ☐ Dispensing Optical Company
- ☐ Drug and Department Stores
- ☐ Durable Medical Equipment (DME)
- ☐ Early Childhood Intervention (ECI)
- ☐ Emergency Response Service/System
- ☐ Employment Assistance
- ☐ End Stage Renal Disease Facility (ESRD)

Facility/Ancillary/Long-term Care Provider Credentialing Application

Provider type (continued)

- ☐ Endoscopy Facility
- ☐ Family Counseling and Training
- ☐ Family Planning Clinic
- ☐ Federal Qualified Health Center (FQHC)
- ☐ Financial Management Service Agency
- ☐ Free Standing Emergency Room
- ☐ Hearing Aid Equipment
- ☐ Hemophilia Treatment Center
- ☐ Home and Community Support Services
- ☐ Home Health Agency
- ☐ Home Infusion
- ☐ Hospice
- ☐ Hospital
- ☐ Independent Lab/Privately Owned Lab
- ☐ Infertility Center
- ☐ Infusion Therapy Clinic
- ☐ Laboratory
- ☐ Local Health Department (LHD)
- ☐ Magnetic Resonance Imaging (MRI)
- ☐ Maternity Service Clinic
- ☐ Meals, Home Delivered Meals
- ☐ Minor Home Modification
- ☐ Mobile X-Ray/Mobile Diagnostic Provider
- ☐ Non-Emergent Transportation Services
- ☐ Nursing Home
- ☐ Nursing/Health Care Staffing Service
- ☐ Organ Procurement Organization
- ☐ Orthotics/Prosthetics
- ☐ Outpatient Rehab Facility (ORF)
- ☐ Pediatric Day Health Care
- ☐ Personal Assistance Services Agency
- ☐ Personal Care Services (PCS)
- ☐ Pest Control
- ☐ Pharmacy
- ☐ Pharmacy-Home Health IV LTC
- ☐ Prescribed Pediatric Extended Care Centers (PPECC)
- ☐ Public Health Agency
- ☐ Radiation / Cancer Treatment Centers
- ☐ Retail Clinic
- ☐ Rural Health Clinic
- ☐ Skilled Nursing Facility (SNF)
- ☐ Sleep Medicine Center
- ☐ Supported Employment/Employment Assistance
- ☐ Transition Assistance Services (LTSS)
- ☐ Tuberculosis (TB) Clinic-Group
- ☐ Urgent Care Center
- ☐ Vehicle Modification (LTSS)

Behavioral Health Provider Types

- ☐ Behavioral Health Facility
- ☐ Behavioral Health Unit
- ☐ Certified Community Behavioral Health Clinics (CCBHCs)
- ☐ Clinic/Group Practice
- ☐ Hospital, Behavioral Health
- ☐ Intensive Family Intervention Adult Living Facility
- ☐ Local Behavioral Health Authority (LBHA)
- ☐ Local Mental Health Authority (LMHA)
- ☐ Mental Retardation Diagnostic Services (MRDA)
- ☐ Opioid Treatment Program (OTP)
- ☐ Physiological-Independent Diagnostic Testing (IDTF)
- ☐ Psychiatric Clinic
- ☐ Psychiatric Residential Treatment Facility
- ☐ Rehab Behavioral Health Service Assisted Long-Term Care
- ☐ Residential-Based Supported Community Living Service
- ☐ Residential Treatment Facility/Program
- ☐ Targeted Case Management Provider (LMHA/LBHA)
- ☐ Chemical Dependency Treatment Facility (CDTF)
- ☐ Community Mental Health Center (CMHC)

Facility/Ancillary/Long-term Care Provider Credentialing Application

STAR Kids Providers Must Answer the Following:

All questions must be answered with a checked "Yes" or "No". Do not mark N/A for any questions.

Do you participate in the Medically Dependent Children Program (MDCP)? ☐ Yes ☐ No

Do you participate in the Community First Choice (CFC) Program? ☐ Yes ☐ No

Are you a Home and Community Support Service Agency (HCSSA) Provider? ☐ Yes ☐ No

Are you a Community Living Assistance and Support Services (CLASS) Provider? ☐ Yes ☐ No

Do you participate in the Deaf, Blind, & Multiple Disabilities (DBMD) Program? ☐ Yes ☐ No

Are you a Youth Empowerment Services (YES) Provider? ☐ Yes ☐ No

Are you recognized as a NCQA Patient-Centered Medical Home? ☐ Yes ☐ No

If yes, what level? _____

Please give a list of where telemedicine services are provided if in addition to services locations

_____

_____

Do you participate in an Electronic Visit Verification (EVV) Program? ☐ Yes ☐ No Vendor: _____

Are you a Historically Under-Utilized Business? ☐ Yes ☐ No

Licensure & Certificates (attach a copy of current licensure and Clinical Laboratory Improvements Amendment [CLIA] certification, if applicable)			
Type of License: State:	License issuance date:	License number:	Expiration date:
Type of License: State:	License issuance date:	License number:	Expiration date:
Type of License: State:	License issuance date:	License number:	Expiration date:
Radiology Certificate #:		Radiology Expiration Date:	
CLIA Certificate #:		CLIA Expiration Date:	

Facility/Ancillary/Long-term Care Provider Credentialing Application

Accreditation/certification (attach a copy of current accreditation, certificate or survey)

A.

☐ Accreditation Association of Ambulatory Health Care (AAAHC)

☐ Accreditation Commission for Health Care (ACHC)

☐ Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

☐ American Board for Certification in Orthotics & Prosthetics

☐ American College of Radiology (ACR)

☐ Board of Certification

☐ Center for Improvement in Healthcare Quality

☐ Clinical Laboratory Improvement Amendments (CLIA)

☐ Commission on Accreditation of Rehabilitation Facilities (CARF)

Note: Continuing Care Accreditation Commission (CCAC) and CARF have merged, so CCAC not included separately

☐ Commission on Office Laboratory Accreditation (COLA)

☐ Community Health Action Partnership (CHAP)

☐ Council on Accreditations (COA)

☐ Det Norske Veritas Healthcare, Inc (DNV)

☐ Healthcare Facility Accreditation Program (HFAP)

☐ Healthcare Quality Association on Accreditation

☐ Intersocietal Accreditation Commission (IAC)

☐ Joint Commission for the Accreditation of HealthCare Organization (TJC or JCAHO)

☐ National Association of Boards of Pharmacy (NABP)

☐ National Board of Accreditation for Orthotic Suppliers

☐ RadSite

☐ The Compliance Team

Accrediting Body:	Expiration Date (mm/dd/yyyy):
Accrediting Body:	Expiration Date (mm/dd/yyyy):
Accrediting Body:	Expiration Date (mm/dd/yyyy):

☐ Not accredited — Expected date of accreditation (mm/dd/yyyy): _____

B. Site Survey — Visit May Be Required

Nonaccredited providers must provide a copy of:

- Most recent government agency survey (may not be older than 36 months),
- Corrective action plan (if deficiencies were cited), and attach the proof from the government agency stating facility is in substantial compliance with most recent survey standards.

Facilities that don't meet the requirements above require an onsite visit before network status may be granted. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.

Has the provider had an on-site survey by CMS or state agency? ☐ Yes ☐ No

(YES) Date of most recent full survey _____

(NO) Successful completion of a health plan onsite visit will be required to complete credentialing.

Facility/Ancillary/Long-term Care Provider Credentialing Application

General and professional liability insurance – Please submit a copy of your certificate of insurance.	
General liability coverage	
Current carrier name:	
Policy number:	Coverage type: ☐ Occurrence -based ☐ Claims-based
Effective date:	Expiration date:
Per incident: $	Aggregate: $
Professional/Malpractice liability coverage – Please submit a copy of your certificate of insurance.	
Current carrier name:	
Policy number:	Coverage type: ☐ Occurrence -based ☐ Claims-based
Effective date:	Expiration date:
Per incident: $	Aggregate: $
Automobile Insurance	
Are you required to carry automobile insurance? ☐ Yes ☐ No (If yes, submit a copy of your certificate.)	

Professional Disclosure Questions

Please include an explanation on a separate sheet for any question(s) answered Yes.

1. Has the organization ever been reprimanded, fined by any state agency that disciplines allied health professionals or health organizations? ☐ Yes ☐ No
2. Has the organization's license to practice or operate in any jurisdiction (state or county) ever been denied, revoked, suspended, sanctioned or subject to probation or any conditions or limitations? ☐ Yes ☐ No
3. Have any disciplinary proceedings ever been instituted against the organization by any medical organization or medical institute? ☐ Yes ☐ No
4. Has the organization ever been convicted of a felony? ☐ Yes ☐ No
5. Have any malpractice suits, arbitration or other proceeding ever been instituted against the organization (regardless of outcome)? ☐ Yes ☐ No
6. Has the organization ever been investigated, reprimanded, censured, excluded, suspended or disqualified by Medicare or Medicaid program? ☐ Yes ☐ No
7. Has the organization's liability insurance policy ever been canceled? ☐ Yes ☐ No
8. Has the organization ever been denied renewal of the liability insurance policy or had any limitations placed on the scope of coverage? ☐ Yes ☐ No

Note: This impacts the section called "Enclosures."

Explanation of "Yes" answers to attestation questions Credentialing Questionnaire

Facility/Ancillary/Long-term Care Provider Credentialing Application

Attestation Consent and Release

All information provided in this, or in connection with this application, is complete and accurate to the best of my knowledge, and I shall immediately notify the Plan(s) of any changes thereto. I understand that this application does not entitle me to participation in the Plan(s) network. By applying for appointment as a TAHP participating provider, I authorize the Plan(s) plan, its medical director, and appropriate representatives to consult with administrators and members of other institutions where I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to the inspection by the Plan(s), and their representatives, its medical director and appropriate representatives, of all records and documents, excluding medical records of nonmembers of TAHP Participating Plans, that may be material to an evaluation of any professional qualifications and competence to carry out the requested duties, as well as my moral and ethical qualifications for participating provider status with the Plan(s) participating with TAHP. I consent and agree that TAHP Participating Plans will complete a criminal history background check to determine if I, or any subcontracted providers, have any history of felony convictions, including adjudication withheld on a felony, plea or nolo contendere to a felony or entry into a pretrial for a felony. I agree to obtain any consents or approvals required for my subcontracted providers to undergo such background checks. I hereby release the Plan(s) and its representatives, including TAHP and Verisys, from any liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I hereby release any individuals and organizations from any liability that provide information to the Plan(s) and its representatives or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the ancillary agreement between me or my group and the Plan(s), as such terms may be applicable to me. I understand that as an applicant for participation in the Plan(s), I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from the Plan(s), I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the credentialing committee, if they so request. I further understand that I may appeal the committee's decision either in writing or by appearance before the credentialing committee, if they so request.

By signing below, I attest that I have reviewed and understand all terms and conditions contained in this Attestation/Consent & Release. I agree that my electronic signature is equivalent to my hand-written signature.

I certify that the on-online exclusion lists for the Health and Human Services Office of Inspector General and System for Award Management are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthly basis to ensure that no state or federally excluded individuals perform any function related to any state or federal health care program. I certify that I will remove any employee or contracted service provider found on one of the above referenced federal exclusion lists from any functions related to a state or federal health care program.

Type or Print Name _____

Title _____

Signature _____ Date _____

Enclosures

Please submit all applicable documents from the list below with your completed and signed application. Failure to provide this information will prohibit completion of your credentialing and/or contracting process. Please submit enclosures for each location.

- ☐ Copy of all federal, state and/or local licenses required to operate as a health care facility (by location)
- ☐ Copy of accreditation certificate or letter
- ☐ Copy of most recent CMS or state survey, including your corrective action plan if deficiencies were cited or cover letter from CMS/state agency stating facility is in substantial compliance
- ☐ Copy of CLIA certificate for each location, as applicable
- ☐ Copy of current DEA certificate (if applicable);
- ☐ Current TDH Radiology certificate for each location (if applicable);
- ☐ Evidence of Texas Mental Health and Mental Retardation certification (REQUIRED for community mental health centers)
- ☐ Evidence of Medicare certification (REQUIRED for institutional centers)
- ☐ Professional/Malpractice liability of Insurance (AS REQUIRED ABOVE);

Facility/Ancillary/Long-term Care Provider Credentialing Application

Enclosures (continued)

- ☐ Copy of TMHP Medicaid Letter (when applicable)
- ☐ Evidence of an Agreement with HHSC [REQUIRED for CORF providers]
- ☐ Medical Staff / Allied Health Professional Roster
- ☐ Explanation of "Yes" answers to attestation questions
- ☐ Company brochure (if available)
- ☐ Current Signed W-9

Attachment A - Hospital Facilities

Hospital - part of multi-hospital system? ☐ Yes ☐ No

Are you considered an Essential Community Provider as defined by CMS? ☐ Yes ☐ No

Hospital Services/Treatment Levels:

- ☐ Adult acute care
- ☐ Level 1 trauma
- ☐ Level 2 trauma
- ☐ Level 3 trauma
- ☐ Level 4 trauma
- ☐ Children's Hospital — [CMS Designated]
- ☐ Designated Childrens Unit/Wing
- ☐ Specializes in Pediatric Services

Are you a member of the American Hospital Association? ☐ Yes ☐ No

Number of Certified Beds _____

NICU Level _____ Certification Date _____

Medicare - Certified Acute Inpatient Facility Information

Medicare Certified Bed Count: _____ ICU Bed Count (excluding Neonatology): _____

Skilled Nursing or Swing Bed Count: _____ Inpatient Psychiatric Bed Count: _____

- ☐ Acute Inpatient Rehab Services
- ☐ Cardiac Catheterization Services
- ☐ Outpatient Occupational Therapy
- ☐ Cardiac Surgery Program
- ☐ Outpatient Physical Therapy
- ☐ Critical Care Services– Intensive Care Unit (ICU)
- ☐ Outpatient Speech Therapy
- ☐ Diagnostic Radiology
- ☐ Skilled Nursing Unit
- ☐ Durable Medical Equipment (DME)
- ☐ Surgical Services (Outpatient or ASC)
- ☐ Inpatient Psychiatric Facility Services
- ☐ Mammography
- ☐ Orthotics and Prosthetics
- ☐ Outpatient Dialysis
- ☐ Outpatient Infusion/Chemotherapy

Medicare-Approved Transplant Programs

- ☐ Heart/Lung
- ☐ Heart
- ☐ Intestinal
- ☐ Kidney
- ☐ Liver
- ☐ Lung
- ☐ Pancreas
- ☐ Other _____

Attachment B - Texas Long-Term Services and Supports

Provider type Services Details			
Personal assistance service direct: ☐ Consumer-directed block grant model ☐ Consumer-directed services (CDS) model ☐ Consumer-delegated agency model ☐ Financial management/ CDS ☐ Rate enhancement program Participant contract number: _____ List level: _____	Day activity/health services: ☐ Rate enhancement program Participant contract number: _____ List level: _____	Residential care/assisted living facility: ☐ Rate enhancement program Participant contract number: _____ List level: _____	☐ Transition/relocation services

Counties Served: Please select the ones in which services can be provided or check here ☐ STATEWIDE [servicing all]

☐ Anderson	☐ Andrews	☐ Angelina	☐ Aransas	☐ Archer
☐ Armstrong	☐ Atascosa	☐ Austin	☐ Bailey	☐ Bandera
☐ Bastrop	☐ Baylor	☐ Bee	☐ Bell	☐ Bexar
☐ Blanco	☐ Borden	☐ Bosque	☐ Bowie	☐ Brazoria
☐ Brazos	☐ Brewster	☐ Briscoe	☐ Brooks	☐ Brown
☐ Burleson	☐ Burnet	☐ Caldewll	☐ Calhoun	☐ Callahan
☐ Cameron	☐ Camp	☐ Carson	☐ Cass	☐ Castro
☐ Chambers	☐ Cherokee	☐ Childress	☐ Clay	☐ Cochran
☐ Coke	☐ Coleman	☐ Collin	☐ Collingsworth	☐ Colorado
☐ Comal	☐ Comanche	☐ Concho	☐ Cooke	☐ Coryell
☐ Cottle	☐ Crane	☐ Crockett	☐ Crosby	☐ Culberson
☐ Dallam	☐ Dallas	☐ Dawson	☐ Deaf Smith	☐ Delta
☐ Denton	☐ DeWitt	☐ Dickens	☐ Dimmit	☐ Donley
☐ Duval	☐ Eastland	☐ Ector	☐ Edwards	☐ El Paso
☐ Ellis	☐ Erath	☐ Falls	☐ Fannin	☐ Fayette
☐ Fisher	☐ Floyd	☐ Foard	☐ Fort Bend	☐ Franklin
☐ Freestone	☐ Frio	☐ Gaines	☐ Galveston	☐ Garza
☐ Gillespie	☐ Glasscock	☐ Goliad	☐ Gonzales	☐ Gray
☐ Grayson	☐ Gregg	☐ Grimes	☐ Guadalupe	☐ Hale
☐ Hall	☐ Hamilton	☐ Hansford	☐ Hardeman	☐ Hardin
☐ Harris	☐ Harrison	☐ Hartley	☐ Haskell	☐ Hays
☐ Hemphill	☐ Henderson	☐ Hidalgo	☐ Hill	☐ Hockley
☐ Hood	☐ Hopkins	☐ Houston	☐ Howard	☐ Hudspeth

Facility/Ancillary/Long-term Care Provider Credentialing Application

Counties Served (continued)

☐ Hunt	☐ Hutchinson	☐ Irion	☐ Jack	☐ Jackson
☐ Jasper	☐ Jeff Davis	☐ Jefferson	☐ Jim Hogg	☐ Jim Wells
☐ Johnson	☐ Jones	☐ Karnes	☐ Kaufman	☐ Kendall
☐ Kenedy	☐ Kent	☐ Kerr	☐ Kimble	☐ King
☐ Kinney	☐ Kleberg	☐ Knox	☐ La Salle	☐ Lamar
☐ Lamb	☐ Lampasas	☐ Lavaca	☐ Lee	☐ Leon
☐ Liberty	☐ Limestone	☐ Lipscomb	☐ Live Oak	☐ Llano
☐ Loving	☐ Lubbock	☐ Lynn	☐ Madison	☐ Marion
☐ Martin	☐ Mason	☐ Matagorda	☐ Maverick	☐ McCulloch
☐ McLennan	☐ McMullen	☐ Medina	☐ Menard	☐ Midland
☐ Milam	☐ Mills	☐ Mitchell	☐ Montague	☐ Montgomery
☐ Moore	☐ Morris	☐ Motley	☐ Nacogdoches	☐ Navarro
☐ Newton	☐ Nolan	☐ Nueces	☐ Ochiltree	☐ Oldham
☐ Orange	☐ Palo	☐ Panola	☐ Parker	☐ Parmer
☐ Pecos	☐ Pinto	☐ Polk	☐ Potter	☐ Presidio
☐ Rains	☐ Randall	☐ Reagan	☐ Real	☐ Red River
☐ Reeves	☐ Refugio	☐ Roberts	☐ Robertson	☐ Rockwall
☐ Runnells	☐ Rusk	☐ Sabine	☐ San Augustine	☐ San Jacinto
☐ San Patricio	☐ San Saba	☐ Schleicher	☐ Scurry	☐ Shackelford
☐ Shelby	☐ Sherman	☐ Smith	☐ Somervell	☐ Starr
☐ Stephens	☐ Sterling	☐ Stonewall	☐ Sutton	☐ Swisher
☐ Tarrant	☐ Taylor	☐ Terrell	☐ Terry	☐ Throckmorton
☐ Titus	☐ Tom Green	☐ Travis	☐ Trinity	☐ Tyler
☐ Upshur	☐ Upton	☐ Uvalde	☐ Val Verde	☐ Van Zandt
☐ Victoria	☐ Walker	☐ Waller	☐ Ward	☐ Washington
☐ Webb	☐ Wharton	☐ Wheeler	☐ Wichita	☐ Wilbarger
☐ Willacy	☐ Williamson	☐ Wilson	☐ Winkler	☐ Wise
☐ Wood	☐ Yoakum	☐ Young	☐ Zapata	☐ Zavala

Facility/Ancillary/Long-term Care Provider Credentialing Application

Attachment C - Behavioral Health Facilities/Providers - Locations & Level of Care

Facility Practice Locations and Levels of Care per location

	Age Category	Inpatient	Partial	IOP	Residential	Observation		I/P Detox	I/P Rehab	Partial	IOP	Residential	Ambulatory Detox	
Location #1														
Address:	Child	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
	Adol.	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
Phone:	Adult	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
Secure Fax:	Geriatric	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
NPI:		ECT	☐ I/P		☐ O/P				☐ Methadone			☐ Suboxone		
Location #2														
Address:	Child	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
	Adol.	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
Phone:	Adult	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
Secure Fax:	Geriatric	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
NPI:		ECT	☐ I/P		☐ O/P				☐ Methadone			☐ Suboxone		
Location #3														
Address:	Child	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
	Adol.	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
Phone:	Adult	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
Secure Fax:	Geriatric	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
NPI:		ECT	☐ I/P		☐ O/P				☐ Methadone			☐ Suboxone		
Location #4														
Address:	Child	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
	Adol.	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
Phone:	Adult	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
Secure Fax:	Geriatric	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
NPI:		ECT	☐ I/P		☐ O/P				☐ Methadone			☐ Suboxone		
Location #5														
Address:	Child	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
	Adol.	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
Phone:	Adult	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
Secure Fax:	Geriatric	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	
NPI:		ECT	☐ I/P		☐ O/P				☐ Methadone			☐ Suboxone		

Facility/Ancillary/Long-term Care Provider Credentialing Application

Attachment C - Behavioral Health Facilities/Providers Specialty Services

Instructions: Indicate which specialty services are offered at the location provided on page 12 (Location #1-5)

Identify specialty services offered	Available	Not Available	Location # Indicated on Page 11	Comments/Descriptions
Eating Disorder Treatment – Inpatient	☐	☐		
Eating Disorder Treatment – Outpatient	☐	☐		
Electro-convulsive Therapy (ECT) - Inpatient	☐	☐		
Electro-convulsive Therapy (ECT) – Outpatient	☐	☐		
Dual Diagnosis Services	☐	☐		
Continuing Day Treatment	☐	☐		
LGBT services	☐	☐		
Domiciliary Services in an IOP or PHP setting (program must be formally approved by UBH)	☐	☐		
Chronically Mentally Ill Services (CMI)/ Severely Mentally Ill Services (SMI)	☐	☐		
Respite Care Services	☐	☐		
Emergency Room Services (assessment only)	☐	☐		
Twenty-three (23) Hour Crisis Observation	☐	☐		
Mobile Crisis Stabilization	☐	☐		
MHSA Outpatient Clinics in a hospital	☐	☐		
Ambulatory Detox - Drug	☐	☐		
Ambulatory Detox - Alcohol	☐	☐		
Medication Assisted Treatment (MAT) - in an Detox, IOP or PHP setting ☐ Methadone ☐ Suboxone ☐ Buprenorphine ☐ Naltrexone (i.e. vivitrol)	☐	☐		
Sober Living/Supervised Living	☐	☐		
Halfway House	☐	☐		
Group Home	☐	☐		
Therapeutic Foster Care	☐	☐		
ASAM Residential Services	☐	☐		☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7
Bridge on Discharge (aftercare planning immediately post IP discharge)	☐	☐		☐ Geriatric ☐ Adult ☐ Adol. ☐ Child