

**GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH
AND DEVELOPMENTAL DISABILITIES**

**BEHAVIORAL HEALTH PROVIDER APPLICATION
CHILD & ADOLESCENT CORE SERVICES**

USER'S GUIDE



DBHDD

OVERVIEW

This revised guideline and accompanying Behavioral Health Provider Application are targeted for prospective providers of these services. Consideration will only be given to providers who are currently and appropriately accredited by one of the approved accrediting agencies and have been providing behavioral health services for a minimum of one year.

The DBHDD accepts accreditation from the following agencies:

- **CARF** – Commission on Rehabilitation of Rehabilitative Facilities
www.carf.org
- **TJC** – The Joint Commission
www.jointcommission.org
- **CQL** – The Council on Quality and Leadership
www.thecouncil.org
- **COA** – Council on Accreditation
www.coanet.org

Medicaid Application Requirements:

Details regarding Medicaid provider requirements can be found at www.ghp.georgia.gov. Click on the “Provider Information” tab and the link to “Medicaid Provider Manuals”, particular attention should be given to the links for [Part I Policies and Procedures / Billing Manual](#) and [Community Mental Health Services](#) for provider details.

- To access the Georgia Department of Community Health (DCH), Division of Medical Assistance (DMA) Provider Enrollment Application Instructions (the 27-page Medicaid application) click on the link “**Become a Provider**” then click on the link for “**Enroll as a Facility**”

This is the Medicaid application, which must be submitted to the Department of Behavioral Health and Developmental Disabilities, along with the DBHDD’s Provider Application, when applying for Medicaid reimbursed services at a new DBHDD behavioral health site.

Submission Requirements:

The following describes the specific elements of the application, which are required, and the Division’s protocol for application review:

- The completed Medicaid and DBHDD applications, with required supporting documentation must be submitted simultaneously to the DBHDD.
- This submission must include a single hard copy of all elements, submitted in a 3 - ring binder and tabbed for easy review.
- Both applications (Medicaid and DBHDD)must be sent to the address listed below via U S Postal Service or other recognized mail carrier such as UPS, FedEx, DHL, etc.:

**Provider Enrollment
Office of Provider Network Management
Department of Behavioral Health and Developmental Disabilities
2 Peachtree Street, 23rd Floor
Atlanta, Georgia 30303**

HAND DELIVERIES WILL NOT BE ACCEPTED

- Once the Office of Provider Network Management receives the application, a tracking number will be assigned.
- Confirmation of application receipt and tracking number will be provided to the organization via email within 48 business hours.
- All communications, updates, modifications to the original application including the deletion of services and site locations as well as requests for additional information must reference this tracking number. Note: Any questions regarding your application must be submitted via email to the following address: MHDDAD-serviceapps@dhr.state.ga.us. Please add this email address to your email address book so emails are delivered to you and are not picked up as spam mail.
- In order for the provider's Medicaid application to be reviewed, it must be accompanied by the DBHDD's Provider application.
- A determination on the application will occur upon receipt of all required information and at the discretion of DBHDD.
- Upon review, DBHDD will recommend the organization for Medicaid approval or denial and forward the Medicaid application to DCH. The approval recommendation by DBHDD does not guarantee a Medicaid Provider Enrollment Number. This number is issued at the discretion of DCH.

Considerations:

- While the DBHDD will review the Medicaid Application, DBHDD does not determine the time frame that DCH uses to issue a Provider number for Medicaid billing.
- DBHDD will closely monitor its need and capacity to add new providers to the network. If necessary, solicitation in some or all areas may be closed to new providers for participation in the DBHDD State Funded reimbursement. **In this scenario, organizations may elect to apply as a Medicaid Provider only.** This suspension of solicitation for State Funded service applications does not preclude providers from continuing to submit the Medicaid Provider Application. However, in order to fully review and consider the Medicaid application, the information from the *Behavioral Health Provider Application* is necessary and must also be submitted with the Medicaid application even though it is not being used to enroll the agency as a DBHDD State Funded provider.

Section I:

Check the appropriate **Behavioral Health Provider Category** and **Services** that describe your organization and intent. **The agency must be ready to provide CORE services listed when the contractual agreement is signed between the agency and the DBHDD.**

- A complete list of the services, definitions and staff qualifications and required standards can be found in the DBHDD Provider Manual.
- Click on the “**Provider Information**” link on the web page www.dbhdd.georgia.gov
- Particular attention should be directed to Parts I and II for the standards, service definitions and staffing requirements.

Check the appropriate **Behavioral Health Provider Category** and **Services** that describe your organization and intent. **The agency must be ready to provide the ALL C&A Core services when the contract or agreement is signed between the agency and the DBHDD.**

Note: Agency must provide ALL the Core services listed with the exception of Behavioral Assistance and Structured Activities Support services. These two services are state funded services and not

Medicaid Rehab Option services. Applications that are approved for Core Services will be approved for these services but the delivery is optional.

Section II:

All fields are required for a complete application. The person identified, as the contact should be easily accessible via email for providing additional information should it be required. Also note in Section B, it is critical to provide the agency's d/b/a or any other associated or alternative business names, if applicable.

Section III:

Core Services Delivery Location Section: Multiple copes are appropriate and acceptable, as each service location must be identified and enrolled. Complete pages 4 & 5 for each service location.

County of Service Delivery: List each county your agency is requesting to serve. Note that you must have the capacity to provide all the Core services in the counties listed.

Business Hours: The business hours are specific to Core Services. Core Service providers shall have services available in the evenings or weekends to allow access for consumers who work or are in school. Be specific regarding the sites' business hours by completing the grid to demonstrate how the agency will meet these requirements. It is also expected that Core Service providers be prepared to respond within 2 hours when an existing consumer in treatment needs an intervention.

Complete a Staffing Form for each Core service location. All positions listed with an asterisk are the minimum staffing requirements for C&A Core services. To Be Hired (TBH) etc. will not be accepted. The minimum staffing requirements are as follows:

- Medical Doctor or Psychiatrist
- Registered Nurse
- Licensed Clinicians (LCSW, LPC or LMFT)
- Substance Abuse Professionals (MAC, CACII, CADC, CCADC, or GCADC (II or III)
- Paraprofessionals. Each paraprofessional must complete the mandatory DBHDD Standard Training Requirement for Paraprofessionals.

Section IV:

Georgia Medicaid Participation: Indicate any Medicaid participation in the State of Georgia.

Previous Participation: Indicate and complete the table if the agency or key management staff has had a contract and/or agreement with the DBHDD or the Department of Human Services (formerly Department of Human Resources) within the last five years.

Section V:

If a "yes" is provided to any of these questions, supporting documentation is required that fully explains the circumstances surrounding the event, details of any resulting settlements, and or resolutions.

Section VI:

Copies of the following documents must be submitted with the application:

1. Evidence of business recorded with Georgia's Secretary of State Office (Must match the corporate name in Section IIB as the legal name and the legal address).
2. Evidence of agency delivering behavioral health services for at least one year. This may be a copy of contracts, annual business reports, or any official documentation to substantiate delivery of behavioral health services.

3. Include a copy of accreditation certificate and most recent accreditation survey report. Agency must be accredited by one of the four accrediting bodies before submitting an application:
 - a. The Joint Commission (TJC)
 - b. Commission on Rehabilitative Facilities (CARF)
 - c. Council on Accreditation (COA)
 - d. The Council on Quality and Leadership (CQL)

4. DBHDD requires that all its providers are adequately insured. Requirement is Commercial General Liability or Comprehensive Liability Insurance in the amount of \$1,000,000 /per occurrence, \$3,000,000/ general aggregate. Include a copy of the Insurance certificate. The State of Georgia must be listed as a certificate holder. This should be addressed:

State of Georgia
Department of Behavioral Health and Developmental Disabilities
2 Peachtree St., NW
Atlanta, GA 30303

5. A copy of each employee's license or credential, including the Medical Doctor, PA, CNS, etc. A print out from the Secretary of State website will not be accepted.
6. Resume for the Georgia CEO/Director which documents work history for the past five years.
7. Resume for the Owner which documents work history for the past five years.
8. Organizational chart for the Georgia operations for C&A Core services. Show the number of full-time employees for each position to manage all Core services.
9. Attestations signed by the authorized agency representative (FORM 1). This is the Owner, CEO or Director.
10. Narrative that describes the agency's plan for after hours accessibility for consumers in treatment and for new referrals. Narrative is limited to one page.
11. Narrative that describes the agency's philosophical approach for providing services to behavioral health consumers. The narrative will enumerate the evidenced based practices that the agency will utilize in the provision of behavioral health services. The narrative must also include the agency's mission statement, vision, and values. Narrative is limited to two pages.
12. If the agency has done business with any arm of the State of Georgia in the past 5 years, please provide validation by submitting a copy of the face and signature sheets of the contract.
13. If the agency (for profit and non-profit) has not done business with the state within the past 5 years and if the agency has never had a Contract, Letter of Agreement, Provider Agreement or a Memorandum of Agreement with any division within the Department of Human Services, formerly Department of Human Resources, or the Department of Behavioral Health and Developmental Disabilities, the following information must be submitted for the last fiscal year or a pro-forma format which outlines a projection for the next fiscal year:
 - a. Financial Statement
 - b. Balance Sheet
 - c. Statement of Business Activities
 - d. Statement of Functional Expenses
 - e. Cash Flow Statement

14. If the agency is a non-profit entity, submit a copy of the organization's most recent, Return of Organization Exempt form, from the Income Tax (IRS Form 990 or Form 990EZ), or a copy of the IRS Exempt Status Determination Letter.
15. Completed DCH, Division of Medical Assistance Provider (Medicaid) application for first service delivery location. If applying for more than one service delivery location or if the agency is already an approved Medicaid Rehab Option provider a Medicaid Additional Location application must be completed for each additional site. Each approved service delivery location will receive a unique Medicaid Provider number. Medicaid does not enroll group practices. Each site must be individually enrolled. Only applications with **original** signatures will be accepted.

Any questions regarding your application must be submitted via email to the following address. MHDDAD-serviceapps@dhr.state.ga.us. Be sure to include the tracking number assigned to your application in the email

APPLICATION CHECK LIST

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| APPLICATION ITEMS: | |
| 1. Section I - Application Type (Page 1 and 2) | |
| 2. Section II - Corporate Entity / Main Georgia Site (Page 3) | |
| 3. Section III – Core Service Location (Page 4 and 5) | |
| 4. Section IV – Participation (Page 6) | |
| 5. Section V – Professional and General Liability Information (Page 7) | |
| 6. Section VI- Other Required Information (Page 8) | |
| • Secretary of State Certificate | |
| • Evidence of agency delivering behavioral health services for at least one year | |
| • Copy of Accreditation Certificate and most recent accreditation survey report. | |
| • Copy of Commercial General Liability or Comprehensive Liability Insurance certificate | |
| • Copy of each employee’s license or credentials | |
| • Resume of Agency CEO or Director | |
| • Resume of Owner of the agency | |
| • Organizational Chart | |
| • Narrative - After Hours Accessibility | |
| • Narrative - Philosophical Approach for providing services | |
| • Financial Information | |
| 7. Attestations – Form 1 (Page 9) | |
| 8. Department of Community Health Application, Division of Medical Assistance (Medicaid) | |
| • Provider Enrollment Application | |
| • Statement of Participation | |
| • Disclosure of Ownership | |
| • Electronic Funds Transfer (EFT) | |
| • W9 Form | |
| • Additional Location Form for each location, if applicable | |
| Please Mail Application to: Provider Enrollment Unit Office of Provider Network Management Department of Behavioral Health and Developmental Disabilities 2 Peachtree Street, 23rd Floor Atlanta, Georgia 30303 | |
| Any questions regarding your application must be submitted via email to the following address: MHDDAD-serviceapps@dhr.state.ga.us . | |