GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

BEHAVIORAL HEALTH PROVIDER APPLICATION
CHILD & ADOLESCENT SPECIALTY SERVICES

SECTION I - APPLICATION TYPE

Qualified Provider: Applicants must also submit simultaneously, the Medicaid Provider application materials that are found at https://www.ghp.georgia.gov in order to be enrolled as Medicaid Rehabilitation Option (MRO) provider once approved as a Qualified Provide thru this DBHDD process.

Check all applicable boxes:

- ❒ 1. New Provider of DBHDD Services that has been in business for one year delivering behavioral health services, Applying for Qualified Provider Status.
- ❒ 2. Currently Approved DBHDD Qualified Provider Applying for New Service at a Currently Established Site with the two most recent APS audit scores resulting in at least 70%.
- ❒ 3. Currently Approved DBHDD Qualified Provider Applying for New Service at a New Site with the two most recent APS audit scores resulting in at least 70%.

Child and Adolescent Specialty Services: The organization will provide (check appropriate boxes):

- ❒ Intensive Family Intervention
  - o Behavioral Assistance (State funded only)
  - o Community Transition Planning (State funded only)

- ❒ Substance Abuse (SA) Adolescent Intensive Outpatient (agency must provide all services listed)
  - o Behavioral Health Assessment
  - o Diagnostic Assessment
  - o Nursing Assessment and Health Services
  - o Community Support – Individual
  - o Individual Counseling
  - o Group Outpatient Services:
    - ▪ Group Counseling
    - ▪ Group Training
  - o Family Outpatient Services:
    - ▪ Family Counseling
    - ▪ Family Training
  - o Service Plan Development

Accreditation: Indicate the type of Accreditation and Expiration Date of Accreditation. Copy of accreditation certificate must be submitted. **Agencies must be accredited by one of the accrediting bodies listed below for community behavioral health services prior to submitting the application.**

Accrediting Body	Accreditation Expiration Date	Accreditation Type
The Joint Commission (TJC)	___/___/_____	☐Intensive Outpatient ☐Outpatient
Commission on Rehabilitation of Rehabilitative Facilities (CARF)	___/___/_____	☐Intensive Outpatient ☐Outpatient
Council on Accreditation (COA)	___/___/_____	☐Intensive Outpatient ☐Outpatient
The Council on Quality and Leadership (CQL)	___/___/_____	☐Intensive Outpatient ☐Outpatient

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

SECTION II - CORPORATE ENTITY/MAIN GEORGIA SITE

A. CORPORATE HEADQUARTERS

Legal Name:		
FEI Number:	National Provider Identification # (NPI):	
Street Address:		
City:	County:	Zip:
Mailing Address (if different):		
City:	County:	Zip:
Owner:		
Telephone:	Fax:	Email:
CEO/Director:		
Telephone:	Fax:	Email:
Contact Name:		
Telephone:	Fax:	Email:

B. MAIN GEORGIA SITE

(Legal name and address that is registered with the Georgia Secretary of State's office)

Legal Name:		
FEI Number:	National Provider Identification # (NPI):	
Street Address:		
City:	County:	Zip:
Mailing Address (if different):		
City:	County:	Zip:
Owner:		
Telephone:	Fax:	Email:
CEO/Director:		
Telephone:	Fax:	Email:
Contact Name:		
Telephone:	Fax:	Email:
Human Rights Contact Name:		
Telephone:	Fax:	Email:
The agency is: ❒ Non-Profit	❒ For-Profit	
Website:		
d/b/a or other alternate business name (if any):		
Does this agency have Medicaid certification in another state? ❒ Yes ❒ No If Yes, which state(s):_____		

SECTION III – SPECIALTY SERVICES LOCATION

Complete Pages 4 & 5 and the appropriate Staffing Form (s) for the Specialty Service(s) applying to provide. Complete one for each service location.

A. SERVICE DELIVERY LOCATION

Location Name:		
Street Address:		
City:	County:	Zip:
Clinical Contact Person		Title:
Telephone:		Fax:
Email Address:		

B. SPECIALTY SERVICE(S): Check appropriate box(es) for service(s) requested at this location**:**

❒ Intensive Family Intervention

- o Behavioral Assistance (State funded only)
- o Community Transition Planning (State funded only)

❒ Substance Abuse (SA) Adolescent Intensive Outpatient (agency must provide all services listed)

- o Behavioral Health Assessment
- o Diagnostic Assessment
- o Nursing Assessment and Health Services
- o Community Support – Individual
- o Individual Counseling
- o Group Outpatient Services:
  - Group Counseling
  - Group Training
- o Family Outpatient Services:
  - Family Counseling
  - Family Training
- o Service Plan Development

COUNTY OF SERVICE DELIVERY (please list the county or counties you are proposing to serve)

Please note that there may be situations when eligible consumers presenting for services at your agency may reside outside of the counties you have chosen to serve. It is expected that your agency provide these services.

C. BILLING INFORMATION:

Billing Name:		
Billing Address:		
City:	State:	Zip:
Billing Contact Person		Title:
Telephone:	Fax:	
Email Address:	Website:	

D. BUSINESS HOURS:

Specialty Services: Some of the Specialty services are not facility based and promote a flexible service delivery, however, an office location and office hours are required. Indicate times in the appropriate block.

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
AM							
PM							
Evening							
By Appt							

Does this location have a Telecommunications Device for the Deaf (TDD)? ☐ Yes ☐ No

E. STAFFING: Complete separate Staffing Forms for each location. Please duplicate page if necessary.

C&A Specialty Services Staffing Form
(Complete one form for each service location)

Service: Intensive Family Intervention Services
Site Name:
Site Address:

NOTE: Positions indicated below with an asterisk (*) are the minimum staffing requirements for Intensive Family Intervention Services. Please include a copy of all applicable licenses or certificates. All positions listed with a * must have staff names in addition to the applicable licenses or certificates. To Be Hired (TBH), etc will not be accepted. Please duplicate form if necessary

Position Title	Name and Title	License Type and Expiration Date	Number of Weekly Hours
* Team Leader Licensed Clinician (LCSW, LPC, LMFT)			
*2 or 3 Paraprofessionals (Must complete the mandatory DBHDD Standard Training Requirement for Paraprofessionals)			
* Team Leader Licensed Clinician (LCSW, LPC, LMFT)			
*2 or 3 Paraprofessionals (Must complete the mandatory DBHDD Standard Training Requirement for Paraprofessionals)			

C&A Specialty Services Staffing Form
(Complete one form for each service location)

Service: Substance Abuse (SA) Adolescent Intensive Outpatient
Site Name:
Site Address:

NOTE: Positions indicated below with an asterisk (*) are the minimum staffing requirements for Substance Abuse (SA) Adolescent Intensive Outpatient services. Please include a copy of all applicable licenses or certificates. All positions listed with an asterisk must have staff names in addition to the applicable licenses or certificates. To Be Hired (TBH), etc. will not be accepted. Please duplicate form if necessary.

Position title	Name and Title	License Type and Expiration Date	Number of Weekly Hours
Medical Doctor/ Psychiatrist			
Physician's Assistant, Advanced Practice RN (Clinical Nurse Specialist or Nurse Practitioner)			
Psychologist			
RN			
LPN			
*Licensed Clinicians LCSW, LPC, LMFT LMSW, LAPC, LAMFT			
*MAC, CACII, CADC, CCADC, GCADC (II,III)			
*Paraprofessionals **Must complete the mandatory DBHDD Standard Training Requirement for Paraprofessionals.**			

SECTION IV – PARTICIPATION

A. GEORGIA MEDICAID PARTICIPATION

Does this agency have Medicaid certification in the state of Georgia? ☐Yes ☐ No

Is this agency currently certified as a Georgia Medicaid Rehabilitation Option Provider? ☐Yes ☐ No

If yes to either question above, complete table below.

Program Name	Service (e.g. Independent Care Waiver (ICWP), Community Care Service Program (CCSP) etc.)	Location Name and Address	Assigned Medicaid Number

B. PREVIOUS PARTICIPATION

Has the organization or key management staff had a contract and/or agreement with the Department of Behavioral Health and Developmental Disabilities (DBHDD) or the Department of Human Services (formerly Department of Human Resources) within the last five years? ☐Yes ☐ No

If yes, complete table below.

Agency or Individual Name	Department / Division Issuing Contract	Brief Description of the Scope of Work

SECTION V - PROFESSIONAL AND GENERAL LIABILITY INFORMATION

In answering the questions listed below, if you answer YES, please provide documentation describing the circumstances surrounding the event, settlements, and or resolutions of the issues in the state of Georgia or in any other state.

A. Has the organization or program or any of the organization or program's staff been named in any malpractice and / or other legal action within the last five (5) years in which a lawsuit was filed against the agency?	☐ **Yes** ☐ **No**
B. Has the organization or program or any of the organization's or program's staff members' malpractice and/or liability insurance been canceled, non-renewed, restricted or special rated during the last five (5) year?	☐ **Yes** ☐ **No**
C. Has any government agency in the state of Georgia or any other state investigated, suspended, revoked or taken any other action against the organization or program or any of the organization's or program's staff members license to practice within the last five (5) years?	☐ **Yes** ☐ **No**
D. At any time has any license, specialty board certification or eligibility been revoked, reduced, denied, or suspended by the issuing entity or voluntarily given up by the organization or program or members of the organization or program's staff within the last five (5) years?	☐ **Yes** ☐ **No**
E. Has the organization or program or members of the organization's or program's staff had any legal actions brought against them within the last five (5) years or are there any legal actions currently pending?	☐ **Yes** ☐ **No**
F. Has the organization or program or members of the organization's or program's staff received any sanction letters or related documents from any licensing, certifying or credentialing entity within the last five (5) years?	☐ **Yes** ☐ **No**
G. If you answered **Yes** to any of the questions in paragraphs C, D, E or F, above, did it result in the termination or suspension of your organization's or program's contract or agreement with any government agency in the state of Georgia or in any other state within the last five (5) years?	☐ **Yes** ☐ **No**
H. Has the organization or program or members of the organization's or program's staff been debarred or suspended from receiving payment under the Medicare and/or Medicaid Program within the last five (5) years?	☐ **Yes** ☐ **No**

SECTION VI- OTHER REQUIRED INFORMATION

Current copies of the following documents must be submitted with this application:

1. Copy of agency's Georgia's Secretary of State Registration.
2. Evidence of agency delivering behavioral health services for at least one year.
3. Copy of accreditation certificate and most recent accreditation survey report. Agency must be accredited by one of the four accrediting bodies listed on page 2 before submitting an application:
4. Copy of certificate for Commercial General Liability Insurance or Comprehensive General Liability Insurance policy.
5. Copy of each employee's license or credential, including the Medical Doctor, PA, CNS, etc. A print out from the Secretary of State's website is not sufficient.
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.
9. Attestations signed by the CEO, Director or Owner (FORM 1).
10. Narrative that describes the agency's plan for after hours accessibility for consumers in treatment and for new referrals. Limit the narrative 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. Limit the narrative 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 of Georgia 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.

FORM 1. ATTESTATIONS

A. Specialty Services

Georgia Department of Behavioral Health and Developmental Disabilities requires, that only certain licensed clinicians may order Specialty services, that only certain practitioner levels can provide Specialty services, that services be provided according to the service guidelines, and that the agency will operate in accordance with applicable standards, rules, regulations and policies. Consistent with this requirement, I do hereby certify that the organization that is seeking to become a provider of Specialty Services, and on whose behalf I'm acting, will only allow the appropriate licensed clinicians to order services, the appropriate practitioner levels to deliver services and will operate in accordance with the contract or agreement between the agency and DBHDD.

B. E-Commerce Capacity

The Georgia Department of Behavioral Health and Developmental Disabilities requires all providers to be computer literate. This includes the following minimum components:

- Office computer capacity
- Internet capacity
- Email capacity
- Electronic data transfer capacity

Consistent with this requirement, I do hereby certify that this organization, and on whose behalf I'm acting, does maintain each of these components.

C. Providing Services – I attest that:

i. As a Specialty services provider, this agency is responsible for providing the Specialty services that we are approved to provide and will be ready to accept consumers upon approval.
ii. This agency is responsible for meeting all of the minimum staffing requirements for Specialty services providers as defined in the each service guideline.
iii. The site location(s) has a Telecommunications Device for the Deaf (TDD).
iv. Each service location is wheelchair accessible.
v. Each service location will provide interpreter/translator services free to LEP/SI consumers.
vi. This agency will implement behavioral health policies from the most recent Provider Manual.

D. I attest that the agency will be ready to provide ALL APPROVED SPECIALTY services when the contract or agreement is signed between the agency and the DBHDD.

E. Authorized Agent

Under penalty for perjury, I do hereby affirm that I am the authorized agent to complete this application and that the information contained in this application is complete, true, and correct.

Printed Name of Organization	Printed Name of CEO/Director / Owner
Signature of CEO/Director/ Owner	Date