



MID-SOUTH SUBSTANCE ABUSE COMMISSION

Provider Application and Data Record: please attach the following information to the application.

- A copy of most recent Michigan Department of Community Health, Bureau of Health Systems, Division of Licensing & Certification, Substance Abuse Licensing Section treatment and/or prevention license.
- A copy of most recent accreditation and copy of management letter.
- A copy of current Drug Enforcement Agency license (if applicable)
- A copy of Medical Director's Board/Specialty Certification (if applicable)
- Signed Verification of Staff Credentials Providing Direct Services Form
- A copy of Form W-9 Request for Taxpayer ID Number and Tax ID number
- A copy of Federal Tax Exempt Status Determination Letter from the IRS (if applicable)
- A copy of Declaration Page of Current Malpractice/Professional Liabilities Insurance
- A copy of the most recent financial Audit
- A copy of the Provider Organizational Chart
- A list of the Provider's Governing Board members, specifying the Board Chair
- A copy of current Conflicts of Interest Policy
- A copy of Articles of Incorporation
- A copy of Provider's By-Laws
- A list of Professional References (for 1st time Applicants)

For MSSAC Use Only:
Date Stamp & Staff Initials:

Please complete the following application completely and sign all required sections.

Administrative Information

Street Address:

Mailing Address (if different):

City: County: Zip Code:

Main Telephone Number: Fax Number:

Executive Director: Telephone Number:

E-mail Address:

Billing Agent: Telephone Number:

E-mail Address:

Clinical Supervisor: Telephone Number:

E-mail Address:

Website Address:

Is the organization affiliated with or controlled by another entity? Yes No

If yes, Entity Name:

Entity Address:

Office Locations & Service Information (Provide information for each location services are provided.)

Service Hours: Monday

Service(s) provided at this location: (Please Check all that apply.) Tuesday

 Outpatient IOP Residential Sub-acute Detox SARF Other Wednesday

Thursday

Friday

Saturday

 Methadone Maintenance Prevention

Office Name: Sunday

Street Address if different from above:

City: County: Zip Code:

Number to call to make appointment at this location if different from above:

Site Supervisor: Telephone Number:

E-mail Address: Fax Number:

License Information: (MDCH/BHS/Division of Licensing & Certification/Substance Abuse Licensing Section)

Substance Abuse Services	License Number/ County	Type of License (Standard, Provisional, Temporary)	Expiration Date (if listed)
Prevention			
Outpatient (IOP)			
Inpatient			
Residential			
Sub-acute Detox			
SARF			
Methadone Services			
Other			

Specialty Designation: (Please check all that apply) Co-Occurring Disorders Hispanic Older Adult Adolescents African American Native American Women with Families Deaf/Hearing Impaired Other

Drug Enforcement Agency (Narcotics) License Information:

DEA Registration Number	Date Issued	Expiration Date

Accreditation Information:

Accreditation Body	Expiration Date	Date of Last Survey	Number of Years Accredited	Accreditation Areas (Please ✓ all that apply)
				<input type="radio"/> Substance Abuse <input type="radio"/> Mental Health <input type="radio"/> Methadone Dosing

Medicaid & Medicare Provider Status:

	Provider Number	Approved Services
Medicaid		
Medicare		

Third Party Insurance Contracts::

Name of 3 rd Party Insurance Company	Does the contract contain an exclusivity clause?
	<input type="radio"/> Yes <input type="radio"/> No
	<input type="radio"/> Yes <input type="radio"/> No
	<input type="radio"/> Yes <input type="radio"/> No
	<input type="radio"/> Yes <input type="radio"/> No

History of Revocations, Restrictions, or Limitations:

Check if the status of any of the following has ever been revoked, restricted or limited in any respect.

<input type="radio"/> MDCH/Substance Abuse Licensing Section	<input type="radio"/> Medicaid Provider Status
<input type="radio"/> Accreditation	<input type="radio"/> Medicare Provider Status
<input type="radio"/> DEA Certificate	(If any are checked, attach an explanation including date of the action and reinstatement, resolution and cause for revocation, restriction or limitation.)

Professional Liability Insurance: (Prevention & Treatment Providers)

Present Carrier	
Address/City/State/Zip	
Policy Number	
Level of Coverage	Per Occurrence Per Aggregate
Expiration Date of Policy	

General Liability Insurance: (Prevention & Treatment Providers)

Present Carrier	
Address/City/State/Zip	
Policy Number	
Level of Coverage	Per Occurrence Per Aggregate
Expiration Date of Policy	

Workers' Compensation Insurance: (Prevention & Treatment Providers)

Present Carrier	
Address/City/State/Zip	
Policy Number	
Level of Coverage	Per Occurrence Per Aggregate
Expiration Date of Policy	

Certification of Provider Application & Release of Information:

I hereby certify that all information contained herein is complete and accurate to the best of my knowledge. I understand that any misleading statement or omission in this Application may constitute cause for immediate termination from the Mid-South Substance Abuse Commission (MSSAC) Provider Panel and Network. I authorize MSSAC and its agents and representatives to consult with, and receive documents from individuals and organizations possessing information bearing on this Application. I release from any liability to the fullest extent permitted by law, all individuals and organizations that provide information regarding me, including otherwise confidential information to the extent that such information is necessary in connection with this Application.

I agree that MSSAC, its agents, representatives and any individuals or entities providing information to MSSAC in good faith and pursuant to this release, shall not be liable for any act or omission related to the evaluation or verification of information contained herein.

I understand that this Provider Application does not guaranty participation in the Mid-South Substance Abuse Commission panel and network. I further understand that, if selected to the MSSAC panel and network, I have a continuing duty to update the information reported in this Application, as necessary to maintain as current. Such updates will be made within ten (10) days of their occurrence.

Please Print Name:

Signature:

Date:

Additional Office Location & Service Information

Office Locations & Service Information (Provide information for each location services are provided.)						
					Service Hours:	Monday
Service(s) provided at this location: (Please Check all that apply.)						Tuesday
<input type="radio"/> Outpatient	<input type="radio"/> IOP	<input type="radio"/> Residential	<input type="radio"/> Sub-acute Detox	<input type="radio"/> SARF	<input type="radio"/> Other	Wednesday
						Thursday
						Friday
						Saturday
<input type="radio"/> Methadone Maintenance					<input type="radio"/> Prevention	Sunday
Office Name:						
Street Address if different from above:						
City:		County:		Zip Code:		
Number to call to make appointment at this location if different from above:						
Site Supervisor:			Telephone Number:			
E-mail Address:			Fax Number:			

Office Locations & Service Information (Provide information for each location services are provided.)						
					Service Hours:	Monday
Service(s) provided at this location: (Please Check all that apply.)						Tuesday
<input type="radio"/> Outpatient	<input type="radio"/> IOP	<input type="radio"/> Residential	<input type="radio"/> Sub-acute Detox	<input type="radio"/> SARF	<input type="radio"/> Other	Wednesday
						Thursday
						Friday
						Saturday
<input type="radio"/> Methadone Maintenance					<input type="radio"/> Prevention	Sunday
Office Name:						
Street Address if different from above:						
City:		County:		Zip Code:		
Number to call to make appointment at this location if different from above:						
Site Supervisor:			Telephone Number:			
E-mail Address:			Fax Number:			

Office Locations & Service Information (Provide information for each location services are provided.)						
					Service Hours:	Monday
Service(s) provided at this location: (Please Check all that apply.)						Tuesday
<input type="radio"/> Outpatient	<input type="radio"/> IOP	<input type="radio"/> Residential	<input type="radio"/> Sub-acute Detox	<input type="radio"/> SARF	<input type="radio"/> Other	Wednesday
						Thursday
						Friday
						Saturday
<input type="radio"/> Methadone Maintenance					<input type="radio"/> Prevention	Sunday
Office Name:						
Street Address if different from above:						
City:		County:		Zip Code:		
Number to call to make appointment at this location if different from above:						
Site Supervisor:			Telephone Number:			
E-mail Address:			Fax Number:			

Medical Director Information: (Complete if have a Medical Director)

Name:

Medical Specialty:

Secondary Specialty:

Employment Status with Agency: Consulting Salaried Contractual

Number of Hours Available Weekly:

Hospital Affiliations of Medical Director:

List hospitals where the Medical Director currently has staff privileges and the type of privileges. If privileges are restricted or other is indicated, please attach an explanation.

Hospital Name & City	Type of Privilege	Type of Facility
	<input type="radio"/> Full <input type="radio"/> Courtesy <input type="radio"/> Restricted <input type="radio"/> Other	<input type="radio"/> Psychiatric <input type="radio"/> General/Med
	<input type="radio"/> Full <input type="radio"/> Courtesy <input type="radio"/> Restricted <input type="radio"/> Other	<input type="radio"/> Psychiatric <input type="radio"/> General/Med
	<input type="radio"/> Full <input type="radio"/> Courtesy <input type="radio"/> Restricted <input type="radio"/> Other	<input type="radio"/> Psychiatric <input type="radio"/> General/Med

Medical Director's Board Certification(s): If not currently certified, please explain on an attachment.

Board Name	Date Certified	Date Re-certified

Medical Director's Medical Training:

	Institution, Country, and City	Type	Date Completed
Internship			
Residencies			
Fellowships/ Preceptorships			

Medical Director's Certification of Information & Release of Information:

I authorize Mid-South Substance Abuse Commission to consult with, and inspect all documents from, individuals and organizations possessing information bearing on this Application. I hereby further authorize and consent to the release of information related to my medical staff status and clinical privileges, including any suspension, removal, termination, reduction, restriction, and/or limitation, and any probation monitoring requirements (that may be other than usual and customary) set forth by hospitals at which I hold membership and clinical privileges. I release from any liability to the fullest extent permitted by law, all individuals and organizations that provide information regarding me, including otherwise confidential information to the extent that such information is necessary in connection with this Application.

I agree that Mid-South Substance Abuse Commission, its representatives, and any individuals or entities providing information to Mid-South Substance Abuse Commission in good faith and pursuant to this release, shall not be liable for any act or omission related to the evaluation or verification of information contained herein.

Please Print Name:

Signature:

Date: