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Family Services Provider – Network Provider Application

Instructions: For an individual or organization to be considered for "Network Provider" status, a Network Provider Application must be completed. Once received OCOK will review the application and will notify the applicant to engage in the credentialing and contracting process. Organization refers to any individual that will be considered a Network Provider.

Please provide all information requested below.

I. Network Provider Profile Information

Organization Name: _____

Name and title of key contact for application, credentialing and contracting activities:

_____

Name and title of authorized person to sign contract documents and addendums:

_____

Name and title of primary contact for on-going communication between Provider and OCOK:

_____

_____

Main Phone Number: _____ Fax Number: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Address for Claims Payment (if different from above): _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Federal Tax ID #:_____ State Tax ID# or Vendor ID # _____

Is the organization a Medicaid Provider? Yes: ☐ No: ☐

II. Organization Liability Information

Professional Liability Policy Number: _____

Current Independent Carrier Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Current Policy Begin Date: _____ Current Policy End Date: _____

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Professional Liability Coverage

Limits of Coverage:	Per Occurrence:	Per Aggregate:

Crime Policy Number: _____

Current Independent Carrier Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Current Policy Begin Date: _____ Current Policy End Date: _____

Crime Policy Coverage

Limits of Coverage:	Per Occurrence:	Per Aggregate:

General Liability Policy Number: _____

Current Independent Carrier Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Current Policy Begin Date: _____ Current Policy End Date: _____

General Liability Coverage

Limits of Coverage:	Per Occurrence:	Per Aggregate:

Liability Questions

The following questions apply to applicant (individual and/or organization).

1. Has the individual/organization or members of the staff been named in any malpractice action in the last five (5) years?

Yes: ☐ No: ☐

2. Has the malpractice insurance of the individual/organization or individual staff members been canceled, non-renewed or special rated in the last five (5) years?

Yes: ☐ No: ☐

3. Has any government, private accreditation or licensing agency investigated, suspended, revoked or taken any other action against the individual/ organization or staff members licensed to practice in the last five (5) years?

Yes: ☐ No: ☐

4. Has the individual/organization or staff members had, or does it currently have pending, any: litigation, claims, protests, suspensions, placement holds, actions or proceedings, whether judicial, arbitral or administrative, and any government investigations or inquiries which affect or may affect any grants, contracts, licenses, accreditations, property or business involving either applicant or its employees in the last five (5) years?

Yes: ☐ No: ☐

5. Does the invididual/organization require criminal history background screenings of all staff prior to hiring?

Yes: ☐ No: ☐

6. Does the invidual/organization require screenings of all employees and contractors to determine whether an individual has been excluded, suspended, debarred or otherwise ineligible to participate in the federal health care programs?

Yes: ☐ No: ☐

7. At any time, have any memberships in professional organizations or accreditations by national or state bodies been revoked, denied or suspended by others or voluntarily given up by the individual/organization or members of the organization?

Yes: ☐ No: ☐

8. Has the individual/organization or staff members been removed, sanctioned or suspended from membership in a professional association for violation(s) of an ethical code of practice in the last five (5) years?

Yes: ☐ No: ☐

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III. **Licensure and Accreditation** (Please attach a copy of all state licenses and accreditations that are applicable to any of your programs)

A. Describe your organization's licenses.

Programs to which this license applies: _____

Licensing Body: _____

Licensing Type: _____

License Number: _____ Issuance Date: _____ __

Expiration Date: _____

Programs to which this license applies: _____

Licensing Body: _____

Licensing Type: _____

License Number: _____ Issuance Date: _____ __

Expiration Date: _____

B. Describe any applicable accreditation (e.g. COA, JCAHO and/or CARF). If the organization holds more than one accreditation, please use additional sheets of paper.

Accrediting Body: _____ Accreditation Status: _____

Expiration Date: _____ Date of most recent survey: _____

C. Program and Clinical Staff: Please list below the names of all program and clinical staff that are licensed, complete with the state license number and their educational degree(s).

Name	Type	State License #	Degree

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Do you currently hold a contract with DFPS? Yes ☐ No ☐

If applicable, does your organization plan to become accredited?

If yes, by which body and when:

_____

Which services will be accredited? _____

Please list any Evidence-Based Programs or Promising Practices and which programs they are in use:

Name of Model	Programs Implementing

Do you use a model for Trauma-Informed Care?

Which model: _____

IV. Program and/or Services Offered through the Organization

Using the chart below, indicate the services your agency is able to provide to children, youth and families.

Family Services					
	Program/Service *(check all that apply)*	**Ages Served**	**Gender**	**Maximum Daily Capacity**	**Current or Most Recent Fee/ Reimbursement Rate and by Whom**
☐	Mobile Emergency Services				
☐	Medication Management				
☐	Intensive Outpatient (Specify Type)				
☐	Day Treatment				
☐	Extended Day Treatment				
☐	Individual Therapy: Home-Based				

	Individual Therapy: Outpatient				
	Family Therapy: Home-Based				
	Family Therapy: Outpatient				
	Group Therapy				
	Independent Living/Community Life Skills				
	Other (Please specify):				
	Other (Please specify):				

Evaluations/Assessments					
	Program/Service *(check all that apply)*	**Ages Served**	**Gender**	**Maximum Daily Capacity**	**Current or Most Recent Fee/ Reimbursement Rate and by Whom**
	Psychiatric Evaluations				
	Psychological Evaluations				
	Substance Abuse Evaluations				
	Psychological Testing				
	Other Specialized Assessments (Please specify):				
	Other Specialized Assessments (Please specify):				

Home and Community-Based Services and Supports					
	Program/Service *(check all that apply)*	**Ages Served**	**Gender**	**Maximum Daily Capacity**	**Current or Most Recent Fee/ Reimbursement Rate and by Whom**
	In-Home Parent Aide				

	Household supports (cleaning, cooking, budgeting)				
	Youth Mentoring				
	Parent Education, Training				
	Case Management				
	Childcare				
	Family Reunification				
	Kinship Care (Home of Relatives)				
	Aftercare (Please specify type):				
	Wraparound				
	Visitation Supervision				
	Other (Please specify):				
	Other (Please specify):				

Other Community Services and Support					
	Program/Service *(check all that apply)*	**Ages Served**	**Gender**	**Maximum Daily Capacity**	**Current or Most Recent Fee/ Reimbursement Rate and by Whom**
	Outreach				
	Information & Referral				
	Transportation (Medical)				
	Transportation (Non-Medical)				
	Youth Recreation/Social Activities (Please specity type):				
	Behavioral Services				
	Family-to-Family Support				
	Self-help Groups				

	Job Training/Work Adjustment/Employment Services (Please specify type):				
	Supported Recreation				
	Other (Please specify):				

Educational Services					
	Program/Service *(check all that apply)*	**Ages Served**	**Gender**	**Maximum Daily Capacity**	**Current Rate/Fee**
	Campus-Based School				
	After School Supports				
	Alternative Educational Programs				
	School-Based Behavioral Health Services				
	School Liaison				
	Other (Please specify):				
	Other (Please specify):				

V. Referral Process

Routine Hours to Accept Referrals: _____

Contact person for referrals during routine business hours: _____

_____

Referral process after hours, weekends and holidays:

_____

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VI. Information Systems		
Identify any information systems currently in use by your organization and those programs using any systems only if not used throughout agency.		
Hardware	Software	Program

Is your information system web-enabled? **Yes:** ☐ **No:** ☐

Is your system able to export data? **Yes:** ☐ **No:** ☐

Is your system able to submit claims electronically? **Yes:** ☐ **No:** ☐

VII. Attestation to Correctness of Application

I hereby attest that all information provided in this application is accurate and correct to the best of my knowledge.

Form completed by (print name): _____

Title: _____

Signature: _____ Date: _____

Please email the completed application to familyservicesproviders@oc-ok.org or mail to 7700 AWG Way, Fort Worth, TX 76140.