BEHAVIORAL HEALTH SYSTEMS
Behavioral Healthcare Programs for Business & Industry Since 1989
www.behavioralhealthsystems.com • Phone: 800-245-1150 • Fax: 205-879-1178
Corporate Office: Two Metroplex Dr., Ste 500, Birmingham, AL 35209 • **Midwest Office**: John Hancock Center, Ste 3137, 875 N. Michigan Ave., Chicago, IL 60611

Outpatient Facility Provider Application

Please complete all sections of this application. If a section is not applicable, mark it N/A. Please print or type information. If there are any questions, please contact the representative listed in the cover letter accompanying this application.

Identifying Information

Facility Name	Patient ages treated by facility

DBA Name (If your facility does business under a different name from the facility name listed)

Federal Tax ID Number	National Provider Identification Number	Administrator's/CEO's Name/Title

Facility Type *(Please check all that apply)* ❑ For Profit ❑ Non-Profit ❑ Publicly Held ❑ Privately Owned ❑ Partnership

❑ Partial Hospitalization Facility ❑ Intensive Outpatient Psychiatric Program ❑ Intensive Outpatient Substance Abuse Program

❑ Mental Health Center ❑ Home Health Agency ❑ Other _____

Address Information (Please list all locations. Complete the enclosed Multiple Practice Location Form, if applicable.)

Primary Location

Practice/Business Name

Street Address	Suite #

City	State	Zip	County

Phone	Fax	Scheduling Phone	Email

Normal Business Hours	Schedule (Check all that apply to this location.) ❑ S ❑ M ❑ T ❑ W ❑ Th ❑ F ❑ S

Office Contact Person	Counties Served

Credentialing Contact Person (Required)	Credentialing Contact Phone	Credentialing Contact Email (Required)

Accommodations (Please check all that apply.) ❑ Handicapped Accessible ❑ Smoke-Free ❑ Fire Exits ❑ Fire Extinguisher ❑ Fire Plan

❑ Free Parking ❑ Lighted Parking ❑ Off-Street Parking ❑ Public Transportation ❑ Sign Language ❑ Hearing Impaired w/Translator

❑ TTY ❑ Locked Medication Storage ❑ Locked Records Storage

Mailing Address (if different)

Street Address or PO Box	Suite #

City	State	Zip

Phone	Fax

Claims Payment Address (if different)

Street Address or PO Box	Suite #

City	State	Zip

Phone	Fax

Additional Address Information

Practice/Business Name			
Street Address			Suite #
City	State	Zip	County
Phone	Fax	Scheduling Phone	Email
Normal Business Hours	Schedule (Check all that apply to this location.) ❑ S ❑ M ❑ T ❑ W ❑ Th ❑ F ❑ S		
Office Contact Person	Counties Served		
Credentialing Contact Person (Required)	Credentialing Contact Phone	Credentialing Contact Email (Required)	

Accommodations (Please check all that apply.) ❑ Handicapped Accessible ❑ Smoke-Free ❑ Fire Exits ❑ Fire Extinguisher ❑ Fire Plan ❑ Free Parking ❑ Lighted Parking ❑ Off-Street Parking ❑ Public Transportation ❑ Sign Language ❑ Hearing Impaired w/Translator ❑ TTY ❑ Locked Medication Storage ❑ Locked Records Storage

Mailing Address (if different)			**Claims Payment Address** (if different)		
Street Address or PO Box		Suite #	Street Address or PO Box		Suite #
City	State	Zip	City	State	Zip
Phone	Fax		Phone	Fax	

License History (Please list licensure information for the past 10 years.)

Type	State	License Type (i.e., CMHC, IOP etc.)	Number	Issue/Renewal Date	Expiration Date
State License					
Other State License					
Other State License					
CDS					
Federal DEA	US				

Insurance Information (Please attach a copy of current insurance certificates or declaration pages showing the dates and amounts of coverage.)

Professional Liability Insurance

Current Insurance Carrier		Policy #	
Amounts of Coverage $ Occurrence / $ Aggregate	Effective Date	Expiration Date	Years with Carrier
Patient Compensation Fund Carrier (if applicable)			
Effective Date	Expiration Date	Coverage Amount $	

General Liability Insurance

Current Insurance Carrier		Policy #	
Amounts of Coverage $ Occurrence / $ Aggregate	Effective Date	Expiration Date	Years with Carrier

Administrative Staff (Please list name and credentials, if applicable.)
Executive Director:
Clinical Director:
Medical Director:

Work History (Please attach each director's CV including month/year dates (required). Include a written explanation for any employment gaps greater than 6 months.)

Professional Staff (Please show number.)	**Full-Time**	**Part-Time**
Licensed Psychologists		
Licensed Social Workers		
Licensed Counselors		
Licensed Marriage & Family Therapists		
Certified Substance Abuse Counselors		
Registered Nurses		
Psychiatrists		
Other Physicians		
Others:		

Specialty Certifications

Are any staff members board certified or do any hold specialized credentials? ❑ Yes ❑ No ❑ N/A

If yes, please list below and attach copy of certificate(s).

Certification Board	**Specialty**	**Certification Number**	**Issue/Renewal Date**	**Expiration Date**

Hospital Privileges

Do any staff members have hospital staff privileges? ❑ Yes (Indicate below.) ❑ No If no, how do you handle admissions? _____

Staff Name	**Facility Name**	**Address, City, State & Zip Code**	**Affiliation Type**

Languages

Do any staff members speak a language other than English? ❑ Yes (If yes, please list below.) ❑ No

Specialty Services (Staff members must meet criteria for treatment providers as detailed on page 7 for those checked.)

❑ General ❑ Child/Adolescent ❑ Substance Abuse

❑ Critical Incident Stress Debriefing ❑ Disability Management/Workers Compensation

Practice Information
Please indicate the percentage of your current caseload which falls into each of the following categories. (**Your total caseload should add up to 100%.)**

Client Groups
(In order to qualify for the Child/Adolescent specialty or the Substance Abuse specialty, the provider must carry a child/adolescent or substance abuse caseload of at least **33**%). Please see page 6 for additional criteria information

Child _____**%** Adolescent _____**%** Adult _____**%** Geriatric/Elderly_____**%**

Client age range: Minimum age: _____ Maximum age: _____ What percent of total caseload, if any, is substance abuse? _____**%**

Number of years at current practice _____ Number of years clinical experience _____

Percent of referrals from EAP _____% Managed care _____%

Treatment Modalities ❑ Individual ❑ Family/Marital ❑ Group (Types: _____)

Treatment Options ❑ In person ❑ Virtual

Number of hours per week in direct care activities: _____

Do you currently receive professional supervision? ❑ Yes ❑ No Ratio supervised/direct care hours: _____

To which area professionals do you refer? _____

Briefly describe staff's therapeutic orientation.

Please describe the treatment approach staff *typically* employs when seeing a new client, including reliance on psychological testing.

How does staff handle cases that require hospitalization or detoxification?

Clinical Support Information (Select plans and certain services require BHS precertification. This information is required to process application.)	
Is staff willing to participate in periodic clinical reviews with BHS case managers regarding the clinical status and progress of BHS clients?	❑ Yes ❑ No
Is staff willing to submit a brief client progress summary and/or treatment plan to BHS if requested?	❑ Yes ❑ No
Please answer the following questions if you checked Disability Management/Workers Compensation as a specialty.	
Do any staff members have specialized education, experience or certification in evaluation or treatment for disability/workers compensation cases? If yes, please list:_____	❑ Yes ❑ No ❑ NA
Do any staff members require psychological testing for evaluation of disability or workers compensation cases? If yes, please list standardized instruments used: _____	❑ Yes ❑ No ❑ NA

Facility Referrals (Please indicate to which area facilities staff refers.)

Patient Type	**Outpatient Facilities**	**Inpatient Facilities**
General Adult		
Child/Adolescent		
Substance Abuse		
Other Specialties		

Specialty/Treatment Categories (Please check all that apply.)					
	Abuse & Trauma		Eating Disorders		Parenting Issues
	Acculturation Problem		ECT (MD only)		Psychological Testing
	ADHD		EMDR		PTSD
	Anger Management		Faith Based		Reality Therapy
	Applied Behavioral Analysis (ABA)		Family Therapy		Reproductive Issues
	Autism Spectrum Disorders		Forensics		Return to Work Evaluations/Disability
	Chronic Medical Conditions		Grief Issues		Rogerian Therapy
	Codependency		Insight Therapy		Solution-Oriented Therapy
	Cognitive–Behavioral Therapy		LGBTQIA+		Stress Management
	Conflict Resolution		Medication Assisted Treatment (MAT)		Substance Abuse
	Couples/Relational Problems		Men's Issues		Suicide Prevention
	Crisis Intervention		Neuropsychology		Telehealth
	Critical Incidents		Occupational Problem		Transcranial Magnetic Stimulation (TMS)
	Dialectical Behavioral Therapy (DBT)		Other Addictions		Women's Issues
	DOT-Approved SAP		Out-Placement/Relocation		Worker's Compensation
Other:					

Presenting Problems (Please check the disorders you treat most frequently.)
Only check Child & Adolescent and Substance Abuse if you meet criteria for those specialties. Please see page 6 for additional criteria information.

- ❑ Adjustment Disorder
- ❑ Anxiety Disorder
- ❑ Child & Adolescent Disorder
- ❑ Disorders due to General Medical Conditions
- ❑ Dissociative Disorder
- ❑ Eating Disorder
- ❑ Impulse Control Disorder
- ❑ Mood Disorder
- ❑ Personality Disorder
- ❑ Schizophrenia/Psychotic Disorder
- ❑ Sexual/Gender Identity Disorder
- ❑ Somatoform Disorder
- ❑ Substance Abuse Disorder
- ❑ Other _____

What disorders/clinical areas does staff not treat?

Availability

- ❑ Immediately (crises)
- ❑ 24 hours
- ❑ 48 hours
- ❑ 72 hours
- ❑ More than three days for appointment

Describe back-up coverage:

Mandatory Questionnaire

IMPORTANT: If any of the following questions are answered "Yes", please provide a summary below or attach an explanation for each answer. If any questions do not apply to your facility, please answer "No". **Failure to respond or provide explanations for "Yes" responses may result in delay of application processing.**

Licensure Information

In the last ten (10) years:

1. Has your facility or any staff member been censured, reprimanded, or had disciplinary action taken by an ethical standards committee, licensing board, or other board of inquiry, or is any such action currently pending or under investigation? ❑ Yes ❑ No
2. Has your facility or any staff member voluntarily surrendered its license, had its license revoked, suspended, or limited, or operated under a probationary license or consent agreement? ❑ Yes ❑ No
3. Has your facility or any staff member been the subject of any investigation by any private, federal, or state health program or is any such action pending? ❑ Yes ❑ No
4. Has your facility's or any staff member's Federal DEA and/or State Controlled Dangerous Substance (CDS) Certificate(s) been voluntarily or involuntarily limited, suspended, revoked, surrendered, or not renewed, or is any such action currently pending? ❑ Yes ❑ No
5. Has your facility lost any accreditation? ❑ Yes ❑ No

Insurance Information

In the last ten (10) years:

1. Has your facility's or any staff member's professional liability insurance coverage been involuntarily terminated, or modified by action of any insurance company? ❑ Yes ❑ No
2. Has your facility or any staff member been denied or refused renewal of professional liability coverage, rated in a higher-than-average risk class for its specialty, or had a surcharge relative to claims? ❑ Yes ❑ No
3. Has your facility or any staff member filed a claim under professional liability insurance, have any suits, actions, or claims alleging malpractice been filed, or are there any pending against your facility or any staff member? ❑ Yes ❑ No
4. Has your facility filed a claim under general liability insurance, have any suits, actions, or claims been filed, or are there any pending against your facility? ❑ Yes ❑ No
5. Have any judgments been made against your facility or any staff member in professional liability cases or claims, or has your facility or any staff member entered into any settlements? ❑ Yes ❑ No
6. To your knowledge, has information pertaining to your facility or any staff member been reported to the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank? ❑ Yes ❑ No

Hospital and Other Affiliations

In the last ten (10) years:

1. Has any staff member been denied hospital privileges? ❑ Yes ❑ No
2. If any staff member was granted hospital privileges, were they voluntarily or involuntarily limited, suspended, revoked, or denied renewal, or is any such action currently pending, or has any such action been recommended? ❑ Yes ❑ No
3. Has any staff member resigned from, or withdrawn an application for privileges or membership with, the staff of any hospital or medical organization because of problems regarding privileges or credentials, or is any such action currently pending? ❑ Yes ❑ No
4. Has any staff member's membership in any professional organization been revoked, suspended, or terminated involuntarily for any reason other than failure to pay membership fees, or is any such action currently pending? ❑ Yes ❑ No

Health Status

In the last ten (10) years:

1. Is any staff member currently using any illegal drugs? ❑ Yes ❑ No
2. Has any staff member been under the influence of alcohol during working hours, or used drugs illegally? ❑ Yes ❑ No
3. Does any staff member suffer from any medical or mental health condition which impairs his/her ability to practice to the fullest extent of his/her license, qualifications, and privileges with or without reasonable accommodations? ❑ Yes ❑ No
4. Has any staff member received any mental health treatment for a diagnosis identified in DSM-IV-TR which was ordered by an ethical standards committee, licensing board, or other board of inquiry? ❑ Yes ❑ No
5. In the last four (4) years, has any staff member voluntarily participated in a rehabilitation program or other treatment for substance abuse? ❑ Yes ❑ No

Criminal History

In the last ten (10) years:

1. Has your facility or any staff member been indicted for, convicted of, or pleaded guilty to a crime, or is your facility or any staff member presently under investigation for a crime? ❑ Yes ❑ No
2. Has your facility or any staff member entered into a consent agreement, entered a plea of guilty, or been found guilty of, fraud or abuse involving payment of health care claims by any health care payor or been sanctioned by any third party payor or health care claims or professional review organization, governmental entity or agency, or is any such action pending? ❑ Yes ❑ No

BHS Criteria

Part One – Professional Provider Network Affiliation

I. Professional providers must have at least one of the following:
   A. Masters degree in behavioral sciences/human services (i.e., psychology, counseling, social work, psychiatric nursing); or
   B. Doctoral degree in behavioral sciences/human services; or
   C. Medical degree with completion of ABMS-approved residency program in psychiatry or addictionology.

II. Professional providers must meet the following qualifications:
   A. State licensure in related discipline (not including an "associate" or other license status which requires [non-disciplinary] supervision with a goal of achieving full licensure). Masters-prepared individuals not currently licensed may satisfy this requirement with: (1) three years post-masters supervised clinical (direct care) experience and current employment in a community mental health center; or (2) certification as an employee assistance professional (CEAP) by the Employer Assistance Certification Commission (referrals to these individual may be limited to only EAP treatment/services).
   B. Continuing education at no less than the minimum level required by the state of licensure.
   C. Support a least restrictive treatment philosophy and a managed care approach.
   D. In practice at least 20 hours per week.

III. Professional providers with a **Child/Adolescent** specialty must meet the following qualifications in addition to those in I. and II. above:
   A. Current active child/adolescent caseload averaging 33% or more.
   B. Experience in court hearing process desirable.
   C. A minimum of 4 – 6 hours continuing education specific to treatment of children/adolescents per licensure period.

IV. Professional providers with a **Substance Abuse** specialty must meet the following qualifications in addition to those in I. and II. above:
   A. Certification as an Addictions Specialist, or two years post-degree clinical (direct care) experience in the field of substance abuse, as defined by association with a formal, structured substance abuse program or carrying a caseload of at least 33% substance abuse cases.
   B. Current active substance abuse caseload averaging 33% or more.
   C. A minimum of 4 – 6 hours continuing education specific to substance abuse pre licensure period.

V. Professional providers with a **Critical Incident Stress Debriefing** specialty must meet the following qualification in addition to those in I. and II. above:
   A. Documented completion of a group debriefing course, or two Critical Incident Stress Debriefing cases done within the past two years.

VI. Professional providers with a **Disability Management/Workers Compensation** specialty must meet the following qualification in addition to those in I. and II. above:
   A. Two years post-degree clinical (direct care) experience in the field of disability management/workers compensation.

VII. Professional providers with an **Applied Behavior Analysis** specialty must meet the following qualifications in addition to those in I. above:
   A. Certification through the Behavior Analysis Certification Board as a Behavior Analyst (BCBA or BCBA-D), and comparable state licensure, if applicable. Board Certified Assistant Behavior Analysts (BCaBA) and Registered Behavior Technicians (RBT) who do not meet the qualifications in I. above may satisfy this requirement through the supervision of a BHS-approved BCBA or BCBA-D.
   B. Current active ABA caseload pertinent to Autism Spectrum Disorders averaging 50% or more.
   C. In practice at least 20 hours per week.
   D. Continuing education specific to ABA.

Part Two – Facility Network Affiliation

Because Behavioral Health Systems (BHS) has the utmost concern about both the quality of care provided to the patient, and the patient's perception of that quality of care, and because BHS operates as a preferred provider organization rather than as a health

maintenance organization, BHS is adopting the following criteria for its organizational provider network. These criteria apply to all BHS providers, present and future. These criteria may be amended by BHS from time to time.

Licensure

A. The provider may not have had a revoked, suspended, limited, or probationary license within the last ten years.

B. If applicable, the provider must be accredited by an accrediting agency, e.g., JCAHO, CARF. Any provider awarded JCAHO accreditation subject to Type I recommendations must demonstrate compliance with the relevant JCAHO standard(s) within the time specified by JCAHO. Any provider that has lost, been refused accreditation, or been awarded conditional accreditation within the last ten years must provide evidence of compliance with all standards since that time.

C. The provider may not have any actions or formal complaints pending or currently under investigation by any ethical standards committee, licensing board, accrediting agency, or other board of inquiry or authority. (Provider status shall be suspended until the outcome is known.)

Insurance

A. BHS reserves the right to terminate, suspend, or refuse/reject any application for provider status if the provider or any member of the provider's staff have had any substantive* liability claims, settlements, or judgments within the last ten years. *Substantive shall be defined as either: (1) a combined dollar amount paid for compensatory damages within the ten year period in excess of $3,000,000.00, or (2) any determination of sexual misconduct, patient injury/negligence/unwarranted confinement, or administrative/professional misconduct.

B. BHS reserves the right to terminate, suspend, or refuse/reject any application for provider status if the provider or any member of the provider's staff have any pending liability claims, settlements, or judgments of the substantive nature described in paragraph A above. (Provider status shall be suspended until the outcome is known.)

C. The provider may not have been denied or refused renewal of liability insurance, or had liability insurance involuntarily terminated, within the last ten years.

Miscellaneous

A. Neither the provider nor any member of the provider's staff may have entered into a consent agreement, entered into a plea of guilty, or been found guilty of fraud or abuse involving payment of health care claims by any health care payor or health care claims or professional review organization, governmental entity, or agency, within the past ten years.

B. The provider may not have had membership in any professional organization revoked, suspended, or terminated involuntarily for any reason other than failure to pay membership fees, within the last ten years.

C. The provider may not currently be in bankruptcy proceedings. If the provider filed for bankruptcy within the last ten years, the provider must demonstrate two subsequent continuous years of financial stability under the purview of the bankruptcy court.

D. BHS reserves the right to terminate, suspend, or refuse/reject any application for provider status after reasonable investigation by BHS in the event: 1) more than five patients complain to BHS regarding the provider and/or any member of the provider's staff, and/or any allegation of sexual misconduct is made by a BHS patient with respect to any member of the provider's staff; or 2) BHS receives such direction by one or more of its corporate clients; or 3) BHS learns of inappropriate or unprofessional conduct on the part of any member of the provider's staff.

E. The provider must have completed an Inpatient Provider Application, an Outpatient Facility Provider Application, and/or a PHP/IOP Application Addendum, as applicable, and in all cases a Certification and Authorization. The information contained in said application must be true and complete, and any material misstatement, error, or omission in, said application shall constitute cause for: 1) denial of said application; or 2) immediate termination of provider's participation in the network. The qualifications set forth in said applications are incorporated herein by reference.

Certification, Authorization and Attestation

I acknowledge and agree that Behavioral Health Systems, Inc. (BHS) has a valid interest in obtaining and verifying information concerning my facility's professional competence, in determining whether to enter into an agreement with my facility for the provision of services to BHS members.

I represent and certify to BHS that the information contained in this Application is true and complete to the best of my knowledge and belief, that my facility and staff members meet the BHS Criteria set forth above and, if applicable, the Assessment/Case Manager Criteria, for those specialties I have indicated on the Application, and I agree to inform BHS promptly if any material change in such information occurs, whether before or after acceptance by BHS of this Application for affiliation with BHS' provider network.

I understand and agree that I have the burden of producing adequate information for proper evaluation of my facility's and staff members' professional qualifications, credentials, clinical and mental competence, clinical performance, ethics, or any other matter that might directly or indirectly have an effect on competence, performance, or patient care and for resolving any reasonable questions regarding such qualifications, and that BHS has no responsibility to consider this Application until all necessary information is received by BHS.

I authorize BHS to consult with state licensing boards, hospital administrators, members of staffs of hospitals, malpractice carriers and other persons to obtain and verify information concerning my facility's and staff members' professional competence, character and moral and ethical qualifications, and I release BHS and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my Application.

I consent to the release by any persons to BHS of all information that may reasonably be relevant to an evaluation of professional competence, character and moral and ethical qualifications, including any information relating to any disciplinary action, suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

I warrant that I have the authority to sign this Application on behalf of the entity I represent. I agree that submission of this Application does not constitute approval or acceptance as a participating provider.

I understand that any material misstatement, error, or omission in this Application shall constitute cause for denial of this Application and of my facility's participation in the network. I further understand that if this Application is rejected, BHS may report the rejection to the appropriate state licensing board, National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank, or other professional data bank(s).

Legal representative's signature is required to complete this Application. Stamped signatures are not acceptable.

Name (Please Print or Type)	**Signature**	**Date**