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| **Agency Contact Information**  |
| Agency Name:  | Website:       |
| Chief Administrator Contact/Title:  |
| Phone #:  | email:  |
| Recipient Rights Contact:  |
| Phone #:  | email:  |
| Finance Contact:  |
| Phone #:  | email:  |
| Site Review/Quality Contact:  |
| Phone #:  | email:  |
| Check Appropriate Status: [ ] Sole Prop. [ ] Partnership [ ] Corp. [ ] LLC [ ]  Non-Profit [ ] Other:        |

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| **Program Information -** *attach additional sheets if necessary for multiple sites* |
| Facility/Program #1 Name:       | SA License #:  |
| Office Address #1:  | City:  | Zip:  | County:  |
| Primary Contact/Title:      | email:  |
| Phone:  | Fax:  |
| Hours of Operation: | M:  | T:  | W:  | R:  | F:  | Sa:  | Su:  |
| Response time (days) from first point of contact:  | # of new referrals you will accept per week:  |
| Same Day Service? [ ]  Yes [ ]  No | 24 hr on-call? [ ]  Yes [ ]  No | ADA Accessible? [ ]  Yes [ ]  No |
| Please specify all fluent communicable languages, including sign language:  |
| Women’s Specialty Designation, if applicable: [ ]  Designated [ ]  Enhanced |

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| Facility/Program #2 Name:       | SA License #:  |
| Office Address #1:  | City:  | Zip:  | County:  |
| Primary Contact/Title:      | email:  |
| Phone:  | Fax:  |
| Hours of Operation: | M:  | T:  | W:  | R:  | F:  | Sa:  | Su:  |
| Response time (days) from first point of contact:  | # of new referrals you will accept per week:  |
| Same Day Service? [ ]  Yes [ ]  No | 24 hr on-call? [ ]  Yes [ ]  No | ADA Accessible? [ ]  Yes [ ]  No |
| Please specify all fluent communicable languages, including sign language:  |
| Women’s Specialty Designation, if applicable: [ ]  Designated [ ]  Enhanced |

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| Facility/Program #3 Name:       | SA License #:  |
| Office Address #1:  | City:  | Zip:  | County:  |
| Primary Contact/Title:      | email:  |
| Phone:  | Fax:  |
| Hours of Operation: | M:  | T:  | W:  | R:  | F:  | Sa:  | Su:  |
| Response time (days) from first point of contact:  | # of new referrals you will accept per week:  |
| Same Day Service? [ ]  Yes [ ]  No | 24 hr on-call? [ ]  Yes [ ]  No | ADA Accessible? [ ]  Yes [ ]  No |
| Please specify all fluent communicable languages, including sign language:  |
| Women’s Specialty Designation, if applicable: [ ]  Designated [ ]  Enhanced |

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| **Accreditation -** *attach a copy of the most recent accreditation certificate* |
| Accrediting Body:  | Expiration Date:  |

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| **Current Malpractice and Professional Liability Insurance Information** (attach copy of cover sheet) |
| Insurance Carrier:       | Policy #:       |
| Address:       | Coverage Amount:       |
| City:       | State:       | Zip:       | Expiration Date:       |

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| **Privileges, Licensure, and Malpractice History**   |
| Has your organization had any of the following **denied, revoked, suspended, reduced, limited, or placed on probation or have voluntarily relinquished** any of the following in anticipation of these actions, or are any of these actions now pending? I*f you answer yes to any of the following, attach full explanation.* |
| 1. License to operate
 | [ ]  Yes [ ]  No |
| 1. Accreditation/Certification
 | [ ]  Yes [ ]  No |
| 1. Medical/Hospital Staff Membership
 | [ ]  Yes [ ]  No |
| 1. Clinical Privileges
 | [ ]  Yes [ ]  No |
| 1. Professional Liability Insurance
 | [ ]  Yes [ ]  No |
| 1. Malpractice suits settled resulting in a judgment against you in the past five (5) year, or currently pending?
 | [ ]  Yes [ ]  No |
| 1. Are any malpractice judgements pending?
 | [ ]  Yes [ ]  No |
| 1. Within the past ten (10) years, has your organization ever been convicted of, or plead guilty to, a criminal offense?
 | [ ]  Yes [ ]  No |
| 1. Are there any medical incidents for which you have been contacted by an attorney regarding potential malpractice liability (settlement request, writ of summons, etc.)?
 | [ ]  Yes [ ]  No |
| 1. Have your organization had any Medicaid, Medicare, or other governmental or third-party payor sanctions?
 | [ ]  Yes [ ]  No |
| 1. Have your organization ever been excluded from the Medicaid or Medicare program?

If yes, specify date:       Date of Reinstatement:       | [ ]  Yes [ ]  No |
| 1. Have civil and monetary penalties been levied against your organization by Medicare or Medicaid programs?
 | [ ]  Yes [ ]  No |
| 1. You must provide, at minimum, the prior 5 year’s history of any professional liability claims resulting in a judgement or settlement.

***Complete Attachment E -Professional Liability Action Detail***  | [ ]  Attached [ ]  N/A |

Consent and Release of Liability

Upon the signing of this application, I/This Organization represent that all of the information now or hereafter given in support of this application is true, correct and complete to the best of my knowledge and belief. I/This Organization agree to promptly notify MSHN if there are any material changes in the information provided, whether prior to or after acceptance as a MSHN participating provider. I/This Organization hereby authorize the release of any information from any source including but not limited to information from individuals, peers, customers, companies, institutions, agencies, data banks or references who may have information bearing on my/ This Organization’s moral and ethical qualifications and competence to carry out the privileges I/This Organization have requested, and further authorize them to release such information as MSHN may require, including prior disciplinary records, for purposes of verifying information obtained in the attached application or any re-application information without any obligation to give me/This Organization written notice of such disclosure. I/This Organization agree to hold MSHN and the informant harmless from any liability to me and/or my organization for providing such information.

I/This Organization hereby further authorize MSHN to release any and all information related in any way to the professional practice to any person, entity or governmental agency which: (a) provides MSHN with an authorization signed by me/this organization; or (b) has a legal right to know under any state or Federal law. I/This Organization agree to hold MSHN harmless from any liability for providing any such information as specified herein.

I/This Organization release all parties from all liability from any damages, causes of action, including, but not limited to, slander and libel, that may result from furnishing any information to MSHN. I/This Organization agree that any false information in support of this application may result in action up to and including cancellation of any or all contracts subject to contract provisions regardless of when discovered by MSHN. I/This Organization release MSHN, the MSHN Credentialing Committee, individually and collectively, from any and all liability from any damages and/or causes of action associated with the MSHN credentialing and privileging process.

I/This Organization hereby signify the willingness to appear for interviews with MSHN. I/This Organization fully consent to the inspection of any and all records and documents pertinent to this application for appointment and/or privileges. If there is a doubt as to the competence, morals, or ethics, the burden shall be on me/this Organization to resolve the same. I/This Organization understand and agree that if MSHN determines that this application contains any significant misstatements, misrepresentations, or omissions, MSHN’s acceptance of this application for participation and any subsequent participating provider agreement which MSHN enters into will be voidable at MSHN’s sole discretion.

I/This Organization understand and agree that: (a) I/This Organization have the burden of producing all information required or requested by MSHN in connection with this application; (b) MSHN is under no obligation to complete the processing of this application until all information requested is provided; (c) MSHN has the sole discretion to determine whether or not I/This Organization will be accepted as a participating provider; and (d) in the event that MSHN decides not to accept me or my organization as a participating provider, I/This Organization may initiate administrative appeal procedures as defined in the instructions for completing the application.

I/This Organization understand and agree that the certifications, authorizations and other provisions contained herein shall remain in force for so long as this application is pending and, if accepted for participation, for so long as my and/or my organizations’ provider agreement with MSHN remains in force.

I/This Organization understand that MSHN is not obligated to grant any or all requested privileges and that application for such is not a guarantee of a contract with MSHN.

Applicant/Organization Authorized Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:

Print Name:

Application for Re-Credentialing Checklist

The following items are required:

[ ]  All applicable items on the application are complete and legible, signed and dated

[ ]  Copy of current Malpractice and Professional Liability Policy

[ ]  Copy of current licenses/certificates/approvals necessary to support requested privileges

[ ]  Attachment C – [Disclosure of Ownership and Controlling Interest](http://www.midstatehealthnetwork.org/provider-network/Provider-Applications.php)

If applicable:

[ ]  Written explanations attached for any privilege, licensure, or malpractice history questions answered “Yes”

[ ]  Attachment D – [Professional Liability Action Detail](http://www.midstatehealthnetwork.org/provider-network/Provider-Applications.php)