

**DIVISION OF CHILD MENTAL HEALTH SERVICES
OUTPATIENT AND RELATED NON-RESIDENTIAL SERVICES**

INDIVIDUAL AND GROUP PRACTICE APPLICATION

GENERAL DIRECTIONS:

The Division of Child Mental Health Services (DCMHS) application is required as the first step in obtaining a contract and must be completed by all potential providers requesting panel membership. There are different sets of applications for different types of providers. This application is for the category of individual practitioner/group practice. The application provides information about the potential provider's qualifications and clinical practice. It must be printed legibly or typed and all sections fully completed.

Section I. BUSINESS INFORMATION

A. *Individual/Group Practice Legal Name – This is the legal business entity signing the contract.*

Name _____

If different from above, Name of Business _____

Address _____

City _____ State _____ Zip _____

Telephone: (____) _____ FAX: (____) _____

E-Mail _____

B. *Administrative Contacts*

Chief Administrator _____ Telephone: (____) _____

E-Mail _____

Office Manager _____ Telephone: (____) _____

E-Mail _____

C. *Complete this section if group practice is part of a larger organization:*

Corporate Owner Name: _____

Contact Name _____

Corporate Address _____

City _____ State _____ Zip _____

Telephone: (_____) _____ FAX: (_____) _____

E-Mail _____

D. *Business Classification:*

1. Ownership Private Public
2. Status For-Profit Not-for-Profit (*Enclose documentation of 504C3*)

Model: (Check the type that best fits your staffing)

- Each Clinician is Self Employed Clinicians are Employees Clinicians are Partners

E. *Employee Identification Number (E.I)/Tax or Social Security Number* _____

Enclose a copy of your current business license.

F. *Malpractice Insurance Information*

Attach a copy of professional liability insurance for the individual/group practice and each of its members.

Section II. PRACTICE INFORMATION

A. Primary Practice Location

Address _____

City _____ County _____ State _____ Zip _____

Telephone: (____) _____ Fax: (____) _____

Office Manager _____

E-Mail _____

B. Type of Facility

Individual/Group Practice is located in Office Building Medical Facility

Therapist Home with private entrance

Location is handicapped accessible? Yes No

C. Hours of Operation

Indicate the actual hours the individual/group practice is offering each day (e.g. 8 AM - 12 PM)

Monday _____ Tuesday _____ Wednesday _____

Thursday _____ Friday _____ Saturday _____

D. Additional Practice Locations

Reproduce the information under Section II. Practice Information A – C for each additional location.

E. Contracts/Agreements with the following funding sources:

Medicaid – Delaware State Partners Yes No

Medicaid – Delaware Physicians Care Yes No

F. *CALL COVERAGE - The individual/group practice under contract must arrange for 24-hour, 7 day/week coverage for clients. This on-call coverage must be approved by DCMHS and services performed are subject to the same clinical standards as those of the contracted provider.*

Call coverage practitioners:

1. Name _____ Licensed as _____
Address _____ Telephone _____

2. Name _____ Licensed as _____
Address _____ Telephone _____

Does the individual/group practice have “live voice” answering service? Yes No

After-hours “live” phone answering service:

Name _____ Telephone: _____

Beeper: _____ Cell phone: _____

Section III. INDIVIDUAL/GROUP PRACTICE CHECKLIST

DIRECTIONS: Check yes or no for each item as it applies to the business entity identified under Section I. Business Information, A., and Page 1. For each item checked yes, attach a detailed description of the event, including copies of relevant documentation. Failure to provide sufficient information required for determining a clear understanding of the nature and outcome of the event can result in rejection of the application.

1. Has the business entity ever had professional liability insurance denied, canceled, or non-renewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the business entity ever had a medical or professional license or registration revoked, suspended, or limited?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has the business entity ever voluntarily relinquished a professional license or registration when there was a challenge or pending challenge to the professional license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is there a pending challenge to the business entity's professional license or registration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has the business entity ever been voluntarily or involuntarily suspended or terminated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has the business entity ever surrendered clinical privileges upon threat of censure, restriction, suspension, or revocation of such privilege?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has Medicare, Medicaid, or any other federal, state or local authority brought charges against the business entity for alleged inappropriate rates, billing, or quality of care issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has the business entity ever been named as a defendant in any criminal proceeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has the business entity ever been convicted of any crime involving the abuse of minors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has the business entity ever been subject of disciplinary actions by any professional association or organization, e.g., licensing board?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has the business entity's membership in any medical or other professional school ever not been renewed or subject to disciplinary action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Are there any current health problems that make the business entity unable to carry out any essential professional duties as defined by the requested appointment(s), privileges, and job description(s) in the agency under the contract being sought?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Is the business entity aware of any pending malpractice claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Has the business entity ever had any malpractice claims settled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Has the business entity ever been debarred from contracting with the State of Delaware, any other State or the government of the United States?	
16. Has the business entity ever had a permit to prescribe drugs revoked or suspended?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Has the business entity ever had a specialty board status suspended, diminished, revoked or not renewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section IV. INDIVIDUAL AND GROUP PRACTICE STATEMENT

This individual/group practice as it applies to the business entity identified under Section I. Business Information, A., Page 1 grants the Division of Child Mental Health Services permission and consent to obtain and verify information contained in this application and consent for any person, organization, or other entity to release to the Division of Child Mental Health Services all information that may be reasonably relevant to an evaluation of the individual/group practice and its professional competence to or ability to render clinical services in a professional and cost-effective manner.

The individual/group practice understands that the award of a contract with the Division of Child Mental Health Services is dependent upon a thorough review of this application and completion of the credentialing process.

The individual/group practice certifies that the information in this application is true, correct and complete, including information about employees who have a proprietary interest in the practice who are also employees of the Department of Services for Children, Youth and Their Families.

The individual/group practice further understands that any information entered in this application which is subsequently found to be false may result in the termination of any contract which may be developed as a result of this application.

Individual/Group Practice Legal Name _____

Authorized Signature _____ Date ____/____/____

Title _____

Print Name _____