Southwest Family Care Alliance

Service Provider Authorization and Release

Submit form to: **Southwest Family Care Alliance, Attn: Provider Network Manager**

Mail: 28526 US HWY 14, Lone Rock, WI 53556 or *Fax*: (608) 647-4754

Provider Name ____

Address ______________________________ ____________________ _____ ________

(street) (city) (state) (zip)

I understand and acknowledge that, as a provider applicant (herein after referred to as "Applicant") for the Southwest Family Care Management Organization (SFCA), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my facility's current licensure, certification, training experience, competence, health status, character, ethics and any other criteria adopted by SFCA for provider applicants.

I further understand that SFCA will investigate the information submitted as part of the application process. By submitting this, I agree to such investigation and to the disciplinary reporting and information exchange activities of SFCA as follows:

1. *Authorization of Investigation and Release of Information Concerning Application to Participate in the SFCA Provider Network*. I authorize SFCA to consult with any third party who may have information bearing on my agencies, qualifications, credentials, competence, ethics, or any other reasonable matter have a bearing on our qualifications for participation in the SFCA Provider Network, and authorize such third parties to release such information to SFCA.
2. *Authorization of Release and Exchange of Disciplinary Information*. I hereby further authorize any state or county agency to release Disciplinary Information about any disciplinary action taken against me to SFCA. Disciplinary Information means information concerning any action taken by such agency to revoke, deny, suspend, restrict, or condition my licensure/ certification or contractual relationship or impose a corrective action plan.
3. Release of Liability. I hereby further release from liability SFCA and all entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunity provided by law.

I understand and agree that this Authorization and Release is irrevocable for any period during which we are an applicant or participating provider for SFCA.

I acknowledge that the investigation of information in this application and the release and exchange of Disciplinary Information by SFCA is done to achieve, maintain, and improve quality care.

All information provided by me in the application is true to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the application may constitute grounds for denial or revocation of participating as a provider in the SFCA Provider Network. I understand and acknowledge that SFCA shall have sole responsibility for all decisions concerning the granting of participation in the SFCA Provider Network.

I further acknowledge that I have read and fully understand the foregoing Authorization and Release.

A photocopy of this Authorization and Release shall be as effective as the original.

______________________________ ____________

(provider signature) (date)

____

(print name)