

Southwest Family Care Alliance Service Provider Application



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

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

Please print or type all responses

General Provider Information

Name _____
(name of business, service or facility used by general public)

Address _____
(street) _____ (city) _____ (state) _____ (zip)

Contact Name _____ Phone _____ Fax _____
(for admissions/orders/service questions)

Contact Email _____

Office Hours _____

Website _____

Service Hours _____

Target Group(s) (on license/certification)
(check all that apply)

Facility Accessibility
(check one)

Service Details: Expertise / Languages / Other
(i.e., Alzheimer's, behavioral health, mental illness, Spanish)

- DD (developmentally disabled)
- FE (frail elderly)
- PD (physically disabled)
- All of the above

- Wheelchair accessible
- Not wheelchair accessible
- N/A: Member does not receive services on provider premises

Billing Information

Tax ID# _____ NPI# _____ WI Medicaid# _____
(EIN SSN - circle one) (if applicable) (if applicable)

Billing Company Name _____
(name you will use on claims and name that will be on payment checks)

Billing Address _____
(street) _____ (city) _____ (state) _____ (zip)
(address you will use on claims and where payments will be sent)

Billing Contact Name _____ Phone _____ Fax _____

Email _____

Contract Information

Contracting Company Name _____
(business name that will be on contract)

Contract Administrator Name _____
(administrator name that will be on contract; limited agreements do not have administrator name)

Contract Communications Contact

Name _____ Phone _____ Fax _____

Address _____
(street) _____ (city) _____ (state) _____ (zip)

Email _____

Services to be Provided

Description	Current Rate
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you able to begin services when requested within 72 hours? _____

Provider Organizational Information

(attach additional pages or documents as necessary)

Describe your cultural competency:

Describe any limitations in providing the services listed above:

Describe your organization's Quality Improvement/Quality Assurance Plan:

Describe your training plan/schedule for your staff:

Describe the pay levels and benefits provided for your direct service staff/providers:

Describe your organization's policy/process for identifying, reporting, evaluating, correcting, and resolving events and incidents:

Caregiver Background Checks Affirmation

Background checks are required by all providers who have direct contact with SFCA members. This includes initial checks and new checks every four (4) years (or at any time you have reason to believe a new check should be obtained). You do not need to send SFCA the results of the background checks, but must keep them on file and make them available for inspection upon request. (Contact SFCA if you require assistance with obtaining background checks.) Please read the following and initial to affirm that you obtain necessary background checks:

_____ As a provider agency, we obtain caregiver background checks for ourselves and any employees who have direct contact with SFCA Members, as required under HFS 12. The results of these checks are kept in our files or with our certifying agency and will be made available for inspection to SFCA upon request.

Provider Disclosure Questions

Please provide a complete explanation for any "Yes" answers. Attach additional sheets as necessary.

1. Yes Has your licensure or certification (if applicable) ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing/certification agency or board or any agency or organization, or is there a review pending?
 No

2. Yes Has your participation (if applicable) in any professional organization ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended, or revoked?
 No

3. Yes Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action plan with any licensing board, peer review organization, state agency, county agency, or any provider related agency or organization?
 No

4. Yes Has your certificate or participation in any private, federal (e.g., Medicare, Medicaid) or state health insurance program ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?
 No

5. Yes Have you ever been found liable, guilty, or responsible for sexual impropriety or misconduct or sexual harassment with a client, co-worker, or other?
 No

6. Yes Have you ever had any liability claims or lawsuits brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments?
 No

7. Yes Do you have a physical or mental condition that would affect your ability, with or without reasonable accommodation, to provide appropriate care to clients and otherwise perform the essential functions of a provider in your area of service provision? If yes, what accommodations would help you provide appropriate care to clients and perform other essential functions?
 No

Provider Signature

I assure that the information provided on this application is truthful and accurate and I understand that knowingly providing false information or omitting information may result in contract denial or termination. I agree to update this information as necessary so that it remains complete, true, and accurate while my provider application is being processed. I also confirm that I am not excluded from participation in federal health care programs as a provider.

(provider signature)

(date)

(print name)

We appreciate your interest in becoming a Service Provider for the Southwest Family Care Alliance. The next step in the contracting process will be to review and approve/reject your application. You will be informed of our decision in the near future. If you have questions regarding your application, please contact the Provider Network Department at 608-647-4729.

For Office Use Only

Application Approved

Application Rejected,
Reason:

Additional follow up required:

Notes: