North Sound BH-ASO
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North Sound Behavioral Health Administrative Services Organization

Agency Credentialing Application

INSTRUCTIONS:

Complete all items as noted below and submit this application and attachments in order to apply for credentialing with North Sound Behavioral Health Administrative Services Organization (North Sound BH-ASO). Please note that completed and approved credentialing is required prior to completion of a contract for any agency/facility currently contracted with North Sound BH-ASO, and that approval of your credentialing does not constitute finalization/approval of your contract and network participation.

A completed credentialing application packet should include:

- ✓ One **Agency Credentialing Application** (this form) is to be completed with general agency information. *Only one Agency Credentialing Application form is required for each agency.*
- ✓ A **Facility Site** form should be completed for each site North Sound BH-ASO will be contracted to utilize for services. *If multiple facilities/sites are to be used, a separate Facility Site form for each site is required*.
- ✓ Current agency and/or facility **licenses.**
- ✓ A completed **Ownership and Control Interest disclosure** form.
- ✓ A copy of the most recent on-site **survey results** for each contracted facility site.
- ✓ A copy of current **insurance** face sheet.

Incomplete applications will be returned for completion prior to processing. If you have any questions or concerns about this application or North Sound BH-ASO Credentialing requirements, please reach out to your Credentialing contact person or the Credentialing Committee: credentialing@nsbhaso.org.

Initial Credentialing **Recredentialing**

1. AGENCY INFORMATION

Legal Name of Agency: *(Legal name listed with IRS)*	
DBA Name of Agency: *(If applicable)*	
Historic Name(s) of Agency: *(If under same ownership)*	

Agency Medicare # *(primary)*:	
Agency Medicaid # *(primary):*	
Agency TIN *(primary)*:	
Agency NPI *(primary):*	

Ownership Type:	Sole Proprietorship City/County/State Owned	Corporation/LLC/Partnership Federally Owned
Profit/Non-Profit:	Profit	Non-Profit

Agency Address *(headquarters, etc.):*	
Billing Address *(if different than above)*:	

Contact Person:			
Email:		**Phone**:	

2. INSURANCE INFORMATION

Please attach a copy of your current facility professional or general liability insurance face sheet.	
Please check here if your facility is not required to carry liability insurance.	
Current Carrier Name:	**Policy Number:**
Policy Start Date:	**Policy End Date:**

3. AGENCY ACCREDITATION/CERTIFICATION INFORMATION

	Accreditation Organization (CMS, NCQA, TJC, etc.)	Date of Last Survey
	(CMS) Medicare Certification (attach most recent survey and acceptance letter)	
	(AAAHC) Accreditation Association for Ambulatory Health Care	
	(ACHC) Accreditation Commission for Health Care	
	(CARF) Commission on Accreditation of Rehabilitation Facilities	
	(CHAP) Community Health Accreditation Program	
	(DNV) Det Norske Veritas	
	(HFAP) Healthcare Facilities Accreditation Program - AOA	
	(HQAA) Healthcare Quality Association on Accreditation	
	(NCQA) National Commission for Quality Assurance	
	(TJC) The Joint Commission	
	(URAC) URAC, (aka, American Accreditation Healthcare Commission)	
	Other:	
	Other:	
	Please check here if the State conducts routine surveys of your agency for license, registration, or clinical oversight.	
	Please check here if your agency is NOT accredited and NOT required to be surveyed by ANY organization.	
Additional Comments:		

4. CREDENTIALING PROGRAM

Agency Service Provider Screening (please choose ONE option for each question).
1. Please select the method utilized to verify the license/certification of individuals rendering services for your agency: Online directly with the appropriate State and/or Federal licensure or certification board

Background check agency, contracted organization, or vendor

Other process (please describe):

No process (please explain):

2. **Please indicate the method utilized to ensure that each license/certification (and all other credentials) of individuals rendering services for your agency is renewed before expiration?**

Online directly with the appropriate State and/or Federal licensure or certification board

Obtaining a current copy of the license/certification

Background check agency, contracted organization, or vendor

Other process (please describe):

No process (please explain):

3. **Please indicate the method utilized to verify the identity of individuals rendering services for your agency:**

Verification of a state driver's license or other government identification

Background check agency, contracted organization, or vendor

Other process (please describe):

No process (please explain):

4. **Please indicate the method utilized to ensure that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service, and that no individuals convicted of a felony for a health-care related crime (including but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispensing of controlled substance) are rendering services:**

Federal and/or State Criminal Background Check(s)

Background check agency, contracted organization, or vendor

Search a State 'Misconduct Registry' or equivalent

Other process (please describe):

No process (please explain):

Facility/Agency Disclosure

1. **Has your agency or any of its authorized representatives ever been convicted of, pled guilty to, or pled nolo contendre to any legal actions (excluding misdemeanors)?**

No

Yes (provide an explanation):

2. **Does your agency or any of its authorized representatives currently have any pending legal actions (excluding misdemeanors)?**

   No

   Yes (provide an explanation):

3. **Has your agency ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military and State Department of Health programs?**

   No

   Yes (provide an explanation):

4. **At any time, has any license or certification held by the agency or its branch locations ever been revoked, denied or suspended, or has the agency or its branch locations ever voluntarily surrendered any license or certification while under investigation, or are there any actions or investigations currently under way which may lead to one of these outcomes?**

   No

   Yes (provide an explanation):

5. **Has your agency's liability insurance coverage ever been restricted, limited, denied, not renewed, or special rated for any reasons other than the carrier's termination of operations in your State?**

   No

   Yes (provide an explanation):

6. **At any time, has any third party payer ever revoked, reduced, denied, or suspended your agency's participation due to inappropriate utilization management or quality of care issues?**

   No

   Yes (provide an explanation):

7. **Does your agency currently employ any person who has been or is currently excluded from participation in a government program (e.g., Medicare, Medicaid)?**

   No

   Yes (provide an explanation):

Additional Comments:

ATTESTATION AND RELEASE OF INFORMATION FORM

Modifications Will Not Be Accepted

RELEASE OF INFORMATION:

As part of the application process and for the purpose of verifying any information provided on this application, I, the undersigned authorized agent of the applicant facility/agency, grant North Sound BH-ASO permission to contact any individual, institution, facility or agency identified on, or relative to, this application. Further, I hereby consent and authorize North Sound BH-ASO to request, receive and inspect any and all records pertinent to consideration of this application.

As a North Sound BH-ASO facility/agency applicant, I, the undersigned authorized agent, acknowledge that I am required to supply North Sound BH-ASO with verification of current malpractice coverage and any additional documentation necessary and relevant to the review of this application.

SITE REVIEW AUTHORIZATION:

I hereby grant permission for North Sound BH-ASO to conduct on-site and document reviews as necessary. I further agree that this facility will participate in and support North Sound BH-ASO's quality improvement and utilization review programs.

ATTESTATION:

I certify the information on this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitutes grounds for denial or summary dismissal. A copy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

I acknowledge that decision of participation for the agency on this application will be delayed until all required information is received and/or verified. I acknowledge that acceptance of this application does not constitute approval or acceptance or participating status with North Sound BH-ASO and does not grant this facility any rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this facility by North Sound BH-ASO. All services rendered to North Sound BH-ASO members must be individually authorized until a written notice of participation and conditions of participation is issued the North Sound BH-ASO.

This facility/agency complies with all federal, state, and local accessibility requirements as well as the standards required by the 1992 Federal Americans with Disabilities Act.

I certify that the appropriate state license or certification source is checked for all new employees or contracted service providers prior to the first provision of service. I certify that the appropriate state license or certification source is checked at least annually for existing and contracted service providers in order to ensure that every licensed individual providing services as a representative of the applicant holds a current license or certification to

provide services. I certify that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service. I certify the applicant does not employ or contract with any individual convicted of a felony for a health-care related crime, including but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispensing of controlled substance.

I certify that the on-line exclusion lists for the **Health and Human Services Office of Inspector General**, **System for Award Management,** **Washington State HCA Provider termination and exclusion list**, and **Washington State Department of Health News Release**, are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthly basis to ensure that no state or federally excluded individuals perform any function related to any state or federal health care program. I certify that I will remove any employee or contracted service provider found on one of the above referenced federal exclusion lists from any functions related to a North Sound BH-ASO program.

The individual executing this Attestation is duly authorized and has the proper authority and proper authorization to execute this Attestation and does so with the intent to fully bind Facility/Agency to the truthfulness of its answers.

Signature: ____

(Stamped signature is not acceptable)

Printed Name: ____

Date: ____