Provider Contract Application

Please print or type all information. If the question does not apply, enter N/A.
Blank applications could result in a denied application.

Name of Organization with DBA:			
Parent Organization (if applicable):			
Federal Tax ID#:		NPI or UMPI:	
Website:		Business Email:	
Mailing Address:			
City:	State:	Zip:	County:
Primary Location #1 Address:			
City:	State:	Zip:	County:
Phone Number:		Fax Number:	
Do you have additional Locations? ☐ Yes *(Please complete Page 3 for additional Locations)* ☐ No			
Do you offer Telehealth Services? ☐ Yes ☐ No Types of services: ☐ Phone ☐ Video			
Do you provide interpreter services for your clients/customers? ☐ Yes ☐ No			
If yes, which languages?			
Are you enrolled as a Medicaid provider with the State of Minnesota? ☐ Yes ☐ No The Joint Commission Accredited?: ☐ Yes ☐ No			
Are you Medicare (CMS) Certified? ☐ Yes ☐ No *If yes, Medicare Facility ID:*			
List hospitals you have admitting privileges at, or other facilities you are affiliated with for services, *if applicable*:			

Provide the following information for contact people.

Person Responsible for:	**Name**	**Telephone**	**Email Address**
Contracting			
CEO/Director/Owner			
Credentialing			
Organizational Assessment *(if applicable)*			

Describe the type of services offered by your organization and why they are unique:

Describe the ways you provide services to specific segments of the population (i.e. cultural, gender, race/ethnicity, LGBTQ+)

BEHAVIORAL HEALTH PROVIDERS *(Please check all that apply)*	
☐ Adult Day Treatment	☐ Outpatient Psychotherapy
☐ Adult Rehabilitative Mental Health Services (ARMHS)	☐ Outpatient Substance Use Disorder Treatment
☐ Assertive Community Treatment (ACT)	☐ Partial Hospitalization Program
☐ Behavioral Health Home	☐ Peer Recovery Support
☐ Certified Community Behavioral Health Clinic (CCBHC)	☐ Psychiatry
☐ Children's Day Treatment	☐ Psychological/Neuropsychological Testing
☐ Children's Group Residential Treatment Facility (CGRTF)	☐ Recovery Community Organization
☐ Children's Therapeutic Services and Support (CTSS)	☐ Residential Substance Use Disorder Treatment
☐ In Patient Mental Health Facility	☐ Substance Use Disorder Treatment (SUD)
☐ Intensive Residential Treatment Services (IRTS)	☐ SUD Comprehensive Assessment
☐ Outpatient Mental Health	☐ Targeted Case Management (TCM)
☐ Other:	

SPECIALTY PROVIDERS *(Please check all that apply)*				
☐ Acupuncture	☐ Early Intensive Developmental and Behavioral Intervention (EIDBI)		☐ Oral Surgery	☐ Specialists
☐ Audiology	☐ Essential Community Providers		☐ Physical Therapy	☐ Speech Therapy
☐ Chiropractic	☐ Occupational Therapy	☐ Optometry	☐ Physician	☐ Specialty Hospital
☐ Other:				

HOSPITAL/CLINIC/SURGERY CENTER/FREE STANDING FACILITY/SKILLED NURSING FACILITY *(Please check all that apply)*			
☐ Ambulatory Surgery Center	☐ Free Standing Clinic	☐ Hospice	☐ Primary Care Clinic
☐ Critical Access Hospital	☐ Free Standing Facility	☐ Hospital	☐ Provider Based Clinic
☐ Dialysis	☐ Free Standing Birthing Center		☐ Rural Health Clinic
☐ Federally Qualified Health Center		☐ Hospital Based Clinic	☐ Skilled Nursing Facility
☐ Other:			

HOME CARE/DME/LAB/ INTERPRETER *(Please check all that apply)*		
☐ Doula Services	☐ Home Infusion	☐ Public Health
☐ Durable Medical Equipment	☐ Independent Laboratory	☐ Social Services
☐ Home Health	☐ Interpreter	☐ Other:
☐ Home Health w/ Skilled Nursing	☐ Personal Care Agency (PCA)	

TRANSPORTATION PROVIDERS *(Please check all that apply)*		
☐ Non-Emergency Medical Transportation (NEMT)	☐ Emergency Medical Transportation	
(Please check all that apply below for non-Emergency and include how many vehicles of each you service)	**Please list the counties that you service below.**	
☐ Ambulatory How many?		
☐ Lift/Ramp How many?		
☐ Stretcher How many?		
☐ Unassisted How many?		
☐ Volunteer Drivers How many?		
☐ Wheelchair How many?		

Location # **Legal Name with dba:** ***IMPORTANT: This should be the business name you use to file income to the IRS (This is also the first line of the W-9 Form.)***		
Federal Tax ID:	NPI:	Phone Number:
Physical Address:		
City, State Zip:		County:
Fax Number:	Toll Free/TDD:	
Types of Services provided at this location:		
Do you provide Telehealth Services? ☐ Yes ☐ No Types of telehealth services: ☐ Phone ☐ Video		

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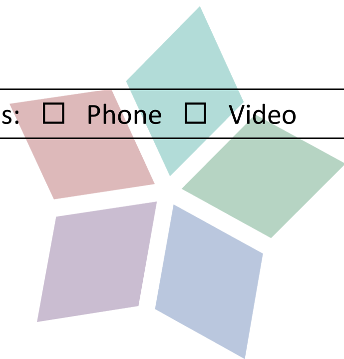

South Country Health Alliance serves a diverse population in our member counties and has had multiple instances of members requesting primary care or therapy providers who speak the primary language of the member and/or resembles the appearance of the member. Currently a significant amount of time is put into finding a provider for the member.

In an effort to gather diversity information about our provider network we ask that you please indicate the percentage of your Primary Care, Specialty Care or Mental Health **Providers** who identify as one of following groups:

	Behavioral Health	Drivers	Primary Care	Specialty Care
1. Asian	%	%	%	%
2. Black or African American	%	%	%	%
3. Hawaiian or Pacific Islander	%	%	%	%
4. Hispanic or Latinx	%	%	%	%
5. Middle Eastern	%	%	%	%
6. Native American or Alaskan Native	%	%	%	%
7. White	%	%	%	%
8. Multiracial or Biracial	%	%	%	%
9. A race/ethnicity not listed here	%	%	%	%
Please Specify which race/ethnicity for #9				

Return this form to providerinfo@mnscha.org

It may take up to 90 days for the application to be reviewed by our contracting review committee. We are sorry for the delay but be assured your application will remain on file with us and will be reviewed as soon as possible.

NOTE: Network Providers must be enrolled with the State of Minnesota Department of Human Services as MHCP Providers.

Network Providers must comply with the provider disclosure, screening, and enrollment requirements in 42 CFR §455.
[Minnesota Statues, §256B.69, subd. 37; and 42 CFR §438.602(b)]

I certify that the information provided on this form is true and correct.

Application signor name (Print):	Title:
Application signor signature:	Date:
Email Address:	Phone Number: