

Facility/Ancillary/Long-term Care Provider Credentialing Application

Provider identification	
Legal Business Name:	
Doing Business As (if applicable):	
Credentialing Contact:	Credentialing Contact Email:
Credentialing Contact Phone:	Secure Fax:
Alternative Contact:	Alternative Contact Phone:
Taxpayer Identification Number:	National Provider Identifier (NPI):
Taxonomy:	Atypical Provider Identifier (API):

Location/Service Address to be Credentialed (Please note: if any of your locations has a unique license, unique NPI and/or a unique Tax ID number, a separate credentialing event and application will be required. If you have multiple locations that bill under the same license/NPI/Tax ID, please complete the Secondary Locations Excel Template.)			
Practice location name:			
Medicaid Number/TPI:	Medicare ID:		
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Preferred):	County:
Phone:	Fax:	Primary contact:	

Billing information (if different than above)			
Billing name:			
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Optional):	County:

Credentialing Address (Please Note: Aperture will send credentialing correspondence to this address.)			
Credentialing Contact:			
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Optional):	County:

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Primary Office Hours						
Mon	Tue	Wed	Thur	Fri	Sat	Sun

After-hours coverage: Yes No

Age of patients served:

- Newborn Adolescents (13-18 years)
 Preschool (3 to 5 years) Adults
 Children (6-12 years) Geriatrics (65+ years)

Patient program/population served:

- Serves Intellectual & Developmental Disabilities (IDD) population
 Services pediatric population

Please indicate any age limitations: _____ Please indicate any gender limitations: _____

Do you offer the following services:

Telemedicine Services Yes No Telehealth Services Yes No Telemonitoring Services Yes No

ADA Requirements

Access & Availability Yes No

Appropriate Equipment Available Yes No

Languages Spoken

Languages Spoken By Provider Staff Other Than English:

- Spanish Vietnamese
 American Sign Language Other: _____

Provider Type

- | | |
|--|---|
| <input type="checkbox"/> Adaptive Aids/Medical Equipment (LTSS) | <input type="checkbox"/> Cardiac Diagnostic Center |
| <input type="checkbox"/> Adaptive Assistance Devices | <input type="checkbox"/> Cardiac Rehab Center |
| <input type="checkbox"/> Adult Day Care | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Adult Foster Care | <input type="checkbox"/> Certified Registered Nurse Anesthesia (CRNA) Group |
| <input type="checkbox"/> Allied Health Professional Group | <input type="checkbox"/> Chiropractic Group/Practice |
| <input type="checkbox"/> Ambulance Service/Transportation Company | <input type="checkbox"/> Chore Service |
| <input type="checkbox"/> Ambulatory Surgical Center (ASC)-Freestanding/Independent | <input type="checkbox"/> Companion Services |
| <input type="checkbox"/> Ambulatory Surgical Center (ASC)-Hospital Based | <input type="checkbox"/> Comprehensive Care Program (CCP) |
| <input type="checkbox"/> Amputee Center | <input type="checkbox"/> Comprehensive Health Center (CHC) |
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Comprehensive Outpatient Rehab Facility (CORF) |
| <input type="checkbox"/> Audiology/Hearing Center | <input type="checkbox"/> Congregate Care Facility |
| <input type="checkbox"/> Biological Products Manufacturer | <input type="checkbox"/> Convalescent Facility |
| <input type="checkbox"/> Birthing Center | <input type="checkbox"/> County Indigent Health Care Program (CIHCP) |
| <input type="checkbox"/> Blood Bank | <input type="checkbox"/> Day Habilitation (LTSS) |
| | <input type="checkbox"/> Dental Group/Practice |

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Provider type (continued)

- | | |
|--|--|
| <input type="checkbox"/> Diabetes Education Center | <input type="checkbox"/> Lithotripsy Center |
| <input type="checkbox"/> Diagnostic and Treatment Center | <input type="checkbox"/> Local Health Department |
| <input type="checkbox"/> Dialysis Center | <input type="checkbox"/> Magnetic Resonance Imaging (MRI) |
| <input type="checkbox"/> Dispensing Optical Company | <input type="checkbox"/> Maternity Service Clinic |
| <input type="checkbox"/> Drug and Department Stores | <input type="checkbox"/> Meals, Home Delivered Meals |
| <input type="checkbox"/> Durable Medical Equipment (DME) | <input type="checkbox"/> Minor Home Modification |
| <input type="checkbox"/> Early Childhood Intervention (ECI) | <input type="checkbox"/> Mobile X-Ray/Mobile Diagnostic Provider |
| <input type="checkbox"/> Early Intervention Provider Agency | <input type="checkbox"/> Multi Specialty Group |
| <input type="checkbox"/> Emergency Response Service/System | <input type="checkbox"/> Non-Emergent Transportation Services |
| <input type="checkbox"/> Employment Assistance | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> End Stage Renal Disease Facility (ESRD) | <input type="checkbox"/> Nursing/Health Care Staffing Service |
| <input type="checkbox"/> Endoscopy Facility | <input type="checkbox"/> Nutritional Counseling |
| <input type="checkbox"/> Family Counseling and Training | <input type="checkbox"/> Occupational Therapy Group/Clinic |
| <input type="checkbox"/> Family Planning Clinic | <input type="checkbox"/> Optometric Group/Practice |
| <input type="checkbox"/> Federal Qualified Health Center (FQHC) | <input type="checkbox"/> Oral and Maxillofacial Surgery Clinic |
| <input type="checkbox"/> Financial Management Service Agency | <input type="checkbox"/> Organ Procurement Organization |
| <input type="checkbox"/> Free Standing Emergency Room | <input type="checkbox"/> Orthodontist Group |
| <input type="checkbox"/> Habilitation (LTSS) | <input type="checkbox"/> Orthotics/Prosthetics |
| <input type="checkbox"/> Hearing Aid Equipment | <input type="checkbox"/> Oxygen Supplier |
| <input type="checkbox"/> Hemophilia Treatment Center | <input type="checkbox"/> Pediatric Day Health Care |
| <input type="checkbox"/> Home and Community Support Services | <input type="checkbox"/> Personal Assistance Services Agency |
| <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Personal Care Services (PCS) |
| <input type="checkbox"/> Home Infusion | <input type="checkbox"/> Pest Control |
| <input type="checkbox"/> Homemaker Service | <input type="checkbox"/> Pharmacist Group |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Hospital Long Term, Limited or Specialized Care | <input type="checkbox"/> Pharmacy-Chain |
| <input type="checkbox"/> Hospital, Acute Care | <input type="checkbox"/> Pharmacy-Close Operation |
| <input type="checkbox"/> Hospital, Military | <input type="checkbox"/> Pharmacy-Home Health IV LTC |
| <input type="checkbox"/> Hospital, Pediatric | <input type="checkbox"/> Pharmacy-Hospital Class C |
| <input type="checkbox"/> Hospital, Private, Full Care | <input type="checkbox"/> Pharmacy-Independent |
| <input type="checkbox"/> Hospital, Rehabilitation | <input type="checkbox"/> Pharmacy-Out of State Contracted |
| <input type="checkbox"/> Independent Lab/Private Owned Lab | <input type="checkbox"/> Pharmacy-Out of State Non-contracted |
| <input type="checkbox"/> Infertility Center | <input type="checkbox"/> Pharmacy-Out of State TMHCN |
| <input type="checkbox"/> Infusion Therapy Clinic | <input type="checkbox"/> Physical Therapy Group/Clinic |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Physician Group |

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Provider type (continued)

- | | |
|---|---|
| <input type="checkbox"/> Podiatric Group/Practice | <input type="checkbox"/> Skilled Nursing Facility (SNF) |
| <input type="checkbox"/> Prescribed Pediatric Extended Care Centers (PPECC) | <input type="checkbox"/> Sleep Medicine Center |
| <input type="checkbox"/> Public Health Agency | <input type="checkbox"/> Supported Employment/Employment Assistance |
| <input type="checkbox"/> Radiation / Cancer Treatment Centers | <input type="checkbox"/> Transition Assistance Services (LTSS) |
| <input type="checkbox"/> Respiratory Therapy | <input type="checkbox"/> Tuberculosis (TB) Clinic-Group |
| <input type="checkbox"/> Retail Clinic | <input type="checkbox"/> Urgent Care Center |
| <input type="checkbox"/> Rural Health Clinic-Freestanding/Independent | <input type="checkbox"/> Vehicle Modification (LTSS) |
| <input type="checkbox"/> Rural Health Clinic-Hospital Based | |

STAR Kids Providers Must Answer the Following:

All questions must be answered with a checked "Yes" or "No". Do not mark N/A for any questions.

Do you participate in the Medically Dependent Children Program (MDCP)? Yes No

Do you participate in the Community First Choice (CFC) Program? Yes No

Are you a Home and Community Support Service Agency (HCSSA) Provider? Yes No

Are you a Community Living Assistance and Support Services (CLASS) Provider? Yes No

Do you participate in the Deaf, Blind, & Multiple Disabilities (DBMD) Program? Yes No

Are you a Youth Empowerment Services (YES) Provider? Yes No

Are you recognized as a NCQA Patient-Centered Medical Home? Yes No

If yes, what level? _____

Please give a list of where telemedicine services are provided if in addition to services locations

Do you participate in an Electronic Visit Verification (EVV) Program? Yes No

Licensure & Certificates (attach a copy of current licensure and Clinical Laboratory Improvements Amendment [CLIA] certification, if applicable)

Type of License:	License issuance date:	License number:	Expiration date:
State:			
Type of License:	License issuance date:	License number:	Expiration date:
State:			
Type of License:	License issuance date:	License number:	Expiration date:
State:			
Radiology Certificate #:		Radiology Expiration Date:	
CLIA Certificate #:		CLIA Expiration Date:	

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Accreditation/certification (attach a copy of current accreditation, certificate or survey)

A.

Accreditation Association of Ambulatory Health Care (AAAHC)

Accreditation Commission for Health Care (ACHC)

Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

American Board for Certification in Orthotics & Prosthetics

American College of Radiology (ACR)

Board of Certification

Center for Improvement in Healthcare Quality

Clinical Laboratory Improvement Amendments (CLIA)

Commission on Accreditation of Rehabilitation Facilities (CARF)

Note: Continuing Care Accreditation Commission (CCAC) and CARF have merged, so CCAC not included separately

Commission on Office Laboratory Accreditation (COLA)

Community Health Action Partnership (CHAP)

Council on Accreditations (COA)

Det Norske Veritas Healthcare, Inc (DNV)

Healthcare Facility Accreditation Program (HFAP)

Healthcare Quality Association on Accreditation

Intersocietal Accreditation

Commission (IAC)

Joint Commission for the Accreditation of HealthCare Organization (TJC or JCAHO)

National Association of Boards of Pharmacy (NABP)

National Board of Accreditation for Orthotic Suppliers

RadSite

The Compliance Team

Accrediting Body:	Expiration Date (mm/dd/yyyy):
Accrediting Body:	Expiration Date (mm/dd/yyyy):
Accrediting Body:	Expiration Date (mm/dd/yyyy):

Not accredited — Expected date of accreditation (mm/dd/yyyy): _____

B. Site Survey — Visit May Be Required

Nonaccredited providers must provide a copy of:

- Most recent government agency survey (may not be older than 36 months),
- Corrective action plan (if deficiencies were cited), and attach the proof from the government agency stating facility is in substantial compliance with most recent survey standards.

Facilities that don't meet the requirements above require an onsite visit before network status may be granted. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.

Has the provider had an on-site survey by CMS or state agency? Yes No

(YES) Date of most recent full survey _____

(NO) Successful completion of a health plan onsite visit will be required to complete credentialing.

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General and professional liability insurance – Please submit a copy of your certificate of insurance.	
General liability coverage	
Current carrier name:	
Policy number:	Coverage type: Occurrence-based Claims-based
Effective date:	Expiration date:
Per incident: \$	Aggregate: \$

Professional/Malpractice liability coverage – Please submit a copy of your certificate of insurance.	
Current carrier name:	
Policy number:	Coverage type: Occurrence-based Claims-based
Effective date:	Expiration date:
Per incident: \$	Aggregate: \$

Automobile Insurance	
Are you required to carry automobile insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, submit a copy of your certificate.)	

Professional Disclosure Questions

Please include an explanation on a separate sheet for any question(s) answered Yes.

1. Has the organization ever been reprimanded, fined by any state agency that disciplines allied health professionals or health organizations? Yes No

Has the organization’s license to practice or operate in any jurisdiction (state or county) ever been denied, revoked, suspended, sanctioned or subject to probation or any conditions or limitations? Yes No

2. Have any disciplinary proceedings ever been instituted against the organization by any medical organization or medical institute? Yes No

3. Has the organization ever been convicted of a felony? Yes No

4. Have any malpractice suits, arbitration or other proceeding ever been instituted against the organization (regardless of outcome)? Yes No

5. Has the organization ever been investigated, reprimanded, censured, excluded, suspended or disqualified by Medicare or Medicaid program? Yes No

6. Has the organization’s liability insurance policy ever been canceled? Yes No

7. Has the organization ever been denied renewal of the liability insurance policy or had any limitations placed on the scope of coverage? Yes No

Note: This impacts the section called “Enclosures.”

Explanation of “Yes” answers to attestation questions Credentialing Questionnaire

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Attestation Consent and Release

All information provided in this, or in connection with this application, is complete and accurate to the best of my knowledge, and I shall immediately notify the Plan(s) of any changes thereto. I understand that this application does not entitle me to participation in the Plan(s) network. By applying for appointment as a TAHP participating provider, I authorize the Plan(s) plan, its medical director, and appropriate representatives to consult with administrators and members of other institutions where I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to the inspection by the Plan(s), and their representatives, its medical director and appropriate representatives, of all records and documents, excluding medical records of nonmembers of TAHP Participating Plans, that may be material to an evaluation of any professional qualifications and competence to carry out the requested duties, as well as my moral and ethical qualifications for participating provider status with the Plan(s) participating with TAHP. I consent and agree that TAHP Participating Plans will complete a criminal history background check to determine if I, or any subcontracted providers, have any history of felony convictions, including adjudication withheld on a felony, plea or nolo contendere to a felony or entry into a pretrial for a felony. I agree to obtain any consents or approvals required for my subcontracted providers to undergo such background checks. I hereby release the Plan(s) and its representatives, including TAHP and Aperture Credentialing, LLC, from any liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I hereby release any individuals and organizations from any liability that provide information to the Plan(s) and its representatives or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the ancillary agreement between me or my group and the Plan(s), as such terms may be applicable to me. I understand that as an applicant for participation in the Plan(s), I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from the Plan(s), I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the credentialing committee, if they so request. I further understand that I may appeal the committee's decision either in writing or by appearance before the credentialing committee, if they so request.

By signing below, I attest that I have reviewed and understand all terms and conditions contained in this Attestation/Consent & Release. I agree that my electronic signature is equivalent to my hand-written signature.

I certify that the on-online exclusion lists for the [Health and Human Services Office of Inspector General](#) and [System for Award Management](#) 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 state or federal health care program.

Type or Print Name _____ Date _____

Title _____

Signature _____

Enclosures

Please submit all applicable documents from the list below with your completed and signed application. Failure to provide this information will prohibit completion of your credentialing and/or contracting process. Please submit enclosures for each location.

- Copy of all federal, state and/or local licenses required to operate as a health care facility (by location)
- Copy of accreditation certificate or letter
- Copy of most recent CMS or state survey, including your corrective action plan if deficiencies were cited or cover letter from CMS/state agency stating facility is in substantial compliance
- Copy of CLIA certificate for each location, as applicable
- Copy of current DEA certificate (if applicable);
- Current TDH Radiology certificate for each location (if applicable);
- Evidence of Texas Mental Health and Mental Retardation certification (REQUIRED for community mental health centers)
- Evidence of Medicare certification (REQUIRED for institutional centers)
- Professional/Malpractice liability of Insurance (AS REQUIRED ABOVE);

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Enclosures (continued)

- Copy of TMHP Medicaid Letter (when applicable)
- Evidence of an Agreement with HHSC [REQUIRED for CORF providers]
- Medical Staff / Allied Health Professional Roster
- Explanation of "Yes" answers to attestation questions
- Company brochure (if available)
- Current Signed W-9

Attachment A - Hospital Facilities

Hospital - part of multi-hospital system? Yes No

Are you considered an Essential Community Provider as defined by CMS? Yes No

Hospital Services/Treatment Levels:

- Adult acute care
- Level 1 trauma
- Level 2 trauma
- Level 3 trauma
- Level 4 trauma
- Children's Hospital — [CMS Designated]
- Designated Childrens Unit/Wing
- Specializes in Pediatric Services

Are you a member of the American Hospital Association? Yes No

Number of Certified Beds _____

NICU Level _____ Certification Date _____

Medicare - Certified Acute Inpatient Facility Information

Medicare Certified Bed Count: _____ ICU Bed Count(excluding Neonatology): _____

Skilled Nursing or Swing Bed Count: _____ Inpatient Psychiatric Bed Count: _____

- Acute Inpatient Rehab Services
- Cardiac Catheterization Services
- Outpatient Occupational Therapy
- Cardiac Surgery Program
- Outpatient Physical Therapy
- Critical Care Services- Intensive Care Unit (ICU)
- Outpatient Speech Therapy
- Diagnostic Radiology
- Skilled Nursing Unit
- Durable Medical Equipment (DME)
- Surgical Services (Outpatient or ASC)
- Inpatient Psychiatric Facility Services
- Mammography
- Orthotics and Prosthetics
- Outpatient Dialysis
- Outpatient Infusion/Chemotherapy

Medicare-Approved Transplant Programs

- Heart/Lung
- Heart
- Intestinal
- Kidney
- Liver
- Lung
- Pancreas
- Other _____

Attachment B - Texas Long-Term Services and Supports

Provider type Services Details

<p>Personal assistance service direct:</p> <p><input type="checkbox"/> Consumer-directed block grant model</p> <p><input type="checkbox"/> Consumer-directed services (CDS) model</p> <p><input type="checkbox"/> Consumer-delegated agency model</p> <p><input type="checkbox"/> Financial management/ CDS</p> <p><input type="checkbox"/> Rate enhancement program</p> <p>Participant contract number: _____</p> <p>List level: _____</p>	<p>Day activity/health services:</p> <p><input type="checkbox"/> Rate enhancement program</p> <p>Participant contract number: _____</p> <p>List level: _____</p>	<p>Residential care/assisted living facility:</p> <p><input type="checkbox"/> Rate enhancement program</p> <p>Participant contract number: _____</p> <p>List level: _____</p>	<p><input type="checkbox"/> Transition/relocation services</p>
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Counties Served: Please select the ones in which services can be provided or check here STATEWIDE [servicing all

<input type="checkbox"/> Anderson	<input type="checkbox"/> Andrews	<input type="checkbox"/> Angelina	<input type="checkbox"/> Aransas	<input type="checkbox"/> Archer
<input type="checkbox"/> Armstrong	<input type="checkbox"/> Atascosa	<input type="checkbox"/> Austin	<input type="checkbox"/> Bailey	<input type="checkbox"/> Bandera
<input type="checkbox"/> Bastrop	<input type="checkbox"/> Baylor	<input type="checkbox"/> Bee	<input type="checkbox"/> Bell	<input type="checkbox"/> Bexar
<input type="checkbox"/> Blanco	<input type="checkbox"/> Borden	<input type="checkbox"/> Bosque	<input type="checkbox"/> Bowie	<input type="checkbox"/> Brazoria
<input type="checkbox"/> Brazos	<input type="checkbox"/> Brewster	<input type="checkbox"/> Briscoe	<input type="checkbox"/> Brooks	<input type="checkbox"/> Brown
<input type="checkbox"/> Burleson	<input type="checkbox"/> Burnet	<input type="checkbox"/> Caldwell	<input type="checkbox"/> Calhoun	<input type="checkbox"/> Callahan
<input type="checkbox"/> Cameron	<input type="checkbox"/> Camp	<input type="checkbox"/> Carson	<input type="checkbox"/> Cass	<input type="checkbox"/> Castro
<input type="checkbox"/> Chambers	<input type="checkbox"/> Cherokee	<input type="checkbox"/> Childress	<input type="checkbox"/> Clay	<input type="checkbox"/> Cochran
<input type="checkbox"/> Coke	<input type="checkbox"/> Coleman	<input type="checkbox"/> Collin	<input type="checkbox"/> Collingsworth	<input type="checkbox"/> Colorado
<input type="checkbox"/> Comal	<input type="checkbox"/> Comanche	<input type="checkbox"/> Concho	<input type="checkbox"/> Coryell	<input type="checkbox"/> Cottle
<input type="checkbox"/> Crane	<input type="checkbox"/> Crockett	<input type="checkbox"/> Crosby	<input type="checkbox"/> Culberson	<input type="checkbox"/> Dallam
<input type="checkbox"/> Dallas	<input type="checkbox"/> Dawson	<input type="checkbox"/> Deaf Smith	<input type="checkbox"/> Delta	<input type="checkbox"/> Denton
<input type="checkbox"/> DeWitt	<input type="checkbox"/> Dickens	<input type="checkbox"/> Dimmit	<input type="checkbox"/> Donley	<input type="checkbox"/> Duval
<input type="checkbox"/> Eastland	<input type="checkbox"/> Ector	<input type="checkbox"/> Edwards	<input type="checkbox"/> El Paso	<input type="checkbox"/> Ellis
<input type="checkbox"/> Erath	<input type="checkbox"/> Falls	<input type="checkbox"/> Fannin	<input type="checkbox"/> Fayette	<input type="checkbox"/> Fisher
<input type="checkbox"/> Floyd	<input type="checkbox"/> Foard	<input type="checkbox"/> Fort Bend	<input type="checkbox"/> Franklin	<input type="checkbox"/> Freestone
<input type="checkbox"/> Frio	<input type="checkbox"/> Gaines	<input type="checkbox"/> Galveston	<input type="checkbox"/> Garza	<input type="checkbox"/> Gillespie
<input type="checkbox"/> Glasscock	<input type="checkbox"/> Goliad	<input type="checkbox"/> Gonzales	<input type="checkbox"/> Gray	<input type="checkbox"/> Grayson
<input type="checkbox"/> Gregg	<input type="checkbox"/> Grimes	<input type="checkbox"/> Guadalupe	<input type="checkbox"/> Hale	<input type="checkbox"/> Hall
<input type="checkbox"/> Hamilton	<input type="checkbox"/> Hansford	<input type="checkbox"/> Hardeman	<input type="checkbox"/> Hardin	<input type="checkbox"/> Harris
<input type="checkbox"/> Harrison	<input type="checkbox"/> Hartley	<input type="checkbox"/> Haskell	<input type="checkbox"/> Hays	<input type="checkbox"/> Hemphill
<input type="checkbox"/> Henderson	<input type="checkbox"/> Hidalgo	<input type="checkbox"/> Hill	<input type="checkbox"/> Hockley	<input type="checkbox"/> Hood
<input type="checkbox"/> Hopkins	<input type="checkbox"/> Houston	<input type="checkbox"/> Howard	<input type="checkbox"/> Hudspeth	<input type="checkbox"/> Hunt

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Counties Served (continued)

<input type="checkbox"/> Hutchinson	<input type="checkbox"/> Irion	<input type="checkbox"/> Jack	<input type="checkbox"/> Jackson	<input type="checkbox"/> Jasper
<input type="checkbox"/> Jeff Davis	<input type="checkbox"/> Jefferson	<input type="checkbox"/> Jim Hogg	<input type="checkbox"/> Jim Wells	<input type="checkbox"/> Johnson
<input type="checkbox"/> Jones	<input type="checkbox"/> Karnes	<input type="checkbox"/> Kaufman	<input type="checkbox"/> Kendall	<input type="checkbox"/> Kenedy
<input type="checkbox"/> Kent	<input type="checkbox"/> Kerr	<input type="checkbox"/> Kimble	<input type="checkbox"/> King	<input type="checkbox"/> Kinney
<input type="checkbox"/> Kleberg	<input type="checkbox"/> Knox	<input type="checkbox"/> La Salle	<input type="checkbox"/> Lamar	<input type="checkbox"/> Lamb
<input type="checkbox"/> Lampasas	<input type="checkbox"/> Lavaca	<input type="checkbox"/> Lee	<input type="checkbox"/> Leon	<input type="checkbox"/> Liberty
<input type="checkbox"/> Limestone	<input type="checkbox"/> Lipscomb	<input type="checkbox"/> Live Oak	<input type="checkbox"/> Llano	<input type="checkbox"/> Loving
<input type="checkbox"/> Lubbock	<input type="checkbox"/> Lynn	<input type="checkbox"/> Madison	<input type="checkbox"/> Marion	<input type="checkbox"/> Martin
<input type="checkbox"/> Mason	<input type="checkbox"/> Matagorda	<input type="checkbox"/> Maverick	<input type="checkbox"/> McCulloch	<input type="checkbox"/> McLennan
<input type="checkbox"/> McMullen	<input type="checkbox"/> Medina	<input type="checkbox"/> Menard	<input type="checkbox"/> Midland	<input type="checkbox"/> Milam
<input type="checkbox"/> Mills	<input type="checkbox"/> Mitchell	<input type="checkbox"/> Montague	<input type="checkbox"/> Montgomery	<input type="checkbox"/> Moore
<input type="checkbox"/> Morris	<input type="checkbox"/> Motley	<input type="checkbox"/> Nacogdoches	<input type="checkbox"/> Navarro	<input type="checkbox"/> Newton
<input type="checkbox"/> Nolan	<input type="checkbox"/> Nueces	<input type="checkbox"/> Ochiltree	<input type="checkbox"/> Oldham	<input type="checkbox"/> Orange
<input type="checkbox"/> Palo	<input type="checkbox"/> Panola	<input type="checkbox"/> Parker	<input type="checkbox"/> Parmer	<input type="checkbox"/> Pecos
<input type="checkbox"/> Pinto	<input type="checkbox"/> Polk	<input type="checkbox"/> Potter	<input type="checkbox"/> Presidio	<input type="checkbox"/> Rains
<input type="checkbox"/> Randall	<input type="checkbox"/> Reagan	<input type="checkbox"/> Real	<input type="checkbox"/> Red River	<input type="checkbox"/> Reeves
<input type="checkbox"/> Refugio	<input type="checkbox"/> Roberts	<input type="checkbox"/> Robertson	<input type="checkbox"/> Rockwall	<input type="checkbox"/> Runnels
<input type="checkbox"/> Rusk	<input type="checkbox"/> Sabine	<input type="checkbox"/> San Jacinto	<input type="checkbox"/> San Patricio	<input type="checkbox"/> San Saba
<input type="checkbox"/> Schleicher	<input type="checkbox"/> Scurry	<input type="checkbox"/> Shackelford	<input type="checkbox"/> Shelby	<input type="checkbox"/> Sherman
<input type="checkbox"/> Smith	<input type="checkbox"/> Somervell	<input type="checkbox"/> Starr	<input type="checkbox"/> Stephens	<input type="checkbox"/> Sterling
<input type="checkbox"/> Stonewall	<input type="checkbox"/> Sutton	<input type="checkbox"/> Swisher	<input type="checkbox"/> Tarrant	<input type="checkbox"/> Taylor
<input type="checkbox"/> Terrell	<input type="checkbox"/> Terry	<input type="checkbox"/> Throckmorton	<input type="checkbox"/> Tom Green	<input type="checkbox"/> Travis
<input type="checkbox"/> Tyler	<input type="checkbox"/> Upton	<input type="checkbox"/> Uvalde	<input type="checkbox"/> Val Verde	<input type="checkbox"/> Victoria
<input type="checkbox"/> Walker	<input type="checkbox"/> Waller	<input type="checkbox"/> Ward	<input type="checkbox"/> Washington	<input type="checkbox"/> Webb
<input type="checkbox"/> Wharton	<input type="checkbox"/> Wheeler	<input type="checkbox"/> Wichita	<input type="checkbox"/> Wilbarger	<input type="checkbox"/> Willacy
<input type="checkbox"/> Williamson	<input type="checkbox"/> Wilson	<input type="checkbox"/> Winkler	<input type="checkbox"/> Wise	<input type="checkbox"/> Yoakum
<input type="checkbox"/> Young	<input type="checkbox"/> Zapata	<input type="checkbox"/> Zavala		

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Attachment C - Behavioral Health Facilities/Providers

Specialty Service Identified (examples ECT, Eating Disorders, Ambulatory Detox....) _____

Place of service location for each program/service _____

Secure fax number for each place of service address _____

Bed Counts for inpatient Mental Health or Substance Use Disorder _____

Behavioral Health (BH):

- Behavioral Health (MH) Rehabilitation
- Behavioral Health Facility
- Behavioral Health Intensive Outpatient
- Behavioral Health Partial Hospitalization
- Behavioral Health Residential Treatment
- Behavioral Health Unit
- Chemical Dependency Intensive Outpatient
- Chemical Dependency Partial Hospitalization
- Develop/Behavioral Pediatric
- Hospital, Behavioral Health
- Local Behavioral Health Authority (LBHA)
- Mental Retardation Diagnostic Services (MRDA)
- Outpatient Behavioral Health
- Outpatient Diag/Treatment Ctr
- Physiological-Independent Diagnostic Testing Facilities (IDTF)
- Psychiatric Clinic
- Psychology Group
- Residential Treatment Facility/Program
- Residential-Based Supported Community Living Services
- Substance Abuse Treatment Center
- Adolescent & Children Behavioral Health
- DUI/DWI Education Program
- Intensive Family Intervention Adult Living Facility
- Rehabilitative Behavioral Health Services (RBHS) Assisted Long-Term Care Facility
- Statewide Inpatient Psychiatric Program
- Psychiatric Residential Treatment Facility

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Identify specialty services offered	Available	Not Available	Location(s)	Comments/Descriptions
Eating Disorder Treatment – Inpatient	<input type="checkbox"/>	<input type="checkbox"/>		
Eating Disorder Treatment – Outpatient	<input type="checkbox"/>	<input type="checkbox"/>		
Electro-convulsive Therapy (ECT) - Inpatient	<input type="checkbox"/>	<input type="checkbox"/>		
Electro-convulsive Therapy (ECT) – Outpatient	<input type="checkbox"/>	<input type="checkbox"/>		
Dual Diagnosis Services	<input type="checkbox"/>	<input type="checkbox"/>		
Continuing Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>		
LGBT services	<input type="checkbox"/>	<input type="checkbox"/>		
Domiciliary Services in an IOP or PHP setting (program must be formally approved by UBH)	<input type="checkbox"/>	<input type="checkbox"/>		
Chronically Mentally Ill Services (CMI)/ Severely Mentally Ill Services (SMI)	<input type="checkbox"/>	<input type="checkbox"/>		
Respite Care Services	<input type="checkbox"/>	<input type="checkbox"/>		
Emergency Room Services (assessment only)	<input type="checkbox"/>	<input type="checkbox"/>		
Twenty-three (23) Hour Crisis Observation	<input type="checkbox"/>	<input type="checkbox"/>		
Mobile Crisis Stabilization	<input type="checkbox"/>	<input type="checkbox"/>		
MHSA Outpatient Clinics in a hospital	<input type="checkbox"/>	<input type="checkbox"/>		
Ambulatory Detox - Drug	<input type="checkbox"/>	<input type="checkbox"/>		
Ambulatory Detox - Alcohol	<input type="checkbox"/>	<input type="checkbox"/>		
Medication Assisted Treatment (MAT) - in an Detox, IOP or PHP setting <input type="checkbox"/> Methadone <input type="checkbox"/> Suboxone <input type="checkbox"/> Buprenorphine <input type="checkbox"/> Naltrexone (i.e. vivitrol)	<input type="checkbox"/>	<input type="checkbox"/>		
Sober Living/Supervised Living				
Halfway House				
Group Home				
Therapeutic Foster Care				
ASAM Residential Services				<input type="checkbox"/> 3.1 <input type="checkbox"/> 3.3 <input type="checkbox"/> 3.5 <input type="checkbox"/> 3.7
Bridge on Discharge (aftercare planning immediately post IP discharge)				<input type="checkbox"/> Geriatric <input type="checkbox"/> Adult <input type="checkbox"/> Adol. <input type="checkbox"/> Child

Facility Type:

- Hospital
- Intensive Family Intervention Adult Living Facility
- Home Health Agency
- Rehabilitation Center
- Rehabilitative Behavioral Health Services (RBHS) Assisted Long-Term Care Facility
- Substance Use Treatment Facility
- Statewide Inpatient Psychiatric Program
- Psychiatric Residential Treatment Facility

Facility/Ancillary/Long-term Care Provider Credentialing Application

Facility Practice Locations and Levels of Care per Location

Facility Locations	Age Category	Mental Health					Substance Abuse					
		Inpatient	Partial	IOP	Residential	Observation	I/P Detox	I/P Rehab	Partial	IOP	Residential	Ambulatory Detox
Location #1												
Address:	Child											
	Adol.											
Phone:	Adult											
Secure Fax:	Geriatric											
NPI:		ECT	<input type="checkbox"/> I/P	<input type="checkbox"/> O/P			<input type="checkbox"/> Methadone		<input type="checkbox"/> Suboxone			

Location #2												
Address:	Child											
	Adol.											
Phone:	Adult											
Secure Fax:	Geriatric											
NPI:		ECT	<input type="checkbox"/> I/P	<input type="checkbox"/> O/P			<input type="checkbox"/> Methadone		<input type="checkbox"/> Suboxone			

Location #3												
Address:	Child											
	Adol.											
Phone:	Adult											
Secure Fax:	Geriatric											
NPI:		ECT	<input type="checkbox"/> I/P	<input type="checkbox"/> O/P			<input type="checkbox"/> Methadone		<input type="checkbox"/> Suboxone			

Location #4												
Address:	Child											
	Adol.											
Phone:	Adult											
Secure Fax:	Geriatric											
NPI:		ECT	<input type="checkbox"/> I/P	<input type="checkbox"/> O/P			<input type="checkbox"/> Methadone		<input type="checkbox"/> Suboxone			

Location #5												
Address:	Child											
	Adol.											
Phone:	Adult											
Secure Fax:	Geriatric											
NPI:		ECT	<input type="checkbox"/> I/P	<input type="checkbox"/> O/P			<input type="checkbox"/> Methadone		<input type="checkbox"/> Suboxone			