BPA Health SUD Provider Initial Application

Please asnwer the questions as listed below. You will be able to save and resume your work at anytime by choosing the "save" button on the bottom right hand of the page. Please note you will need to fill out this form sequentially, page by page, and will be unable to skip forward to another page without finishing the page you are on.

Introduction

Section 1: Introduction

Thank you for your interest in joining the BPA Health SUD Provider network.

In order to apply to for Treatment or Recovery Support Services (RSS), you will need the following information:

All Applicants:

1. Business License
2. Enhanced Background Check letter of clearance complete for all staff members with contact or access to PHI of State funded clients.

3. Proof of insurance (liability, and/or commercial)

Treatment Providers Only:

1. IDHW Behavioral Health Certificate

2. Copy of resume and:

- License (Licensed Clinicians)
- Degree (Non-licensed Clinical Staff)
- Certificate (Recovery Coach)

3. Proof of Professional Liability

4. Be prepared to provide written descriptions of Evidence-Based Practices (EBP). Existing providers have already submitted written descriptions. Please feel free to use the same information from a previous

submission to complete the appropriate fields.

5. All treatment providers in the BPA Health network must be co-occurring capable. Be prepared to demonstrate these capabilities in a co-occurring assessment form.

6. Clinical supervision certificate (if applicable)

Please ensure you have this information prior to starting this application.

You will be allowed to save your progress by clicking the "Save" button on the bottom right hand of each page. An email will be sent to you with a "Resume" link to continue.

If you have questions or need help with this form, please contact Provider Relations at providerrelations@bpahealth.com.

Which type of agency are you?
⦿ Treatment ○ RSS (Recovery Support Services) ○ Both

Below are the items you will need to continue your application. Please check each item to indicate if you have this information and would like to proceed.

Are you ready to proceed?
⦿ Yes ○ No

Agency Information

Section 2: Agency Information

Do you offer video counseling (tele behavioral health) to your SUD clients? Region Map

○ Yes ◉ No

○

Are you interested in learning more about offering video counseling, including access to a HIPAA compliant video solution offered by BPA Health at no cost to you?

◉ Yes ○ No

○

Certificate of Facility Approval from the State of Idaho

Location Details

Section 3: Locations

Please enter each service location individually.

Is this the sole agency location for services, billing, mailing and tax purposes?
⦿ Yes ○ No

Please enter ONE address below.

Please enter information below:

Location/Address 1

Please list below the hours you maintain in this location, in general:

Co-Occuring Capability Assessment for this Location

Will there be Licensed Masters Degree capable of diagnosing mental health disorders and experience treating individuals with co-occurring disorders at this location?
○ Yes ⦿ No

Agency Staff

Section 4: Agency Staff

List ALL Staff Members Individually

Please list each and every member of the staff at your agency. Use the "+ Add Name" to add more people.

Name 1

Does this staff member have a clinical supervisor?
○ Yes ⦿ No

Is this staff member a licensed, supervised, or certified clinician?
○ Yes ⦿ No

Liability Coverage

Section 5: Professional Liability Information

Current Insurance

Note: BPA Health requires you carry $1,000,000/$3,000,000 Liability Coverage for a Treatment Provider, $1,000,000/$2,000,000 for Safe and Sober Housing Provider, and $1,000,000/$1,000,000 for a Transportation Provider. If you do not have this amount in coverage, you will need to secure it before continuing with your application.

Have you been with this insurer more than 5 years?

○ Yes ⊙ No

If you have not been in practice 5 years, select "Yes"

Action History

Section 6: Action History

Evidenced Based Programs & Practices

Section 7: Written Description of Evidence Based Programs and Practices (EBP)

Evidence Based Programs and Practices (EBP) is:

Please note that BPA Health is requiring you to fill out each question as listed below, for each EBP you are using at this location. We such you copy and paste from any internal documents.

I attest the information I have provided is current, that all group facilitators are appropriately trained, and when required, certified to facilitate group. I will send in updated descriptions when changes are made.

Signature

Release & Signature

Section 8: Release & Signature

Master Site Only
As part of the application process and for the purpose of verifying any information provided onthis application, I grant BPA Health and its designated representatives permission to contact any individual, institution, facility or agency identified on, or relative to, this application.

Further, I hereby consent and authorize BPA Health to request, receive, inspect and release any and all information pertinent to consideration of this application to other insurance companies for whom BPA Health performs delegated credentialing.

I hereby release from any liability and hold harmless BPA Health and all individuals and organizations who provide BPA Health and its designated representatives with information – including otherwise privileged or confidential information – concerning my competence,
professional ethics, character, physical and mental health, emotional stability, and other qualifications pertinent to BPA Health's needs.

SITE REVIEW AUTHORIZATION:
I hereby grant permission for BPA Health or its designee to conduct on-site and clinical record review of clients managed by BPA Health as necessary to determine their quality and completeness.

I further agree that I will participate in and support BPA Health's Quality Improvement and Utilization Review Programs.

ATTESTATION:
I, the undersigned applicant, hereby attest and certify that to the best of my knowledge, I am free of any physical and mental health impairments and impairment due to chemical dependency or substance abuse that would adversely affect my ability to deliver the care
expected of my profession.

I, attest to the below staff qualifications:

Clinical Staff employed by the agency meet all State qualifications (IDAPA 16.07.17.200).

The agency has employed or contracted with a **Clinical Supervisor** who meets the following:
a. Master's Degree from an accredited, approved, and recognized college or university in health and human services and the equivalent of four (4) years paid full-time professional experience with three (3) years providing direct substance use disorders treatment and one (1) year paid fulltime supervision experience in a substance use disorders treatment services state, federal, Joint Commission, or CARF-approved program

or

b. IBADCC Certified Clinical Supervisor.
For outpatient programs providing services to children and adolescents, the clinical supervisor must have two (2) years of experience working with families or children in an alcohol and substance use disorders treatment services setting in a state, federal, Joint Commission, or CARFapproved program.

Case Managers employed by the agency are a Qualified Substance Use Disorder Professional or ISAS trainee; a person wit:

a. Bachelor’s Degree in Human Services or related field or higher from a nationally-accredited university or college;

or

b. a Bachelor’s Degree and 2 years of experience working as a case manager in a related field.

Recovery Coaches employed by the agency are certified by IBADCC or have received recovery coach and ethics training under the CCAR model. The Recovery Coaches have a supervisor that meets the state qualifications.

Drug Testing meet all State qualifications (IDAPA 16.07.17.360).
I also attest and certify that this application has been completed truthfully and accurately. I understand that falsification of information on this application or substantial error of fact involving documents discovered, can be grounds for termination of present and/or future contracts with BPA Health.

Further, I understand that acceptance of this application does not constitute approval or acceptance of participating status with BPA Health and grants me no rights or privileges of participation until such time as a contract is signed and written notice of participating status is received.

I acknowledge that action on this application will be delayed until all required information is received and/or verified.

A photocopy or electronic copy of this document will serve as the original. I understand that BPA Health or its designee will use this information in confidence and only in conjunction with this application.

In agreement with the Release of Information/Liability, and hereby submitting your completed application, please sign and date below:

Are you the Director or Authorized Signer for this Agency?
○ Yes ⦿ No

Date Signed
9/26/2018 11:25 AM

I attest that I am authorized to submit this application on the Agency's behalf:

Direct Deposit Authorization

Authorization Agreement for Automatic Deposit (Credits)

We hereby authorize BPA Health, hereinafter called COMPANY, to initiate credit entries to our Checking/Transaction Account indicated below and the depository named below, hereinafter called DEPOSITORY, to credit the same to such account. We acknowledge that the origination of ACH transactions to our account must comply with the provisions of U.S. law.

This authorization is to remain in full force and effect until COMPANY has received written notification from us of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it. We understand that thirty (30) days notice, in writing, to the COMPANY is required if we change banks and/or accounts.

Signature