PreferredOne®

Provider Selection Criteria for PreferredOne Participating Mental Health Practitioners

General Criteria

1. Practitioner must serve a specialty and/or geographic need for the good of the PreferredOne product for which they are applying.

2. Practitioner must have a current unrestricted/unconditioned license/registration in each state services are provided and certification as required.

3. If a practitioner has hospital admitting or attending privileges, the practitioner must have privileges and be a member in good standing of the medical staff at a PreferredOne participating hospital. The existence of any restrictions on privileges must be disclosed and will be examined and acted upon as deemed necessary by the Credentialing Committee.

4. Practitioner must accept PreferredOne fee schedules.

5. Practitioner must have arranged for 24-hour coverage, 7 days per week.

6. Practitioner must accept patients from all purchasers of the specific PreferredOne products applied for.

7. Practitioner must agree to maintain referrals and admissions at all times within the existing provider network except as authorized by the Medical Director or designee.

8. Practitioner must maintain professional liability (malpractice) insurance in amounts as established from time to time by PreferredOne Boards of Directors.

9. The presence of any past disciplinary or corrective action or current investigation by the State Licensing, Certifying or Registering Board or any other regulatory authority (i.e. Medicare, Medicaid, etc) having jurisdiction over the practitioner must be disclosed and will be examined and acted upon as deemed necessary by the Credentialing Committee.

10. The existence of any pending or past professional liability claims must be disclosed and will be examined and acted upon as deemed necessary by the Credentialing Committee.

11. Practitioner agrees to authorize review organizations to release to PreferredOne any information relating to practitioner's professional competence or conduct. Practitioner may present his/her own information also.

12. Practitioner agrees to participate in and cooperate fully with all procedural terms and requirements of the PreferredOne Network Management Services Program that monitors provider performance in terms of chart review (both inpatient and outpatient) for the purpose of identifying quality issues.

13. Practitioner agrees to meet PreferredOne's performance standards, which may change from time to time, as defined by the PreferredOne Boards of Directors.

14. Practitioner must disclose any restricted/conditioned licensure/registration in each state services are provided. The information will be examined and acted upon as deemed necessary by the Credentialing Committee.

15. A practitioner must be able to document his/her:

    - Training, experience, and demonstrated competence
    - Adherence to the ethics of their profession, good reputation, and character
    - Physical and emotional health status

- Ability to work with others

16. Practitioner agrees to promptly inform PreferredOne of any changes in licensure, disciplinary actions, professional liability actions, or practice circumstances.

17. Practitioner agrees to inform PreferredOne if charges are pending or if currently charged with or ever been indicted or found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense.

18. Practitioner must have an absence of a physical or mental condition that would adversely affect the practitioner's ability with or without accommodation, to provide appropriate care to patients and must be able to perform the essential functions in the practitioner's area of practice without posing a health or safety risk to patients.

Specific Criteria for Mental Health Practitioners

1. Only Psychiatrists, Doctoral Level Psychologists, or Licensed Master Level practitioners may practice independently.

2. All Bachelor Level mental health practitioners will practice in a Rule 29 clinic, community mental health center or hospital.

3. All practitioners will use the current "Diagnostic & Statistical Manual V Axial Diagnostic System" for diagnosis and care management.

4. Non-physician prescribers shall practice under the scope of their licensure.

5. All practitioners must have arranged for 24-hour coverage, 7 days per week.

PreferredOne MENTAL HEALTH & SUBSTANCE ABUSE FACILITY FORM

Corporate Name:	**Facility Name:**	
Administrator Name & Phone #:	**Billing Manager Name & Phone:**	
Tax ID# as filed with IRS:	**NPI:**	**Website Address:**

Billing Name:	**Billing Address:**	**Billing City/State/Zip:**
Billing Phone:	**NPI:**	**Email:**

Section A. Facilities List

Please list all the facilities names and addresses under the Tax ID as listed above. Please indicate the services provided at each site as listed in section B into the last column. Enter these services using the Number listed in the left hand column. Multiple services can be added if applicable.

Facility Location #	Facility Site Name	Facility Site Address	City	State & Zip	Phone	NPI	Services- See below for list
1							
2							
3							
4							
5							
6							
7							

**See next page for Services list

Section B. Services List

Number	Services	*Internal use only*
1	Professional provider fees -if chosen, must complete Section below	*Profees*
2	Adult Inpatient Mental Health Services	IAMH
3	Adolescent Inpatient Mental Health Services	ITMH
4	Adult Outpatient Mental Health Partial Hospital/Day Program Services	OAMH
5	Adolescent Outpatient Mental Partial Hospital Day Treatment Services	OTMH
6	Adult Inpatient Substance Related Disorder Services	IASA
7	Adolescent Inpatient Substance Related Disorder Services	ITSA
8	Adult Outpatient Substance Related Disorder Services	OASA
9	Adolescent Outpatient Substance Related Disorder Services	OTSA

Section C. Practitioner List **Only complete this section if you will be billing for individual practitioners on a 1500 form. You must indicate the facility that the practitioner should be added to. The facility location number can be found in the far left hand column under Section A.**

Practitioner Name:	**Practitioner NPI:**	
Practicing Specialty:	**Effective Date:**	**Facility Location #'s:**

Practitioner Name:	**Practitioner NPI:**	
Practicing Specialty:	**Effective Date:**	**Facility Location #'s:**

Practitioner Name:	**Practitioner NPI:**	
Practicing Specialty:	**Effective Date:**	**Facility Location #'s:**

Practitioner Name:	**Practitioner NPI:**	
Practicing Specialty:	**Effective Date:**	**Facility Location #'s:**

Practitioner Name:	**Practitioner NPI:**	
Practicing Specialty:	**Effective Date:**	**Facility Location #'s:**

Practitioner Name:	**Practitioner NPI:**	
Practicing Specialty:	**Effective Date:**	**Facility Location #'s:**

Practitioner Name:	**Practitioner NPI:**	
Practicing Specialty:	**Effective Date:**	**Facility Location #'s:**

Practitioner Name:	**Practitioner NPI:**	
Practicing Specialty:	**Effective Date:**	**Facility Location #'s:**

Practitioner Name:	**Practitioner NPI:**	
Practicing Specialty:	**Effective Date:**	**Facility Location #'s:**

Practitioner Name:	**Practitioner NPI:**	
Practicing Specialty:	**Effective Date:**	**Facility Location #'s:**

Attach additional pages if necessary.

PreferredOne®

Pre-Application for Mental Health/Substance Use Disorder

This pre-application serves to provide us with general information regarding your practice and professional background. **This form must be completed for each practitioner in the clinic.** Incomplete pre-applications will be immediately pended. Thank you for your interest. Please print or type.

Name:	**Degree/License:**
NPI #:	

1. Please list all current State Licensure numbers:

State Licensure:	**Number:**	**Expiration Date:**

2. Are you currently a PreferredOne Provider with a different practice? ☐ **Yes** ☐ **No**

3. Current Clinic Group Locations

4. For Minnesota-based clinics only – Is your clinic: ☐ **Rule 29** ☐ **Rule 43**

5. Please list any Special/Unusual Skills or Services?

6. Please list Hospital Staff Appointments:

Hospital	***Department***

7. Who provides on-call coverage for your practice?

8. Consulting/Supervising Psychiatrist?
9. Does Supervising Psychiatrist provide only outpatient services at your site? ☐ **Yes** ☐ **No**
10. Does Supervising Psychiatrist admit to a facility for inpatient services? ☐ **Yes** ☐ **No**
11. If so, which facility(s)?

I affirm that the foregoing are True Statements & Facts ☐

Signature:	**Date:**

(If filling out this form electronically, please just check the above box and type in your name and date)

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Mental Health/Chemical Dependency Provider Survey

PreferredOne would like your assistance in identifying your specialty and subspecialty areas. Please complete the attached survey form and return it with your pre-application.

Area of Specialization

One in which 1) there is a large body of research on theory and treatment such that at least one year of graduate study must be devoted to this area, and 2) supervised experience of at least a year's duration was required in a specialized environment, utilizing supervisors who are recognized as specialists.

Or

One in which a state licensing authority sets standards for educational background, supervised experience and documented competence.

An example of the first criteria would be neuropsychologist who obtained a graduate degree in neuropsychology and did either an internship or postdoctoral fellowship in neuropsychology at a designated neuropsychology clinic supervised by a neuropsychologist; a psychologist who obtained a graduate degree with either a major or minor in child psychology and did an internship or postdoctoral fellowship in a child/adolescent psychology setting, supervised by designated child/adolescent psychologists.

An example of the second criteria would be a provider who is licensed as a Marriage and Family Therapist, by a regulatory agency such as the Minnesota Board of Marriage and Family Therapy. This licensing board requires certain educational requirements, supervised experience and an examination for candidates.

Areas of Special Interest

These are areas of competence and experience in which the clinician has expanded upon from a relatively generalist training. Such providers would have self-selected to develop a practice focused on certain services or specific needs. Continuing education courses would have further developed their skills. Examples would be providers who are uniquely competent in certain aspects of assessment and treatment, such as psychodiagnostics or group therapy; or providers who have focused on treating specific needs, such as victims of abuse, gay, lesbian or bisexual clients, or eating disorders.

Special Skills

Special skills are those which providers bring to work. Examples would be proficiency in a second language, special understanding of diversity or multi-cultural needs, sign language, etc.

PreferredOne®

Mental Health/Substance Use Disorder Provider Survey

Name:	NPI #:
Address:	

Area of Specialization Based on Education & Training

Degree:	Institution:
Major:	Minor:

Internship or Postdoctoral Fellowship

(Please provide address of institution, description or setting, supervisors, duration, etc.)

Area of Specialization Based on Licensure

Type of Licensure:	
State Issued:	License Number

Areas of Special Interest

Special Skills

I affirm that the foregoing are True Statements & Facts ☐

Signature:	Date:

(If filling out this form electronically, please just check the above box and type in your name and date)

PreferredOne®

Telemental Health Compliance Attestation – Prescriber

I understand that PreferredOne may require documentation to verify that I meet the criteria for delivery of Telemental Health as outlined below. I will cooperate with a PreferredOne documentation or site audit, if requested, to verify that I meet, at all times applicable, the required criteria.

I hereby attest that all of the information below is true and accurate to the best of my knowledge. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the PreferredOne Network.

	Check box - Yes
I have confirmed that the videoconferencing technology that will be used to deliver Telemental Health is compliant with HIPPA requirements as well as current American Telemedicine Association (ATA) minimum standards including: a minimum internet connection bandwidth of 384 kilobits per second, a minimum live video display resolution of 640 x 360 pixels at 30 frames per second. The videoconference equipment conforms with applicable federal and state regulations. The videoconferencing technology I will be using: _____ _____	☐
I am and will remain in compliance with all applicable laws, rules, regulations and state board requirements applicable to the delivery of Telemental Health, prescribing, coding requirements, and documented protocols (e.g., informed consent, emergency contact information).	☐
I will provide Telemental Health in a private and secure environment. Rooms to be used for Telemental Health will have adequate lighting and will be reasonably soundproof for patient privacy.	☐
I will ensure that all documents containing protected health information or personal health information, including prescriptions, are transmitted securely in accordance with all privacy rules including HIPPA.	☐
I have the appropriate protocols in place and have trained my staff on protocols and procedures related to technical or other types of failure that may disrupt service delivery.	☐
I understand and agree that I must hold and will only provide services when properly licensed according to state requirements for providing services within the state where the member is physically located at the time of the services.	☐
I meet the prescriptive authority requirements for each state in which I am licensed, prescribe or dispense prescriptions in accordance with applicable laws, rules and regulations.	☐
I and applicable staff are appropriately trained in and will comply with proper claim submission procedures, including but not limited to the PreferredOne Telemedicine Policy (P-30) outlined in the PreferredOne Office Procedures Manual.	☐
My malpractice insurance carrier has been notified and has delivered the appropriate rider or proof of coverage for Telemental Health, as applicable to my scope of practice.	☐

	Yes	No
I have completed the ATA online course “Delivering Online Video-Based Mental Health Services” (highly recommended)	☐	☐

Provider Information

Are you currently a participating provider in the PreferredOne behavioral health network:

☐ Yes ☐ No

Are you interested in joining the PreferredOne behavioral health network:

☐ Yes ☐ No

Group Name _____

Provider First Name _____

Provider Last Name _____

Provider contact phone number _____

Provider email address _____

Provider Main Practice Address _____

City_____State_____County_____Zip_____

Individual NPI # _____

Tax ID _____

Individual Medicare # _____

Individual Medicaid # _____

Provider will be delivering Telemental Health to the following states and hold current license/DEA license:

State #1_____Lic #_____Lic Type_____DEA #_____

Tax ID _____

_____

_____

State #2_____Lic #_____Lic Type_____DEA #_____

Tax ID _____

_____

_____

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New Inpatient/Outpatient Behavioral Health Facility Services

Check the box next to the type of therapy services you provide
Age Definitions: Child = Ages 0-12, Adolescent = Ages 13-17, Adult 18+, Senior 60+

Date:	**Location Name:**		**Tax ID:**
Address:	**City:**	**State:**	**Zip:**

Services Provided:

☐	23 Hr Observation Bed - Adolescent	☐	Chemical Health Intensive Outpt Program - Adolescent	☐	Dual Diagnosis Day Treatment - Adolescent
☐	23 Hr Observation Bed - Adult	☐	Chemical Health Intensive Outpt Program - Adult	☐	Dual Diagnosis Day Treatment - Adult
☐	23 Hr Observation Bed - Child	☐	Chemical Health Intensive Outpt Program - Child	☐	Dual Diagnosis Day Treatment - Child
☐	23 Hr Observation Bed - Senior	☐	Chemical Health Intensive Outpt Program - Senior	☐	Dual Diagnosis Day Treatment - Senior
☐	Chemical Health Assessments/Mobile - Adolescent	☐	Chemical Health Outpt Treatment - Adolescent	☐	Dual Diagnosis Inpt - Adolescent
☐	Chemical Health Assessments/Mobile - Adult	☐	Chemical Health Outpt Treatment - Adult	☐	Dual Diagnosis Inpt - Adult
☐	Chemical Health Assessments/Mobile - Child	☐	Chemical Health Outpt Treatment - Child	☐	Dual Diagnosis Inpt - Child
☐	Chemical Health Assessments/Mobile - Senior	☐	Chemical Health Outpt Treatment - Senior	☐	Dual Diagnosis Inpt - Senior
☐	Chemical Health Assessments/non-Rule 25 - Adolescent	☐	Chemical Health Outpt Treatment w/Lodging - Adolescent	☐	Dual Diagnosis Intensive Outpt Program - Adolescent
☐	Chemical Health Assessments/non-Rule 25 - Adult	☐	Chemical Health Outpt Treatment w/Lodging - Adult	☐	Dual Diagnosis Intensive Outpt Program - Adult
☐	Chemical Health Assessments/non-Rule 25 - Child	☐	Chemical Health Outpt Treatment w/Lodging - Child	☐	Dual Diagnosis Intensive Outpt Program - Child
☐	Chemical Health Assessments/non-Rule 25 - Senior	☐	Chemical Health Outpt Treatment w/Lodging - Senior	☐	Dual Diagnosis Intensive Outpt Program - Senior
☐	Chemical Health Assessments/Rule 25 - Adolescent	☐	Crisis Triage Assessment - Adolescent	☐	Dual Diagnosis Partial - Adolescent
☐	Chemical Health Assessments/Rule 25 - Adult	☐	Crisis Triage Assessment - Adult	☐	Dual Diagnosis Partial - Adult
☐	Chemical Health Assessments/Rule 25 - Child	☐	Crisis Triage Assessment - Child	☐	Dual Diagnosis Partial - Child
☐	Chemical Health Assessments/Rule 25 - Senior	☐	Crisis Triage Assessment - Senior	☐	Dual Diagnosis Partial - Senior
☐	Chemical Health Day Treatment - Adolescent	☐	Crisis Triage Intervention - Adolescent	☐	Dual Diagnosis Residential - Adolescent
☐	Chemical Health Day Treatment - Adult	☐	Crisis Triage Intervention - Adult	☐	Dual Diagnosis Residential - Adult
☐	Chemical Health Day Treatment - Child	☐	Crisis Triage Intervention - Child	☐	Dual Diagnosis Residential - Child
☐	Chemical Health Day Treatment - Senior	☐	Crisis Triage Intervention - Senior	☐	Dual Diagnosis Residential - Senior
☐	Chemical Health Inpt Free Standing Facility - Adolescent	☐	Detox Ambulatory - Adolescent	☐	Eating Disorders Day Treatment - Adolescent
☐	Chemical Health Inpt Free Standing Facility - Adult	☐	Detox Ambulatory - Adult	☐	Eating Disorders Day Treatment - Adult
☐	Chemical Health Inpt Free Standing Facility - Child	☐	Detox Ambulatory - Child	☐	Eating Disorders Day Treatment - Child
☐	Chemical Health Inpt Free Standing Facility - Senior	☐	Detox Ambulatory - Senior	☐	Eating Disorders Day Treatment - Senior
☐	Chemical Health Inpt Hospital - Adolescent	☐	Detox Inpatient - Adolescent	☐	Eating Disorders Inpatient - Adolescent
☐	Chemical Health Inpt Hospital - Adult	☐	Detox Inpatient - Adult	☐	Eating Disorders Inpatient - Adult
☐	Chemical Health Inpt Hospital - Child	☐	Detox Inpatient - Child	☐	Eating Disorders Inpatient - Child
☐	Chemical Health Inpt Hospital - Senior	☐	Detox Inpatient - Senior	☐	Eating Disorders Inpatient – Senior

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☐	Eating Disorders Intensive Outpt Prgm - Adolescent	☐	Mental Health Day Treatment - Adult	☐	Outpatient Individual - Adolescent
☐	Eating Disorders Intensive Outpt Prgm - Adult	☐	Mental Health Day Treatment - Child	☐	Outpatient Individual - Adult
☐	Eating Disorders Intensive Outpt Prgm - Child	☐	Mental Health Day Treatment - Senior	☐	Outpatient Individual - Child
☐	Eating Disorders Intensive Outpt Prgm - Senior	☐	Mental Health Inpt Free Standing Facility - Adolescent	☐	Outpatient Individual - Senior
☐	Eating Disorders Partial - Adolescent	☐	Mental Health Inpt Free Standing Facility - Adult	☐	Partial Hospitalization Program - Adolescent
☐	Eating Disorders Partial - Adult	☐	Mental Health Inpt Free Standing Facility - Child	☐	Partial Hospitalization Program - Adult
☐	Eating Disorders Partial - Child	☐	Mental Health Inpt Free Standing Facility - Senior	☐	Partial Hospitalization Program - Child
☐	Eating Disorders Partial - Senior	☐	Mental Health Inpt Hospital - Adolescent	☐	Partial Hospitalization Program - Senior
☐	Eating Disorders Residential - Adolescent	☐	Mental Health Inpt Hospital - Adult	☐	Post Partum Depression
☐	Eating Disorders Residential - Adult	☐	Mental Health Inpt Hospital - Child	☐	Residential Chemical Health - Adolescent
☐	Eating Disorders Residential - Child	☐	Mental Health Inpt Hospital - Senior	☐	Residential Chemical Health - Adult
☐	Eating Disorders Residential - Senior	☐	Mental Health Intensive Outpt Program - Adolescent	☐	Residential Chemical Health - Child
☐	Electroconvulsive Therapy Inpt - Adolescent	☐	Mental Health Intensive Outpt Program - Adult	☐	Residential Chemical Health - Senior
☐	Electroconvulsive Therapy Inpt - Adult	☐	Mental Health Intensive Outpt Program - Child	☐	Residential Mental Health - Adolescent
☐	Electroconvulsive Therapy Inpt - Child	☐	Mental Health Intensive Outpt Program - Senior	☐	Residential Mental Health - Adult
☐	Electroconvulsive Therapy Inpt - Senior	☐	Mental Health Outpt Services - Adolescent	☐	Residential Mental Health - Child
☐	Electroconvulsive Therapy Outpt - Adolescent	☐	Mental Health Outpt Services - Adult	☐	Residential Mental Health - Senior
☐	Electroconvulsive Therapy Outpt - Adult	☐	Mental Health Outpt Services - Child	☐	Women's Chemical Health Services
☐	Electroconvulsive Therapy Outpt - Child	☐	Mental Health Outpt Services - Senior	☐	Women's Mental Health Services
☐	Electroconvulsive Therapy Outpt - Senior	☐	Methadone Maintenance Services - Adolescent		
☐	Home Health Mental/Chemical Health - Adolescent	☐	Methadone Maintenance Services - Adult		
☐	Home Health Mental/Chemical Health - Adult	☐	Methadone Maintenance Services - Child		
☐	Home Health Mental/Chemical Health - Child	☐	Methadone Maintenance Services - Senior		
☐	Home Health Mental/Chemical Health - Senior	☐	Suboxone Maintenance Services - Adolescent		
☐	Medication Evaluation & Management - Adolescent	☐	Suboxone Maintenance Services - Adult		
☐	Medication Evaluation & Management - Adult	☐	Suboxone Maintenance Services - Child		
☐	Medication Evaluation & Management - Child	☐	Suboxone Maintenance Services - Senior		
☐	Medication Evaluation & Management - Senior	☐	Multidisciplinary Pain Programs - Adolescent		
☐	Men's Chemical Health Services	☐	Multidisciplinary Pain Programs - Adult		
☐	Men's Mental Health Services	☐	Multidisciplinary Pain Programs - Child		
☐	Mental Health Assessment - Adolescent	☐	Multidisciplinary Pain Programs - Senior		
☐	Mental Health Assessment - Adult	☐	Outpatient Group - Adolescent		
☐	Mental Health Assessment - Child	☐	Outpatient Group - Adult		
☐	Mental Health Assessment - Senior	☐	Outpatient Group - Child		
☐	Mental Health Day Treatment - Adolescent	☐	Outpatient Group - Senior		

PreferredOne
Organizational Assessment Application

Complete this form to apply for assessment for the facility types listed below. Incomplete applications will be delayed. Completed forms can be sent via email, mail or fax:

Mail: PreferredOne
Attn: Credentialing
6105 Golden Hills Drive
Golden Valley, MN 55416

Email: Credentialing@PreferredOne.com

Fax: 763-847-4010

PROVIDER INFORMATION			
Name:			
Address:			
City	**State:**	**Zip Code:**	
County:	**Federal Tax ID Number**	**Telephone Number:**	**Fax Number:**
Contact Person:		**Title:**	
Contact Person Telephone Number:		**Minnesota Medicaid Provider ID (DHS Number):**	

LICENSE/INSURANCE – Attach a current legible copy of the following items:

- State License
- General Liability Coverage Policy (showing coverage amounts and dates).

SPECIALTY TYPE – Check all that apply

- ☐ Hospital
- ☐ Skilled Nursing Facility
- ☐ Home Health Agency
- ☐ Free Standing Surgical Center
- ☐ Nursing Home
- ☐ Outpatient Mental Health or Chemical Dependency Center
- ☐ Inpatient Mental Health or Chemical Dependency Center
- ☐ Residential Treatment Center for Mental Health or Chemical Dependency

ACCREDITATION/CERTIFICATION OR CMS/STATE REVIEW – Check all that apply and attach a current legible copy.

- ☐ Joint Commission on Accreditation of Health Care Organizations (JCAHO)
- ☐ Community Health Accreditation Programs (CHAPS)
- ☐ American Association of Ambulatory Health Centers (AAAHC)
- ☐ American Osteopathic Association (AOA)
- ☐ American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
- ☐ CMC certification (Formerly HCFA-Medicare). Attach a copy of site survey findings, corrective action plan (if applicable), and cover letter.
- ☐ Organizations **without** Accreditation or certification. If hospital, complete page 2 – Attestation For Hospitals Without JCAHO Accreditation. If home health agency, complete page 3 – Medicare Certification Exception form.
- ☐ Certified Laboratory Improvement Amendments (CLIA) certification.

*** Organizations without current Accreditation or Medicare Certification may require an onsite visit by the health plan.**

ORGANIZATIONAL PROVIDER ASSESSMENT APPLICATION

Attestation For Hospitals Without JCAHO Accreditation

1. Do you have a patient safety goal of improving the accuracy of patient identification using at least two patient identifiers whenever taking blood samples or administering mediations or blood products? ☐ Yes ☐ No
2. Do you have a patient safety goal of improving the accuracy of patient identification prior to the start of any surgical or invasive procedure, conduct a final verification process such as time out, to confirm the correct patient, procedure and site, using active – not passive – communication techniques? ☐ Yes ☐ No
3. Do you have a policy and process credentialing all employed and contracted practitioners? ☐ Yes ☐ No
4. Do you have a documented process for credentialing or privileging practitioners employed by or contracted by our facility? ☐ Yes ☐ No
5. Do you have criteria developed that determines an applicant's ability to provide patient care, treatment and services within the scope of privileges requested including evidence of current competence and peer recommendations when required? ☐ Yes ☐ No
6. Do you have contracting, credentialing or privileging time frames not exceeding 3 years? ☐ Yes ☐ No
7. Do you have a governing body or delegated committee that has final authority to approve or deny privileges? ☐ Yes ☐ No
8. Do you have medical staff that implements a process to identify and manage matters of individual health related impairment for all Licensed Independent Practitioners separate form actions taken for disciplinary purposes? ☐ Yes ☐ No

If you answered NO to any question(s), list number, explain the reason and describe your plan to become compliant.

I hereby certify that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary so that it remains complete, true and accurate while the application is being processed. Furthermore, I certify that I am authorized to represent my organization to make these statements. Any material misstatement in or omission from the application my constitute grounds for denial or revocation of participation.

Attestation Signature **Date**

Printed Name **Title**

ORGANIZATIONAL PROVIDER ASSESSMENT APPLICATION

Home Health Agency Medicare Certification Exception Form

Name: _____

1. State the number of hours/days per week you are available to serve clients: _____/_____
Hours Days

2. Check services your agency provides to clients:

Nursing	**Social Work**	**Therapies**	**Other**
☐ RN	☐ LICSW	☐ Occupational Therapy	☐ Home Health Aide/Personal Care Attendant
☐ LPN	☐ LCSW	☐ Physical Therapy	
	☐ CSW - PIP	☐ Speech Therapy	
		☐ Respiratory Therapy	

3. List all states and years that you have been in business:

	State	**Years**
(Example)	MN	1985-current

4. List number of clients you have serviced in the past three years:

Year	**# of clients**

5. Agency is owned and operated by a Minnesota county ☐ Yes ☐ No
If yes, name county: _____

6. Agency provides services mainly or exclusively to Pediatric clients ☐ Yes ☐ No

7. Agency provides services mainly or exclusively to Obstetric clients ☐ Yes ☐ No

8. Indicate percentage of clients (past year through present) who primarily received home health aide or personal care attendant services: _____%

9. Attach your most recent evidence-based and measurable Quality Improvement (QI) plan. This must be in place before your application will be considered. If you answered NO to # 5, 6, and 7 above; or if you answered # 8 above at 100%, you do not have to submit a Quality Improvement plan.

Completed by: _____ Date: _____ / _____/ _____

PreferredOne®

Credentialing

Effective September 1, 2010 PreferredOne requires initial credentialing applications to be submitted using the MCC (Minnesota Credentialing Collaborative) Electronic Application.

For the Credentialing portion of your pre-application, please visit http://www.mncred.org/ to submit your Credentialing application.

Thank you!