# SUBSTANCE USE DISORDER PROVIDER APPLICATION FORM

## Substance Use Disorder Provider: Application Process

Overview

Colorado Access' greatest priority is maintaining a high clinical standard of care for our members. We are clinically assessing providers to be part of our substance use disorder (SUD) network.

**Please submit policies, program descriptions, and client materials that document how you meet or plan to meet each measure**. Please use this form to help the reviewers identify where in your documentation to look for details about how you meet the measure. Include document names and page numbers in the application text boxes to guide the reviewers and summarize or clarify the written material provided. Please refer to the Quality Measures Guidance for Providers document found here for details about the measures.

If you have any questions, please contact clinical@coaccess.com.

## Required Application Materials

- ☐ Must be enrolled and validated by Health First Colorado (Medicaid)
- ☐ Complete this application, including signed and dated attestation and authorization, and Appendix 1 (pages 7-20 of this application)
- ☐ Copy of organization's W9
- ☐ A copy of the current professional liability insurance policy declaration sheet with the name of the organization, coverage dates, and the amounts of coverage listed. Professional liability includes insurance coverage with minimum limits of $500,000 per incident and $3 million aggregate, which are required for network participation. If the entity is covered through self-insurance trust, the Federal Tort Claims Act (FTCA) or have governmental immunity, please not below and provide such documentation.
- ☐ A copy of the organization's current Colorado license, or if not subject to Colorado licensure, a copy of the certification notification from the State of Colorado
- ☐ If the organization provides in-house laboratory services, please submit a copy of the Clinical Laboratory Improvement Amendments (CLIA) certificate
- ☐ If accredited, a copy of the most recent accreditation certificate
- ☐ If the organization is not accredited, please include the most recent copy of the outpatient behavioral health (OBH) site survey, or a copy of the letter from OBH that shows that the facility was reviewed, the findings of the review, and that the facility corrected any findings
- ☐ Documentation or policy and procedures that are informative to the SUD facility procedures

**Please return completed application and supporting documentation to clinical@coaccess.com.**

# SUBSTANCE USE DISORDER PROVIDER APPLICATION FORM

## Measure 1

*The organizational leadership demonstrates a commitment to quality treatment of substance use disorders.*

Provide materials that depict the organization's commitment and capacity to oversee substance use services such as organizational charts; documents outlining training and credentialing of clinical/medical leadership; organizational mission, vision, and values; clinical supervisory structure; and policies on how the organization uses data to improve clinical care.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

## Measure 2

*The organization and its programs have clear operational definitions.*

Provide a program description for each program and level of care within the program that includes the services provided, service approach, and staffing. Provide admission, discharge, and continuing stay criteria for each program (and level of care within the program if multiple levels of care are provided in the same program). For Level 3 residential and withdrawal management programs, include medical and other exclusion criteria based on the program and population served.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

## Measure 3

*Clinically integrated provider trainings are regularly provided to staff.*

Provide policies, training descriptions, and other materials that demonstrate how staff are trained in substance use disorders and related clinical and administrative content at hire and throughout their employment. Include documentation that demonstrates that training is tailored to the populations you serve and the levels of care you provide.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

## Measure 4

*Treatment approaches used are based on current evidence of clinical effectiveness.*

Provide policies or program descriptions that identify the specific evidence-based and best practices in use in each level of care. Provide documentation about the rationale for the use of these practices based on the population served and level of care. Include policies outlining how staff are trained or supervised to ensure that these practices are fully implemented with fidelity.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

## Measure 5

*The provider implements procedures to continually assess and adjust treatment planning and level of care.*

Provide documentation about how screening and assessment procedures address the six dimensions outlined by American Society of Addiction Medicine (ASAM). Include admission, discharge, and continuing stay criteria that are aligned with ASAM for the level(s) of care provided. Provide policies that outline the staff responsible to assess level of care in between formal treatment plan reviews and how transfer/discharge needs are assessed prior to step-down or discharge.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

## Measure 6

*Substance use monitoring (urine screening, oral fluid tests, breathalyzers) is a standard part of substance use treatment at all levels of care.*

Provide policies and/or program materials that discuss the clinical rationale for substance use monitoring as a component of clinical care.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

## Measure 7

*Relapse is not a criterion for discharge and is considered a part of the recovery process.*

Provide policies and/or program materials describing the organization or program's approach to continued use and relapse. Include client materials that describe how relapse is addressed as a part of treatment planning.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

## Measure 8

*Patients are actively encouraged to become involved in social and recovery support activities tailored to their individual needs and preferences.*

Provide policies and/or client materials that demonstrate the program philosophy related to social and recovery support. Include written documentation on any specific efforts to assist clients in building new skills and interests and in withdrawal management programs demonstrate how patients are referred for ongoing social support following discharge/transfer.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

### Measure 9

*Individual counseling is a standard part of treatment.*

Provide policies, program descriptions, or other materials that demonstrate how often individual counseling is provided and the kinds of issues addressed. Include written documentation about how the mix of individual and group treatment is determined and how resistance to participation in group treatment is handled. In withdrawal management programs, demonstrate how individualized counseling is provided to enhance motivation to seek ongoing care.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

### Measure 10

*The initial contact is predominately a clinical intervention rather than an administrative intake exercise.*

Provide policies, training materials, patient materials, and other documentation that demonstrates that developing a therapeutic alliance and engaging the individual in treatment is the goal of the initial contact. Include documentation of the steps taken to reduce motivational and tangible barriers in access to care and how the program ensures that when the program or level of care they provide is not the best fit, the program ensures that the individual gets to the level of care/program needed.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

### Measure 11

*Family and other support systems are routinely involved in treatment.*

Provide documentation that relapse prevention planning includes addressing family stressors and support. Level 2.1 Intensive Outpatient, Level 3 residential programs and all adolescent services provide program descriptions or other documentation of how family involvement is a routine part of treatment. (This measure does not apply to withdrawal management programs.)

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

### Measure 12

*Providers have procedures to complete follow-up calls on all patient no-shows and these procedures include working with patients on motivational and tangible barriers to access to care.*

Provide policies related to missed appointments and/or admissions, how staff are trained to address motivational or tangible barriers to access and how support is provided to individuals who have patterns of repeated no-shows. (This measure is not applicable to withdrawal management programs.)

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

### Measure 13

*Providers accept patients who are currently receiving medications for treatment of addiction and do not discourage the use of medication for treatment of alcohol and opioid use disorders.*

Provide admission criteria and policies demonstrating that receiving medication for treatment of addiction is not a reason for denial of treatment, procedures for educating patients on the potential benefit of medications for treatment of alcohol use and opioid use disorders, and how patients are provided with medications for treatment of addiction either directly or through referral. Provide written documentation demonstrating expertise and procedures for treating pregnant women who are seeking treatment for opioid use disorders.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

### Measure 14

*All providers treating substance use disorders are capable to screen for mental health conditions and provide a basic level of mental health treatment.*

Provide admission criteria, program descriptions, and/or policies that demonstrate that people are not excluded from treatment due to a mild or moderate mental health disorder and how properly credentialed staff are made available to screen for mental health disorders and treat or refer to treatment.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

### Measure 15

*Providers continually assess the treatment needs of patients, tailor length of stay to individual needs, and provide coordinated transitions between levels of care.*

Provide program descriptions and/or patient materials that demonstrate that the duration and intensity of treatment will vary based on the needs of the patient and how transitions to higher or lower levels of care are facilitated.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

### Measure 16

*Emergency services are available to active patients.*

Provide documentation about how enrolled patients can reach a clinician affiliated with the organization in the event of an emergency and how staff in Level 3 residential and withdrawal management programs have access to medical/clinical consultation outside of regular business hours.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

### Measure 17

*Program employs strategies to provide easy access to treatment.*

Provide policies or other documentation demonstrating how the organization facilitates access to treatment for the population they serve and makes appointments/admissions available outside business hours.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

### Measure 18

*Programs screen and refer for infectious diseases that commonly co-occur with substance use disorders.*

Provide policies outlining the protocols for screening, testing, and referring patients for treatment of infectious illnesses that commonly co-occur with substance use disorders.

| NAME OF POLICY DOCUMENT AND/OR PAGE NUMBER OF SUPPORTING DOCUMENTATION: |
|---|
| |

## ADOLESCENT TREATMENT (Skip this section if you are NOT providing adolescent treatment)

### Measure 19

*Providers working with adolescents rely on evidence-based practices and highly trained staff when delivering group therapy.*

Provide documentation related to the credentialing of staff conducting adolescent group therapy and the way the use of group therapy is planned based on the needs of the population.

### Measure 20

*Providers serving adolescents provide care that is developmentally appropriate to their needs.*

Provide documentation outlining how the organization ensures that staff is skilled in work with adolescents and clinical interventions are appropriate to the needs of adolescent populations.

### Measure 21

*Providers serving adolescents use evidence-based treatment approaches that are specific to adolescent substance use.*

Provide program descriptions and policies that identify the evidence-based approaches used and their rationale based on the population served.

| NAME OF POLICY DOCUMENTS AND/OR PAGE NUMBERS OF SUPPORTING DOCUMENTATION FOR MEASURES 19, 20, & 21: |
|---|
| |

# SUBSTANCE USE DISORDER PROVIDER APPLICATION FORM

## Application Information

| | | |
|---|---|---|
| Legal name of organization: | | |
| DBA name (if applicable): | | |
| NPI number: | Tax ID: | Medicaid site ID: |
| Physical address: (Please attach a clinic roster if there are multiple sites and include NPI, Medicaid site ID, program/ASAM level, and age range served for each location) | | |
| Credentialing mailing address (if different from above): | | |
| Administrative contact (person responsible for the completion of this application): | | |
| Contact name: | | |
| Phone: | | |
| Email address: | | |
| Fax number: | | |
| Application contact and title (if not the CEO or executive director) | | |
| Phone: | | |
| Email: | | |

## Attestation And Consent for Release of Information

Please include an explanation of any question(s) answered yes.

1. Within the past three years, has the facility had any Medicare and/or Medicaid sanctions?

Y ☐ N ☐

2. Within the past three years, has the facility had any remedies imposed by the State to include State monitoring, civil monetary penalties, denial of Medicaid payment for new admissions, or temporary management and/or closure?

Y ☐ N ☐

All information provided on this application or in connection with this application is complete and accurate to the best of the organization's knowledge. The organization understands that this application does not entitle the organization to participation in Colorado Access and/or Child Health Plan *Plus* (CHP+) networks. The organization agrees that entities providing information in good faith, pursuant to this release, shall not be liable for any act or omission related to the evaluation or verification of information contained in this application. All information submitted to Colorado Access by such entities will be treated as confidential. The organization further agrees to notify Colorado Access in a timely manner of any changes to the information provided on the application, including any Medicare and Medicaid sanctions or remedies imposed by the State.

I attest and certify that the medical and/or clinical staff is legally and professionally qualified for the positions to which they are appointed.

I attest that this organization credentials its individual practitioners.

The organization hereby authorizes any accrediting body, governmental entity, association, organization, person or Insurance Company to release the information requested herein and to provide confirmation of the answers contained herein to Colorado Access or any affiliate of Colorado Access. This authorization shall be valid for so long as the organization is a Colorado Access and/or CHP+ contracted provider. A copy of the signature is as binding as the original.

_____ _____

Signature of chief administrator or authorized Person Date

_____

Print name of chief administrator or authorized Person

# APPENDIX 1 (Professional Provider Agreement Application)

**Complete all applicable boxes and put N/A in any boxes left blank.**

| | |
|---|---|
| **Legal name:** (As registered with the Secretary of State) | |
| **DBA/Directory listing name:** (If applicable) | |
| **Office contact name and title:** | **Email address:** |
| **Contract Signature of Authority:**(who will sign the contract?) | **Email address:** |
| **Phone:** | **Fax:** |
| **Website address:** | |

**Please mark all that apply to the practice:**

***Colorado Access does not discriminate regardless of race, color, national origin, age, sex, genetic information, religion, pregnancy, disability, sexual orientation, veteran status, or any other status protected by applicable law.***

**The information below will help Colorado Access inform its diverse membership of the providers in our network and help them make a choice in providers that best serves them and will not be used for any other purpose. You are not required to answer the optional questions below.**

**Practice is owned by a woman** ☐

**Practice is owned by a person of color (Black, Indigenous, Asian/Pacific Islander, LatinX)** ☐
**If yes, please specify:** _____

**Practice is owned by a veteran** ☐

**Practice is owned by a veteran who is differently abled** ☐

**Practice is owned by a person who is differently abled** ☐

**Practice is 100% telehealth** ☐

**Community Mental Health Center (CMHC)** ☐

**Substance Use Disorder clinic** ☐

**Indian Health Care Provider (IHCP)** ☐

**Essential Community Provider (ECP)** ☐

**School-Based Health Center (SBHC)** ☐



**Continued on next page**

**Practice provides a HIPAA compliant, private/secure location to render telehealth services** ☐

**Practice provides American Sign Language (ASL) services** ☐

**Federally Qualified Health Center (FQHC)** ☐

**Rural Health Center (RHC)** ☐

**Pediatric only** ☐

**Women only** ☐

**Adults only** ☐

**Capable of billing Medicare** ☐

**Capable of billing Medicaid** ☐

**Please indicate which medical home accreditations, if any, have been awarded to your practice by any of the following agencies:**

**Accreditation Association for Ambulatory Health Care (AAAHC)** ☐ **What year?** _____

**Joint Commission on Accreditation of Healthcare Organizations (JCAHO)** ☐ **What year?** _____

**National Committee for Quality Assurance (NCQA)** ☐ **What year?** _____

**Utilization Review Accreditation Commission (URAC)** ☐ **What year?** _____

**Continued on next page**

**Ages seen in your practice (please mark all that apply)**:

| | | |
|---|---|---|
| ☐ 0-1 | ☐ 14-18 | ☐ 26-50 |
| ☐ 2-5 | ☐ 19-20 | ☐ 51-64 |
| ☐ 6-13 | ☐ 21-25 | ☐ 65+ |

| | |
|---|---|
| **Make checks payable to** (Box 33 of CMS 1500 form)**:**<br>☐ Legal Name (must have an organizational NPI for this option)<br>☐ DBA Name (must have an organizational NPI for this option)<br>☐ Individual Provider | |
| **Federal tax ID (TIN):** | **Organizational NPI #:** |
| **Organizational Medicaid #:** | **Organizational Medicare #:** |
| **Billing/remit address, city, state, zip code:** | |
| **Mailing address, city, state, zip code:** | |
| **County:** | |
| **Billing contact name:** | **Billing phone:** |
| **Billing fax:** | |
| **Billing contact email address:** | |

**Billing Format:** **CMS 1500** ☐ **UB04** (FQHCs and Facilities only. Clinics must bill using CMS 1500) ☐
**Directory:** **Yes** ☐ **No** ☐

## APPENDIX 1 (Continued)

**Complete for each practice/site location included in this Agreement.**

**Please copy this page if necessary, in order to complete for each practice/site location.**

**(1- Primary) Do you have multiple sites? Yes ☐ No ☐** If yes, how many?
**Practice site location name:**

**Does your practice provide care for underserved or special populations? Yes ☐ No ☐**
If yes, please list:

**Address, City, State, Zip Code:**

**County:**

| **NPI:** | **TIN:** | **Phone:** | **Fax:** |
|---|---|---|---|
| **Site-specific Medicaid ID:** | **Enrollment limit?** **Yes** ☐ **No** ☐ If yes, list maximum # of Medicaid members: | | |

**Office Hours: (add your hours of operation for each day of the week, indicating AM or PM)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Mon | **to** | | ☐ | Fri | **to** | |
| ☐ | Tues | **to** | | ☐ | Sat | **to** | |
| ☐ | Wed | **to** | | ☐ | Sun | **to** | |
| ☐ | Thurs | **to** | | | | | |

**Does the practice provide 24/7 phone coverage with access to a clinician that can triage the member's health need?** **Yes** ☐ **No** ☐

**ADA Compliance:**

Is there an ADA accessible approach (e.g., ramps, stability, curbs, stairs, width, etc.) to the entrance of your building/office, with accessible parking spaces that are identified with signage? **Yes** ☐ **No** ☐

Are any of the parking spaces van-accessible? **Yes** ☐ **No** ☐

Do you have an accessible examination room for individuals with disabilities? **Yes** ☐ **No** ☐

Do you have accessible medical equipment to accommodate examining individuals with disabilities? **Yes** ☐ **No** ☐

Are you able to effectively communicate with individuals who have hearing, vision, speech or cognitive disabilities? **Yes** ☐ **No** ☐

**Continued on next page**

| | | | |
|---|---|---|---|
| **(2) Practice/site location name:** | | | |
| **Address, City, State, Zip Code:** | | | |
| **County:** | | | |
| **NPI:** | **TIN** | **Phone:** | **Fax:** |
| **Site-specific Medicaid ID:** | **Enrollment limit?**<br>**Yes** ☐ **No** ☐ If yes, list maximum # of Medicaid members: | | |

**Office Hours: (add your hours of operation for each day of the week, indicating AM or PM)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Mon | **to** | | ☐ | Fri | **to** | |
| ☐ | Tues | **to** | | ☐ | Sat | **to** | |
| ☐ | Wed | **to** | | ☐ | Sun | **to** | |
| ☐ | Thurs | **to** | | | | | |

**Does the practice provide 24/7 phone coverage with access to a clinician that can triage the member's health need?** **Yes** ☐ **No** ☐

**ADA Compliance:**

Is there an ADA accessible approach (e.g., ramps, stability, curbs, stairs, width, etc.) to the entrance of your building/office, with accessible parking spaces that are identified with signage? **Yes** ☐ **No** ☐

Are any of the parking spaces van-accessible? **Yes** ☐ **No** ☐

Do you have an accessible treatment room or office for individuals with disabilities? **Yes** ☐ **No** ☐

Are you able to effectively communicate with individuals who have hearing, vision, speech or cognitive disabilities? **Yes** ☐ **No** ☐

| | | | |
|---|---|---|---|
| **(3) Practice/site location name:** | | | |
| **Address, City, State, Zip Code:** | | | |
| **County:** | | | |
| **NPI:** | **TIN** | **Phone:** | **Fax:** |
| **Site-specific Medicaid ID:** | **Enrollment limit?**<br>**Yes** ☐ **No** ☐ If yes, list maximum # of Medicaid members: | | |

**Office Hours: (add your hours of operation for each day of the week, indication AM or PM)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | Mon | **to** | | ☐ | Fri | **to** | |
| ☐ | Tues | **to** | | ☐ | Sat | **to** | |
| ☐ | Wed | **to** | | ☐ | Sun | **to** | |
| ☐ | Thurs | **to** | | | | | |

**Does the practice provide 24/7 phone coverage with access to a clinician that can triage the member's health need?** **Yes** ☐ **No** ☐

**ADA Compliance:**

Is there an ADA accessible approach (e.g., ramps, stability, curbs, stairs, width, etc.) to the entrance of your building/office, with accessible parking spaces that are identified with signage? **Yes** ☐ **No** ☐

Are any of the parking spaces van-accessible? **Yes** ☐ **No** ☐

Do you have an accessible treatment room or office for individuals with disabilities? **Yes** ☐ **No** ☐

Are you able to effectively communicate with individuals who have hearing, vision, speech or cognitive disabilities? **Yes** ☐ **No** ☐

## APPENDIX 1 (Continued)

**Please complete for each individual licensed practitioner (physicians and non-physician practitioners) included in this Agreement and indicate all site locations where practitioner will be providing services.**

**Please copy this page, if necessary, in order to complete for each individual practitioner.**

***Colorado Access does not discriminate regardless of race, color, national origin, age, sex, genetic information, religion, pregnancy, disability, sexual orientation, veteran status, or any other status protected by applicable law.***

<table>
<tr><td colspan="2">Full name:</td><td>Date of birth:</td><td colspan="2">Degree/licensures:</td><td>Practicing specialty:</td></tr>
<tr><td colspan="3">Subspecialty:</td><td colspan="3">Primary taxonomy code:</td></tr>
<tr><td colspan="3">Secondary taxonomy code:</td><td colspan="3">Medication Assistance Treatment (MAT) certified:<br>Yes ☐ No ☐</td></tr>
<tr><td>Medicare ID #:</td><td>Medicaid ID #:</td><td colspan="2">Individual NPI #: (Box 24J of the CMS 1500 form):</td><td colspan="2">CAQH #:</td></tr>
<tr><td colspan="3">Additional languages spoken:</td><td colspan="3">Accepting new patients: Yes ☐ No ☐</td></tr>
<tr><td colspan="6">My clients include: (mark all that apply) Males ☐ Females ☐ Trans ☐ Other ☐</td></tr>
<tr><td colspan="6">Interpretive services provided: Yes ☐ No ☐</td></tr>
<tr><td colspan="6">Provider gender: Female ☐ Male ☐ Other ☐</td></tr>
<tr><td colspan="3">Provider race:</td><td colspan="3">Provider ethnicity:</td></tr>
<tr><td colspan="6">Provider gender pronouns:</td></tr>
<tr><td colspan="6">Has completed cultural competency responsiveness training? Yes ☐ Date: No ☐<br><br>Training provided by Colorado Access: Yes ☐ No ☐<br>If no, provide name of training and by whom:</td></tr>
<tr><td colspan="6">Practice site location(s) from previous pages:</td></tr>
<tr><td colspan="3">Is provider practicing only in an inpatient/hospitalist capacity?<br>Yes ☐ No ☐</td><td colspan="3">Are services provided only in nursing or hospital facilities?<br>Yes ☐ No ☐</td></tr>
</table>

| **Full name:** | **Date of birth:** | **Degree/licensures:** | **Practicing specialty:** |
|---|---|---|---|
| | | | |

| **Subspecialty:** | **Primary taxonomy code:** |
|---|---|
| **Secondary taxonomy code:** | **Medication Assistance Treatment (MAT) certified:** **Yes** ☐ **No** ☐ |

| **Medicare ID #:** | **Medicaid ID #:** | **Individual NPI #:** (Box 24J of the CMS 1500 form): | **CAQH #:** |
|---|---|---|---|
| | | | |

| **Additional languages spoken (list all):** | **Accepting new patients:** **Yes** ☐ **No** ☐ |
|---|---|
| | |

**My clients include:** (mark all that apply) **Males** ☐ **Females** ☐ **Trans** ☐ **Other** ☐

**Interpretive services provided: Yes** ☐ **No** ☐
**Languages:**

**Provider gender: Female** ☐ **Male** ☐ **Other** ☐

| **Provider race:** | **Provider ethnicity:** |
|---|---|
| | |

**Provider gender pronouns:**

**Has completed cultural competency responsiveness training? Yes** ☐ **Date:** **No** ☐

**Training provided by Colorado Access: Yes** ☐ **No** ☐
If no, provide name of training and by whom:

**Practice site location(s)** from previous pages:

| **Is provider practicing only in an inpatient/hospitalist capacity?** **Yes** ☐ **No** ☐ | **Are services provided only in nursing or hospital facilities?** **Yes** ☐ **No** ☐ |
|---|---|
| | |

| **Full name:** | **Date of birth:** | **Degree/licensures:** | **Practicing specialty:** |
|---|---|---|---|
| | | | |

| **Subspecialty:** | **Primary taxonomy code:** |
|---|---|
| **Secondary taxonomy code:** | **Medication Assistance Treatment (MAT) certified:** **Yes** ☐ **No** ☐ |

| **Medicare ID #:** | **Medicaid ID #:** | **Individual NPI #:** (Box 24J of the CMS 1500 form): | **CAQH #:** |
|---|---|---|---|
| | | | |

| **Additional languages spoken:** | **Accepting new patients:** **Yes** ☐ **No** ☐ |
|---|---|
| | |

**My clients include:** (mark all that apply) **Males** ☐ **Females** ☐ **Trans** ☐ **Other** ☐

**Interpretive services provided: Yes** ☐ **No** ☐

**Provider gender: Female ☐ Male ☐ Other ☐**

| **Provider race:** | **Provider ethnicity:** |
|---|---|

**Provider gender pronouns:**

**Has completed cultural competency responsiveness training? Yes ☐ Date: No ☐**

**Training provided by Colorado Access: Yes ☐ No ☐**
If no, provide name of training and by whom:

**Practice site location(s)** from previous pages:

| **Is provider practicing only in an inpatient/hospitalist capacity?** **Yes ☐ No ☐** | **Are services provided only in nursing or hospital facilities?** **Yes ☐ No ☐** |
|---|---|

**Does any other Individual have an Ownership or Control Interest in Provider's business?** **Yes ☐ No ☐**

If your answer is **YES**, please list all such individuals with an ownership or control interest in the applicant. Include each person's name, address, date of birth (DOB), and Social Security Number (SSN). Also indicate the title (e.g. chief executive officer, owner) and if an owner, the percent of ownership. Please see the definition of "persons with an ownership or control interest" to ensure that all individuals are included. Attach additional pages as needed.

| Name | Title | % of ownership (if applicable) | Address | DOB | SSN |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Does any other Corporation have an Ownership or Control Interest in Provider?** **Yes ☐ No ☐**

If your answer is YES, please list all corporations with an ownership or control interest in the applicant. Include the Tax Identification Number (TIN), the percent of ownership in the applicant, the primary business address, every business location, and P.O. Box address(es). Attach additional pages as needed.

| Name of Corporation | TIN | % of ownership (if applicable) | Primary Business Address | Every Business Location | PO Box Addresses |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**For purposes of the above questions**, "**Person/Corporation with an ownership or control interest**" means a person or corporation that:

a) Has an ownership interest totaling 5 percent or more in Provider;
b) Has an indirect ownership interest equal to 5 percent or more in Provider;
c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in Provider;
d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by Provider if that
interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
e) Is an officer or director of Provider that is organized as a corporation; **or**
f) Is a partner in a Provider that is organized as a partnership?

**Attestation:**

All information provided on this application or in connection with this application is complete, truthful and accurate to the best of Provider's knowledge.

Provider further agrees to notify Colorado Access in a timely manner of any changes to the information provided on the application, including any Medicare and Medicaid sanctions or remedies imposed by the State.

Provider further certifies that the medical and/or clinical staff is legally and professionally qualified for the positions to which they are appointed and that the organization credentials its individual practitioners.

Signature:_____

Print Name:_____

Title:_____

Organization (if applicable):_____

Date:_____

# Behavioral Health Specialty

Please indicate which specialty population you work with below:

- ☐ Children (12 and younger)
- ☐ Adolescents (13 to 18)
- ☐ Foster Care
- ☐ Adults (19 to 64)
- ☐ Seniors (65 and older)
- ☐ Males
- ☐ Females

Treatment modalities:

- ☐ Aggression Replacement Therapy
- ☐ Animal-assisted
- ☐ Art Therapy
- ☐ Attachment-based Therapy
- ☐ Biofeedback
- ☐ Cognitive Behavioral Therapy
- ☐ Dialectical Behavior Therapy
- ☐ Eye Movement Desensitization and Reprocessing Therapy (EMDR)
- ☐ Exposure and Response Prevention
- ☐ Habit Reversal Therapy
- ☐ Multisystemic Therapy (MST)
- ☐ Psychological Testing and Evaluation
- ☐ Play Therapy
- ☐ Sex Offender Management Board (SOMB Treatment Provider)

Please check only the top 10 specialty(s) of your practice below:

- ☐ Adoption
- ☐ AIDS/HIV
- ☐ Alzheimer's/dementia
- ☐ Anxiety/panic
- ☐ AIDS/HIV
- ☐ ADD/ADHD
- ☐ Autism Spectrum
- ☐ Bipolar disorder
- ☐ Borderline Personality Disorder
- ☐ Brain Injury (TBI)
- ☐ Child abuse
- ☐ Children of alcoholics
- ☐ Chronic pain or illness
- ☐ Compulsive behaviors
- ☐ Conduct disorder
- ☐ Criminal justice
- ☐ Cultural issues
- ☐ Depression
- ☐ Developmental disorders
- ☐ Disruptive behavior disorders
- ☐ Dissociative disorders
- ☐ Divorce/custody
- ☐ Domestic violence
- ☐ Eating disorders
- ☐ Elder abuse
- ☐ End-of-life
- ☐ Family therapy
- ☐ Gender identity counseling
- ☐ Grief and loss
- ☐ Impulse control
- ☐ Intellectual disabilities
- ☐ Intimacy issues
- ☐ LGBTQ counseling
- ☐ Learning disabilities
- ☐ Life transitions
- ☐ Men's issues
- ☐ Mental Health Certifications designated by the Office of Behavioral Health (OBH)
- ☐ Mood disorders
- ☐ Neuropsychiatry
- ☐ Neuropsychology
- ☐ Obesity
- ☐ Obsessive compulsive disorders
- ☐ Parenting issues
- ☐ Personality Disorders
- ☐ Phobias
- ☐ Postpartum
- ☐ Post-traumatic stress
- ☐ Psychological illness
- ☐ Psychosis
- ☐ Psychosomatic illness
- ☐ Queer/Questioning
- ☐ Relationship issues
- ☐ Relinquishment counseling
- ☐ Reproductive
- ☐ Schizophrenia
- ☐ Self-harm/self-injury
- ☐ Sexual harassment
- ☐ Sexual issues
- ☐ Sexual offenders
- ☐ Sleep/insomnia
- ☐ Spiritual concerns
- ☐ Stress management
- ☐ Substance Use Disorder
- ☐ Trauma
- ☐ Violent offenders
- ☐ Women's issues