BEHAVIORAL HEALTH ORGANIZATIONAL ENDORSEMENT APPLICATION FORM

Behavioral Health Organizational Provider Endorsement: Application Process

Overview

Colorado Access' greatest priority is maintaining a high clinical standard of care for our members. Our organizational credentialing policy will help ensure that providers within mental health organizations and primary care settings are receiving the appropriate level of supervision and oversight. Our goal is to ensure excellent member care and support expansion of the behavioral health workforce. Additionally, COA is allowing organizationally credentialed provider groups to explore the deployment of staff to function as case managers, community outreach personnel, or peers. This will allow clinics to design a high-quality continuum of care by effectively using staff that can deliver services appropriate to their level of training and education.

If you have any credentialing questions, please contact credentialing@coaccess.com.
If you have any questions about the requirements on page 2, please contact clinical@coaccess.com.

Required Application Materials

- ☐ Must be enrolled and validated by Health First Colorado (Medicaid)
- ☐ Completed CAQH profile for licensed clinicians responsible for supervision. Licensed clinicians will be individually credentialed by Colorado Access.
- ☐ Complete this application, including signed and dated attestation and authorization, and Appendix 1 (pages 5-15 of this application)
- ☐ Copy of organization's W9
- ☐ Copy of malpractice insurance
  - Demonstration of sufficient liability coverage for supervisors' supervision activities and for the clinical work performed by trainees and unlicensed practitioners), and
  - Minimum limits of liability of $1 million per incident and $3 million aggregate, with the exception of public entities that have coverage through a Self-Insurance Trust, the Federal Tort Claims Act (FTCA) or have governmental immunity (must be in effect at the time of the decision date).
- ☐ Copy of organization's clinical supervision policy (requirements for supervision policy found on page 2)
- ☐ Copy of organization's policy ensuring that the providers credential their practitioners (HR onboarding process is acceptable for this requirement) Must require monthly checks of OIG and SAM databases of the unlicensed providers.
- ☐ If organization is licensed through OBH or as a Behavioral Health Entity (NOT REQUIRED), a copy of the organization's current license, or a copy of the certification notification from the State of Colorado.
- ☐ If accredited, a copy of the most recent accreditation certificate
- ☐ Site visit with COA staff (will be scheduled as part of clinical review; see page 2)

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

Site Visit

As required by NCQA, Colorado Access will conduct a site review of the organization to assess physical environment, processes to ensure member rights, and/or confirmation of implementation of the policies and procedures above. Colorado Access conducts an on-site review of the provider organization as part of the initial credentialing assessment.

Clinical Supervision Policy Requirements

STANDARD	REQUIREMENTS
Informed Consent	• Provide copy of supervisor's mandatory disclosure statement • Provide sample copy of supervisee's mandatory disclosure statement
Criteria for Evaluation	• Provide rubric or feedback mechanism for evaluating supervisee's progress that is tied to the responsibilities assigned
Frequency	• Policy addresses frequency of formal supervision sessions • Policy addresses frequency that supervisor reviews (and provides feedback on) documentation
Interventions	• Policy addresses a variety of supervisory mechanisms, including direct observation (recordings of counseling sessions, live observation), case conceptualization presentations, review of documentation, and/or individual/triadic/group supervision • Policy addresses counseling skills, self of the therapist, professional behaviors, ethical/legal issues, cultural considerations, evidence-based practices • Policy addresses maximum number of supervisees a supervisor oversees
Documentation	• Policy requires licensed supervisor to co-sign all documentation produced by unlicensed supervisee • Policy outlines how supervisor will document supervision sessions
Legal	• Policy requires supervisor and supervisee to follow all applicable laws and ethical guidelines of the profession • LPC Supervisors meet all criteria for supervisors outlined in 4 CCR 737-1 • LCSW, LMFT, PsyD/PhD Supervisors have advanced training/experience in supervising unlicensed clinicians
Crisis	• Policy outlines protocol for managing a client in crisis or urgent/emergent situations including the availability of the supervisor to the supervisee in the event of a crisis

BEHAVIORAL HEALTH ORGANIZATIONAL ENDORSEMENT 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 and Medicaid site ID 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:		

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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+) State Managed Care Network 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+ State Managed Care Network 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)**:** ☐ Legal Name (must have an organizational NPI for this option) ☐ DBA Name (must have an organizational NPI for this option) ☐ 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?** **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?** **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:
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 ☐

Training provided by Colorado Access: Yes ☐ No ☐
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?
Yes ☐ No ☐</td><td colspan="3">Are services provided only in nursing or hospital facilities?
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