PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

To ensure timely processing of your change/addition, please return the following:

- ☐ Current copies of all applicable state licenses and letters of support/approval. (All letters are needed for initial credentialing but only time-limited letters need to be re-submitted at the time of re-credentialing.)
- ☐ Copy of the most recent state licensing site visit report for each license (i.e. the state performed a site visit or site survey as a part of the licensure and/or certification process)
- ☐ Copy of current medical malpractice, comprehensive professional, general and/or umbrella liability insurance certificates that identify the limits of liability and the policy effective dates (documents must include "Professional Liability").
- ☐ Copy of a completed W9 form or IRS letter
- ☐ NPI Enumerator Documentation
- ☐ Staff Roster for each site and program
- ☐ Accreditation Certificate(s):
  - ☐ JC – The Joint Commission (formerly JCAHO)
  - ☐ CARF – Council on Accreditation of Rehabilitation Facilities
  - ☐ COA – Council on Accreditation
  - ☐ HFAP – The AOA's Healthcare Facilities Accreditation Program
  - ☐ Other _____

PERFORMCARE ADDENDUM (Part II)

Please complete this section for each Site or Program that has been added or changed since the last credential. **If you are unsure if anything changed, you should complete one Part II for each program or service site.** Please include the provider type and MA number as well as Medicare number associated with each site, as applicable. Be sure to complete services associated with each site and populations, disorders and specialties specific to each site. Please make additional copies as needed.

Provider Name:		**License Type:**	
		License Number:	

MENTAL HEALTH LEVELS OF CARE

√	Level of Care Description	Medical Assistance Provider Number and Location Code
	Abuse Resolution & Recovery Treatment (ARRTS)	
	Acute Care Hospital	
	Applied Behav Analysis (ABA) for Autism Spectrum (ASD)	
	Brief Treatment Model	
	Clozapine/Clozaril Support Services	
	Clubhouse	
	FQHC or Rural Health Center	
	Functional Behavioral Assessments	
	Intensive Day Treatment (Behavioral Health Day Tx)	
	MH After School Program	
	MH Art Therapy	
	MH BHRS (MT/BSC/TSS)	
	MH BHRS Evaluation	
	MH Community Treatment Teams (ACT/CCT)	
	MH Crisis Intervention	
	MH CRR Host Home	
	MH Electroconvulsive Therapy (ECT)	
	MH Family Based Mental Health	
	MH TCM (ICM, RC, BC)	
	MH Inpatient – Extended Acute Psych Inpatient Unit	
	MH Inpatient – Private Psych Hospital	
	MH Inpatient – Private Psych Unit	
	MH Music Therapy	
	MH Outpatient – Medication Management	
	MH Outpatient – Psychiatric Evaluation	
	MH Outpatient – Psychological Testing	
	MH Outpatient – Therapy	
	MH Partial Hospitalization – Adult	
	MH Partial Hospitalization – Child/Adolescent	
	MH Residential Treatment – Accredited	
	MH Residential Treatment – Non-Accredited	
	Mobile Mental Health Treatment	
	Neuropsychological Evaluation	
	Peer Support Services (DHS Approved)	

	Psychiatric Rehab	
	School-Based Outpatient Site	
	Specialized In-Home Treatment Program (SPIN)	
	Stepping Stones	
	Summer Therapeutic Activity Program (STAP)	
	Telepsychiatry	
SUBSTANCE USE LEVELS OF CARE		
√	**Level of Care Description**	**Medical Assistance Provider Number and Location Code**
	SU Intensive Outpatient (1B)	
	SU Hospital Detoxification (4A)	
	SU Hospital Rehabilitation (4B)	
	SU Buprenorphine Services (Suboxone)	
	SU Methadone Maintenance	
	SU Vivitrol Services (Naltrexone)	
	SU Halfway House (2B)	
	SU Non-Hospital Detoxification (3A)	
	SU Non-Hospital Rehabilitation – Long Term (3C)	
	SU Non-Hospital Rehabilitation – Short Term (3B)	
	SU D&A Level of Care Assessment	
	SU Outpatient (1A)	
	Tobacco Cessation Treatment	
	SU Partial Hospitalization (2A)	
	SU TCM (ICM, RC)	
MISCELLANEOUS LEVELS OF CARE		
√	**Level of Care Description**	**Medical Assistance Provider Number and Location Code**
	Administrative Site Only	N/A
	LAB	
	Mobile Psych Nursing	

Practice Site Address: (Address where services will be rendered)

Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**ZIP Code:**

Telephone Number:	**Fax Number:**	**After Hours Telephone Number:**

Administrative Address: (Address where contract correspondence of mail occurs)

Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**ZIP Code:**
Telephone Number:		**Fax Number:**	

Accounts Payable Address: (Finance Address; where checks are mailed)

Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**ZIP Code:**
Telephone Number:		**Fax Number:**	

IRS Address: (Address for tax reporting purposes – must match W9 or IRS documentation)

Tax Id Number:			
Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**ZIP Code:**
Telephone Number:		**Fax Number:**	

Contact Person for this Site:	Name and Title:	
	Telephone:	
	Email:	

POPULATION AND SPECIALTY INFORMATION AT THIS SITE

Please identify your clinical interests and populations served by check marking applicable items. Perform Care will put this information in your provider profile and referrals will be made based on your responses.

√	Description
	Biofeedback
	Cognitive Behavioral Therapy (CBT)
	Dialectical Behavioral Therapy (DBT)
	Eye Movement Desensitization and Reprocessing (EMDR)
	Faith-based Counseling
	Family/Couples Therapy
	Functional Family Therapy (FFT)
	Lesbian/Gay/Bi-sexual/Transgender/Questioning Issues (LGBTQ)
	Multi-systemic Therapy (MST)
	Neuropsychological Testing
	Pain Management
	Parent/Child Interaction Therapy (PCIT)
	Play Therapy
	Psychological Testing
	Sex Offender Therapy
	The Incredible Years
	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
	SU D&A Contingency Management
	Description
	Anxiety Disorders/Phobias/Panic Disorders
	Attention Deficit Disorders / Oppositional Disorders (ADD/OD)
	Autism/Developmental Disorders
	Co-Occurring (MH/D&A)
	Co-Occurring (MH/ID)
	Depression/Mood Disorder
	Eating Disorders
	Obsessive Compulsive Disorders (OCD)
	Personality Disorders
	Reactive Attachment Disorder (RAD)/Attachment Issues
	Sexual Disorders/Dysfunction
	Trauma/Physical/Sexual Abuse Issues (PTSD)
	Description
	Handicap Accessible
	Wheelchair Accessible
	Restrooms Accessible to Physically Disabled
	Deaf/Hard of Hearing Accommodations
	Blind/Visually Impaired Accommodations

√	Description
	Children (13-17)
	Adults (18-64)
	Children (preschool 0-4)
	Gay / Lesbian / Bisexual / Transgendered/Questioning
	Geriatric (65+)
	Hispanic/Latino
	Deaf/Hearing Impaired
	Children (5-12)
	Description
	Spanish
	Chinese
	English
	French
	German
	Hawaiian
	Hebrew
	Italian
	Japanese
	Korean
	Latin
	Portuguese
	Russian
	Swahili
	Thai
	Urdu
	Vietnamese
	American Sign Language
	Ukranian
	Hindi
	Punjabi
	Yiddish
	Telugu
	Farsi
	Arabic
	Syrian
	Tagalog
	Yoruba
	Romanian
	Polish
	Amharic

GEOGRAPHIC COVERAGE/ACCESS

County(ies) in which this Program is located	
County(ies) Served	

Do you believe that you are meeting PA Health Choices access standards as listed below?	**YES**	**NO**
Routine – offered an appointment within 7 days		
Urgent – offered an appointment within 24 hours		
Emergent – offered an appointment within 1 hour		

Accessibility Questions		
Is this site accessible to public transportation?		
Is this site handicapped accessible?		
If this site is an Inpatient or Residential Program, please include the number of beds:		

What are your normal business hours for seeing clients?						
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

CULTURAL COMPETENCY SURVEY

Question	**YES**	**NO**
Does the agency have Policies and Procedures or provide training opportunities that cover areas of cultural diversity and cultural competence to all applicable staff members?		

Clinical Staff Overview:

LANGUAGES SPOKEN FLUENTLY BY CLINICAL STAFF **Fluently is defined as able to speak with ease or express effortlessly and correctly.**			
# of Each	**Descriptor**	**Language(s)**	**Service(s)**
	Physician(s)		
	Therapist(s)		
	Therapeutic Support Staff (TSS)		
	Behavioral Specialist Consultant (BSC/BSL)		
	Mobile Therapist(s) (MT)		
	Other (list):		

NUMBER OF EACH OF THE FOLLOWING: (Specify the number of clinical staff only – include names on the rosters attached)					
#	**Descriptor**	**#**	**Descriptor**	**#**	**Descriptor**
	Psychiatrist – Board Certified		Psychiatrist – Board Eligible		Psychologist – Doctoral Level
	Psychologist – Masters Level		LCSW or LSW		Lic Professional Counselor (LPC)
	LMFT		Cert Addictions Counselor		MH Counselor – Masters Level

STAFF ROSTERS

(Licensed and Non-Licensed Clinicians at this Service Site)

Providers must have Policy and Procedure in place to assure that employees have appropriate credentials. Per Perform Care policy, members under the age of thirteen (13) must be treated by a Board Certified Psychiatrist with a subspecialty certification in Child & Adolescent Psychiatry. <u>If a facility provides child/adolescent RTF and/or child/adolescent IP services and does not employ the above qualified staff, the facility will be required to submit a statement with the credentialing application which informs Perform Care of the provisions the facility will make to meet this expectation</u>. You may submit this information in an alternate format.

Clinician's Name	Clinician's Highest Level of Education (i.e. BS, MS, PhD)	Clinician's License Number	Clinician's Specialties/Areas of Interest (indicate if MT, BSC, or TSS for BHRS Programs)

PROGRAM EXCEPTION ATTESTATION

Submit an updated signed attestation form to the attention of your Provider Relations Representative by January 1 of each year for each Program Exception Service. Failure to submit this attestation may result in suspension of referrals to the program. Program exception services must comply with Federal rules and requirements for Medicaid. DHS/OMHSAS staff approve service descriptions that comply with those requirements. Providers must assure that service delivery is consistent with the DPW/OMHSAS approved service description. Perform Care Quality Improvement Staff will audit records against the service description. Payment made for services not delivered in accordance with the approved service description is subject to repayment.

I, _____ assure that _____-(Program Name) was approved by OMHSAS and deemed compensable using Medical Assistance Identification Number / Service Location Code _____ for _____County(ies).

I affirm that:

1) I have reviewed the current approved service description against operations and attest that service delivery is occurring in accordance with the DHS/OMHSAS approved service description. _____ Initial Here

2) I understand that any change to the service description requires approval by Perform Care, the County(ies) and DHS/OMHSAS. Approval must be in writing. _____ Initial Here

3) I certify that documentation of services delivered is in accordance with the service description or, in the absence of such detail, in accordance with 1101.51 of the Medical Assistance Manual. _____ Initial Here

4) I certify that clinical staff is receiving appropriate supervision. _____ Initial Here

5) I have attached a staff roster reflecting current staff complement in the program and confirm that ratios remain consistent with that defined in the approved service description. _____ Initial Here

_____	_____	_____
Agency Director Signature	**Agency License Number & Type**	**Date**

PerformCare Use:

Verified by:_____ Date:_____

Provider Notification Date:_____

Method of notice: FAX (keep coversheet confirming deliver attached)
Mail (keep letter attached)

PARTICIPATION STATEMENT

Please select the Behavioral Health Managed Care Organization to whom you are attesting the application information (hereafter listed as "BHMCO"):

☐ Community Care Behavioral Health Organization (CCBHO)	Date of Last Credentialing:_____
☐ Community Behavioral Health (CBH)	Date of Last Credentialing:_____
☐ Magellan Behavioral Health	Date of Last Credentialing:_____
☐ PerformCare	Date of Last Credentialing:_____
☐ Value Behavioral Health of Pennsylvania (VBH)	Date of Last Credentialing:_____

For purposes of making this application for participation in the BHMCO provider network, the Facility/Program certifies that all information provided to the BHMCO is complete and correct to the best of the Facility/Program's knowledge. The Facility/Program agrees to notify the BHMCO promptly if there are any material changes in the information provided, whether prior to or after the Facility/Program's acceptance as a the BHMCO participating provider. The Facility/Program understands and agrees that if the BHMCO discovers that this application contains any significant misstatement, misrepresentations or omissions, the BHMCO may void, in its sole discretion, its application and any related participating provider agreements.

The Facility/Program authorizes the BHMCO and its Credentialing Verification Organization (CVO) to consult with State licensing agencies, accreditation bodies, malpractice insurance carriers, and, upon notification to Facility/Program of additional specific entities or organizations, any other entity from which information may be needed to complete the credentialing process, and the Facility/Program authorizes the release of such information to the BHMCO and its CVO. The Facility/Program releases the BHMCO and its CVO and its employees and agents and all those whom the BHMCO contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating the Facility/Program's application.

The Facility/Program further understands and agrees that; (a) the Facility/Program is responsible for producing all information required or re quested by the BHMCO and its CVO in connection with this application; (b) the BHMCO is under no obligation to complete the processing of this application until such information is provided by the Facility/Program; (c) in the event that the BHMCO decides not to accept the Facility/Program as a participating provider and the Facility/Program desires to have this decision reviewed, the Facility/Program will appeal such determination via the BHMCO's appeal process.

_____

Facility Name

_____ Dated (mm/dd/yy)_____/_____/_____

Authorized Signature

_____

Name (Please Print)

_____

Title

For Internal Use Only:

Date application received from Provider: