

APPENDIX 1 (Professional Provider Agreement Application)

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

Attach the following:

IRS W-9

Copy of Professional Liability Insurance

CLIA Certification (If applicable)

Legal name: (As registered with the Secretary of State)	
DBA/Directory listing name: (If applicable)	
Office contact name:	Email address:
Contract Signature of Authority (who will sign the contract?):	Email address:
Phone:	Fax:
Website address:	
Is practice female-owned? Yes <input type="checkbox"/> No <input type="checkbox"/> (Optional)	
Is practice minority-owned? Yes <input type="checkbox"/> No <input type="checkbox"/> (Optional)	
Ages seen in your practice:	
0-3 Yes <input type="checkbox"/> No <input type="checkbox"/>	
4-11 Yes <input type="checkbox"/> No <input type="checkbox"/>	
12-17 Yes <input type="checkbox"/> No <input type="checkbox"/>	
18+ Yes <input type="checkbox"/> No <input type="checkbox"/>	
Make checks payable to (Box 33 of CMS 1500 form): <input type="checkbox"/> Legal Name (must have an organizational NPI for this option) <input type="checkbox"/> DBA Name (must have an organizational NPI for this option) <input type="checkbox"/> Individual Provider	
Federal tax ID	Organizational NPI #:
Organizational Medicaid #:	
Billing/remit Address:	
County:	Organizational Medicare #:

Billing contact name:	Billing phone:
Billing contact email address:	
Billing Format CMS 1500 <input type="checkbox"/> UB04 <input type="checkbox"/>	
Directory: Yes <input type="checkbox"/> No <input type="checkbox"/>	

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 <input type="checkbox"/> No <input type="checkbox"/>									
Practice Site location name:									
Address:									
County:									
NPI:			TIN		Phone:		Fax:		
Office Hours: (add your hours of operation for each day of the week)									
	Mon	AM/PM	to	AM/PM		Fri	AM/PM	to	AM/PM
	Tues	AM/PM	to	AM/PM		Sat	AM/PM	to	AM/PM
	Wed	AM/PM	to	AM/PM		Sun	AM/PM	to	AM/PM
	Thurs	AM/PM	to	AM/PM					
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 <input type="checkbox"/>	No <input type="checkbox"/>	
Are any of the parking spaces van-accessible?							Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Do you have an accessible examination room for individuals with disabilities?							Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Do you have accessible medical equipment to accommodate examining individuals with disabilities?							Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Are you able to effectively communicate with individuals who have hearing, vision, speech or cognitive disabilities?							Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Continued on next page

(2) Practice/site location name:

Address:

County:

NPI:	TIN	Phone:	Fax:
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Office Hours: (add your hours of operation for each day of the week)

	Mon	AM/PM	to	AM/PM		Fri	AM/PM	to	AM/PM
	Tues	AM/PM	to	AM/PM		Sat	AM/PM	to	AM/PM
	Wed	AM/PM	to	AM/PM		Sun	AM/PM	to	AM/PM
	Thurs	AM/PM	to	AM/PM					

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:

County:

NPI:	TIN	Phone:	Fax:
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Office Hours: (add your hours of operation for each day of the week)

	Mon	AM/PM	to	AM/PM		Fri	AM/PM	to	AM/PM
	Tues	AM/PM	to	AM/PM		Sat	AM/PM	to	AM/PM
	Wed	AM/PM	to	AM/PM		Sun	AM/PM	to	AM/PM
	Thurs	AM/PM	to	AM/PM					

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.

Full name:		Date of birth:	Degree/licensure:	Practicing specialty:
Subspecialty:				
Medicare ID #:	Medicaid ID #:	Individual NPI #: (Box 24J of the CMS 1500 form):		CAQH #:
Additional languages spoken:			Accepting new patients: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Interpretive services provided: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Provider gender (optional): Female <input type="checkbox"/> Male <input type="checkbox"/>				
Has completed cultural competency training? Yes <input type="checkbox"/> Date: _____ No <input type="checkbox"/>				
Training provided by: (list OBH, Colorado Access, other) – attach certificate of completion for non-Colorado Access training				
Practice site location(s) from previous pages:				

Full name:		Date of birth:	Degree/licensure:	Practicing specialty:
Subspecialty:				
Medicare ID #:	Medicaid ID #:	Individual NPI #: (Box 24J of the CMS 1500 form):		CAQH #:
Additional languages spoken (list all):			Accepting new patients: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Interpretive services provided: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Languages:				
Provider gender (optional): Female <input type="checkbox"/> Male <input type="checkbox"/>				
Has completed cultural competency training? Yes <input type="checkbox"/> Date: _____ No <input type="checkbox"/>				
Training provided by: (list OBH, Colorado Access, other) – attach certificate of completion for non-Colorado Access training				
Practice site location(s) from previous pages:				

Full name:		Date of birth:	Degree/licensure:	Practicing specialty:	
Subspecialty:					
Medicare ID #:	Medicaid ID #:	Individual NPI #: (Box 24J of the CMS 1500 form):		CAQH #:	
Additional languages spoken:			Accepting new patients: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Interpretive services provided: Yes <input type="checkbox"/> No <input type="checkbox"/>					
Provider gender (optional): Female <input type="checkbox"/> Male <input type="checkbox"/>					
Has completed cultural competency training? Yes <input type="checkbox"/> Date: _____ No <input type="checkbox"/>					
Training provided by: (list OBH, Colorado Access, other) – attach certificate of completion for non-Colorado Access training					
Practice site location(s) from previous pages:					
Does any other Individual have an Ownership or Control Interest in Provider's business? Yes <input type="checkbox"/> No <input type="checkbox"/>					
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 <input type="checkbox"/> No <input type="checkbox"/>					
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 Locations	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 speciality population you work with below:

- | | |
|--|---|
| <input type="checkbox"/> Children (12 and younger) | <input type="checkbox"/> Foster Care |
| <input type="checkbox"/> Adolescents (13 to 18) | <input type="checkbox"/> Seniors (65 and older) |

Please check only the top 3 speciality(s) of your practice below:

- | | |
|--|---|
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Learning disabilities |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Life transitions |
| <input type="checkbox"/> Alzheimer's/dementia | <input type="checkbox"/> Men's issues |
| <input type="checkbox"/> Animal-assisted | <input type="checkbox"/> Mood disorders |
| <input type="checkbox"/> Anxiety/panic | <input type="checkbox"/> Neuropsychiatry |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Neuropsychology |
| <input type="checkbox"/> Autism spectrum | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Obsessive compulsive disorders |
| <input type="checkbox"/> Brain injury (TBI) | <input type="checkbox"/> Parenting issues |
| <input type="checkbox"/> Child Abuse | <input type="checkbox"/> Personality disorders |
| <input type="checkbox"/> Children of alcoholics | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Chronic pain or illness | <input type="checkbox"/> Postpartum |
| <input type="checkbox"/> Compulsive behaviors | <input type="checkbox"/> Psychological testing/assessment |
| <input type="checkbox"/> Conduct disorder | <input type="checkbox"/> Psychosis |
| <input type="checkbox"/> Criminal justice | <input type="checkbox"/> Psychosomatic illness |
| <input type="checkbox"/> Cultural issues | <input type="checkbox"/> Queer/Questioning |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Relationship issues |
| <input type="checkbox"/> Developmental disorders | <input type="checkbox"/> Relinquishment counseling |
| <input type="checkbox"/> Disruptive behavior disorders | <input type="checkbox"/> Reproductive |
| <input type="checkbox"/> Dissociative disorders | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Divorce/custody | <input type="checkbox"/> Self-harm/self-injury |
| <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Sexual harassment |
| <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Sexual issues |
| <input type="checkbox"/> Elder abuse | <input type="checkbox"/> Sleep/insomnia |
| <input type="checkbox"/> End-of-life | <input type="checkbox"/> Spiritual concerns |
| <input type="checkbox"/> Family therapy | <input type="checkbox"/> Stress management |
| <input type="checkbox"/> Gender identity issues | <input type="checkbox"/> Substance Use Disorder |
| <input type="checkbox"/> Grief and loss | <input type="checkbox"/> Trauma/PTSD |
| <input type="checkbox"/> Impulse control | <input type="checkbox"/> Violent offenders |
| <input type="checkbox"/> Intellectual disabilities | <input type="checkbox"/> Women's issues |
| <input type="checkbox"/> Intimacy issues | |