South Country HEALTH ALLIANCE

LEAVE NOTHING BLANK *Please print or type all information.* ***If the question does not apply, enter N/A.***

PROVIDER CONTRACT APPLICATION

Name of Organization with DBA:_____

Parent Organization(if different from Organization name):_____

Federal Tax ID#: _____ NPI or UMPI:_____

Website: _____ Business Email: _____

As it will be listed in the ***Provider Directory***

Provide the following information for contact people.

Title	Name	Telephone	Email Address
Person Responsible for Contracting			
CEO / Director / Owner			
Credentialing			
Organizational Assessments			

Provider Specialty (select all that apply)

Mental Health	Specialty Services	Hospital / Clinic / Surgery / Free Standing Facility / Skilled Nursing	Transportation / Home Care Lab / DME / Interpreter
☐ Adult Rehabilitative Mental Health Services (ARMHS)	☐ Acupuncture	☐ **Ambulatory Surgery Center**	☐ Non-Emergency Medical Transportation
☐ Assertive Community Treatment (ACT)	☐ Audiology	☐ **Critical Access Hospital**	☐ Emergency Medical Transportation
☐ Certified Community Behavioral Health Clinic (CCBHC)	☐ Chiropractic	☐ Dialysis	☐ Home Health
☐ **Children's Group Residential Treatment Facility (CGRTF)**	☐ Essential Community Providers	☐ Federally Qualified Health Center	☐ **Home Health w/ Skilled Nursing**
☐ Children's Therapeutic Services and Support (CTSS)	☐ Occupational Therapy	☐ Free Standing Clinic	☐ Home and Community Based Services
☐ Consolidated Chemical Dependency Treatment Fund (CCDTF)	☐ Optometry	☐ **Free Standing Facility**	☐ Community Health Worker
☐ **In Patient Mental Health Facility**	☐ Oral Surgery	☐ **Free Standing Birth Center**	☐ Personal Care Agency
☐ **Intensive Residential Treatment Services (IRTS)**	☐ Physical Therapy	☐ Hospice	☐ Doula Services
☐ Outpatient Mental Health	☐ Physician	☐ **Hospital**	☐ Public Health
☐ Psychiatry	☐ Specialists	☐ Hospital Based Clinic	☐ Social Services
☐ **Substance Use Disorder Treatment (SUD)**	☐ Speech Therapy	☐ Primary Care Clinic	☐ Independent Laboratory
☐ SUD Comprehensive Assessment	☐ **Specialty Hospital**	☐ Provider Based Clinic	☐ Durable Medical Equip
☐ Targeted Case Management	☐ Other	☐ Rural Health Clinic	☐ Home Infusion
☐ Other	☐ Other	☐ **Skilled Nursing Facility**	☐ Interpreter

Type of Services offered by your Organization and why are they unique:

Do you offer Telehealth Services: ☐ Yes ☐ No Type of services: ☐ Phone ☐ Video ☐ Other:_____

Describe the ways you provide services to specific segments of the population i.e. cultural, LGBTQ, gender, race/ethnicity?

Do you provide interpreter services for your clients/customers? ☐ Yes ☐ No
If yes which languages: _____

List hospitals you have admitting privileges at, or other facilities you are affiliated with for services:

Are you enrolled as a Medicaid provider with the State of Minnesota: ☐ Yes ☐ No TJC Accredited: ☐ Yes ☐ No

Are you Medicare (CMS) Certified: ☐ Yes ☐ No If yes Medicare Facility ID: _____

Primary Location #1: _____ County: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

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Mailing Address: _____ County: _____

City: _____ State: _____ Zip: _____

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Additional practice locations - If needed, copy this page and complete for each location associated with the primary facility. (Change Location # on copies)

Location # Legal name: _____
IMPORTANT: *This should be the business name you use to file income to the IRS. (This is also the first line of the **W-9 Form**.)*
Doing Business As name: _____
Federal tax ID #: _____ NPI or UMPI#: _____
Physical address: _____
City, State Zip: _____ County: _____
Telephone: _____ Toll Free / TDD: _____
Fax: _____
Type of Services provided at this location: _____

Location # Legal name: _____
IMPORTANT: *This should be the business name you use to file income to the IRS. (This is also the first line of the **W-9 Form**.)*
Doing Business As name: _____
Federal tax ID #: _____ NPI or UMPI#: _____
Physical address: _____
City, State Zip: _____ County: _____
Telephone: _____ Toll Free / TDD: _____
Fax: _____
Type of Services provided at this location: _____

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I certify that the information provided on this form is true and correct.

Application signor name (print):	Title:
Application signor signature:	Date:
Telephone number:	Email address:

South Country Health Alliance serves a diverse population in our member counties and has had multiple instances of members requesting primary care or therapy providers who speak the primary language of the member and/or resembles the appearance of the member. Currently a significant amount of time is put into finding a provider for the member.

In an effort to gather diversity information about our provider network we ask that you complete the question below.

Please indicate the percentage of your Primary Care, Specialty Care or Mental Health Providers who identify as one of following groups:

	Primary Care	Mental Health	Specialty Care
1. Asian	%	%	%
2. Black or African American	%	%	%
3. Hawaiian or Pacific Islander	%	%	%
4. Hispanic or Latinx	%	%	%
5. Middle Eastern	%	%	%
6. Native American or Alaskan Native	%	%	%
7. White	%	%	%
8. Multiracial or Biracial	%	%	%
9. A race/ethnicity not listed here	%	%	%
Please Specify for #9			

Return this form to providerinfo@mnscha.org

It may take up to 90 days for the application to be reviewed by our contracting review committee. We are sorry for the delay but be assured your application will remain on file with us and will be reviewed as soon as possible.

NOTE: Network Providers must be enrolled with the State of Minnesota Department of Human Services as MHCP Providers.

Network Providers must comply with the provider disclosure, screening, and enrollment requirements in 42 CFR §455. [Minnesota Statues, §256B.69, subd. 37; and 42 CFR §438.602(b)]