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*P.O. Box 2555*

*Kearney, NE 68848*

*Phone: (308) 237-5113*

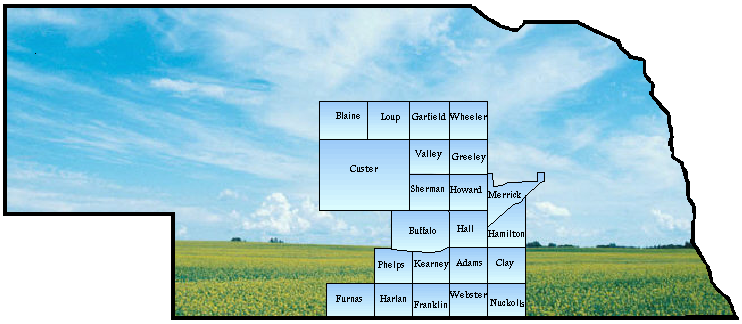
*Fax: (308) 236-7669*

**NETWORK PROVIDER ENROLLMENT**

**MINIMUM STANDARDS**

**APPLICATION**

*The mission of Region 3 Behavioral Health Services is to foster recovery and resiliency for individuals and their families who experience a behavioral Health challenge.*



Revised: 10/26/21

**Region 3 Behavioral Health Service**

**Network Provider Enrollment Minimum Standards Application**

1. **AGENCY IDENTIFICATION INFORMATION**

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| --- | --- | --- |
| Application Date:       Check one:  Initial Enrollment  Retention | | |
| Agency Name: | | |
| Agency Phone Number: | Fax Number: | |
| Mailing Address: | | |
| Federal Tax Identification: | | |
| Social Security # (Individual): | | |
| NPI (National Plan & Provider Enumeration System) #: | | |
| Medicaid #:  The applicant must be enrolled as a Medicaid provider if the service is eligible for Medicaid funding. | | |
| Is the Applicant an (check one):  Organization/Facility  Group Practice  Individual/Professional Practice | | |
| Legal Status:  For Profit  Non-Profit  Quasi-Governmental  Public  Other | | |
| Name of Agency Director/CEO: | | |
| Phone Number: | Email: | |
| Name of Financial Officer/CFO: | | |
| Phone Number: | Email: | |
| Name of Contact Person: | | |
| Phone Number: | Email: | |
| Is Agency part of Larger Organization?  Yes (if yes, provide name, address, phone, fax below) | | No |
| Larger Organization Name: | | |
| Mailing Address: | | |
| Phone Number: | Fax Number: | |
| Identify foreign language(s) or sign language which the agency has capacity to speak fluently in treating clients:  Sign Language (SL)  Spanish (SP)  Other (specify) | | |
| Identify racial/ethnic/cultural populations the agency has special competency to serve (please list): | | |
| The Organization’s services are available in the following Region 3 Counties (please list): | | |

1. **AGENCY PHILOSOPHY**

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| --- |
| Does this agency commit to the opportunity for consumer choice?  Yes  No |
| Does this agency screen for trauma?  Yes  No |
| Provide your agency’s Mission Statement: |

1. **LICENSES/CERTIFICATIONS/CAPACITY**

State/Facility licenses, fire inspections and food permits, as required (attach additional sheet if necessary):

|  |  |  |  |
| --- | --- | --- | --- |
| **Licensing/Certifying/**  **Inspection Body** | **Document**  **Number / Identifier** | **Date Issued** | **Expiration Date** |
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Staff licenses, as required (attach additional sheet if necessary):

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| --- | --- | --- | --- | --- |
| **Staff Name** | **Position** | **License Discipline** | **License**  **Number** | **Date Issued** |
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**Capacity**

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| **Service** | **Applicant’s Full Capacity in this Service** |
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1. **FISCAL**

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| Agency fiscal year:       Submission date of next annual independent audit report: |

*Attach a Certificate of Liability which includes the following:*

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| --- | --- | --- |
| **COMMERCIAL GENERAL LIABILITY** | | |
| General Aggregate | $2,000,000 | |
| Products/Completed Operations Aggregate | $2,000,000 | |
| Personal/Advertising Injury | $1,000,000 per occurrence | |
| Bodily Injury/Property Damage | $1,000,000 per occurrence | |
| Fire Damage | $50,000 any one fire | |
| Medical Payments | $10,000 any one person | |
| Abuse & Molestation | Included | |
| Contractual Liability | Included | |
| ***If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.*** | | |
| **WORKER’S COMPENSATION** | | |
| Employers Liability Limits | $500K/$500K/$500K | |
| Statutory Limits- All States | Statutory - State of Nebraska | |
| Voluntary Compensation | Statutory | |
| **COMMERCIAL AUTOMOBILE LIABILITY** | | |
| Bodily Injury/Property Damage | $1,000,000 combined single limit | |
| Include All Owned, Hired & Non-Owned Automobile liability | Included | |
| Motor Carrier Act Endorsement | Where Applicable | |
| **UMBRELLA/EXCESS LIABILITY** | | |
| Over Primary Insurance | $1,000,000 | |
| **SUBROGATION WAIVER** | | |
| “Workers’ Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska.” | | |
| **LIABILITY WAIVER** | | |
| “Commercial General Liability & Commercial Automobile Liability policies shall be primary and any insurance or self-insurance carried by the State shall be considered excess and non-contributory.” | | |
| **PROFESSIONAL LIABILITY** | | |
| Professional liability (Medical Malpractice) | | Limits consistent with Nebraska Medical Malpractice Cap |
| Qualification Under Nebraska Excess Fund | |
| All Other Professional Liability (Errors & Omissions) - Director and Officers’ Liability or a Fidelity bond for all members or boards and commissions | | $1,000,000 Per Claim / Aggregate |
| **CYBER LIABILITY** | | |
| Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties | | $1,000,000 |

1. **POLICIES AND PROCEDURES**

*Place an “X” in the box if policy/procedure is in place*

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| **“X”** | **Policies and Procedures** |
|  | Americans with Disabilities Act Policy |
|  | Accessibility |
|  | Background checks policy which clearly indicates provider agrees that its staff having any direct contact with consumers of any age will have initial background checks to include a check of the following registries: |
|  | Sex Offender Registry |
|  | Nebraska Child Abuse and Neglect Registry |
|  | Nebraska Adult Abuse and Neglect Registry |
|  | Criminal Records Check by the NE State Patrol |
|  | Department of Motor Vehicles (as applicable) |
|  | Out-of-state background checks will be completed on all newly hired employees, interns, and volunteers who have resided in Nebraska for less than two years if it is foreseeable that the individual may have contact with consumers of any age during the course of providing direct services. |
|  | Chronic Infectious Diseases |
|  | CLAS STANDARDS Matrix Worksheet to be completed |
|  | Cultural Responsiveness |
|  | Client Rights and Responsibilities |
|  | Code of Ethics |
|  | Confidentiality of Case Records |
|  | Conflict of Interest which includes disclosure and resolution. |
|  | Continuing education/training for employees – policy in place. |
|  | Continuity of Operations Plan (COOP) which includes protecting the life and safety of participants. |
|  | Corporate Compliance Plan |
|  | Critical Incident to include the definition of a critical incident, how to investigate, including follow up; documentation requirements, and notifications required when a critical incident occurs. Procedures must address prevention, reporting, documentation, remedial actions and timely debriefings for critical incidents occurring within a provider agency. Providers will have a system and be able to demonstrate that personnel are trained in and aware of reporting requirements. If enrolled within the network, the provider shall provide the region with an Annual Incident Summary to determine compliance and appropriate actions taken to address identified needs. |
|  | Drug-Free Workplace |
|  | Ethics |
|  | EOE / Affirmative Action |
|  | Financial Eligibility |
|  | Grievance procedures regarding employees and participants. Must include how participant's rights will be protected when report is received. |
|  | Health and Safety |
|  | License revocation and/or suspension - annual verification processes in place regarding all applicable employee's required license(s) to ensure such license(s) has not been revoked and/or suspended. |
|  | Medication Assisted Treatment - ensure consumers are not denied access to mental health or substance use treatment solely based on participation in Medication Assisted Treatment for a substance use disorder. |
|  | Medication Assisted Treatment refers to a range of pharmacotherapy available to detoxify, maintain, or otherwise medically manage clients to treat addiction. |
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| **“X”** | **Policies and Procedures** |
|  | No refusal approach - utilize a “no refusal” approach to admitting persons determined eligible by the DHHS system management agent for community-based BH services in REGION 3’s network. |
|  | Policy which includes the following language “Any youth who have not attained the age of eighteen (18) years shall be prohibited from using tobacco products on agency premises or at agency functions.” |
|  | Pro-Children Act of 1994 (Act) which clearly indicates compliance with the requirements of P.L. 103-327 will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. |
|  | Record Management/Retention to include timelines re: |
|  | Client Records Retention Following Discharge Service Records |
|  | Methods for Disposal of client records |
|  | Listing of documents included in personnel files |
|  | How information re: personnel is accessed |
|  | Sexual Harassment |
|  | Trauma Education - documentation which clearly indicates all new staff shall receive at least one hour of trauma education as part of employment orientation. |
|  | Trauma-specific techniques - documentation which clearly indicates all direct service staff shall receive at least one hour of education involving trauma-specific techniques annually. |
|  | Voter Registration Bill (LB76 passed in 1994) documentation clearly indicates compliance with process. |
|  | Workplace Harassment |

1. **PROGRAM PLAN**

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| Submit a current program plan for each service that receives Region funds. Include the following:  a. Entry (admission) and exit (discharge) criteria  b. Description of the assessment procedures  c. Description of how consumer input into the program is completed.  d. Staffing  e. Quality improvement  f. Administrative and operational overview of applicant  g. Purpose of program  h. Need for the program  i. Target population  j. Organization of program  k. Program goals  l. Specific program services  m. Procedures for direct consumer involvement  n. Capacity  o. Facility needs |

1. **NATIONAL ACCREDITATION**

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| --- |
| Date of last accreditation:       Date when accreditation expires:  Type of National Accreditation:  The Commission on Accreditation of Rehabilitation Facilities (CARF)  Council on Accreditation (COA)  Joint Commission Other: |
| Provide a complete copy of the most recent:   * + official accreditation report;   + official award of accreditation; and   + plan of correction submitted in response to the site visit |

1. **LEGAL ACTIONS / PENALTIES / SUSPENSIONS**

Has the agency had professional liability insurance refused, revoked, declined, or accepted on special terms?

Yes  No

If yes, please explain:

Has the program been assessed a penalty, conviction, or suspension or is the facility currently under investigation by the Medicare or Medicaid programs?

Yes  No

If yes, please explain:

1. **PRIMARY SOURCE VERIFICATION**

Does the agency conduct primary source verification on professional licenses?

Yes  No

Does the agency conduct criminal history checks with law enforcement officials in any states in which persons considered for employment, clinical consultants, or volunteers have previously resided to see if there is any criminal record involving crimes against children?

Yes  No

Does the agency conduct Adult Protective Services registry checks on clinical consultants and persons considered for employment?

Yes  No

Does the agency conduct Child Protective Services registry checks on volunteers, clinical consultants and persons considered for employment?

Yes  No

By signing this application, the undersigned certifies that the information is true, accurate and complete:

Signature of Agency Director / CEO Date