

Provider Interest to Join Network Form

Corporate Name:

Contact Name:

Contact Phone:

Contact Email:

Corporate Address:
(include city, state, zip)

Service Location Address:
(include city, state, zip)

Service Location County:

Years In Service:

Months In Service:

Certified?

Licensed?

Please return the completed form to our Contracting Department:

By Fax: 414-287-7704 ATTN: Contracts

By Email: dlfamcontracts@mychoicefamilycare.com

Questions? Please contact our contracts department at 414-287-7640

PROVIDER INTEREST TO JOIN NETWORK FORM
Complete all information.

GENERAL INFORMATION

Services Provided (list all services provided at or from this location AFH, CBRF, Supportive Home Care, transportation, etc.)

If a Residential Facility:
 Number of beds Licensed or Certified for: _____ Number of beds in Private Rooms _____ in Shared Rooms _____
 Which agency certified your home: _____
 Staffing Patterns: 1st shift _____ 2nd shift _____ 3rd shift _____ For 3rd shift is staff awake or asleep _____

Service Area (City(s)/County(s)):

Number of Employees	How did you hear about My Choice Wisconsin?
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POPULATION SERVED

Wheelchair Accessibility:
 Yes No Check here if this is N/A because this site provides services to members in their own settings

If Yes, can this facility accommodate someone in a wheelchair: Yes No

Does this facility/agency serve bariatric members?
 Yes No

Does this facility/agency serve members who are convicted felons?
 Yes No

Does the facility/agency serve members who require interventions for complex behavioral needs?

Verbal redirection? Yes No
 Physical redirection? Yes No If Yes, Submit Proof of Training and example of completed Behavioral Support Plan
 Restrictive Measures? Yes No If Yes, Submit Proof of Training and example of completed Behavioral Support Plan

Does this facility/agency offer RN services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable If yes, please describe RN services offered	
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Rate Proposal(s)

Must enter a Dollar Amount - All other responses will be considered incomplete.

Service	Service Rate	Additional Rate Information
Example: Supportive Home Care - Routine	\$5.00 /hour	Travel Time Included
Example : AFH	\$50.00 per day Care and Supervision	All Transportation included

Contracting will review your information and email you confirmation of **acceptance or denial** of your request within 14 business days of receipt of this form. This is neither an application to nor a guarantee of network participation.

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