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: dlfamccontracts@mychoicewi.org

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

my choice WISCONSIN

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?**

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?
☐ **Yes** ☐ **No** ☐ **Not Applicable**
If yes, please describe RN services offered

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.

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