Ancillary Service Provider Detail

Facility Information	
Location Name:	
Location Address:	
Location Tax ID:	

Business Information	
☐ Corporation	☐ Male Owned Business
☐ Partnership	☐ FQHC
☐ Sole Proprietorship	☐ For Profit
☐ Indian Provider	☐ Non-Profit
☐ Minority Business	☐ Meets EVV Requirements: Electronic Visit Verification (EVV) | Wisconsin Department of Health Services (if applicable)
☐ Disadvantaged Business Enterprise	☐ Other (Explain):
☐ Minority Owned Business	
☐ Small Business Enterprise	
☐ Woman Owned Business	

Cultural Competencies

Please indicate the cultural composition of your organization by checking all that apply.

☐ At least 51% of the Board of Directors is comprised of minorities/women?
☐ The agency is "certified" as a Minority-Owned Business Enterprise (MBE) in the state of Wisconsin?
☐ The Agency is "certified" as a Woman-Owned Business Enterprise (WBE) in the state of Wisconsin?
☐ The agency is "certified" as a Disabled Veteran-Owned Business Enterprise (DVB) in the State of Wisconsin?
[See https://doa.wi.gov/Pages/DoingBusiness/SupplierDiversity.aspx for definition]
☐ The agency is a culturally diverse hiring partner
☐ The agency is culturally competent

CONTACT INFORMATION

Contracting Contact Information

This individual is authorized to sign contracts and rate agreement documents.			
Name:			
Title:			
Phone:		**Fax:**	
Email:			

Placement Referral Contact Information

Name:			
Title:			
Phone:		**Fax:**	
Email:			

Quality Contact Information

***This is a mandatory field for quality related items/issues**			
Name:			
Title:			
Phone:		**Fax:**	
Email:			

Billing Contact Information

Name:			
Title:			
Phone:		**Fax:**	
Email:			

FACILITY/SITE LOCATION SPECIFICATIONS & DETAILS

Facility/Site Location Specifications & Details		
Ambulatory ☐ **Non-Ambulatory** ☐ **Semi-Ambulatory** ☐	**Lift-Equipped:** ☐Yes ☐No **Handicap Parking:** ☐ Yes ☐No	**Wheelchair Accessible:** ☐Yes ☐No **Electric Wheelchair Accessible:** ☐Yes ☐No
Please describe any other physical accessibility or safety features of the facility.		
☐ Ramps ☐ Wide doorways ☐ Elevators ☐ Specially equipped toilet facilities ☐ other [list below]		

Please check all client groups listed on your DHS License or Certificate. Enter additional checks for the client groups that you **primarily** serve. **Member Groups Served**: ☐ Population over 60 ☐ Population under 60 ☐ Primarily 18-45 ☐ Primarily 45-60 ☐ Primarily over 60	
Advanced Aged ☐ Certified to Serve ☐ Primarily Serve	Emotionally Disturbed/Mental Illness ☐ Certified to Serve ☐ Primarily Serve
Alcohol/Drug Dependent ☐ Certified to Serve ☐ Primarily Serve	Irreversible Dementia/Alzheimer's ☐ Certified to Serve ☐ Primarily Serve
Corrections ☐ Certified to Serve ☐ Primarily Serve	Physically Disabled ☐ Certified to Serve ☐ Primarily Serve
Developmentally Disabled ☐ Certified to Serve ☐ Primarily Serve	Terminally Ill ☐ Certified to Serve ☐ Primarily Serve
AODA Services ☐ Certified to Serve ☐ Primarily Serve	Traumatic Brain Injury ☐ Certified to Serve ☐ Primarily Serve

Please check each service that the facility/site can provide.

Significant Medical Needs			
☐	Catheter Care	☐	Tracheostomy Care
☐	Ostomy Care	☐	Tube Feeding
☐	Oxygen Administration	☐	Wound Care
☐	Sliding Scale Insulin Management	☐	Ventilator Dependent
☐	Other [Explain]:		

Significant Physical Needs			
☐	Bariatric Care ☐ 250 - 500 lbs. ☐ Over 500 lbs.	☐	Quadriplegic Care
☐	Frequent Repositioning and/or Skin Care	☐	Range of Motion
☐	Mechanical Lifts such as Hoyer Lifts		
☐	Sit to Stand		
☐	Other [Explain]:		

Significant Behavioral Needs*					
☐	Combative/Resistant to Care	☐	Convicted Sex Offender (Not on Sex Offender Registry)		
☐	Excessive Demands for Attention from Others	☐	Registered Sex Offender		
☐	Physical Aggression ☐ To Staff ☐ To Peers	☐	Verbal Aggression ☐ To Staff ☐ To Peers		
☐	Sexually Inappropriate ☐ To Staff ☐ To Peers	☐	Property Destruction ☐ To Staff ☐ To Peers		
☐	Autism Spectrum Disorder (ASD)	☐	Pica	☐	Prader Willi
☐	CPI or Handle w/Care Training	☐	Behavior Support Plan Development/Tracking	☐	Restrictive Measure Requirement Knowledge
☐	Other [Explain]:				

If you checked any of the categories listed under "**Significant Behavioral Needs**", please describe the type of **training**, **experience**, and/or **certifications** of facility staff that enables your agency to serve members with these needs. Please include details on your agency's training in Challenging Behaviors, Restrictive Measures, Behavior Support Plans, and Crisis Prevention.

Staffing Demographics of Ethnicity Group	
☐	Asian or Pacific Highlander
☐	African American
☐	Hispanic
☐	American Indian / Alaskan Native
☐	White
☐	Other

Please check the **counties** you serve							
☐	Adams	☐	Ashland	☐	Barron	☐	Bayfield
☐	Brown	☐	Buffalo	☐	Burnett	☐	Chippewa
☐	Clark	☐	Columbia	☐	Crawford	☐	Dane
☐	Dodge	☐	Douglas	☐	Dunn	☐	Eau Claire
☐	Grant	☐	Green	☐	Green Lake	☐	Iowa
☐	Iron	☐	Jackson	☐	Jefferson	☐	Juneau
☐	Kenosha	☐	La Crosse	☐	Lafayette	☐	Manitowoc
☐	Marquette	☐	Milwaukee	☐	Monroe	☐	Ozaukee
☐	Pepin	☐	Pierce	☐	Polk	☐	Price
☐	Racine	☐	Richland	☐	Rock	☐	Rusk
☐	Sauk	☐	Sawyer	☐	Sheboygan	☐	St Croix
☐	Taylor	☐	Trempealeau	☐	Vernon	☐	Walworth
☐	Washburn	☐	Washington	☐	Waukesha	☐	Waushara
☐	Winnebago						

Communication Needs							
☐	Albanian	☐	Arabic	☐	Bosnian	☐	Burmese	☐	Chinese
☐	Croatian	☐	English	☐	Farsi	☐	Filipino	☐	French
☐	German	☐	Greek	☐	Hindi	☐	Hmong	☐	Italian
☐	Japanese	☐	Korean	☐	Laotian	☐	Latvian	☐	Polish
☐	Russian	☐	Serbian	☐	Somalian	☐	Spanish	☐	Swahili
☐	Thai	☐	Vietnamese	☐	Visually Impaired/Blind	☐	Nonverbal	☐	American Sign Language

Completed Service Provider Application and all documentation must be received **no later** than thirty **(30) days after receipt**.

The provider understands that completion of provider application does not guarantee network admission and/or subsequent contract with the MCO.
Please Note: The MCO is not required to contract with providers beyond the number necessary to meet the needs of its members.

PLEASE RETURN TO:
Molina Healthcare of Wisconsin, Inc. DBA My Choice Wisconsin
Email: MHWIProviderNetworkManagement@MolinaHealthCare.Com