A close up of a logo

Description automatically generated

**Residential Service Provider Detail**

|  |
| --- |
| **Facility Information** |
| **Location Name:** Click or tap here to enter text. |
| **Location Address:** Click or tap here to enter text. |
| **Location Tax ID:** Click or tap here to enter text. |

|  |  |
| --- | --- |
| **Business Information** | |
| Corporation  Partnership  Sole Proprietorship  Indian Provider  Minority Business  Disadvantaged Business Enterprise  Minority Owned Business  Small Business Enterprise  Woman Owned Business | Male Owned Business  FQHC  For Profit  Non-Profit  Other (Explain): Click or tap here to enter text. |
| **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 | |

**Facility / Site Location Specifications & Details – For 1-2 or 3-4 Bed AFH, MUST specify if OWNER OCCUPIED or not:**

|  |  |  |
| --- | --- | --- |
| **Please Chek Facility Type** | | |
|  | **AFH 1-2 Bed Non-Owner Occupied** | **Total Number of Beds:** Click or tap here to enter text. |
|  | **AFH 1-2 Bed Owner Occupied** | **Total Number of Beds:** Click or tap here to enter text. |
|  | **AFH 3-4 Bed Non-Owner Occupied** | **Total Number of Beds:** Click or tap here to enter text. |
|  | **AFH 3-4 Bed Owner Occupied** |  |
|  | **CBRF Up to 8 Bed** | **Total Number of Beds:** Click or tap here to enter text. |
|  | **CBRF 9+ Bed** | **Total Number of Beds:** Click or tap here to enter text. |
|  | **RCAC** | **Total Number of Beds:** Click or tap here to enter text. |

**CONTACT INFORMATION**

**Contracting Contact Information**

|  |  |
| --- | --- |
| This individual is authorized to sign contracts and rate agreement documents. | |
| **Name:** Click or tap here to enter text. | |
| **Title:** Click or tap here to enter text. | |
| **Phone:** Click or tap here to enter text. | **Fax:** Click or tap here to enter text. |
| **Email:** Click or tap here to enter text. | |

**Placement Referral Contact Information**

|  |  |
| --- | --- |
| **Name:** Click or tap here to enter text. | |
| **Title:** Click or tap here to enter text. | |
| **Phone:** Click or tap here to enter text. | **Fax:** Click or tap here to enter text. |
| **Email:** Click or tap here to enter text. | |

**Quality Contact Information**

|  |
| --- |
| **\*This is a mandatory field for quality related items/issues** |

|  |  |
| --- | --- |
| **Name:** Click or tap here to enter text. | |
| **Title:** Click or tap here to enter text. | |
| **Phone:** Click or tap here to enter text. | **Fax:** Click or tap here to enter text. |
| **Email:** Click or tap here to enter text. | |

**Billing Contact Information**

|  |  |
| --- | --- |
| **Name:** Click or tap here to enter text. | |
| **Title:** Click or tap here to enter text. | |
| **Phone:** Click or tap here to enter text. | **Fax:** Click or tap here to enter text. |
| **Email:** Click or tap here to enter text. | |

**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.** Click or tap here to enter text. | | |

|  |  |
| --- | --- |
| 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 |

|  |  |  |  |
| --- | --- | --- | --- |
| **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]: Click or tap here to enter text. | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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]: Click or tap here to enter text. | | | | | | |
| 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. | | | | | | | | |

How many years of experience with high behavioral or medically complex members?

0-1 Years

1-2 Years

2-3 Years

4-5 Years

5+ Years

|  |  |
| --- | --- |
| **Staffing Demographics of Ethnicity Group** | |
|  | Asian or Pacific Highlander |
|  | African American |
|  | Hispanic |
|  | American Indian / Alaskan Native |
|  | White |
|  | Other Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| 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]: Click or tap here to enter text. | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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**.

**Note: All certifications are subject to fees:**

**Fees for a 1-2 Bed AFH:**

* **New Certifications & Change of Address $475.00**
* **Recertifications $350.00**
* **The Credentialling Department will remind you of this fee and fee must be paid by check and prior to a certifier being deployed to your location.**
  + **Fees may not be refundable under these circumstances but not limited to:**
  + **MCW is unable certify due to dual certifications.**
  + **50% of fee may be refunded if provider does not pass credentialing.**
  + **Fees will not be refunded if provider abandons the certification process for any reason**

**Fees should be mailed to:**

Molina Healthcare of Wisconsin Inc d/b/a My Choice Wisconsin Inc

10201 W Innovation Drive, Suite 100 Wauwatosa, WI 53226

Attn: Credentialing/Certification

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](mailto:MHWIProviderNetworkManagement@MolinaHealthCare.Com)