

**Residential Service Provider Detail**

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| **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. |

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| **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:**

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| **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**

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| 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**

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| **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**

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

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| **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**

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| **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**

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| **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. |

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| 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 |

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| **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. |

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| **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 [ ]

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| **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. |

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| 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. |

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| 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 |  |

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| **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