GPATR RECOVERY SUPPORT SERVICES PROVIDER ENROLLMENT FORM

- *Thank you for applying to become a GPATR Recovery Support Services Provider.*

- *Please complete the following and mail in with your application packet:*

  - ❒ *Checklist (Complete all the boxes)*
  - ❒ *Application*
  - ❒ *W-9*
  - ❒ *Release Of Information*
  - ❒ *Organizational Participation Agreement*

- *You will be notified by e-mail or phone if your application is incomplete. You will receive a letter of approval into the GPATR network and a certificate. Please indicate if you will need technical assistance in setting up billing, or if you need a hard copy of the provider manual and service rates and definition, which will be available to download online at www.gpatr.org. Please do not request a hard copy if you have internet access.*

- *If you have any questions about the program or the application requirements, please contact the GPATR Program Director, Regional Trainers, or Treatment Coordinator at the number below.*

- *Please fax or mail your completed application to:*

  Great Plains Tribal Chairmen's Health Board
  GPATR Program
  1770 Rand Road
  Rapid City, SD 57702
  605-721-1922 (office)
  605-716-3127 (fax)

GPATR RECOVERY SUPPORT SERVICES PROVIDER ENROLLMENT FORM

CHECKLIST FOR ATR NETWORK PROVIDER APPLICATION

Please submit this completed checklist with the provider application. *Please indicate that you have included the documentation by placing an "X" in the box below the number. If you will not be submitting one of the documents, place an "NA" in the box below the number. Do not leave any items on the checklist or questions on the application blank.*

Only completed applications will be reviewed.

1.	**Professional Licensure for Individuals (CLINICAL, RECOVERY SUPPORT)**
	For Recovery Support individuals, provide a copy of each individual's license, certification, or registration. (If applicable: **for many Recovery Support providers, this does not apply).**
2.	**Criminal Background Check**
	Certification that each individual in the agency or organization who has client contact has a recent (within 12 months) background check on file and available for audit. Anyone having client contact must have no prior convictions for child abuse or felony firearms charges.
3.	**Professional, Business Liability or Malpractice Insurance (needed if you have a license)**
	Provide a copy of the agency's professional, business or malpractice insurance.
5.	**IRS Form W9**
	Completed and signed W9 form containing Tax ID # or SS# for an individual or sole proprietor.
6.	**Release of Information between GPATR and Provider**
	Signed and dated by an authorized individual on behalf of the organization.
7.	**Letter of Good Standing for Traditional Healer/Faith-Based Provider**
	Signed Letter of Recognition/Letter of Good standing by either Tribal Chairperson, Board of Directors of the Tribal Program for which the person is working, or the faith-based community in which the person is practicing.
8.	**Documentation of Cultural Competence Training**
	If the individual provider has less than one year of experience working with ATR Tribal Clients, he/she must submit documentation of completion of cultural competence training.

This project is funded under the Access to Recovery Initiative Grant # 1H79TI023078-01, Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

Great Plains Tribal Chairmen's Health Board
1770 Rand Road Rapid City, SD 57702
605-721-1922 (office) 605-716-3127 (fax)

GPATR RECOVERY SUPPORT SERVICES PROVIDER ENROLLMENT FORM

PART 1 - GENERAL APPLICATION INFORMATION

Organization is: ☐ *Sole Proprietorship* ☐ *Partnership* ☐ *Tribal* ☐ *Corporation* ☐ *Governmental Entity (State, County)*

Services are: ☐ *Faith-based* ☐ *Secular-based*

If Faith-based : ☐ *AI/AN Traditional* ☐ *Other denomination (describe):* _____

Organization type: ☐ *Profit* ☐ *Non-Profit*

Please note: If you are a community member or grassroots provider and will need help accepting and submitting vouchers, we have technical support that will help you with this process. If you believe that you will need this service, please indicate here:

☐ *I will need technical support to get started.*
☐ *I will need ongoing technical support to accept vouchers, submit billing and file reports.*
☐ *I will need a hard copy of the provider manual and service rates and definitions (I have no internet access)*

Section A – General Information

_____
Applicant Name (Agency, Business or Organization)

_____ _____ _____ _____
Physical Address *City* *State* *ZIP*

_____ _____ _____ _____
Mailing Address (street or PO Box if different from above) *City* *State* *ZIP*

_____ _____
Contact Name *Title*

_____ _____ _____
Telephone Number *Fax Number* *Email*

_____
Tax ID # or SSN

Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*

9. Hours of Operation

Section B –Fiscal/Payment Information

_____ _____
Fiscal Contact Name *Title*

_____ _____ _____ _____
Mailing Address (street or PO Box if different from above) *City* *State* *ZIP*

_____ _____ _____
Telephone Number *Fax Number* *Email*

Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*

Administrative Offices Hours of Operation

Section C –Services

Demographic(s)/Characteristic(s) of the Population Served (check all that apply)

- ☐ *Men*
- ☐ *Women*
- ☐ *Children (under 18)*
- ☐ *Transgender*
- ☐ *Mental Health*
- ☐ *Veterans*
- ☐ *Aging over 65 years*
- ☐ *Disabled*
- ☐ *HIV Positive*
- ☐ *Sex Offenders*
- ☐ *Corrections*
- ☐ *Domestic Violence*

Service(s) that you provide. (Check all that apply)

Intake/Vouchers/Care Management

- ☐ *Intake Interview*
- ☐ *Recovery Management Planning*
- ☐ *GPRA Interviews*
- ☐ *Care Management*

Recovery Support Services

- ☐ *Family Services (Marriage education, parenting and child development services.)*
- ☐ *Child Care Services*
- ☐ *Employment Services*
- ☐ *Pre-Employment Services/ Job Readiness*
- ☐ *Employment Coaching*
- ☐ *Other Educational Services (e.g.GED Preparation)*
- ☐ *Alcohol/Drug Testing*
- ☐ *Acupuncture*
- ☐ *Auricular Acupuncture*
- ☐ *Alternative Therapies*
- ☐ *Physical Fitness and Well-Being Activities*
- ☐ *Nutritional Management*
- ☐ *Stress Management*
- ☐ *Group/Peer Support Services/Self Help Support Groups*
- ☐ *Spiritual Support Services (Traditional/Pastoral)*
- ☐ *Daily Living Skills/Group*
- ☐ *Traditional Healing Services* ☐ *Sweat Lodge*
- ☐ *Talking Circle*
- ☐ *Spiritual/Cultural Retreat*
- ☐ *HIV/AIDS Education*
- ☐ *Other Education Services*
- ☐ *Indigenous Language Recovery/Expression*
- ☐ *Storytelling/Cultural Teaching*
- ☐ *Tribal Song and Dance*
- ☐ *Tribal Arts and Crafts*
- ☐ *Substance Abuse Education*
- ☐ *Transportation Services*
- ☐ *Transitional Drug Free Housing Services*
- ☐ *Individual/Peer Support Service*
- ☐ *Other Recovery Support Services* _____

GPATR RECOVERY SUPPORT SERVICES PROVIDER ENROLLMENT FORM

Section F – Program/Department License

If the services you wish to provide require licensure or certification please provide license or certification information below:

Name of Licensee	*Licensing Agency Name*	*Licensing Type*	*Licensing Number*	*Effective Dates mm/dd/yy – mm/dd/yy*

Section G – Certification

1. I declare that the statements on this application are correct to the best of my knowledge.

2. I am authorized to sign this application on behalf of the named applicant.

Program Contact Name *Title*

Date

PART 2 – PROVIDER PARTICIPATION AGREEMENT

Must be signed and dated by an authorized individual on behalf of the organization. To participate as an ATR provider, our organization, as the provider of services agrees to:

1. *Not charge ATR for services paid for by other funding sources. (Examples of such funding sources are private insurance, Medicaid, Medicare, or State Block Grant funds). ATR Funds are the payer of last resort with the exception of Indian Health Services and Tribal Resources. (CFR 42 136.61) Tribal resources pooled with Indian Health Services resources are covered by the rules established for Indian Health Services funds.* **ATR must supplement, not supplant, other funding sources**.

Do not charge a client for the following:
- *Services for which the provider is entitled to payment from ATR;*
- *Services for which the provider could have been entitled to payment from ATR had the provider complied with certain procedural requirements;*
- *Services not necessary and appropriate for the clinical management of the presenting problem(s);*
- *Services for which the provider could have been entitled to payment from ATR had the provider not been charged with a reduction or denial in payment as a result of quality review; and*
- *Services rendered during a period in which the provider was not authorized to provide services.*

2. *Comply with the applicable provisions related to ATR policy.*

3. *Accept the ATR allowable payment combined with any cost share or other health insurance amounts payable by, or on behalf of, the client, as full payment for authorized services.*

4. *Collect from the client those amounts that the client has a liability to pay for.*

5. *Allow ATR to review the clinical records of clients in accordance with applicable tribal, state and/or federal law.*

6. *Cooperate fully with utilization and clinical quality management reviews conducted by ATR.*

7. *Cooperate fully with GPRA data collection conducted by ATR.*

8. *Obtain authorization via a voucher from ATR before rendering services.*

9. *Maintain clinical and other records related to clients for whom payment was made for services rendered by the provider or otherwise under arrangement, for a period of 5 years from the date of service.*

10. *Maintain clinical records that substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment.*

11. *Notify ATR within five (5) business days when a client's eligibility status has changed.*

12. *Notify ATR immediately of suspected fraud and abuse and notify ATR immediately if either the provider or one of the provider's employees becomes excluded from participation in federal programs.*

13. *Notify ATR immediately when an employee who serves as a provider is no longer employed by the organization or their eligibility status changes.*

14. *Do not use ATR program funds for clinical research involving human subjects, or enroll clients in clinical research involving human subjects.*

15. *Maintain professional liability insurance.*

16. *Provide quality services within the appropriate standards of care for each provider's profession.*

17. *Meet all ATR reporting requirements.*

18. *Agree to provide staff release time for core competency trainings related to ATR.*

19. *The agency/organization agrees and understands that agents of the ATR will conduct random audits and may inspect the premises, review agency, personnel and client records, observe program operations, and interview employees and clients associated with the program(s).*

20. *Meet future requirements established by ATR. (Any change in ATR requirements will be made in the form of a written amendment to this agreement).*

21. *Align current billing & accounting practices with electronic voucher system and orient accounting staff to voucher payment protocols.*

22. *Ensure internet access so that clients and providers can download and print word documents and PDF files.*

The ATR program agrees to make this agreement effective until terminated by either party. The effective date shall be the date on the application acceptance letter.

_____

Agency/ Organization Name (Print)

_____ _____

Authorized Signer's Name (Print) *Authorized Signer's Title (Print)*

_____ _____

Signature, Authorized Signer's Name *Date*

PART 3 – RECOVERY SUPPORT AND CLINICAL TREATMENT STAFF INFORMATION

Make copies of these pages for **Each Individual** *person who will provide service(s).*

Section A—Individual Attestation Questions

Each provider is required to complete, sign, and date this form. An application will not be considered complete unless a completed attestation question form is submitted for each person who is identified to provide services in the provider application.

PLEASE FILL THE FOLLOWING IF YOU ARE ONLY PROVIDING RECOVERY SUPPORT SERVICES WHICH DO NOT NEED A LICENSE, CERTIFICATE, OR OTHER CREDENTIAL.

Please answer "YES" or "NO" to the questions below. If you answer "YES" to questions A through C, please provide a full explanation on a separate sheet of paper referencing the section number.

A. Have you ever been convicted of any crime (other than a minor traffic violation)? ☐ *Yes* ☐ *No*
If yes, give particulars on a separate sheet of paper.

B. Do you presently use any drugs illegally? ☐ *Yes* ☐ *No*

C. Have you had a criminal background check within the last 12 months? ☐ *Yes* ☐ *No*
Is it on file with your organization or agency and/or available for audit? ☐ *Yes* ☐ *No*

I hereby affirm that the information submitted in this Section (Individual Provider Attestation Questions) and any attached addendums is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that omissions and misrepresentations may result in denial of my application or termination of my privileges as a provider under ATR.

_____
Print Name

_____ _____
Signature *Date*

Section B—Individual Attestation Questions if you hold a certification or license

PLEASE FILL OUT THE FOLLOWING IF YOU ARE PROVIDING CLINICAL TREATMENT SERVICES AND/OR RECOVERY SUPPORT SERVICES WHICH REQUIRE A LICENSE, CERTIFICATE, OR OTHER CREDENTIAL

Please answer "YES" or "NO" to the questions below. If you answer "YES" to questions A through K, or if you answer "NO" to question L, please provide a full explanation on a separate sheet of paper referencing the section number.

A. Has your license, registration, or certification to practice in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license, registration, or certification or voluntarily or involuntarily accepted any such actions or conditions, or have been fined or received a letter of reprimand or is such action pending? ☐ *Yes* ☐ *No*

B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subject to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper

professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any other public program, or is any such action pending? ☐ *Yes* ☐ *No*

C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association [IPA], health plan, health maintenance organization [HMO], preferred provider organization [PPO], medical society, professional association, medical school faculty possession, or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct, or breach of contract, or is any such action pending? ☐ *Yes* ☐ *No*

D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association [IPA], health plan, health maintenance organization [HMO], preferred provider organization [PPO], medical society, professional association, medical school faculty position, or other health delivery entity or system) while under investigation for possible incompetence, improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ☐ *Yes* ☐ *No*

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, or other clinical education program? ☐ *Yes* ☐ *No*

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending? ☐ *Yes* ☐ *No*

G. Have you ever been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)? ☐ *Yes* ☐ *No*

H. Have you ever been convicted of any crime (other than a minor traffic violation)? ☐ *Yes* ☐ *No*
If yes, give particulars on a separate sheet of paper.

I. Do you presently use any drugs illegally? ☐ *Yes* ☐ *No*

J. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending? ☐ *Yes* ☐ *No*

K. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with a written notice of any intent to deny, cancel, renew, or limit your professional liability insurance or its coverage of any procedures? ☐ *Yes* ☐ *No*
L. Are you able to perform all of the services required by your agreement with, or the professional staff bylaws of the health organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance standards and without posing a direct threat to the safety of clients? ☐ *Yes* ☐ *No*

M. Have you had a criminal background check within the last 12 months? ☐ *Yes* ☐ *No*

Is it on file with your organization or agency? ☐ *Yes* ☐ *No*

GPATR RECOVERY SUPPORT SERVICES PROVIDER ENROLLMENT FORM

I hereby affirm that the information submitted in this Part 3 – Provider Attestation Questions, and any attached addendums is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that omissions and misrepresentations may result in denial of my application or termination of my privileges as a provider under ATR.

Staff Member (Individual Provider) Name (Print)

Staff Member (Individual Provider) Name (Signature) *Date*

ATTENTION: PLEASE PROVIDE A COPY OF CREDENTIAL INFORMATION OR LICENSEFOR EACH PERSON, IF APPLICABLE

GPATR RECOVERY SUPPORT SERVICES PROVIDER ENROLLMENT FORM

Release of Information

The Release of Information must be signed and dated by an authorized individual on behalf of the organization.

I hereby consent to the disclosure, inspection and copying of information and documents relating to credentials, qualifications, and performance ("credentialing information") by and between GPTCHB or its agent and other businesses and individuals acting as an agent, for the purpose of evaluating this application and any re-application regarding professional training, experience, character, conduct, and judgment, ethics, and ability to work with others.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for act and/or communications in connection with evaluating qualifications of healthcare providers. I hereby release all persons and entities, including GPTCHB, engaged in quality assessment, peer review and credentialing on behalf of GPTCHB, and all persons and entities providing credentialing information to such representatives of AATCHB from any liability incurred for acts and/or communications are protected by state and federal law.

I understand that I shall afford such fair procedures with respect to participation in the Path to Recovery (ATR) program as may be required by state and federal law and regulation. I understand and agree that as an applicant, have the burden of producing adequate information for proper evaluation of professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. During such time as this application is being processed, I agree to update the application should there be any changes in the information provided.

In addition to any notice required by GPTCHB, I agree to notify GPTCHB immediately in writing of the occurrence of any of the following: 1. the unstayed suspension, revocation or nonrenewal of license, registration, and/or certification to practice; or 2. any cancellation or nonrenewal of professional liability insurance coverage.

I further agree to notify GPTCHB in writing, promptly and no later than (14) business days from the occurrence of any of the following: (1) receipt of written notice of any adverse action against the licensing, registration, and/or certification board taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting the license, registration, and/or certification; or (2) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of privileges; or (3) any material reduction in professional liability insurance coverage; or (4) receipt of written notice of any legal action, including, without limitation, any filed and served malpractice suit or arbitration action; or (5) a staff conviction of any crime (excluding minor traffic violations); (6) receipt of written notice of any adverse action under the Medicaid or Medicare programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any attached support documents are true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions and misrepresentations may result in denial of my application or termination of privileges as a GPTCHB provider. A photocopy of this document shall be as effective as the original.

Name (Print) _____ *Program/Facility Name* _____

Signature _____

Title _____ *Date* _____

GPATR RECOVERY SUPPORT SERVICES PROVIDER ENROLLMENT FORM

Letter of Recognition and Good Standing Form (may be used for faith-based and traditional healers and cultural providers)

GPATR
Great Plains Tribal Chairmen's Health Board
1770 Rand Road
Rapid City, SD

Date: _____

To Whom It May Concern:

I attest that _____ is recognized as a
Name of applicant

_____, and is in good standing in the community.
(Medicine Man, Traditional Healer, Pastor, Singer, Storyteller, Artist, etc.)

To my knowledge this person has good character and provides help to the people.

If you have any questions, you can call me at : _____
(daytime phone).

Respectfully,

_____
Print Name

_____
Print Title

_____ _____
Signature *Date*