APPLICATION TO PARTICIPATE AS A HEALTH CARE PROVIDER

Please submit application to:
Credentialing@TrilliumNC.org

Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

ACCREDITED NCQA MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION 1 YEAR

urac ACCREDITED Health Network Expires 03/01/2022

urac ACCREDITED Health Utilization Management Expires 03/01/2022

urac ACCREDITED Health Call Center Expires 03/01/2022

INSTRUCTIONS

A prospective provider must apply for and be credentialed with Trillium Health Resources to qualify for reimbursement of services provided to Trillium Health Resources members.

THE CREDENTIALING PROCESS INCLUDES THE FOLLOWING STEPS:

Provider completes and signs the Credentialing Application and returns it along with the required documentation to Credentialing@TrilliumNC.org

A Credentialing Application is considered to be invalid and must be returned to the provider for correction and/or for additional information if:

- All spaces in the application have not been completed. Must put N/A or Not Applicable
- The Signatures, where required, are not original and dated within 180 days.
- The Signatures are not by the individual applicant or, where applicable, an authorized agent for the entity.
- The text has been altered, highlighted, struck through, or obstructed through the use of correction fluids.
- The responses are illegible.
- The National Provider Identifier is not a valid number.
- Any of the documents or pages that comprise the Credentialing Application are missing.
- Any of the requested information in any of the documents that comprise the Credentialing Application are missing.
- NC Tracks enrollment is incomplete or missing service location, taxonomy, or health plan, as required.

CHECKLIST - Before submitting the Credentialing Application, ensure the necessary components are included in the following order:

- ☐ Attestation Statement
- ☐ Insurance Attestation
- ☐ Insurance Information:
  - ☐ Copy of Certificate of Insurance or Letter of Intent from Carrier
  - ☐ Proof of Auto Insurance for Company Vehicles
  - ☐ Proof of Auto Insurance For Employee Vehicles if Employees Transport Members
- ☐ Background Authorization form(s) for managing employees and persons with an ownership or control interest of 5 % or more in the Provider
- ☐ Copy of Accreditation Certification
- ☐ Copy of Articles filed with the NC Secretary of State
- ☐ Copy of an Organizational Flow Chart including all owners of more than five percent (5%) interest and all parent, sister, and subsidiary entities in the entire chain of ownership up to the ultimate owner of the holding company.
  - ☐ Include a list of all Board Members including their names, titles, and addresses (If applicable).
- ☐ Policy for completing background checks on owners, directors, officers, administrators, and staff
- ☐ Evidence of current DEA Certificate/State controlled dangerous substance certificate (if applicable)
- ☐ Copy of Facility License for each site (If applicable)
- ☐ Required Written References:
  - ☐ Fiscal Operations of the organization (one reference)
  - ☐ Clinical Operations of the organization (one reference)
  - ☐ Service Provision (2 references that reference the quality of service provided)

SECTION 1: CORPORATE INFORMATION

Date of Application: ☐ Agency ☐ Group (Group of Practitioners)

1. Legal Name of Organization (as used for tax reporting purposes/as listed with the NC Secretary of State):

2. Federal Tax ID #: _____

Federal Tax Status:

☐ Not for Profit ☐ For Profit ☐ 501 C 3

3. NPI: | 4. Taxonomy:

5. Organization Address (Mailing)

Address: _____ _____

Street *City* *State* *Zip+4*

6. Number of years doing business under this name?

Has the organization ever been in business under a different name? If yes, ☐ Yes ☐ No

Name:

7. Website:

8. Primary Contact: _____ Title: _____

Phone #: Fax #: Email:

9. CEO/Executive Director:

10. Clinical Director:

11. Medical Director:

12. Organization Legal Entity Type:

☐ C-Corporation ☐ General Partnership ☐ Cooperative

☐ S-Corporation ☐ Sole Proprietorship Limited ☐ Not for Profit

☐ Limited Liability Corporation ☐ Liability Partnership ☐ Government

13. Is the organization accredited? (If yes, please attach verification of accreditation) ☐ Yes ☐ No

☐ JCAHO: Years accredited: _____ Expiration Date: _____

☐ CARF: Years accredited: _____ Expiration Date: _____

☐ COA: Years accredited: _____ Expiration Date: _____

☐ CQL: Years accredited: _____ Expiration Date: _____

☐ Other: _____

Refer to SECTION 10.15A. (c) Article 3A of Chapter 122C of the General Statutes.

SECTION 1: CORPORATE INFORMATION
Continued

14. Has the applicant, managing employees, owners, or agents ever been sanctioned, placed on probation, or lost accreditation or certification status? (If yes, please attach an explanation of the circumstances and how it was resolved.) ☐ Yes ☐ No

15. Liability Insurance:
    a. Has the organization ever had a claim against it? (If yes, please list the name and amounts of the insurance and disposition.) ☐ Yes ☐ No
    b. Are there any current, unsettled claims? (If yes, please attach an explanation.) ☐ Yes ☐ No
    c. Is the organization aware of any circumstances that may result in a claim or suit? (If yes, please attach an explanation.) ☐ Yes ☐ No
    d. Has the organization ever had a policy cancelled? (If yes, please attach an explanation.) ☐ Yes ☐ No

16. Has there ever been any action or investigation against the applicant, managing employees, owners, or agents in the organization relating to any of the following? (If yes, please attach an explanation.)
    a. License? ☐ Yes ☐ No
    b. Certification? ☐ Yes ☐ No
    c. Registration? ☐ Yes ☐ No
    d. Privileges? ☐ Yes ☐ No
    e. Billing Organizations? ☐ Yes ☐ No
    f. Sanctions? ☐ Yes ☐ No

17. Have any adverse actions been filed against the applicant, managing employees, owners, or agents by any of the following? (If yes, please attach an explanation.)
    a. Medicaid? ☐ Yes ☐ No
    b. Medicare? ☐ Yes ☐ No
    c. Other Insurance? ☐ Yes ☐ No

18. Has the applicant, managing employees, owners, or agents ever been sanctioned by any professional or government organization for any of the following in any state or country? (If yes, please attach an explanation.)
    a. Violation of Ethics? ☐ Yes ☐ No
    b. Professional Misconduct? ☐ Yes ☐ No
    c. Unprofessional Conduct? ☐ Yes ☐ No
    d. Incompetence? ☐ Yes ☐ No
    e. Negligence? ☐ Yes ☐ No

19. Is the organization aware of any circumstances that may result in such an action? (If yes, please attach an explanation.) ☐ Yes ☐ No

20. Has the organization ever had a contract cancelled by another LME/Area Authority/County Program in North Carolina, or similar entity in another state? (If yes, please attach an explanation.) ☐ Yes ☐ No

21. Has the applicant, managing employees, owners, or agents ever been convicted of a felony or misdemeanor, or is under investigation with respect to such conduct? (If yes, please attach an explanation.) ☐ Yes ☐ No

SECTION 2: OWNERSHIP INFORMATION

1. List all shareholder/partners (including self) who have 5% or more ownership (or whose spouse, parent, child or sibling as such an interest) AND all individual officers, directors, managers, and Electronic Funds Transfer (EFT) authorized individuals and information requested on each. (This page may be duplicated if necessary).

Name: Address:

Title: SSN: License #:

Date of birth: % Owner:

Check business relationship that applies:

☐ Owner ☐ Shareholder ☐ Partner ☐ Manager ☐ EFT Auth Staff

Check relationship to enrolling provider (if applicable).

☐ Spouse ☐ Parent ☐ Child ☐ Sibling

Name: Address:

Title: SSN: License #:

Date of birth: % Owner:

Check business relationship that applies:

☐ Owner ☐ Shareholder ☐ Partner ☐ Manager ☐ EFT Auth Staff

Check relationship to enrolling provider (if applicable).

☐ Spouse ☐ Parent ☐ Child ☐ Sibling

Name: Address:

Title: SSN: License #:

Date of birth: % Owner:

Check business relationship that applies:

☐ Owner ☐ Shareholder ☐ Partner ☐ Manager ☐ EFT Auth Staff

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☐ Spouse ☐ Parent ☐ Child ☐ Sibling

Name: Address:

Title: SSN: License #:

Date of birth: % Owner:

Check business relationship that applies:

☐ Owner ☐ Shareholder ☐ Partner ☐ Manager ☐ EFT Auth Staff

Check relationship to enrolling provider (if applicable).

☐ Spouse ☐ Parent ☐ Child ☐ Sibling

SECTION 2: OWNERSHIP INFORMATION
Continued

2. Please include the following information if not included above:

CEO/President: _____

SSN: _____ License #: _____

Address: _____

Street *City* *State* *Zip+4*

CFO/Finance: _____

SSN: _____ License #: _____

Address: _____

Street *City* *State* *Zip+4*

3. Identify other providers, if any, which are owned or operated by the applicant under the same owner name.

Provider Name: _____

Address: _____

Street *City* *State* *Zip+4*

Relationship Type:

☐ Nursing Home ☐ Home Health Agency ☐ Community Based Residential Facility

☐ Hospital ☐ Other:

4. Is the applicant a subsidiary company, either wholly or partially owned by another organization or business? If yes, provide the following information:

☐ Yes ☐ No

Legal Business Name – Parent Company: _____

Type of Ownership:

SECTION 3: SITE SPECIFIC INFORMATION

A Site is a physical location where supervision and/or management of services occur. Please attach the facility site license if applicable. Complete this section for each service that the organization is seeking to provide AND for each site. (This section may be duplicated if necessary).

1. Site Name: _____

   Address: _____

   Street *City* *State* *Zip+4*

2. Phone:

3. Fax #:

4. Email:

5. NPI:

6. Taxonomy:

7. Hours:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

8. Services Rendered – PER SITE: Please list the services that will be provided at each site:

Service Code	Service Description

SECTION 3: SITE SPECIFIC INFORMATION
Continued

9. Information about the Facility/Site Director or Supervisor:
   Name: _____
   Education: _____ Credentials: _____
   Have they ever completed an application to Trillium Health Resources? ☐ Yes ☐ No
   If yes, what year: What was the outcome?

10. Is this site licensed by any of the following? (If yes, attach a copy of each license.)
    a. DHSR: ☐ Yes ☐ No License #: _____ State: _____
    b. DSS: ☐ Yes ☐ No License #: _____ State: _____
    c. Other: ☐ Yes ☐ No Type: _____
    License #: State:

11. Is this facility/site staffed and equipped to serve any of the following? (This question is NOT optional. Please check either Yes or No.)
    a. Physically Handicapped: ☐ Yes ☐ No
    b. Blind/Visually Impaired: ☐ Yes ☐ No
    c. Deaf and/or Hearing Impaired: ☐ Yes ☐ No
    d. Sexually Aggressive: ☐ Yes ☐ No
    e. Behaviorally Disruptive: ☐ Yes ☐ No
    f. Foreign Languages: ☐ Yes ☐ No
    Please Specify:

12. **Coverage**: Please indicate what arrangements the organization has to cover member emergency situations during nights, weekends, and holidays.

    Phone: _____

13. **Physician Coverage**: Please indicate what arrangement the organization has made, or are planning to make, to cover the organization for members who need psychiatric evaluation or psychiatric medication. List psychiatrist/physician who will see the members.

    Name: _____ Phone: _____
    Name: _____ Phone: _____

INSURANCE REQUIREMENTS AND ATTESTATIONS PROVIDERS

The CONTRACTOR shall purchase and maintain insurance as listed below from a company, which is licensed and authorized to do business in the State of North Carolina by the North Carolina Department of Insurance. Insurance policies shall require that the coverage cannot be suspended, voided, canceled or reduced in coverage or limits without thirty (30) days prior notice to the LME. Any loss of insurance shall be the basis of a payback to the LME for services billed during this period and may result in the termination of this Contract. All insurance requirements of this Contract must be fully met unless specifically waived in writing by LME.

i. The CONTRACTOR shall purchase and maintain professional liability insurance protecting the CONTRACTOR and any employee performing work under the Contract for an amount of not less than $1,000,000.00 per occurrence and proof of coverage at or exceeding $3,000,000.00 in the annual aggregate. The Provider's professional liability insurance policy shall name the LME as additional insured. In the event that the CONTRACTOR discovers that a claim, suit of criminal/ administrative proceeding has been brought or may be brought against the CONTRACTOR and/or Practitioner relating to the quality of services provided under this Agreement, then CONTRACTOR shall notify LME within ten (10) days and LME will determine whether to terminate this Agreement.

☐ We have provided a Certificate of Insurance showing that we meet this requirement.

ii. Comprehensive General Liability: Bodily Injury and Property Damage Liability Insurance shall protect the CONTRACTOR and any employee performing work under the Contract from claims of Bodily Injury or Property Damage, which may arise from operations under the Contract. The amounts of such insurance shall not be less than $1,000,000.00 per Occurrence/$3,000,000.00 per Aggregate unless Provider, with prior written approval of the LME, names the LME as an additional insured in which case limits of no less than $1,000,000.00 each occurrence and $1,000,000.00 in the annual aggregate would be acceptable. Personal and Advertising Injury/$50,000.00 Fire Damage. The insurance shall not include exclusion for contractual liability.

☐ We have provided a Certificate of Insurance showing that we meet this requirement.

iii. Automobile Liability: Automobile Bodily Injury and Property Damage Liability Insurance covering all owned, non-owned, and hired automobiles for limits of not less than $1,000,000.00 each person and $1,000,000.00 each occurrence of Bodily Injury Liability and $1,000,000.00 each occurrence of Property Damage Liability. Policies written on a combined single limit basis should have a limit of not less than $1,000,000.00.

☐ We have provided a Certificate of Insurance showing that we meet this requirement. OR

☐ We do not transport recipients.

iv. Workers' Compensation and Occupational Disease Insurance, Employer's Liability Insurance: CONTRACTOR with three (3) or more employees shall secure Worker's Compensation and Occupational Disease Insurance. The insurance coverage must meet the statutory requirements of the State of North Carolina; and Employer's Liability Insurance for an amount of not less than: Bodily Injury by Accident $100,000.00 each Accident, Bodily Injury by Disease $100,000.00 each Employee, and Bodily Injury by Disease $500,000.00 Policy Limit.

☐ We have provided a Certificate of Insurance showing that we meet this requirement.

☐ N/A

v. Certificate of Coverage: The CONTRACTOR shall provide the LME with Certificates of Insurance Coverage consistent with the Contract within thirty (30) days following the effective date of the Contract and on an annual basis within ten (10) days of the anniversary date of the Contract, and shall provide a new Certificate within ten (10) days of the expiration date if the Insurance Certificate expires during the contract period. Certificates shall contain the provision that the LME is given thirty (30) days written notice of any intent to amend or terminate by either the CONTRACTOR or the insurance company. The CONTRACTOR shall notify the LME of any cancellation or material change, within forty-eight (48) hours, and within ten (10) days written notice to the certificate holder (THR LME) of any change in insurance provider during the period of the Contract. If the CONTRACTOR changes insurance providers during the performance period of the Contract, the CONTRACTOR shall provide evidence to the LME that the LME will be indemnified to the limits specified above for the entire performance period of the Contract, either under the policy or a combination of old and new policies. THR LME shall be identified as a "Certificate Holder" and included on the Certificate of Liability Insurance.

vi. Liability Coverage: Liability insurance may be on either an occurrence basis or on a claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail coverage) for a period of not less than three (3) years after the end of the contract term, or an agreement to continue liability coverage with a retroactive date on or before the beginning of the contract term, shall also be provided.

vii. Waiver of Subrogation: CONTRACTOR shall obtain and provide to LME waivers from CONTRACTOR'S workers' compensation and occupational disease and commercial general liability carriers of any right of recovery that such liability carriers may have because of payments made by them for injury or damage arising out of work done by CONTRACTOR under this Contract, including contract documents issued under this Contract such as an LME Treatment Authorization Request Form.

PRINT NAME / TITLE (OWNER, MANAGER, CFO, ETC)

SIGNATURE

PROVIDER

DATE

ATTESTATION STATEMENT

I certify the information submitted in this entire application, as well as any attachments or supplemental information, is complete, accurate, and current to my best knowledge and belief as of the date of signature below. I fully understand that any misstatements in or omissions from this application may constitute cause for denial of membership or termination of a resulting participation agreement. A photocopy of this application has the same force and effect as the original.

By application for membership in Trillium Health Resources, I signify my willingness to appear for interview in regard to my application. I authorize Trillium Health Resources to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to Trillium Health Resources materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of Trillium Health Resources of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of Trillium Health Resources for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to Trillium Health Resources in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to Trillium Health Resources.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Trillium Health Resources may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in Trillium Health Resources Network, I hereby consent to Trillium Health Resources for inspection of my patient records relating to Trillium Health Resources enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation. I further agree to notify Trillium Health Resources in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME / TITLE (OWNER, MANAGER, CFO, ETC)

SIGNATURE

PROVIDER

DATE

PLEASE SIGN AND DATE THIS ATTESTATION STATEMENT

Submit