Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Provider Network – Directory and TBS Listing Information

Complete one form for EACH SITE.

All information requested on this form is necessary for the directory on our website, which provides a means to access care for our members. Correct information is vital in assisting members to obtain your services. Not only do members see this on our website, but it is used by our Call Center as well for referrals. In order to avoid further requests, please make sure all sections are completed and any required documentation is submitted with this form to; TrilliumProviderDirectory@TrilliumNC.org.

CORPORATE INFO

Corporate Name _____

Address: Street _____

State _____ City _____ Zip Code _____ County _____

Corporate Phone _____ Corporate Fax _____

Corporate mailing address _____

DHHS REQUIRED FIELDS (BY SITE)

Name of Provider (Legal Name) _____ NPI # _____

'Doing Business As' Name (if applicable) _____

Address : Street _____

State _____ City _____ Zip Code _____ County _____

Phone _____ Fax _____ Accepting New Patients ☐ Yes ☐ No

Include address the directory? ☐ Yes ☐ No **If no, please submit a reason on office letterhead with this form.**

Provider Type ☐ Agency ☐ PRTF ☐ Licensed Independent Practitioner ☐ Hospital ☐ Licensed Independent Practitioner Group ☐ ICF-IDD

The following provider types do not populate in the directory and therefore do not require a form:

- Provider Pay Agreements (PPA)
- ED Claims
- DSOHF Providers
- Single Case Agreements (SCA)
- Non UCR contracted providers that only have Non UCR services in their contract
- Private Residences

LANGUAGES

Bilingual Staff
* Only if staff speaks more than one language

- ☐ American Sign Language
- ☐ Arabic
- ☐ Burmese
- ☐ Cambodian
- ☐ Cantonese
- ☐ Chinese
- ☐ French
- ☐ French Creole
- ☐ Korean
- ☐ Malayalam
- ☐ Polish
- ☐ Russian
- ☐ Spanish
- ☐ Thai
- ☐ Vietnamese
- ☐ None
- ☐ Other (Please List)

ACCREDITATION (DOCUMENTATION REQUIRED)

- ☐ CARF (C)
- ☐ COA – Council on Accreditation (C)
- ☐ CQL – The Council on Quality and Leadership (C)
- ☐ The Joint Commission (C)

OFFICE HOURS (INFORMATION ABOUT SITE)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
General Appointment Hours	to	to	to	to	to	to	to
Walk In Hours	to	to	to	to	to	to	to
Evening Hours	to	to	to	to	to	to	to

Appointments Required? ☐ Yes ☐ No ☐ 24 Hour Location

SPECIALTIES – (Select all that apply) For Specialties labeled with a (C). documentation is required to support certification

- ☐ Addiction Psychiatry **(C)**
- ☐ Addiction Treatment **(C)** – Submit License
- ☐ Addiction/Chemical Dependency/Substance Abuse
- ☐ Adolescent Outpatient Program
- ☐ Adult and Child Mental Health
- ☐ Anger Management Therapy
- ☐ Anxiety Disorders
- ☐ Assessment/Evaluation
- ☐ Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
- ☐ Autism Spectrum
- ☐ Behavior Analysis
- ☐ Bipolar Disorder (manic-depressive illness)
- ☐ Career/Vocational Counseling
- ☐ Child Psychiatry **(C)**
- ☐ Child-Parent Psychotherapy
- ☐ Cognitive Behavioral Therapy
- ☐ Cognitive/IQ Psychological Testing
- ☐ Combat Related PTSD
- ☐ Community Based Services
- ☐ Conduct Disorders
- ☐ Co-Occurring/Dual Diagnosis – IDD/MH/SU
- ☐ Co-Occurring/Dual Diagnosis – MH & IDD
- ☐ Co-Occurring/Dual Diagnosis – MH & SU
- ☐ Crisis Management

SPECIALTIES – (Select all that apply) For Specialties labeled with a (C). documentation is required to support certification

- ☐ Dementia Disorder
- ☐ Depression
- ☐ Developmental Behavioral Pediatrics
- ☐ Developmental Disabilities – Residential
- ☐ Dialectical Behavior Therapy (C)
- ☐ Dissociative Behavior Therapy (C)
- ☐ Eating Disorders
- ☐ Eye Movement Desensitization and Reprocessing Therapy (C)
- ☐ Faith Based Counseling/Services
- ☐ First Level IVC (C)
- ☐ Forensic Psychology/Psychiatry (C)
- ☐ Forensic Screening/Evaluation – Psychological Testing (C)
- ☐ Gay & Lesbian Issues
- ☐ General Psychiatry
- ☐ General Psychology
- ☐ Genetic Disorders
- ☐ Gero Psychiatry
- ☐ Grief and Loss Therapy
- ☐ Hospital Inpatient
- ☐ I Feel Better Now! (C)
- ☐ Intellectual/Developmental Disability
- ☐ Marriage and Family Counseling
- ☐ Medication Management
- ☐ Mental Health Residential – Adult
- ☐ Mental Health Residential – Child
- ☐ Motivational Interviewing (C)
- ☐ Neuro Psych/Psychological Testing
- ☐ Neuropsych Assessment (C)
- ☐ Obsessive-Compulsive Disorder
- ☐ Opioid Dependence with Suboxone/Clozaril
- ☐ Outpatient
- ☐ Peer Support
- ☐ Personality Disorders
- ☐ Personality Psychological Testing
- ☐ Post-Traumatic Stress Disorder (PTSD)
- ☐ Psychiatry
- ☐ Psychological Testing
- ☐ Psychotherapy
- ☐ Relaxation/Meditation – Hypnotherapy
- ☐ Sex Offender Therapy
- ☐ Sexual & Gender Identity Disorders/Issues
- ☐ SITCAP – ART (C)
- ☐ Sleep Disorders
- ☐ Substance Use
- ☐ Telemedicine
- ☐ Testing – Developmental
- ☐ Testing – Intellectual
- ☐ The Seven Challenges (C)
- ☐ Therapeutic Foster Care
- ☐ Trauma Focused – Abuse – Physical, Sexual, and/or Emotional
- ☐ Trauma Focused Cognitive Behavior Therapy (C)
- ☐ Traumatic Brain Injury
- ☐ Wellness Education and Recovery
- ☐ Wellness Recovery Action Plan (WRAP) (C)

RESIDENTIAL SERVICES

Residential ☐ Yes ☐ No Number of Beds _____ Residential Type: Age *(Select all that apply)* ☐ Child ☐ Adult

Residential Type Service *(Select all that apply)*

☐ Intellectual/ Developmental Disability ☐ Mental Health ☐ Substance Use ☐ Traumatic Brain Injured (TBI)

SERVICE FOCUS

Populations Served *(Select all that apply)*

- ☐ Early Childhood (0-3)
- ☐ Children (4-12)
- ☐ Adolescents (13-17)
- ☐ Child and Adolescents (5-21)
- ☐ Adults (18-54)
- ☐ Geriatric (55+)
- ☐ Asexual
- ☐ Bisexual
- ☐ Court Ordered
- ☐ Gay & Lesbian
- ☐ HIV/AIDS
- ☐ Individuals with Hearing Impairment
- ☐ Individuals with Visual Impairment
- ☐ Intersex
- ☐ Men
- ☐ Military Personnel & Families; Veterans
- ☐ Pregnant Women Using Drugs
- ☐ Questioning
- ☐ Sexual Offenders
- ☐ Sexually Reactive/Aggressive Youth
- ☐ Transgender
- ☐ Women

Insurance Accepted *(Select all that apply)*

- ☐ Medicaid
- ☐ State Funds

Additional Practice Designations *(Select all that apply) For Designations with a (C) documentation is required.*

- ☐ AAA (Advanced Access Agency)
- ☐ CABHA (Critical Access Behavioral Health Agency)
- ☐ Cultural Competency Training (C)
- ☐ Telepsychiatry and Face-to-face
- ☐ Telepsychiatry Only
- ☐ Transportation Assistance Available
- ☐ ADA Accessible – If not, please submit a policy/procedure explaining what would be done to accommodate members with physical disabilities.

☐

CONTENT

After-Hours Crisis Phone Number _____ Website Address _____

CONTACTS (If there are any additional contacts please submit on a separate sheet)			
Main Contact Name		Main Contact Email Address	
Main Contact Phone #		Main Contact Fax #	
Main Contact for **publishing** in directory Name		Main Contact for **publishing** in directory Email Address	
Main Contact for **publishing** in directory Phone #		Main Contact for **publishing** in directory Fax #	
CEO Name		CEO Email Address	
CEO Phone #		CEO Fax #	
Authorized Signer of Contracts Name		Authorized Signer of Contracts Email Address	
Authorized Signer of Contracts Phone #		Authorized Signer of Contracts Fax #	
UAFL Contact Name		UAFL Contact Email Address	
UAFL Contact Phone #		UAFL Contact Fax #	

If you would like to list additional contacts, please do so here:

Name and Title	Phone	Fax	Email

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Provider Network – Directory and TBS Listing Information
Staff Site Information

LICENSED STAFF INFORMATION

Complete one copy of the following information for EACH Licensed staff person who works at THIS site

First Name _____ Middle Initial _____ Last Name _____

Gender ☐ Female ☐ Male NPI Number _____

Credentials (select all that apply)

☐ APMHCNS ☐ APRN ☐ APRNBC ☐ APRNCNS ☐ BCBA ☐ CCAS ☐ CCJP ☐ CCS ☐ CSAC
☐ CSAPC ☐ CSARFD ☐ DEA ☐ LCAS ☐ LCASA ☐ LCMHC ☐ LCMHCA ☐ LCMHC-BE ☐ LCMHCS
☐ LCSW ☐ LCSWA ☐ LDN ☐ LMFT ☐ LMFTA ☐ LP ☐ LPA ☐ LPN ☐ LP-P
☐ MD ☐ NP ☐ NT ☐ OT ☐ PA ☐ PhD ☐ P-LPA ☐ PMCHCNS-BE ☐ PMHNP-BC
☐ PsyD ☐ PT ☐ RN ☐ RT ☐ SLP ☐ UND

Race/Ethnicity

☐ American Indian and Alaska Native ☐ Asian, Pacific Islander ☐ Black or African American ☐ Hispanic
☐ Caucasian ☐ I Prefer Not to Answer ☐ Other _____

Certifications – Requires documentation to support certification

☐ Addiction Psychiatry ☐ Addiction Treatment ☐ Cognitive/IQ Psychological Testing ☐ Dialectical Behavior Therapy
☐ Eye Movement Desensitization and Reprocessing Therapy ☐ Forensic Psychology/Psychiatry ☐ Forensic Screening/Evaluation – Psychological Testing ☐ I Feel Better Now!
☐ Motivational Interviewing ☐ Neuropsych Assessment ☐ SITCAP – ART ☐ The Seven Challenges
☐ Trauma Focused Cognitive Behavior Therapy ☐ Wellness Recovery Action Plan (WRAP)

Board Certification – Please List

_____

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