

Texas Facility/Ancillary/Long-term Care Credentialing Application Instructions

- Applications should be typed or legibly printed in black or dark blue ink. If more space is needed, attach additional sheets and reference the question being answered. ALL fields are required to be completed unless otherwise directed.
- Modification to the wording or format of the application will invalidate the application.
- **If any of your locations has a unique license, unique NPI and/or a unique Tax ID number, a separate credentialing event and application will be required.** If you have multiple locations that bill under the same license/NPI/Tax ID, please complete the Secondary Locations Excel Template.
- A Secondary Locations Addendum is required for EACH practice location and for each provider type.
- Mark questions as N/A if they are not applicable.
- Ensure all enclosures listed on pages 7-8 are attached.
- Ensure the Attestation on page 7 is signed and dated.

Provider Groups: Complete pages 1-7

Ancillaries/Clinics: Complete pages 1-7

Hospitals: Complete pages 1-7 and Attachment A

LTSS Providers/Nursing Facilities: Complete pages 1-7 and Attachment B

Behavioral Health Providers: Complete pages 1-7 and Attachment C

(Select your Behavioral Health provider type on pg. 4)

Facility/Ancillary/Long-term Care Provider Credentialing Application

Provider identification

Legal Business Name:

Doing Business As (if applicable):

Credentialing Contact:

Credentialing Contact Email:

Credentialing Contact Phone:

Secure Fax:

Alternative Contact:

Alternative Contact Phone:

Taxpayer Identification Number:

National Provider Identifier (NPI):

Taxonomy:

Atypical Provider Identifier (API):

Name of Medical Director:

Location/Service Address to be Credentialed (Please note: if any of your locations has a unique license, unique NPI and/or a unique Tax ID number, a separate credentialing event and application will be required. If you have multiple locations that bill under the same license/NPI/Tax ID, please complete the Secondary Locations Excel Template. This practice location should agree with the location reflected on the letter you received from Verisys.)

Practice location name:

Medicaid Number/TPI:

Medicare ID:

Address line 1:

Address line 2:

City:

State:

ZIP+4 (Preferred):

County:

Phone:

Fax:

Primary contact:

Billing information (if different than above)

Billing name:

Address line 1:

Address line 2:

City:

State:

ZIP+4 (Optional):

County:

Credentialing Address (Please Note: Verisys will send credentialing correspondence to this address.)

Credentialing Contact:

Address line 1:

Address line 2:

City:

State:

ZIP+4 (Optional):

County:

Facility/Ancillary/Long-term Care Provider Credentialing Application

Primary Office Hours

Mon	Tue	Wed	Thur	Fri	Sat	Sun

Required After-hours coverage: ☐ Answering Service ☐ Voicemail with Instructions

Age of patients served:

- ☐ Newborn ☐ Adolescents (13-18 years)
☐ Preschool (3 to 5 years) ☐ Adults
☐ Children (6-12 years) ☐ Geriatrics (65+ years)
☐ None

Patient program/population served:

- ☐ Serves Intellectual & Developmental Disabilities (IDD) population
☐ Services pediatric population
☐ None

Please indicate any age limitations: _____ Please indicate any gender limitations: _____

Do you offer the following services:

Telemedicine Services ☐ Yes ☐ No
 Telehealth Services ☐ Yes ☐ No
 Telemonitoring Services ☐ Yes ☐ No

ADA Requirements

Access & Availability ☐ Yes ☐ No

Appropriate Equipment Available ☐ Yes ☐ No

Languages Spoken

Languages Spoken By Provider Staff Other Than English:

- ☐ Spanish ☐ Vietnamese
☐ American Sign Language ☐ Other: _____

Provider Type (Only one provider type should be reflected for the location to be credentialed.)

- | | |
|---|---|
| <input type="checkbox"/> Adaptive Aids/Medical Equipment (LTSS) | <input type="checkbox"/> Comprehensive Outpatient Rehab Facility (CORF) |
| <input type="checkbox"/> Adult Day Care | <input type="checkbox"/> Congregate Care Facility |
| <input type="checkbox"/> Adult Foster Care | <input type="checkbox"/> Convalescent Facility |
| <input type="checkbox"/> Ambulance Service/Transportation Company | <input type="checkbox"/> County Indigent Health Care Program (CIHCP) |
| <input type="checkbox"/> Ambulatory Surgical Center | <input type="checkbox"/> Day Habilitation (LTSS) |
| <input type="checkbox"/> Assisted Living | <input type="checkbox"/> Diabetes Education Center |
| <input type="checkbox"/> Audiology/Hearing Center | <input type="checkbox"/> Diagnostic and Treatment Center |
| <input type="checkbox"/> Biological Products Manufacturer | <input type="checkbox"/> Dispensing Optical Company |
| <input type="checkbox"/> Birthing Center | <input type="checkbox"/> Drug and Department Stores |
| <input type="checkbox"/> Blood Bank | <input type="checkbox"/> Durable Medical Equipment (DME) |
| <input type="checkbox"/> Cardiac Rehab Center | <input type="checkbox"/> Early Childhood Intervention (ECI) |
| <input type="checkbox"/> Clinic/Group Practice | <input type="checkbox"/> Emergency Response Service/System |
| <input type="checkbox"/> Comprehensive Care Program (CCP) | <input type="checkbox"/> Employment Assistance |
| <input type="checkbox"/> Comprehensive Health Center (CHC) | <input type="checkbox"/> End Stage Renal Disease Facility (ESRD) |

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Provider type (continued)

- | | |
|--|---|
| <input type="checkbox"/> Endoscopy Facility | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Family Counseling and Training | <input type="checkbox"/> Nursing/Health Care Staffing Service |
| <input type="checkbox"/> Family Planning Clinic | <input type="checkbox"/> Organ Procurement Organization |
| <input type="checkbox"/> Federal Qualified Health Center (FQHC) | <input type="checkbox"/> Orthotics/Prosthetics |
| <input type="checkbox"/> Financial Management Service Agency | <input type="checkbox"/> Outpatient Rehab Facility (ORF) |
| <input type="checkbox"/> Free Standing Emergency Room | <input type="checkbox"/> Pediatric Day Health Care |
| <input type="checkbox"/> Hearing Aid Equipment | <input type="checkbox"/> Personal Assistance Services Agency |
| <input type="checkbox"/> Hemophilia Treatment Center | <input type="checkbox"/> Personal Care Services (PCS) |
| <input type="checkbox"/> Home and Community Support Services | <input type="checkbox"/> Pest Control |
| <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Home Infusion | <input type="checkbox"/> Pharmacy-Home Health IV LTC |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Prescribed Pediatric Extended Care Centers (PPECC) |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Public Health Agency |
| <input type="checkbox"/> Independent Lab/Private Owned Lab | <input type="checkbox"/> Radiation / Cancer Treatment Centers |
| <input type="checkbox"/> Infertility Center | <input type="checkbox"/> Retail Clinic |
| <input type="checkbox"/> Infusion Therapy Clinic | <input type="checkbox"/> Rural Health Clinic |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Skilled Nursing Facility (SNF) |
| <input type="checkbox"/> Local Health Department (LHD) | <input type="checkbox"/> Sleep Medicine Center |
| <input type="checkbox"/> Magnetic Resonance Imaging (MRI) | <input type="checkbox"/> Supported Employment/Employment Assistance |
| <input type="checkbox"/> Maternity Service Clinic | <input type="checkbox"/> Transition Assistance Services (LTSS) |
| <input type="checkbox"/> Meals, Home Delivered Meals | <input type="checkbox"/> Tuberculosis (TB) Clinic-Group |
| <input type="checkbox"/> Minor Home Modification | <input type="checkbox"/> Urgent Care Center |
| <input type="checkbox"/> Mobile X-Ray/Mobile Diagnostic Provider | <input type="checkbox"/> Vehicle Modification (LTSS) |
| <input type="checkbox"/> Non-Emergent Transportation Services | |

Behavioral Health Provider Types

- | | |
|---|--|
| <input type="checkbox"/> Behavioral Health Facility | <input type="checkbox"/> Physiological-Independent Diagnostic Testing (IDTF) |
| <input type="checkbox"/> Behavioral Health Unit | <input type="checkbox"/> Psychiatric Clinic |
| <input type="checkbox"/> Certified Community Behavioral Health Clinics (CCBHCs) | <input type="checkbox"/> Psychiatric Residential Treatment Facility |
| <input type="checkbox"/> Clinic/Group Practice | <input type="checkbox"/> Rehab Behavioral Health Service Assisted Long-Term Care |
| <input type="checkbox"/> Hospital, Behavioral Health | <input type="checkbox"/> Residential-Based Supported Community Living Service |
| <input type="checkbox"/> Intensive Family Intervention Adult Living Facility | <input type="checkbox"/> Residential Treatment Facility/Program |
| <input type="checkbox"/> Local Behavioral Health Authority (LBHA) | <input type="checkbox"/> Targeted Case Management Provider (LMHA/LBHA) |
| <input type="checkbox"/> Local Mental Health Authority (LMHA) | <input type="checkbox"/> Chemical Dependency Treatment Facility (CDTF) |
| <input type="checkbox"/> Mental Retardation Diagnostic Services (MRDA) | <input type="checkbox"/> Community Mental Health Center (CMHC) |
| <input type="checkbox"/> Opioid Treatment Program (OTP) | |

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STAR Kids Providers Must Answer the Following:

All questions must be answered with a checked "Yes" or "No". Do not mark N/A for any questions.

Do you participate in the Medically Dependent Children Program (MDCP)? ☐ Yes ☐ No

Do you participate in the Community First Choice (CFC) Program? ☐ Yes ☐ No

Are you a Home and Community Support Service Agency (HCSSA) Provider? ☐ Yes ☐ No

Are you a Community Living Assistance and Support Services (CLASS) Provider? ☐ Yes ☐ No

Do you participate in the Deaf, Blind, & Multiple Disabilities (DBMD) Program? ☐ Yes ☐ No

Are you a Youth Empowerment Services (YES) Provider? ☐ Yes ☐ No

Are you recognized as a NCQA Patient-Centered Medical Home? ☐ Yes ☐ No

If yes, what level? _____

Please give a list of where telemedicine services are provided if in addition to services locations

Do you participate in an Electronic Visit Verification (EVV) Program? ☐ Yes ☐ No Vendor: _____

Are you a Historically Under-Utilized Business? ☐ Yes ☐ No

Licensure & Certificates (attach a copy of current licensure and Clinical Laboratory Improvements Amendment [CLIA] certification, if applicable)

Type of License:	License issuance date:	License number:	Expiration date:
State:			
Type of License:	License issuance date:	License number:	Expiration date:
State:			
Type of License:	License issuance date:	License number:	Expiration date:
State:			
Radiology Certificate #:		Radiology Expiration Date:	
CLIA Certificate #:		CLIA Expiration Date:	

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Accreditation/certification (attach a copy of current accreditation, certificate or survey)

A.

☐ Accreditation Association of Ambulatory Health Care (AAAHC)

☐ Accreditation Commission for Health Care (ACHC)

☐ Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

☐ American Board for Certification in Orthotics & Prosthetics

☐ American College of Radiology (ACR)

☐ Board of Certification

☐ Center for Improvement in Healthcare Quality

☐ Clinical Laboratory Improvement Amendments (CLIA)

☐ Commission on Accreditation of Rehabilitation Facilities (CARF)

Note: Continuing Care Accreditation Commission (CCAC) and CARF have merged, so CCAC not included separately

☐ Commission on Office Laboratory Accreditation (COLA)

☐ Community Health Action Partnership (CHAP)

☐ Council on Accreditations (COA)

☐ Det Norske Veritas Healthcare, Inc (DNV)

☐ Healthcare Facility Accreditation Program (HFAP)

☐ Healthcare Quality Association on Accreditation

☐ Intersocietal Accreditation Commission (IAC)

☐ Joint Commission for the Accreditation of Healthcare Organization (TJC or JCAHO)

☐ National Association of Boards of Pharmacy (NABP)

☐ National Board of Accreditation for Orthotic Suppliers

☐ RadSite

☐ The Compliance Team

Accrediting Body:	Expiration Date (mm/dd/yyyy):
Accrediting Body:	Expiration Date (mm/dd/yyyy):
Accrediting Body:	Expiration Date (mm/dd/yyyy):

☐ Not accredited — Expected date of accreditation (mm/dd/yyyy): _____

B. Site Survey — Visit May Be Required

Nonaccredited providers must provide a copy of:

- Most recent government agency survey (may not be older than 36 months),
- Corrective action plan (if deficiencies were cited), and attach the proof from the government agency stating facility is in substantial compliance with most recent survey standards.

Facilities that don't meet the requirements above require an onsite visit before network status may be granted. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.

Has the provider had an on-site survey by CMS or state agency? ☐ Yes ☐ No

(YES) Date of most recent full survey _____

(NO) Successful completion of a health plan onsite visit will be required to complete credentialing.

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General and professional liability insurance – Please submit a copy of your certificate of insurance.

General liability coverage

Current carrier name:

Policy number:

Coverage type: ☐ Occurrence -based ☐ Claims-based

Effective date:

Expiration date:

Per incident: \$

Aggregate: \$

Professional/Malpractice liability coverage – Please submit a copy of your certificate of insurance.

Current carrier name:

Policy number:

Coverage type: ☐ Occurrence -based ☐ Claims-based

Effective date:

Expiration date:

Per incident: \$

Aggregate: \$

Automobile Insurance

Are you required to carry automobile insurance? ☐ Yes ☐ No (If yes, submit a copy of your certificate.)

Professional Disclosure Questions

Please include an explanation on a separate sheet for any question(s) answered Yes.

- Has the organization ever been reprimanded, fined by any state agency that disciplines allied health professionals or health organizations? ☐ Yes ☐ No
- Has the organization's license to practice or operate in any jurisdiction (state or county) ever been denied, revoked, suspended, sanctioned or subject to probation or any conditions or limitations? ☐ Yes ☐ No
- Have any disciplinary proceedings ever been instituted against the organization by any medical organization or medical institute? ☐ Yes ☐ No
- Has the organization ever been convicted of a felony? ☐ Yes ☐ No
- Have any malpractice suits, arbitration or other proceeding ever been instituted against the organization (regardless of outcome)? ☐ Yes ☐ No
- Has the organization ever been investigated, reprimanded, censured, excluded, suspended or disqualified by Medicare or Medicaid program? ☐ Yes ☐ No
- Has the organization's liability insurance policy ever been canceled? ☐ Yes ☐ No
- Has the organization ever been denied renewal of the liability insurance policy or had any limitations placed on the scope of coverage? ☐ Yes ☐ No

Note: This impacts the section called "Enclosures."

Explanation of "Yes" answers to attestation questions Credentialing Questionnaire

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Attestation Consent and Release

All information provided in this, or in connection with this application, is complete and accurate to the best of my knowledge, and I shall immediately notify the Plan(s) of any changes thereto. I understand that this application does not entitle me to participation in the Plan(s) network. By applying for appointment as a TAHP participating provider, I authorize the Plan(s) plan, its medical director, and appropriate representatives to consult with administrators and members of other institutions where I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to the inspection by the Plan(s), and their representatives, its medical director and appropriate representatives, of all records and documents, excluding medical records of nonmembers of TAHP Participating Plans, that may be material to an evaluation of any professional qualifications and competence to carry out the requested duties, as well as my moral and ethical qualifications for participating provider status with the Plan(s) participating with TAHP. I consent and agree that TAHP Participating Plans will complete a criminal history background check to determine if I, or any subcontracted providers, have any history of felony convictions, including adjudication withheld on a felony, plea or nolo contendere to a felony or entry into a pretrial for a felony. I agree to obtain any consents or approvals required for my subcontracted providers to undergo such background checks. I hereby release the Plan(s) and its representatives, including TAHP and Verisys, from any liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I hereby release any individuals and organizations from any liability that provide information to the Plan(s) and its representatives or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the ancillary agreement between me or my group and the Plan(s), as such terms may be applicable to me. I understand that as an applicant for participation in the Plan(s), I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from the Plan(s), I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the credentialing committee, if they so request. I further understand that I may appeal the committee's decision either in writing or by appearance before the credentialing committee, if they so request.

By signing below, I attest that I have reviewed and understand all terms and conditions contained in this Attestation/Consent & Release. I agree that my electronic signature is equivalent to my hand-written signature.

I certify that the on-online exclusion lists for the [Health and Human Services Office of Inspector General](#) and [System for Award Management](#) are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthly basis to ensure that no state or federally excluded individuals perform any function related to any state or federal health care program. I certify that I will remove any employee or contracted service provider found on one of the above referenced federal exclusion lists from any functions related to a state or federal health care program.

Type or Print Name _____

Title _____

Signature _____ Date _____

Enclosures

Please submit all applicable documents from the list below with your completed and signed application. Failure to provide this information will prohibit completion of your credentialing and/or contracting process. Please submit enclosures for each location.

- ☐ Copy of all federal, state and/or local licenses required to operate as a health care facility (by location)
- ☐ Copy of accreditation certificate or letter
- ☐ Copy of most recent CMS or state survey, including your corrective action plan if deficiencies were cited or cover letter from CMS/state agency stating facility is in substantial compliance
- ☐ Copy of CLIA certificate for each location, as applicable
- ☐ Copy of current DEA certificate (if applicable);
- ☐ Current TDH Radiology certificate for each location (if applicable);
- ☐ Evidence of Texas Mental Health and Mental Retardation certification (REQUIRED for community mental health centers)
- ☐ Evidence of Medicare certification (REQUIRED for institutional centers)
- ☐ Professional/Malpractice liability of Insurance (AS REQUIRED ABOVE);

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Enclosures (continued)

- | | |
|---|--|
| <input type="checkbox"/> Copy of TMHP Medicaid Letter (when applicable) | <input type="checkbox"/> Explanation of "Yes" answers to attestation questions |
| <input type="checkbox"/> Evidence of an Agreement with HHSC [REQUIRED for CORF providers] | <input type="checkbox"/> Company brochure (if available) |
| <input type="checkbox"/> Medical Staff / Allied Health Professional Roster | <input type="checkbox"/> Current Signed W-9 |

Attachment A - Hospital Facilities

Hospital - part of multi-hospital system? ☐ Yes ☐ No

Are you considered an Essential Community Provider as defined by CMS? ☐ Yes ☐ No

Hospital Services/Treatment Levels:

- | | |
|---|---|
| <input type="checkbox"/> Adult acute care | <input type="checkbox"/> Level 4 trauma |
| <input type="checkbox"/> Level 1 trauma | <input type="checkbox"/> Children's Hospital — [CMS Designated] |
| <input type="checkbox"/> Level 2 trauma | <input type="checkbox"/> Designated Childrens Unit/Wing |
| <input type="checkbox"/> Level 3 trauma | <input type="checkbox"/> Specializes in Pediatric Services |

Are you a member of the American Hospital Association? ☐ Yes ☐ No

Number of Certified Beds _____

NICU Level _____ Certification Date _____

Medicare - Certified Acute Inpatient Facility Information

Medicare Certified Bed Count: _____ ICU Bed Count (excluding Neonatology): _____

Skilled Nursing or Swing Bed Count: _____ Inpatient Psychiatric Bed Count: _____

- | | |
|--|--|
| <input type="checkbox"/> Acute Inpatient Rehab Services | <input type="checkbox"/> Skilled Nursing Unit |
| <input type="checkbox"/> Cardiac Catheterization Services | <input type="checkbox"/> Durable Medical Equipment (DME) |
| <input type="checkbox"/> Outpatient Occupational Therapy | <input type="checkbox"/> Surgical Services (Outpatient or ASC) |
| <input type="checkbox"/> Cardiac Surgery Program | <input type="checkbox"/> Inpatient Psychiatric Facility Services |
| <input type="checkbox"/> Outpatient Physical Therapy | <input type="checkbox"/> Mammography |
| <input type="checkbox"/> Critical Care Services— Intensive Care Unit (ICU) | <input type="checkbox"/> Orthotics and Prosthetics |
| <input type="checkbox"/> Outpatient Speech Therapy | <input type="checkbox"/> Outpatient Dialysis |
| <input type="checkbox"/> Diagnostic Radiology | <input type="checkbox"/> Outpatient Infusion/Chemotherapy |

Medicare-Approved Transplant Programs

- | | |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Heart/Lung | <input type="checkbox"/> Liver |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Lung |
| <input type="checkbox"/> Intestinal | <input type="checkbox"/> Pancreas |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Other _____ |

Attachment B - Texas Long-Term Services and Supports

Provider type Services Details

Personal assistance service direct:

- ☐ Consumer-directed block grant model
- ☐ Consumer-directed services (CDS) model
- ☐ Consumer-delegated agency model
- ☐ Financial management/ CDS
- ☐ Rate enhancement program

Participant contract number: _____

List level: _____

Day activity/health services:

- ☐ Rate enhancement program

Participant contract number: _____

List level: _____

Residential care/assisted living facility:

- ☐ Rate enhancement program

Participant contract number: _____

List level: _____

- ☐ Transition/relocation services

Counties Served: Please select the ones in which services can be provided or check here ☐ STATEWIDE [servicing all]

<input type="checkbox"/> Anderson	<input type="checkbox"/> Andrews	<input type="checkbox"/> Angelina	<input type="checkbox"/> Aransas	<input type="checkbox"/> Archer
<input type="checkbox"/> Armstrong	<input type="checkbox"/> Atascosa	<input type="checkbox"/> Austin	<input type="checkbox"/> Bailey	<input type="checkbox"/> Bandera
<input type="checkbox"/> Bastrop	<input type="checkbox"/> Baylor	<input type="checkbox"/> Bee	<input type="checkbox"/> Bell	<input type="checkbox"/> Bexar
<input type="checkbox"/> Blanco	<input type="checkbox"/> Borden	<input type="checkbox"/> Bosque	<input type="checkbox"/> Bowie	<input type="checkbox"/> Brazoria
<input type="checkbox"/> Brazos	<input type="checkbox"/> Brewster	<input type="checkbox"/> Briscoe	<input type="checkbox"/> Brooks	<input type="checkbox"/> Brown
<input type="checkbox"/> Burleson	<input type="checkbox"/> Burnet	<input type="checkbox"/> Caldwell	<input type="checkbox"/> Calhoun	<input type="checkbox"/> Callahan
<input type="checkbox"/> Cameron	<input type="checkbox"/> Camp	<input type="checkbox"/> Carson	<input type="checkbox"/> Cass	<input type="checkbox"/> Castro
<input type="checkbox"/> Chambers	<input type="checkbox"/> Cherokee	<input type="checkbox"/> Childress	<input type="checkbox"/> Clay	<input type="checkbox"/> Cochran
<input type="checkbox"/> Coke	<input type="checkbox"/> Coleman	<input type="checkbox"/> Collin	<input type="checkbox"/> Collingsworth	<input type="checkbox"/> Colorado
<input type="checkbox"/> Comal	<input type="checkbox"/> Comanche	<input type="checkbox"/> Concho	<input type="checkbox"/> Cooke	<input type="checkbox"/> Coryell
<input type="checkbox"/> Cottle	<input type="checkbox"/> Crane	<input type="checkbox"/> Crockett	<input type="checkbox"/> Crosby	<input type="checkbox"/> Culberson
<input type="checkbox"/> Dallam	<input type="checkbox"/> Dallas	<input type="checkbox"/> Dawson	<input type="checkbox"/> Deaf Smith	<input type="checkbox"/> Delta
<input type="checkbox"/> Denton	<input type="checkbox"/> DeWitt	<input type="checkbox"/> Dickens	<input type="checkbox"/> Dimmit	<input type="checkbox"/> Donley
<input type="checkbox"/> Duval	<input type="checkbox"/> Eastland	<input type="checkbox"/> Ector	<input type="checkbox"/> Edwards	<input type="checkbox"/> El Paso
<input type="checkbox"/> Ellis	<input type="checkbox"/> Erath	<input type="checkbox"/> Falls	<input type="checkbox"/> Fannin	<input type="checkbox"/> Fayette
<input type="checkbox"/> Fisher	<input type="checkbox"/> Floyd	<input type="checkbox"/> Foard	<input type="checkbox"/> Fort Bend	<input type="checkbox"/> Franklin
<input type="checkbox"/> Freestone	<input type="checkbox"/> Frio	<input type="checkbox"/> Gaines	<input type="checkbox"/> Galveston	<input type="checkbox"/> Garza
<input type="checkbox"/> Gillespie	<input type="checkbox"/> Glasscock	<input type="checkbox"/> Goliad	<input type="checkbox"/> Gonzales	<input type="checkbox"/> Gray
<input type="checkbox"/> Grayson	<input type="checkbox"/> Gregg	<input type="checkbox"/> Grimes	<input type="checkbox"/> Guadalupe	<input type="checkbox"/> Hale
<input type="checkbox"/> Hall	<input type="checkbox"/> Hamilton	<input type="checkbox"/> Hansford	<input type="checkbox"/> Hardeman	<input type="checkbox"/> Hardin
<input type="checkbox"/> Harris	<input type="checkbox"/> Harrison	<input type="checkbox"/> Hartley	<input type="checkbox"/> Haskell	<input type="checkbox"/> Hays
<input type="checkbox"/> Hemphill	<input type="checkbox"/> Henderson	<input type="checkbox"/> Hidalgo	<input type="checkbox"/> Hill	<input type="checkbox"/> Hockley
<input type="checkbox"/> Hood	<input type="checkbox"/> Hopkins	<input type="checkbox"/> Houston	<input type="checkbox"/> Howard	<input type="checkbox"/> Hudspeth

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Counties Served (continued)

<input type="checkbox"/> Hunt	<input type="checkbox"/> Hutchinson	<input type="checkbox"/> Irion	<input type="checkbox"/> Jack	<input type="checkbox"/> Jackson
<input type="checkbox"/> Jasper	<input type="checkbox"/> Jeff Davis	<input type="checkbox"/> Jefferson	<input type="checkbox"/> Jim Hogg	<input type="checkbox"/> Jim Wells
<input type="checkbox"/> Johnson	<input type="checkbox"/> Jones	<input type="checkbox"/> Karnes	<input type="checkbox"/> Kaufman	<input type="checkbox"/> Kendall
<input type="checkbox"/> Kenedy	<input type="checkbox"/> Kent	<input type="checkbox"/> Kerr	<input type="checkbox"/> Kimble	<input type="checkbox"/> King
<input type="checkbox"/> Kinney	<input type="checkbox"/> Kleberg	<input type="checkbox"/> Knox	<input type="checkbox"/> La Salle	<input type="checkbox"/> Lamar
<input type="checkbox"/> Lamb	<input type="checkbox"/> Lampasas	<input type="checkbox"/> Lavaca	<input type="checkbox"/> Lee	<input type="checkbox"/> Leon
<input type="checkbox"/> Liberty	<input type="checkbox"/> Limestone	<input type="checkbox"/> Lipscomb	<input type="checkbox"/> Live Oak	<input type="checkbox"/> Llano
<input type="checkbox"/> Loving	<input type="checkbox"/> Lubbock	<input type="checkbox"/> Lynn	<input type="checkbox"/> Madison	<input type="checkbox"/> Marion
<input type="checkbox"/> Martin	<input type="checkbox"/> Mason	<input type="checkbox"/> Matagorda	<input type="checkbox"/> Maverick	<input type="checkbox"/> McCulloch
<input type="checkbox"/> McLennan	<input type="checkbox"/> McMullen	<input type="checkbox"/> Medina	<input type="checkbox"/> Menard	<input type="checkbox"/> Midland
<input type="checkbox"/> Milam	<input type="checkbox"/> Mills	<input type="checkbox"/> Mitchell	<input type="checkbox"/> Montague	<input type="checkbox"/> Montgomery
<input type="checkbox"/> Moore	<input type="checkbox"/> Morris	<input type="checkbox"/> Motley	<input type="checkbox"/> Nacogdoches	<input type="checkbox"/> Navarro
<input type="checkbox"/> Newton	<input type="checkbox"/> Nolan	<input type="checkbox"/> Nueces	<input type="checkbox"/> Ochiltree	<input type="checkbox"/> Oldham
<input type="checkbox"/> Orange	<input type="checkbox"/> Palo	<input type="checkbox"/> Panola	<input type="checkbox"/> Parker	<input type="checkbox"/> Parmer
<input type="checkbox"/> Pecos	<input type="checkbox"/> Pinto	<input type="checkbox"/> Polk	<input type="checkbox"/> Potter	<input type="checkbox"/> Presidio
<input type="checkbox"/> Rains	<input type="checkbox"/> Randall	<input type="checkbox"/> Reagan	<input type="checkbox"/> Real	<input type="checkbox"/> Red River
<input type="checkbox"/> Reeves	<input type="checkbox"/> Refugio	<input type="checkbox"/> Roberts	<input type="checkbox"/> Robertson	<input type="checkbox"/> Rockwall
<input type="checkbox"/> Runnels	<input type="checkbox"/> Rusk	<input type="checkbox"/> Sabine	<input type="checkbox"/> San Augustine	<input type="checkbox"/> San Jacinto
<input type="checkbox"/> San Patricio	<input type="checkbox"/> San Saba	<input type="checkbox"/> Schleicher	<input type="checkbox"/> Scurry	<input type="checkbox"/> Shackelford
<input type="checkbox"/> Shelby	<input type="checkbox"/> Sherman	<input type="checkbox"/> Smith	<input type="checkbox"/> Somervell	<input type="checkbox"/> Starr
<input type="checkbox"/> Stephens	<input type="checkbox"/> Sterling	<input type="checkbox"/> Stonewall	<input type="checkbox"/> Sutton	<input type="checkbox"/> Swisher
<input type="checkbox"/> Tarrant	<input type="checkbox"/> Taylor	<input type="checkbox"/> Terrell	<input type="checkbox"/> Terry	<input type="checkbox"/> Throckmorton
<input type="checkbox"/> Titus	<input type="checkbox"/> Tom Green	<input type="checkbox"/> Travis	<input type="checkbox"/> Trinity	<input type="checkbox"/> Tyler
<input type="checkbox"/> Upshur	<input type="checkbox"/> Upton	<input type="checkbox"/> Uvalde	<input type="checkbox"/> Val Verde	<input type="checkbox"/> Van Zandt
<input type="checkbox"/> Victoria	<input type="checkbox"/> Walker	<input type="checkbox"/> Waller	<input type="checkbox"/> Ward	<input type="checkbox"/> Washington
<input type="checkbox"/> Webb	<input type="checkbox"/> Wharton	<input type="checkbox"/> Wheeler	<input type="checkbox"/> Wichita	<input type="checkbox"/> Wilbarger
<input type="checkbox"/> Willacy	<input type="checkbox"/> Williamson	<input type="checkbox"/> Wilson	<input type="checkbox"/> Winkler	<input type="checkbox"/> Wise
<input type="checkbox"/> Wood	<input type="checkbox"/> Yoakum	<input type="checkbox"/> Young	<input type="checkbox"/> Zapata	<input type="checkbox"/> Zavala

Facility/Ancillary/Long-term Care Provider Credentialing Application

Attachment C - Behavioral Health Facilities/Providers - Locations & Level of Care

Facility Practice Locations and Levels of Care per location

	Age Category	Inpatient	Partial	IOP	Residential	Observation	I/P Detox	I/P Rehab	Partial	IOP	Residential	Ambulatory Detox
Location #1												
Address:	Child											
	Adol.											
Phone:	Adult											
Secure Fax:	Geriatric											
NPI:		ECT	<input type="checkbox"/> I/P	<input type="checkbox"/> O/P			<input type="checkbox"/> Methadone		<input type="checkbox"/> Suboxone			
Location #2												
Address:	Child											
	Adol.											
Phone:	Adult											
Secure Fax:	Geriatric											
NPI:		ECT	<input type="checkbox"/> I/P	<input type="checkbox"/> O/P			<input type="checkbox"/> Methadone		<input type="checkbox"/> Suboxone			
Location #3												
Address:	Child											
	Adol.											
Phone:	Adult											
Secure Fax:	Geriatric											
NPI:		ECT	<input type="checkbox"/> I/P	<input type="checkbox"/> O/P			<input type="checkbox"/> Methadone		<input type="checkbox"/> Suboxone			
Location #4												
Address:	Child											
	Adol.											
Phone:	Adult											
Secure Fax:	Geriatric											
NPI:		ECT	<input type="checkbox"/> I/P	<input type="checkbox"/> O/P			<input type="checkbox"/> Methadone		<input type="checkbox"/> Suboxone			
Location #5												
Address:	Child											
	Adol.											
Phone:	Adult											
Secure Fax:	Geriatric											
NPI:		ECT	<input type="checkbox"/> I/P	<input type="checkbox"/> O/P			<input type="checkbox"/> Methadone		<input type="checkbox"/> Suboxone			

Facility/Ancillary/Long-term Care Provider Credentialing Application

Attachment C - Behavioral Health Facilities/Providers Specialty Services

Instructions: Indicate which specialty services are offered at the location provided on page 12 (Location #1-5)

Identify specialty services offered	Available	Not Available	Location # Indicated on Page 11	Comments/Descriptions
Eating Disorder Treatment – Inpatient	<input type="checkbox"/>	<input type="checkbox"/>		
Eating Disorder Treatment – Outpatient	<input type="checkbox"/>	<input type="checkbox"/>		
Electro-convulsive Therapy (ECT) - Inpatient	<input type="checkbox"/>	<input type="checkbox"/>		
Electro-convulsive Therapy (ECT) – Outpatient	<input type="checkbox"/>	<input type="checkbox"/>		
Dual Diagnosis Services	<input type="checkbox"/>	<input type="checkbox"/>		
Continuing Day Treatment	<input type="checkbox"/>	<input type="checkbox"/>		
LGBT services	<input type="checkbox"/>	<input type="checkbox"/>		
Domiciliary Services in an IOP or PHP setting (program must be formally approved by UBH)	<input type="checkbox"/>	<input type="checkbox"/>		
Chronically Mentally Ill Services (CMI)/ Severely Mentally Ill Services (SMI)	<input type="checkbox"/>	<input type="checkbox"/>		
Respite Care Services	<input type="checkbox"/>	<input type="checkbox"/>		
Emergency Room Services (assessment only)	<input type="checkbox"/>	<input type="checkbox"/>		
Twenty-three (23) Hour Crisis Observation	<input type="checkbox"/>	<input type="checkbox"/>		
Mobile Crisis Stabilization	<input type="checkbox"/>	<input type="checkbox"/>		
MHSA Outpatient Clinics in a hospital	<input type="checkbox"/>	<input type="checkbox"/>		
Ambulatory Detox - Drug	<input type="checkbox"/>	<input type="checkbox"/>		
Ambulatory Detox - Alcohol	<input type="checkbox"/>	<input type="checkbox"/>		
Medication Assisted Treatment (MAT) - in an Detox, IOP or PHP setting <input type="checkbox"/> Methadone <input type="checkbox"/> Suboxone <input type="checkbox"/> Buprenorphine <input type="checkbox"/> Naltrexone (i.e. vivitrol)	<input type="checkbox"/>	<input type="checkbox"/>		
Sober Living/Supervised Living	<input type="checkbox"/>	<input type="checkbox"/>		
Halfway House	<input type="checkbox"/>	<input type="checkbox"/>		
Group Home	<input type="checkbox"/>	<input type="checkbox"/>		
Therapeutic Foster Care	<input type="checkbox"/>	<input type="checkbox"/>		
ASAM Residential Services	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> 3.1 <input type="checkbox"/> 3.3 <input type="checkbox"/> 3.5 <input type="checkbox"/> 3.7
Bridge on Discharge (aftercare planning immediately post IP discharge)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Geriatric <input type="checkbox"/> Adult <input type="checkbox"/> Adol. <input type="checkbox"/> Child