

# FACILITY PROVIDER APPLICATION

**Please Note: All areas must contain a response. If not applicable, "N/A" should appear.**

**If you should have any questions on completion of this form, please call:**

**CAMERON AND ASSOCIATES, INC.  
Employee Assistance Consultants  
Managed Behavioral Health Care  
(404) 843-3399 1(800) 334-6014**

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

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Telephone: \_\_\_\_\_ County : \_\_\_\_\_

Fax: \_\_\_\_\_ Tax ID# \_\_\_\_\_

Administrator: \_\_\_\_\_ Telephone: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone: \_\_\_\_\_ Pager: \_\_\_\_\_

Billing/ Claims Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

Corporate Owner: \_\_\_\_\_

Corporate CEO: \_\_\_\_\_

Address: \_\_\_\_\_

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Date Incorporated: \_\_\_\_\_ County: \_\_\_\_\_

Telephone \_\_\_\_\_ Fax: \_\_\_\_\_

## FACILITY PROVIDER APPLICATION

Facility/Program Description:  General  Psychiatric  Substance Abuse  
 Residential Treatment Center  Intensive Outpatient Program

If Specialty, please describe: \_\_\_\_\_

Facility Type:  Voluntary/ Not for profit  Private/ Not for profit  Proprietary

Government:  Federal  State  City  County  Other \_\_\_\_\_

Services Provided: Please indicate if services are provided by Staff(S) or are Contracted out (C). Mark (S) or (C) as appropriate.

<input type="checkbox"/> Clinical Laboratory	<input type="checkbox"/> Drug Screens
<input type="checkbox"/> Electrocardiograph	<input type="checkbox"/> Pathology
<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Electroencephalograph
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> ECT
<input type="checkbox"/> Therapeutic Education	<input type="checkbox"/> X-Ray Diagnostic
<input type="checkbox"/> Outpatient Psychotherapy	<input type="checkbox"/> Speech Therapy
<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Other _____

Number Of Employees:

<input type="checkbox"/> Physicians (salaried)	<input type="checkbox"/> Residents
<input type="checkbox"/> Psychiatrist (salaried)	<input type="checkbox"/> Psychologists (PhDs)
<input type="checkbox"/> Registered Pharmacists	<input type="checkbox"/> Social Workers (Licensed)
<input type="checkbox"/> Occupational Therapists	<input type="checkbox"/> Professional Counselor (Licensed)
<input type="checkbox"/> Psychiatric Nurses (RNs)	<input type="checkbox"/> Mental Health Workers
<input type="checkbox"/> Special Education Teachers	<input type="checkbox"/> Certified Addiction Specialists
<input type="checkbox"/> Social Worker (MSWs)	<input type="checkbox"/> Other

Accreditation:  State Licensure  JCAHO  Free -standing IOP  
 Certification for Medicare  CARF

Memberships:  GHA  AHA  NAPPH  Other \_\_\_\_\_

If answer to any of the following is "Yes", give full details on separate sheet.

Has your accreditation license for any program/ unit ever been limited, suspended, or revoked?  
 Yes  No

Is there any current or pending litigation involving your facility practice?  Yes  No  
Have you had any judgements or settlements involving your facility during the past five (5) years?  
 Yes  No

## FACILITY PROVIDER APPLICATION

Do you have an affiliated outpatient practice?  yes  no If yes, please attach a description.

Are you a preferred provider for any managed care companies?  yes  no If, yes, please list below:

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Is a transitional unit available (individualized inpatient stay with transition to PHP or IOP)?  
 yes  no If yes, please attach program description.

Do you accept involuntary patients?  yes  no Comment: \_\_\_\_\_

Do you provide emergency services?  yes  no Comment: \_\_\_\_\_

Do you offer transportation to your facility?  yes  no Describe: \_\_\_\_\_

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How many years have you been in operation? \_\_\_\_\_

Do you grant temporary privileges to aid in continuity of care?  yes  no

Do you require your physicians to be board certified or eligible?  yes  no

Comments: \_\_\_\_\_

Please describe structure, length and monitoring mechanisms for clients involved in your continuum of care.

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## FACILITY PROVIDER APPLICATION

Photocopies of the following documents must be submitted:

1. Liability Insurance
2. JCAHO Accreditation
3. Hospital Permit
4. Program Schedules
5. Program Description/ Brochures
6. Proposed Rates, specifying inclusions and exclusions
7. Organizational Chart
8. Professional Staff Roster
9. Key Personnel and their credentials

Send this application and the requested documents to:

**CAMERON AND ASSOCIATES, INC.**  
**6100 Lake Forrest Dr. Suite 550**  
**Atlanta, GA 30328**  
**ATTN: Utilization Management Coordinator**

\_\_\_\_\_  
Print Name of Person Completing Application

\_\_\_\_\_  
Date Submitted

\_\_\_\_\_  
Title

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Signature