Provider Application for Participation Instructions

This is an APPLIED BEHAVIORAL ANALYSIS (ABA) FACILITY/GROUP APPLICATION for consideration into Kaiser Permanente's network of providers.

This application is only for organizations providing Applied Behavioral Analysis (ABA) services. For consideration for inclusion into our network of providers, please complete this application in its entirety and submit it as indicated below. This application should not be used by existing network providers to make demographic changes or add providers to your practice.

Important disclaimer: All Information provided will be assessed against Kaiser Permanente's network needs. Submission of an application does not constitute any obligation on the part of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., the Mid-Atlantic Permanente Medical Group, P.C. or any other or related Kaiser Permanente entity to enter into a contractual obligation.

It is important that you clearly describe the services you offer so that we can best assess our need for your offered services. Your completed application must also include the attached Disclosure of Ownership and Control Information form.

Please complete this application electronically. Do not complete it by hand. We welcome any attachments, brochures or descriptions you may choose to include to support your application.

Incomplete applications will be automatically denied and returned to you at the contact address within ten (10) days of receipt. We will process complete applications and provide notice of our decision in writing within thirty (30) days.

For questions, please contact us at interested.providers@kp.org.

Return completed applications using one of the following options:

Email PDFs to:

interested.providers@kp.org

Provider Application for Participation

ABA Provider Facility/Group Information

General Information

Group/Provider Name: ____

Federal Tax I.D. Number: ______________________ NPI: ______________________

Contact Name: ____

Contact Street Address: ____

City: ________________________ State: _____________________ ZIP: _____________

Phone: ______________________ FAX: ______________________

Email: ____

Group/Provider Name should be exactly as it is on your W-9, please enclose copy of W-9

Services (All Questions Must Be Answered)

Where do you provide services? ☐ Home ☐ School
☐ Daycare ☐ Clinical Facility
☐ Other: ______________________________________

All behavior technicians, tutors and paraprofessionals who provide one-on-one therapy services must be RBT certified, in accordance with the Behavioral Analyst Certification Board (BACB) requirements.

1. How many registered behavior technicians (RBT)s do you have? ______
2. Are your technicians RBT certified? ☐ Yes ☐ No
3. If YES, how many are RBT certified? ______
4. If NO, how long will it take for them to become certified? ______ years ______ months
5. How many board-certified behavior analysts (BCBA)s do you have? ______
6. How many board-certified assistant behavior analysts (BCaBA)s do you have? ______
7. Are you currently accepting new Members? ☒ Yes ☐ No
8. If YES, what is the wait time for a new Member to have an initial assessment/evaluation? ______ months / ______ weeks / ______ (other – specify here: ____________________)
9. What is the wait time for a new Member to be seen after the initial assessment?

   ______ months / ______ weeks / ______ (other – specify here: ____________________)
10. When do you have availability? ☐ Morning(s) ☐ Evening(s)
11. Do you offer weekend appointments? ☐ Yes ☐ No
12. If No, what is the wait time for your waitlist? ______ months / ______ weeks / ______ (other – specify here: ____________________)
13. Do you provide ASD Evaluation Services? ☐ Yes ☐ No

Provider Application for Participation

ABA Provider Facility/Group Information

Clinical Locations (Only Include Locations Where ABA Services Are Performed)

Street Address: ____

City: ____________________ State: __________________ ZIP: ___________

Street Address: ____

City: ____________________ State: __________________ ZIP: ___________

Street Address: ____

City: ____________________ State: __________________ ZIP: ___________

Street Address: ____

City: ____________________ State: __________________ ZIP: ___________

Street Address: ____

City: ____________________ State: __________________ ZIP: ___________

Location Description

Provide a complete listing of all counties in Maryland, Virginia and Washington, D.C. in which you provide ABA services:

____

____

VA Medicaid Certified: ☐ Yes ☐ No   Accepting Medicaid Patients: ☐ Yes ☐ No

Do you maintain general liability insurance of at least $1,000,000/$3,000,000? ☐ Yes ☐ No

Lines of Business*

Check off all lines of business you want to be contracted for:

Commercial ☐ (HMO, PPO, POS, etc.)

Virginia Medicaid ☐, provide licensure #: ______________________________

**Contracting will be done for each line of business as needed by Kaiser Permanente, requesting the line of business does not guarantee a contract will be made for that line of business.*

Provider Application for Participation

Disclosure of Ownership & Control Information

This section must be completed by an authorized representative of the participating provider practitioner, group or facility. An authorized representative is defined as an individual with designated authority to act on behalf of the individual, group of practitioners or disclosing entity. If not a solo practitioner, then the authorized representative must be a partner, president or secretary of the group of practitioners.

1. **Ownership and Control Information for Disclosing Entity, 42 C.F.R. §455.104**
   List any individual who has any ownership or controlling interest in this provider entity or in any subcontractor. List the name, title, (e.g., CEO, President), address, Tax ID Number of any organization, corporation or entity having any ownership or controlling interest in this provider entity. The ownership or controlling interest is an ownership interest of 5% or more in this provider entity.

   ____
   ____
   ____
   ____

2. **Relationships**
   List any individuals named in Question 1 whom are related to each other (e.g., spouse, parent, child or sibling). List their name, state their relationship and include their Social Security Number.

   ____
   ____
   ____
   ____

3. **Subcontractor**
   List any individual with an ownership or control interest in any subcontractor that the disclosing entity has direct or indirect ownership of 5% or more.

   ____
   ____
   ____
   ____

4. **Other Disclosing Entity**
   List the name, address and Tax ID Number of any other disclosing entity other than a subcontractor in which a person with an ownership or controlling interest in this disclosing entity has an ownership or control interest of 5% or more.

   ____
   ____
   ____
   ____

Continued on next page.

5. **Criminal Offenses**
   Has any individual or organization listed in Questions 1, 2, 3 and 4 ever been convicted or assessed fines or penalties for any health-related crimes or misconduct and/or excluded from any federal or state health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct? If your answer to this question is YES, please provide the name, address, Social Security Number, Tax ID Number and percentage of ownership for these individual(s) and/or organization(s).

   ☐ Yes ☐ No

   ____
   ____
   ____
   ____

6. **Criminal Offenses**
   Has ANY individual or contractor connected with your practice been convicted or assessed fines or penalties for any health-related crimes or misconduct, or excluded from any federal or state health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct? If your answer to this question is YES please provide the name, address, and Social Security Number/Tax ID Number for individual(s) or contractor(s).

   ☐ Yes ☐ No

   ____
   ____
   ____
   ____

7. **Criminal Offenses**
   Has the applicant ever had any adverse legal actions imposed by Medicare, Medicaid or any other federal or state agency or program, or any licensing or certification agency?

   ☐ Yes ☐ No

   ____
   ____
   ____
   ____

If yes, please provide a copy of relevant final disposition.

Organizational Providers Credentialing Application Instructions

DO NOT USE THIS APPLICATION TO APPLY TO THE NETWORK.

This CREDENTIALING/RECREDENTIALING APPLICATION is for Kaiser Permanente network organizational providers.

Important disclaimer: Submission of an application does not constitute any obligation on the part of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., the Mid-Atlantic Permanente Medical Group, P.C. or any other or related Kaiser Permanente entity to enter into a new contractual obligation nor renew an earlier contract.

Please complete this application in its entirety. We ask that you complete the application electronically. Do not complete it by hand. We welcome any attachments, beyond those requested, that you may choose to include to support your application.

Required Documentation (Complete This Checklist Notating Included Documentation)

☐ **Accreditation certificates**

(Note: If not accredited, include a copy of your last state or Medicare survey. If neither accreditation or the survey is applicable, Kaiser Permanente will conduct a site visit).

☐ **Professional and general liability certificates of insurance**

(Note: Minimum coverage of $1,000,000/occurrence and $3,000,000 aggregate AND $3,000,000 per occurrence and $5,000,000 aggregate for hospitals).

☐ **State license**

☐ **ARTS Attestation Form, DBHDS License and staff roster (as ASAM Level requires)**

☐ **W9**

Return completed applications using one of the following options:

Email or Mail Initial Credentialing Applications to:

interested.providers@kp.org

Kaiser Foundation Health Plan
of the Mid-Atlantic States, Inc.
Attn: Provider Contracting
2101 E. Jefferson St., Ste. 2 East
Rockville, MD 20852

Email or Mail Recredentialing Applications to:

ppqa-mas@kp.org

Kaiser Foundation Health Plan
of the Mid-Atlantic States, Inc.
Attn: PPQA
2101 E. Jefferson St., Ste. 6 West
Rockville, MD 20852

Provider Credentialing Application

Organizational Provider/Facility Information

Organization Type *(Select all that apply)*

☐ Acute Care Hospital
☐ Behavioral Health Care Facility
- ☐ Ambulatory
- ☐ Applied Behavioral Analysis (ABA)
- ☐ Chemical Dependency Program/Facility
- ☐ Inpatient
- ☐ Methadone Maintenance Program
- ☐ Residential Treatment Facility for Behavioral Health Care
- ☐ Residential Treatment Facility for Substance Abuse

☐ Clinical Laboratory
☐ Community Health Center
☐ Comprehensive Outpatient Rehabilitation Facility (CORF)
☐ Dialysis Center (End Stage Renal Disease (ESRD) Provider)
☐ Durable Medical Equipment Provider
☐ Federally-Qualified Health Center/Rural Health Clinic
☐ Free-Standing Ambulatory Surgery Center
☐ Home Health Agency
☐ Hospice
☐ Hospital
☐ Physical Therapy Facility
☐ Portable X-Ray Supplier
☐ Skilled Nursing Facility/Nursing Home
☐ Speech Pathology Facility
☐ Urgent Care Facility

Provider Credentialing Application

Demographics

Address 1:

Facility Name: ____

Address: ____

City: ____________________ State: ____________________ ZIP: ____________

Phone: ____________________ FAX: ____________________

Federal Tax I.D. Number: ____________________ NPI: ____________________

Contact Name: ____

Contact's Title: ____

Contact's Phone: ____________________

Contact Email Address: ____

Contact Address (if different from above):

Address: ____

City: ____________________ State: ____________________ ZIP: ____________

Address 2:

Facility Name: ____

Address: ____

City: ____________________ State: ____________________ ZIP: ____________

Phone: ____________________ FAX: ____________________

Federal Tax I.D. Number: ____________________ NPI: ____________________

Contact Name: ____

Contact's Title: ____

Contact's Phone: ____________________

Contact Email Address: ____

Contact Address (if different from above):

Address: ____

City: ____________________ State: ____________________ ZIP: ____________

Provider Credentialing Application

Licensure

License Type: ____

License Number: ________________ License Expiration Date: ____ / _____ / _______
MM / DD / YYYY

Have you ever had any action taken against your license? ☐ Yes ☐ No
If YES, provide relevant details below:

____

____

____

Medicare Certification

Do you participate with Medicare? ☐ Yes ☐ No
Is your facility Medicare certified? ☐ Yes ☐ No
If YES, provide your Medicare Certification Number: ________________

Is your Medicare certification in good standing? ☐ Yes ☐ No
If NO, provide relevant details below:

____

Has your participation in Medicare ever been suspended or denied? ☐ Yes ☐ No
If YES, provide relevant details below:

____

Last Medicare Survey Date: ____ / _____ / _______
MM / DD / YYYY

Accreditation

ARTS Provider? ☐ Yes ☐ No
If YES, provide your ASAM Level: ____

Joint Commission Accreditation? ☐ Yes ☐ No
If YES, provide your last survey date: ____ / _____ / _______
MM / DD / YYYY

Other Accreditation? ☐ Yes ☐ No
If YES, name of accrediting agency: ____
If YES, provide your last survey date: ____ / _____ / _______
MM / DD / YYYY

(Note: If not accredited, include a copy of your last state or Medicare survey. The survey must include identified deficiencies and corrective plans, if applicable. If a state or Medicare survey has not been completed, Kaiser Permanente will contact you to conduct a site visit).

Insurance/Claims

Professional Liability Insurance Carrier Name:

____

Policy Number: ____

Level of Coverage: $ ________________ Occurrence / $ ________________ Aggregate

Coverage Dates: ____ / _____ / _______ TO ____ / _____ / _______

Provider Credentialing Application

MM / DD / YYYY MM / DD / YYYY

General Liability Insurance Carrier Name:

____

Policy Number: ____

Level of Coverage: $ __________________ Occurrence / $ __________________ Aggregate

Coverage Dates: ____ / _____ / _______ TO ____ / _____ / _______
MM / DD / YYYY MM / DD / YYYY

(Note: Minimum coverage requirements by organization type are specified on application instructions sheet).

Authorization/Attestation

I hereby submit this application for credentialing/re-credentialing into the provider network administered by Kaiser Permanente of the Mid-Atlantic States (KPMAS) and understand that this application will be reviewed based on the information I have provided. I certify that the information and documentation provided is true and correct, and that this facility is in good standing with all applicable state, federal and other regulatory agencies.

I understand that any information found to be false could result in denial or subsequent termination of this facility's membership in the KPMAS network. I am an officer of the above named organization with the authority to provide KPMAS the requested information, documentation and to execute this attestation.

By the signature below, I hereby attest to the accuracy, validity and completeness of the information and documentation.

Printed Name and Title: ____

Signature: ____

Date: ____ / _____ / _______
MM / DD / YYYY