**Non-Residential Service Provider Application**

Submit form to: Lakeland Care Inc., Attn: Network Relations

 Email: network.relations@lakelandcareinc.com Fax: (920) 906-5103

Service Type: (Please check all Service(s) you are applying for)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Adaptive Aids  |  | Home Delivered Meals  |
|  | Adult Day Care  |  | Home Health / Nursing Services |
|  | Alcohol & Other Drug Abuse (AODA) Day Treatment |  | Home Modifications |
|  | Alternative Therapy  |  | Personal Emergency Response (PERS) |
|  | Consumer Education & Training |  | Prevocational Services  |
|  | Community Support Program (CSP) |  | Respite |
|  | Counseling & Therapeutic Resources |  | Supportive Apartment Program |
|  | Daily Living Skills Training (DLST) |  | Supported Employment |
|  | Durable Medical Equipment (DME) |  | Supportive Home Care |
|  | Durable Medical Supplies (DMS)  |  | Therapy |
|  | Financial Management / Rep Payee Services |  | Transportation  |
|  | Financial Management Service (SDS) |  | Vocational Futures Planning |
|  | Health Screening |  |  |

*Please print all responses*

**General Provider Information**

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

Physical Address of Business: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a new business (within the last 24 months): ☐ Yes ☐ No

If yes, please provide your relevant experience: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, please provide years of relevant experience: \_\_\_\_\_\_\_\_\_\_\_

**Target Group(s) Served (check all that apply) Facility Accessibility (Check one)**

☐ I/DD (intellectually/developmentally disabled) ☐ Wheelchair accessible

☐ FE (frail elderly) ☐ Not wheelchair accessible

☐ PD (physically disabled) ☐ Not Applicable: Member does

☐ Mentally ill not receive services on premises

☐ AODA

☐ All of the above

**Gender Served**

☐ Male only

☐ Female only

☐ Male & Female

**List all languages spoken:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please provide a brief description of your service area specialties:** (i.e., Memory Care, Behavioral Health, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**County Service provided in:**

☐ Brown

☐ Calumet

☐ Door

☐ Florence

☐ Fond du Lac

☐ Forest

☐ Kewaunee

☐ Langlade

☐ Lincoln

☐ Manitowoc

☐ Marathon

☐ Marinette ☐ Menominee

☐ Oconto

☐ Oneida

☐ Outagamie

☐ Portage ☐ Shawano

☐ Vilas

☐ Waupaca

☐ Winnebago

☐ Wood ☐ other; please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any areas, towns or cities within these counties that you will **NOT** serve:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hours of Operation/Availability:**

Monday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Friday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuesday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Saturday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Wednesday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sunday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thursday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any exceptions (i.e. holidays): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing Information**

Tax ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID: SS# ☐ EIN# ☐

NPI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WI Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicare #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Authorization Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Contract Information**

Agency Name or Doing Business as (DBA): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Entity (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contract Administrator Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Information**

Referral Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Provider Disclosure Questions**

Please provide a complete explanation for any “Yes” answers. Attach additional information as necessary.

1. ☐ Yes Has the licensure or certification (if applicable) ever been terminated, stipulated,

☐ No restricted, limited, conditioned, suspended, revoked refused, voluntarily relinquished, or not renewed by any licensing/certifying agency or any agency or organization, or is there a review pending?

1. ☐ Yes Has participation (if applicable) in any professional organization ever been ☐ No voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?
2. ☐ Yes Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ☐ No ever been subject to a corrective action plan with any licensing board, peer review organization, state agency, county agency, or any provider related agency or organization?
3. ☐ Yes Has your certification or participation in any private, federal (e.g. Medicare, Medicaid) or ☐ No state health insurance program ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?
4. ☐ Yes Have you ever been found liable, guilty or responsible for sexual impropriety or ☐ No misconduct or sexual harassment with a client, co-worker or other?
5. ☐ Yes Have you ever had any liability claims or lawsuits brought against you, including pending ☐ No claims or lawsuits, dismissed or dropped claims or dropped claims or lawsuits, settlements or final judgments?
6. ☐ Yes Do you have a physical or mental condition that would affect your ability, with or without ☐ No reasonable accommodation, to provide appropriate care to clients and otherwise perform the essential functions of a provider in your area of service provision? If yes, what accommodations would help you provide appropriate care to clients and perform other essential functions?

**Provider References**

List one (1) reference that has personal knowledge of your organization’s current (within the last 12 months) skills, abilities, judgment, performance and competence or has been responsible for observation of your work. Do not include relatives. Reference will be evaluated according to the extent of their direct observation of your work and other knowledge of your organization.

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

Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Business Information**

LCI must have a signed contract to authorize and pay for services rendered by your agency. To begin the process, the Network Relations staff must receive a completed application packet from your agency, along with additional state required documents, where applicable.

LCI utilizes a service provider contract. The service provider contracts will be automatically renewed each year until cancelled by either party with a written sixty (60) day notice.

LCI pays the Medicaid reimbursable rate for all Medicaid defined services. Other rates are based on rate negotiations and the applicant’s rate proposal (see page 6).

All LCI service contract addenda and contractual expectations can be reviewed on the LCI website.

**Business Attachments**

Include the following state required documents with your agency’s completed application. Please reference the LCI’s website <http://www.lakelandcareinc.com/index.php/for-our-providers/provider-tools-resources/forms-and-materials> for sample forms.

1. Copy of all applicable licensing, certification or accreditation(s)
2. Copy of the business’ Organizational Chart (if requested)
3. Copy of certificate of insurance policy(ies) and/or bonding
4. Copy of business’ W-9
5. Background Checks (Caregiver and Department of Justice):
	1. Attestation letter stating that all current agency employees have current background checks (within four years) and the agency has and will follow its background check policy
6. Debarment:
	1. Attestation letter stating that your agency has and follows its debarment policy
7. Training:
	1. Attestation letter stating that your agency provides standards, training and competency for staff
8. Civil Rights Compliance Plan and/or Civil Rights Compliance Attestation letter. For more information, see: <http://dhs.wisconsin.gov/civilrights/Index.HTM>

**Provider Signature**

I attest that the information provided on this application is truthful and accurate and I understand that knowingly providing false information or omitting information may result in contract denial or termination. I agree to update this information as necessary so that it remains complete, true and accurate at all times. I also confirm that I am not excluded from participation in federal health care programs as a provider for the Lakeland Care Inc.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(Provider Signature) (Date)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Print Name)*

 **Non-Residential Rate Proposal(s):**

|  |  |  |
| --- | --- | --- |
| **Service Category** | **Applicant Proposed Rate** | **Additional Information** |
| Example: Supportive Home Care - Routine  | $16.00/hour | Transportation Included |
|  |  |  |
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