**Residential Service Provider Application**

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

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

Service Type: Choose an item.

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*Please print or type all responses*

**General Provider Information**

Name:

Physical Address of residential facility):

City:       State:       Zip Code:

Facility Phone Number:

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)**

[ ]  DD (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

**Residential Provider Applicants Gender Served**

[ ]  1-2 Bed owner occupied [ ]  Male only

[ ]  1-2 Bed corporate [ ]  Female only

[ ]  3-4 Bed owner occupied [ ]  Male & Female

[ ]  3-4 Bed corporate

[ ]  5-8 Bed

[ ]  9 Bed & over

**List all languages spoken:**

**Please provide a brief description of your service details:** (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

**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 Organizational Information**

(Attach additional pages or documentation as necessary)

Describe your organization’s cultural competency:

Describe any potential service limitations related to the services you are applying for:

Describe your organization’s Quality Improvement/Quality Assurance Plan:

Describe your training plan/schedule for your staff (if applicable):

Describe the pay levels and benefits provided for your direct care staff (if applicable):

Describe your organization’s policy/process for identifying, reporting, evaluating, and resolving unintended events (ie. injury, behavior or quality concern):

Please indicate the length of time your agency has been in business providing the services for which you are applying:

**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 in voluntarily 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?
7. [ ]  Yes Has your facility been issued any Statements of Deficiency by the Department of Quality

Assurance within the last year?

[ ]  No

If yes, please provide details and outcomes for all deficiencies:

**Provider References**

List three (3) references that have personal knowledge of your current (within the last 12 months) skills, abilities, judgment, performance and competence or have been responsible for observation of your work. Limit to one (1) current office associate. Do not include relatives. References will be evaluated according to the extent of their direct observation of your work and other knowledge of you.

Name:       Title:

Organization Name:

Address:

City:       State:       Zip Code:

Phone:       Fax:

Email:

Name:       Title:

Organization Name:

Address:

City:       State:       Zip Code:

Phone:       Fax:

Email:

Name:       Title:

Organization Name:

Address:

City:       State:       Zip Code:

Phone:       Fax:

Email:

**Business Information**

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

The 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.

The LCI pays the Medicaid reimbursable rate for all Medicaid defined services. Other rates are based on rate negotiations and the applicant’s rate proposal.

All LCI service contract addenda and contractual expectations can be reviewed on the LCI website <http://www.lakelandcareinc.com/index.php/for-our-providers/provider-tools-resources/forms-and-materials>

**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 applicable)
3. Copy of certificate of insurance policy(ies) and/or bonding
4. Copy of the business’ W-9
5. Background Checks (Caregiver and Department of Justice):
6. Attestation letter stating that all current agency employees have current background checks (within four years) and the agency will follow its background check policy:
	1. Attestation letter stating that your agency 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>
9. **Residential providers must also submit the following items**:
	1. Residential Face Sheet (if more than one facility)
	2. Attachment 1: Residential Computation Worksheet
	3. Attachment 2: Residential Salary Allocation Worksheet
	4. Attachment 3: Residential Weekly Staffing
	5. Residential Member/Staff Scheduling Form (AFH & CBRF 5-8 Bed only)
	6. Copy of the current Program Statement for each facility

**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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_Click here to enter a date.

 *(Provider Signature) (Date)*

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