To ensure timely processing of your application, please return the following:

- ☐ Completed Facility Credentialing/Re-credentialing Application
- ☐ Current copies of all applicable state licenses and letters of support/approval. (All letters are needed for initial credentialing but only time-limited letters need to be re-submitted at the time of re-credentialing.)
- ☐ Copy of the most recent state licensing site visit report for each license (i.e. the state performed a site visit or site survey as a part of the licensure and/or certification process)
- ☐ Copy of current medical malpractice, comprehensive professional, general and/or umbrella liability insurance certificates that identify the limits of liability and the policy effective dates (documents must include "Professional Liability").
- ☐ Copy of a completed W9 form or IRS letter
- ☐ NPI Enumerator Documentation
- ☐ Staff Roster for each site and program
- ☐ Accreditation Certificate(s):
  - ☐ JC – The Joint Commission (formerly JCAHO)
  - ☐ CARF – Council on Accreditation of Rehabilitation Facilities COA – Council on Accreditation
  - ☐ HFAP – The AOA's Healthcare Facilities Accreditation Program
  - ☐ Other _____
- ☐ Quality Management Program Description – Community Care only
- ☐ Compliance Plan (Fraud, Waste and Abuse) – Community Care only

Pennsylvania Behavioral Health Program Facility Credentialing and Re-credentialing Application

This application is used for the organization provider network of the Behavioral Health Managed Care Programs in the state of Pennsylvania. Organizational providers include: agencies, programs, hospitals, facilities, treatment centers, community mental health centers and others.

Behavioral Health Managed Care Organization:

- ○ Community Care Behavioral Health Organization (CCBH)
  U.S. Steel Tower
  600 Grant Street, 8th Floor
  Pittsburgh, PA 15219
  P: 412-454-2120

- ○ Community Behavioral Health (CBH)
  801 Market St
  Suite 7000
  Philadelphia, PA 19107
  P: 215-413-3100

- ○ Magellan Behavioral Health
  Attn: ONS Network Services
  14100 Magellan Plaza Dr
  Maryland Heights, MO 63043
  P: 610-814-8050

- ○ PerformCare®
  8040 Carlson Rd
  Harrisburg, PA 17112
  P: 888-700-7370

- ○ Value Behavioral Health of Pennsylvania
  ValueOptions® - Facility Credentialing Department
  P O Box 41055
  Norfolk, VA 23541
  P: 800-397-1630

Parent Company Information:

A "Parent Company" is an entity that controls, owns, or overseas organization(s) and retains the Federal Tax Identification number for all of those organizations. The Parent Company is always the contract holder and is always the receiver of payment. A Parent is a single entity at one location.

In this section, enter Name, Administrative Address, Accounts Payable Address, IRS Address, Taxpayer Identification, and Executive Contact information pertaining to the Parent Company.

Parent Company Name:				
Doing Business As: *(if applicable)*				
Tax ID: EIN: FIN:				
Chief Executive Officer:	Name:		Title:	
	Telephone:		Email:	
Medical Director:	Name:		Title:	
	Telephone:		Email:	
Managed Care/Clinical Director:	Name:		Title:	
	Telephone:		Email:	
Credentialing Contact:	Name:		Title:	
	Telephone:		Email:	
Billing/Claims Contact:	Name:		Title:	
	Telephone:		Email:	
Corporate Compliance Officer:	Name:		Title:	
	Telephone:		Email:	
Contracting Contact:	Name:		Title:	
	Telephone:		Email:	
Electronic Funds Transfer Contact:	Electronic Funds Transfer connections will not be finalized without verbal confirmation from the designated EFT contact. You can find Community Care's EFT request form on our website; this form must be submitted to the email listed to begin the process once your contract is effective. For UPMC providers, EFT requests must be initiated in the UPMC Provider Online portal.			
	Name:		Telephone:	

Administrative Address: (Address where contract correspondence of mail occurs)

Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**ZIP Code:**
Telephone Number:		**Fax Number:**	

Accounts Payable Address: (Finance Address; where checks are mailed)

Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**ZIP Code:**
Telephone Number:		**Fax Number:**	

IRS Address: (Address for tax reporting purposes – must match W9 or IRS documentation)

Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**ZIP Code:**
Telephone Number:		**Fax Number:**	

Business Classification:	
Ownership:	Select
Status:	Select
Medicaid:	Select
Demographic Data:	Select

Accreditation Information:

Active Accreditation Agency: (Check all that apply)	**Accredited Date:**	**Expiration Date:**
☐ **Joint Commission**		
☐ **CARF**		
☐ **COA**		
☐ **Other** :		

LIABILITY/MALPRACTICE COVERAGE INFORMATION

Note: If you have different Liability/Malpractice coverage for different programs/sites, you must complete this section for each policy/insurer. For Initial Credentialing Applications, please include any occurrences within the last 5 years. For Re-credentialing Applications, please include any occurrences since the last credentialing date (within the last 3 years).

- Has your agency/program filed a claim under general or professional liability insurance?
  ☐ Yes ☐ No
- Are there any new claims pending against your agency?
  ☐ Yes ☐ No
- Has your agency's liability/malpractice coverage been denied, canceled, or non-renewed?
  ☐ Yes ☐ No

MALPRACTICE CLAIM INFORMATION

Please attach information on what the organization's response was to the allegations and what steps were taken to prevent any future incidents for each claim listed below. This page can be copied to accommodate additional claim information.

1. Date of Occurrence: ☐ Date Claim Filed: ☐ Date of Settlement: ☐
   Allegations and Action Taken: ☐
   Case Settled: Select Total Amount Paid to Claimant: ☐

2. Date of Occurrence: ☐ Date Claim Filed: ☐ Date of Settlement: ☐
   Allegations and Action Taken: ☐
   Case Settled: Select Total Amount Paid to Claimant: ☐

3. Date of Occurrence: ☐ Date Claim Filed: ☐ Date of Settlement: ☐
   Allegations and Action Taken: ☐
   Case Settled: Select Total Amount Paid to Claimant: ☐

General Liability Coverage:

General Liability Carrier:		Policy Number:	Policy Holder:
Effective Date:	**Expiration Date:**	**Per Occurrence Amount $:**	**Aggregate Amount $:**

Professional Liability Coverage:

Professional Liability Carrier:		Policy Number:	Policy Holder:
Effective Date:	**Expiration Date:**	**Per Occurrence Amount $:**	**Aggregate Amount $:**

Excess/Umbrella Liability Coverage:

Excess Umbrella Liability Carrier:		Policy Number:	Policy Holder:
Effective Date:	**Expiration Date:**	**Per Occurrence Amount $:**	**Aggregate Amount $:**

Automobile Insurance Information:

Automobile Liability Carrier:	Policy Holder:	Combined Single Limit Amount $:	
Policy Number:		**Effective Date:**	**Expiration Date:**

Workman's Compensation Information:

Workman's Compensation Insurance Carrier:	Policy Holder:	Per Accident Amount $:	Per Employee Amount $:

Policy Number:	Policy Limit $:	Effective Date:	Expiration Date:

SANCTIONS/LICENSURE INFORMATION

For Initial Credentialing Applications, please include any occurrences within the last 5 years. For Re-credentialing Applications, please include any occurrences since the last credentialing date (within the last 3 years).

- Have there been any disciplinary actions (denied, revoked, suspended or otherwise limited) taken against the facility/program by a state licensing body or voluntarily given up by the facility/program or are any actions now underway which may lead to such sanctions? ☐ Yes ☐ No

- Have any memberships in professional organizations and/or accreditations been revoked, reduced, denied or suspended by others or voluntarily given up by the facility/program or are any actions now underway which may lead to such sanctions? ☐ Yes ☐ No

*** If you answered yes to any of the above, please attach a written explanation providing detail about the sanction or probationary status.**

OPERATIONS

- Confirm that you have an appointed a Corporate Compliance Officer? ☐ Yes ☐ No
- Confirm that you have adopted a Code of Conduct (REQUIRED)? ☐ Yes ☐ No
- Confirm that you have adopted a Corporate Compliance Plan (REQUIRED)? ☐ Yes ☐ No
- Confirm that you have a Quality Improvement (QI) plan (REQUIRED)? ☐ Yes ☐ No
- Confirm that you have a staff credentialing processing place which includes (REQUIRED):
    - Verification of licenses directly with Department of State (DOS) ☐ Yes ☐ No
    - Documentation of disciplinary actions identified by DOS ☐ Yes ☐ No
    - Primary source verification of education is conducted for all clinical staff ☐ Yes ☐ No
    - For physicians, the DEA Certification is confirmed to be current ☐ Yes ☐ No
    - The resume reflects continuous work experience – breaks are explained ☐ Yes ☐ No
    - Medicheck is referenced to assure employees are not precluded or excluded from PA Medical Assistance (**ongoing review required**) ☐ Yes ☐ No
    - U.S. Department of Health & Human Services Office of Inspector General (HHS-OIG) is referenced to assure employee are not excluded from Participation in any federal health care program ☐ Yes ☐ No
    - System for Award Management (SAM formerly known as Excluded Parties List System) is referenced to assure that employees are not excluded from receiving Federal contracts, certain subcontracts and certain Federal financial and non-financial benefits ☐ Yes ☐ No
    - All three lists (Medicheck, HHS-OIG and SAM) are checked prior to hiring an employee or contractor ☐ Yes ☐ No
    - All three lists are checked ***monthly*** for every employee or contractor ☐ Yes ☐ No
- Agency policy supports recovery and resiliency principles? (Required For HealthChoices) ☐ Yes ☐ No
- Members are asked if they have a Wellness Recovery Action Plan (WRAP) or Advanced Directive? (Required For HealthChoices) ☐ Yes ☐ No

PARTICIPATION STATEMENT

Please select the Behavioral Health Managed Care Organization to whom you are attesting the application information (hereafter listed as "BHMCO"):

Community Care Behavioral Health Organization (CCBHO)	Date of Last Credentialing:
Community Behavioral Health (CBH)	Date of Last Credentialing:
Magellan Behavioral Health	Date of Last Credentialing:
PerformCare	Date of Last Credentialing:
Value Behavioral Health of Pennsylvania (VBH)	Date of Last Credentialing:

For purposes of making this application for participation in the BHMCO provider network, the Facility/Program certifies that all information provided to the BHMCO is complete and correct to the best of the Facility/Program's knowledge. The Facility/Program agrees to notify the BHMCO promptly if there are any material changes in the information provided, whether prior to or after the Facility/Program's acceptance as a the BHMCO participating provider. The Facility/Program understands and agrees that if the BHMCO discovers that this application contains any significant misstatement, misrepresentations or omissions, the BHMCO may void, in its sole discretion, its application and any related participating provider agreements.

The Facility/Program authorizes the BHMCO and its Credentialing Verification Organization (CVO) to consult with State licensing agencies, accreditation bodies, malpractice insurance carriers, and, upon notification to Facility/Program of additional specific entities or organizations, any other entity from which information may be needed to complete the credentialing process, and the Facility/Program authorizes the release of such information to the BHMCO and its CVO. The Facility/Program releases the BHMCO and its CVO and its employees and agents and all those whom the BHMCO contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating the Facility/Program's application.

The Facility/Program further understands and agrees that; (a) the Facility/Program is responsible for producing all information required or re quested by the BHMCO and its CVO in connection with this application; (b) the BHMCO is under no obligation to complete the processing of this application until such information is provided by the Facility/Program; (c) in the event that the BHMCO decides not to accept the Facility/Program as a participating provider and the Facility/Program desires to have this decision reviewed, the Facility/Program will appeal such determination via the BHMCO's appeal process.

Facility Name

Authorized Signature
(live or verified signature required)

Dated

Name (Please Print)

Title

For Internal Use Only:

Date application received from Provider:

COMMUNITY CARE
Behavioral Health Organization

339 Sixth Avenue, Suite 1300
Pittsburgh, PA 15222
T 412.454.2120
F 412.454.2177
ccbh.com

Facility Expansion Request Location Information

Incomplete or unreported information may result in delays of a final determination on your request. A full document is required for each level of care being requested at each service location being requested.

If your request is approved, this information will be used for contracting actions, please ensure the accuracy of the information submitted.

A. Program Name and Location			
Program Name (e.g. Unit Name, School Name):		Member Referral Phone #:	
Address:			
City:	State:	Zip Code:	County:
Office Contact:		Title:	
Office Phone:		Office Fax:	
Is this program handicapped accessible?	◯ Yes ◯ No		
If yes, is the program ADA (American Disabilities Act) approved?	◯ Yes ◯ No		
Is public transportation accessible to this program?	◯ Yes ◯ No		
Do you provide Telehealth from this location?	◯ Yes ◯ No		

B. Program Licensure and Enrollment	
Is this program accredited through The Joint Commission, CARF or COA?	◯ Yes ◯ No (If *Yes,* please attach copy of accreditation).
Is this program licensed? ◯ Yes ◯ No If yes, license number?:	(please attach copy of license)

If your facility is **not accredited but licensed,** please attach the following (in addition to copy of license):

- ✓ **Copy of current licensing reports (including documentation of follow-up to any corrective action items or plans).**

Please Note: If approved, Community Care is required to conduct an on-site visit for each service address unless the service address is covered under a facility accreditation or the service is licensed and copies of licensing reports, including any correspondence documenting follow-up to any corrective action items or plans, is obtained.

Is this program enrolled in Medicare? ◯ Yes ◯ No If yes, please provide number:

If your agency is indicating that they have Medicare enrollment, a copy of Medicare enrollment documentation (CMS letter) is required. Requests are not considered complete until all supporting documents have been submitted.

Is this program enrolled in Medical Assistance? ◯ Yes ◯ No

PROMISe enrollment is specific to the type and specialty of the service being rendered as well as to the specific service location. Providers must have and maintain proper PROMISe enrollment to be eligible for contracting under HealthChoices, Medicare Dual Eligible or CHIP products. Enrollments must be revalidated at minimum every 5 years through the Commonwealth PROMISe system.

National Provider Identifier (NPI)? NPI # (10-digits): _____

NPI numbers are a crucial billing element, please ensure they are listed accurately and active in the NPPES. Each PROMISe enrollment is attached to a specific NPI, please list the NPI that this services PROMISe enrollment is connected to if

Facility Name: _____

C. Program Type

Inpatient Hospital Services

- ☐ 23-hour Observation Bed ☐ Adult ☐ Child/Adolescent
- ☐ Inpatient Mental Health ☐ Adult ☐ Child/Adolescent
- ☐ Inpatient Detoxification ☐ Adult ☐ Child/Adolescent
- ☐ Inpatient Rehabilitation ☐ Adult ☐ Child/Adolescent

Laboratory Services

- ☐ Laboratory Services

Electroconvulsive Therapy

- ☐ Inpatient ECT ☐ Adult ☐ Child/Adolescent
- ☐ Ambulatory ECT ☐ Adult ☐ Child/Adolescent

Psychiatric Rehabilitation (PSR)

- ☐ Site Based Psychiatric Rehab
- ☐ Mobile Psychiatric Rehab
- ☐ Club House

Individualized Residential Treatment (IRT)

- ☐ CRR Group Home
- ☐ CRR Host Home

MH Partial Hospital

- ☐ Acute Partial MH ☐ Adult ☐ Child/Adolescent
- ☐ Non-Acute Partial MH ☐ Adult ☐ Child/Adolescent
- ☐ Approved Private School (APS)
- ☐ Clozaril Services

MH Intensive Outpatient

- ☐ MH Intensive Outpatient ☐ Adult ☐ Child/Adolescent

FQHC/Rural Health Clinic

- ☐ Federally Qualified Health Clinic ☐ Adult ☐ Child/Adolescent
- ☐ Rural Health Clinic ☐ Adult ☐ Child/Adolescent

OTHER (Internal Use Only)

Other: _____

Outpatient Mental Health Clinic

- ☐ Outpatient Mental Health ☐ Adult ☐ Child/Adolescent
- ☐ Psychological Testing ☐ Adult ☐ Child/Adolescent
- ☐ Neuro Psychological Testing ☐ Adult ☐ Child/Adolescent
- ☐ Clozaril Services
- ☐ Esketamine Services
- ☐ Transcranial Magnetic Stimulation (TMS)

Mobile Mental Health Treatment

- ☐ Mobile Mental Health Treatment (MMHT)

MH Targeted Case Management

- ☐ Blended Case Management (BCM) ☐ Adult ☐ Child/Adolescent
- ☐ Intensive Case Management (ICM) ☐ Adult ☐ Child/Adolescent
- ☐ Resource Coordination (RC) ☐ Adult ☐ Child/Adolescent

Family Based Mental Health (FBMH)

- ☐ Family Based Mental Health (FBMH)

MH Adult Supplemental Service

- ☐ Assertive Community Treatment (CTT) ☐ Adult ☐ Transition Age
- ☐ Peer Support Services ☐ Adult ☐ Child/Adolescent
- ☐ Community MH Services, Other
- ☐ BSU Diagnostic Assessment

Intensive Behavioral Health Services (IBHS)

- ☐ Group
- ☐ Individual
- ☐ Applied Behavior Analysis (ABA)
- ☐ Community and School Based Behavioral Health

Residential Treatment Facility

- ☐ RTF JCAHO (Accredited)
- ☐ RTF Non-JCAHO (Non-Accredited)
- ☐ Adult Residential Treatment Facility
- ☐ Extended Acute Care Unit (EAC)
- ☐ Long Term Structured Residence (LTSR)

Non-Hospital Substance Use Residential

- ☐ 3.7 Withdrawal Management ☐ Adult ☐ Child/Adolescent
- ☐ 3.7 Medically Monitored Intensive Inpatient Services ☐ Adult ☐ Child/Adolescent
- ☐ 3.5 Clinically Managed High Intensity Residential ☐ Adult ☐ Child/Adolescent
- ☐ 3.1 Clinically Managed Low Intensity Residential Services

Substance Use Intensive Outpatient

- ☐ 2.1 SUD Intensive Outpatient ☐ Adult ☐ Child/Adolescent

Outpatient Substance Use Clinic

- ☐ 1.0 Outpatient SUD Clinic ☐ Adult ☐ Child/Adolescent
- ☐ Buprenorphine Services

Methadone Maintenance

- ☐ Methadone Maintenance

Substance Use Partial Hospital

- ☐ 2.5 Acute Partial D&A ☐ Adult ☐ Child/Adolescent
- ☐ Non-Acute Partial D&A ☐ Adult ☐ Child/Adolescent

MH Crisis Intervention

- ☐ Telephone Crisis (Licensed)
- ☐ Mobile Crisis (Licensed)
- ☐ Medical Mobile Crisis (Licensed)
- ☐ Walk-In Crisis (Licensed)
- ☐ Crisis Residential (Licensed)

Tobacco Cessation

- ☐ Tobacco Cessation ☐ Adult ☐ Child/Adolescent

Substance Use Supplemental Services

- ☐ Certified Recovery Specialist
- ☐ SUD Resource Coordination/ICM
- ☐ SUD LOC Assessment

Center of Excellence

- ☐ Center of Excellence

D. Competencies

LANGUAGES:

Do you have staff fluent in American Sign Language (ASL)?	☐ Yes ☐ No
Do you have access to the language bank?	☐ Yes ☐ No

Please list any foreign languages in which you have staff that are fluent to provide treatment at this program:

1.		3.	
2.		4.	

AGE RANGE:

Please select the age range of clients who may be treated in this program. *(check all that apply)*

Preschool (0-5)	☐	Young Adult (19-20)	☐
School Age (6-13)	☐	Adult (21-59)	☐
Adolescent (14-17)	☐	Older Adult (60+)	☐
Transition Age (18)	☐		

PRIORITY POPULATIONS:

As a primary focus of your program, do you provide services to any of the following priority populations?

PRIORITY POPULATIONS			
MH: Persons with serious mental illness	☐ Yes ☐ No	D/A: Maternal Addictions	☐ Yes ☐ No
MH: Children with serious emotional disturbance	☐ Yes ☐ No	D/A: IV Drug Use	☐ Yes ☐ No
MH: Children at risk of serious emotional disturbance	☐ Yes ☐ No	D/A: Adolescents	☐ Yes ☐ No
D/A: Persons with co-occurring mental illness	☐ Yes ☐ No	D/A: Persons with severe medical conditions	☐ Yes ☐ No

SPECIAL POPULATIONS:

As a primary focus of your program, do you provide services to any of the following special populations?

SPECIAL POPULATIONS			
Children and Adolescents	☐ Yes ☐ No	Persons who are homebound	☐ Yes ☐ No
Older Persons	☐ Yes ☐ No	Persons with HIV/AIDS	☐ Yes ☐ No
		Autism Specialization	☐ Yes ☐ No

HOURS OF OPERATION:

Please list the hours of operation for the services listed at the enclosed location (include AM or PM with start/end times).

☐ 24 hours a day, 7 days a week or:

Day	Start Time	End Time	Day	Start Time	End Time
Monday			Friday		
Tuesday			Saturday		
Wednesday			Sunday		
Thursday					

Facility Name:

Facility Name: _____

E. Areas of Focus:

Please indicate any areas for which your program has staff with additional training or special certification. Documentation of your agencies policy and procedure on verifying employee certifications and specialties must be included with your submission.

Anxiety and/or Depressive Disorders	☐ Yes ☐ No	Intersex Treatment Focus	☐ Yes ☐ No
Applied Behavior Analysis (ABA)	☐ Yes ☐ No	Lesbian Treatment Focus	☐ Yes ☐ No
Autism (adults)	☐ Yes ☐ No	Maternal Depression	☐ Yes ☐ No
Autism (children/adolescents)	☐ Yes ☐ No	Medically Compromised	☐ Yes ☐ No
Bisexual Treatment Focus	☐ Yes ☐ No	Personality Disorders	☐ Yes ☐ No
Buprenorphine (Suboxone) Services	☐ Yes ☐ No	Post-Partum Treatment Focus	☐ Yes ☐ No
Cognitive Behavioral Therapy	☐ Yes ☐ No	Pregnant Females	☐ Yes ☐ No
Co-Occurring MH/SUD	☐ Yes ☐ No	Pregnant IV Drug Users	☐ Yes ☐ No
Co-Occurring MH/IDD	☐ Yes ☐ No	Schizophrenia or Cognitive Disorders	☐ Yes ☐ No
Deaf and Blind	☐ Yes ☐ No	Sexually Reactive Disorder	☐ Yes ☐ No
Deaf / Hard of Hearing (ASL fluency)	☐ Yes ☐ No	Sexual Offenders (adults)	☐ Yes ☐ No
Dialectical Behavioral Therapy	☐ Yes ☐ No	Sexual Offenders (children/adolescents)	☐ Yes ☐ No
Eating Disorders	☐ Yes ☐ No	Sexual Identity Treatment Focus	☐ Yes ☐ No
Eye Movement Desensitization and Reprocessing (EMDR)	☐ Yes ☐ No	Sexual Victims (adults)	☐ Yes ☐ No
Family Therapy	☐ Yes ☐ No	Sexual Victims (children/adolescents)	☐ Yes ☐ No
Fire Setting (adults)	☐ Yes ☐ No	Transgender Treatment Focus	☐ Yes ☐ No
Fire Setting (children/adolescents)	☐ Yes ☐ No	Trauma Informed Care	☐ Yes ☐ No
Gambling Addiction	☐ Yes ☐ No	Veterans Treatment Focus	☐ Yes ☐ No
Gay Treatment Focus	☐ Yes ☐ No	Visually Impaired	☐ Yes ☐ No
Grief Therapy	☐ Yes ☐ No	Women with Children	☐ Yes ☐ No
Geriatric Care	☐ Yes ☐ No	Young Children with Serious Emotional Disturbances	☐ Yes ☐ No
Faith Based Counseling	Please Specify _____		☐ Yes ☐ No
Minority Population(s)	Please Specify _____		☐ Yes ☐ No
Other	Please Specify _____		☐ Yes ☐ No

COMMUNITY CARE
Behavioral Health Organization

339 Sixth Avenue, Suite 1300
Pittsburgh, PA 15222
T 412.454.2120
F 412.454.2177
ccbh.com

Community Care Attestations *(live or verified signatures required)*

(1.) CLEARANCES

Provider attests compliance with Act 79 of 1987 (Older Adults Protective Services Act) as amended by Act 169 of 1996 and Act 13 of 1997, and the Child Protective Services Law (CPSL), as applicable, through attestation. If Provider delivers services in a state other than Pennsylvania, Provider shall attest compliance with the child protective service and older adult protective service clearance requirements in all states in which they provide serrvices.

Signature: Date:

(2.) FRAUD, WASTE AND ABUSE COMPLIANCE PROGRAM (HealthChoices Providers)

Please affirm that your organization has developed and implemented a Fraud, Waste and Abuse Compliance program including the screening of employees and contractors for exclusion in Federal Health Care Programs, including the development, implementation and documentation of monthly verification of employees, contractors and business partners involved in Medical Assistance Funds.

Signature Date:

(3.) QUALITY MANAGEMENT PLAN

Please affirm that your organization has developed and implemented a Quality Management Plan.

Signature: Date:

Facility Name:

COMMUNITY CARE
Behavioral Health Organization

339 Sixth Avenue, Suite 1300
Pittsburgh, PA 15222
T 412. 454.2120
F 412. 454.2177
www.ccbh.com

Provider Contact Addendum

Community Care ePortal

Community Care's ePortal is a secure HIPAA-compliant website allowing network providers to streamline operation, administrative, and clinical workflows. Dependent on a provider's contracted liens of business there are several ePortal centers accessible to providers after the execution date of their contract.

All providers contracted for HealthChoices and or UPMC Health Plan Behavioral Health Services will have access to Business Center within the ePortal. Business Center includes automated features for provides to view and search details related to their contracts, complete required quarterly service validations, and maintain the up to date required Disclosure of Ownership. Service Validation is required on a quarterly basis by regulatory bodies making access to the ePortal crucial in maintaining accurate data with Community Care.

You may register for an ePortal account on the Community Care website. User guides have been developed t assist providers in the registration process and guidance on the many functions available within the ePortal.

Contract Signatory

Community Care uses Adobe Sign electronic signature software for executing Community Care provider contracts and amendments. Contracts are sent to the contract signatory identified below. If someone other than the identified contract signatory needs to sign the contract, the delegate function within Adobe Sign can be used to forward the contract. Reminders will automatically be sent until the contract/ amendment is executed. Once signed, the completed contract is automatically sent to the signatory. The signatory can then forward the completed contract to any other person(s) within the provider's organization.

Community Care acknowledges that provider agencies have several people involved in their credentialing, contracting, and decision-making processes. In order to eliminate confusion and delays in processing contracts, please indicate the person with the facility who has the authority to enter into agreements and sign contracts:

Contract Signatory Name: _____ Email Address: _____

Facility Name: _____

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 7[2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.