RHODE ISLAND PRIMARY CARE PHYSICIANS CORPORATION

BEHAVIORAL HEALTH FACILITY MEMBERSHIP APPLICATION

Behavioral Health Affiliate Membership Committee
Rhode Island Primary Care Physicians Corporation
1150 New London Avenue, Suite 20
Cranston, RI 02920
(401) 654-4000

Facility Name: _____

Legal Business Entity: _____

Mailing Address: _____

Tax ID Number: _____

Contact Email Address: _____

Secure Email Address (i.e. Direct Mail)?_____

Please advise whether or not you would like your email published on the RIPCPC public/external website:

___ Yes ___ No.

Do you have one main intake center? Yes ☐ No ☐

If yes, please provide the following intake information for each intake center:

Please indicate the services provided at your facility and service location information:

Service	**Service Provided**	**Intake Info Phone, fax, email#**	**Location (address)**	**Insurances accepted**	**Hour**
Main or Single Intake Center	**Yes** ☐ **No** ☐				
Child & Adolescent Services:	**Yes** ☐ **No** ☐				
Outpatient Counseling	**Yes** ☐ **No** ☐				
Substance abuse services	**Yes** ☐ **No** ☐				
Medical Evaluation & Monitoring	**Yes** ☐ **No** ☐				
Community Based Intensive Services	**Yes** ☐ **No** ☐				
Day Program/IOP	**Yes** ☐ **No** ☐				

Service	Service Provided	Intake Info Phone, fax, email#	Location (address)	Insurances accepted	Hours
Substance abuse services:	Yes ☐ No ☐				
Detox	Yes ☐ No ☐				
Day Program/IOP	Yes ☐ No ☐				
Residential	Yes ☐ No ☐				
IOP	Yes ☐ No ☐				
Adult Services	Yes ☐ No ☐				
Outpatient Counseling	Yes ☐ No ☐				
Medication Evaluation & Monitoring	Yes ☐ No ☐				

Do you offer open access? Yes ☐ No ☐

FACILITY INFORMATION

Do you provide 24/7 coverage? ? Yes ☐ No ☐

If no, please list providers/facilities that routinely provides coverage for your facility.

_____

_____

_____

Are there any limitations your facility's practice? (Patient served, etc.) _____

_____

_____

_____

_____

_____

_____

LICENSURE

Please list the following information so that we may expedite future credentialing requirements:

State Licenses:

License as	State	License #	Expiration Date
1			
2			
3			
4			

Board Certificates:

Certifying Organization	State	Certificate #	Expiration Date
1			
2			
3			
4			

Registrations:

NPI#	
Federal DEA:	
RI CMD#	
MA DEA#	

Professional Liability Carrier: _____

Policy Limits: _____ Expiration Date: _____

If you answer YES to any of the following questions, please provide a detailed explanation on a separate sheet.

a. Has the facility ever had your state license refused, restricted, suspended or revoked in MA, RI or any other state?	Yes ☐ No ☐
b. Has the Licensing entity of any state ever taken action against the facility?	Yes ☐ No ☐
c. Has the facility license to prescribe narcotics ever been suspended, refused or revoked, if relevant?	Yes ☐ No ☐
d. Is the facility now or has the facility ever been involved in any malpractice suit, including arbitration?	Yes ☐ No ☐
e. Have any malpractice judgments been entered against the facility, including arbitration?	Yes ☐ No ☐
f. Have any malpractice judgments been entered against you?	Yes ☐ No ☐
g. Has any malpractice claim settlement, not involving litigation or arbitration, ever been paid by your facility or on your facility's behalf?	Yes ☐ No ☐
h. Has the facility ever been the subject of investigation by a peer review committee?	Yes ☐ No ☐
i. Has anyone in the employ of the facility ever been convicted of a crime due in connection with their employment?	Yes ☐ No ☐
j. Has the facility or any of its current providers ever been suspended from receiving payment under the Medicare or Medicaid program?	Yes ☐ No ☐
k. Has the facility's malpractice insurance ever been terminated or revoked except with your consent or at your request>	Yes ☐ No ☐
l. Have the facility ever been denied membership or renewal in any professional organization?	Yes ☐ No ☐
m. Has the facility ever been subject to disciplinary action in any professional organization	Yes ☐ No ☐
n. Has the facility ever voluntarily relinquished or not renewed privileges in a professional organization?	Yes ☐ No ☐

DOCUMENTATION

Please attach copies of documentation of each of the following:

_____ Rhode Island facility licenses (if programs have separate licenses please include a copy of each)

_____ Other state facility Licenses

_____ Professional liability insurance

_____ W-9

REFERENCES

List at least two professional references including one current RIPCPC members, not including relatives.

Name _____Telephone_____

Address _____

Name _____Telephone_____

Address _____

MANAGEMENT

RHODE ISLAND PRIMARY CARE PHYSICIANS CORPORATION ***reserves the right to request additional information for purposes of determining membership eligibility.***

I certify that the information provided is true and accurate to the best of my knowledge and understand that if Rhode Island Primary Care Physicians Corporation determines that this information is in any way incomplete, false or misleading, acceptance of this application will be considered void.

Authorized facility signature: _____

Title:_____

Print Name: _____

Date: _____

Please identify any additional individual(s) who is/are also responsible for the management of the facility and the facility's agreement to participate with RIPCPC?

_____

_____

_____

_____

_____

APPLICATION CONSENT

In order to more completely evaluate my application for inclusion in Rhode Island Primary Care Physicians Corporation (RIPCPC) and my continuing participation status with RIPCPC, I hereby give permission to RIPCPC to solicit information regarding my facility's credentials and qualifications.

Specifically included in the consent, but not by way of limitation, is specific data on my agency's quality of care and utilization statistics from chief(s) of Clinical Departments of hospitals or other health care facilities in which I have privileges, the National Data Bank, the State Board of professional regulations, the Department of Welfare, Medicaid and Medicare regulating agencies, drug enforcement agencies and colleagues.

I understand that RIPCPC will use this information solely in confidence.

I hereby release from liability RIPCPC and its employee(s), Members, Directors or agents and any person(s) listed above who is approached for information concerning my professional qualifications.

Signature: _____

Print Name: _____

Date: _____