PerformCARE® | 8040 Carlson Road
Harrisburg, PA 17112

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 _____
- ☐ Copies of evidence of completion of the required Monitoring of Sanctions checks at the time of hire and monthly thereafter for ALL owners, board members, and employees affiliated with the agency.

PERFORMCARE ADDENDUM (Part II)

Please complete a copy of this section for each Site or Program that is currently seeking credentialing with PerformCare.
Be sure to complete levels of care associated with each site and treatment modalities, diagnosis focus, and population information specific to each site. Please make additional copies as needed.

Provider Name:		**License Type:**	
		License Number:	
CONTRACTS	☐ CABHC (Cumberland/Dauphin/Lancaster/Lebanon/Perry) ☐ TMCA (Franklin/Fulton)		

MENTAL HEALTH LEVELS OF CARE

√	**Level of Care Description**	**Medical Assistance Provider Number and Location Code**
	Acute Care Hospital	
	Best Practice Evaluation	
	Clozapine/Clozaril Support Services	
	FQHC or Rural Health Center	
	IBHS - Applied Behavior Analysis (ABA)	
	IBHS Group - After School Program	
	IBHS Group - Stepping Stones	
	IBHS Group – Intensive Day Treatment	
	IBHS/ABA Group	
	IBHS – Functional Family Therapy (FFT)	
	IBHS – Multisystemic Therapy (MST)	
	IBHS – YFACTS	
	IBHS – Individual	
	MH Art Therapy	
	MH Assertive Community Treatment (ACT/CTT)	
	MH Crisis Intervention	
	MH CRR Host Home	
	MH Electroconvulsive Therapy (ECT)	
	MH Family Based Mental Health	
	MH Inpatient – Extended Acute Psych Inpatient Unit	

	MH Inpatient – Private Psych Hospital	
	MH Inpatient – Private Psych Unit	
	MH Mobile MH/ID	
	MH Music Therapy	
	MH Outpatient – Medication Management	
	MH Outpatient – Psychiatric Evaluation	
	MH Outpatient – Psychological Testing	
	MH Outpatient – Therapy	
	MH Partial Hospitalization – Adult	
	MH Partial Hospitalization – Child/Adolescent	
	MH Residential Treatment – Accredited	
	MH Residential Treatment – Non-Accredited	
	MH TCM (ICM, RC, BC)	
	Mobile Mental Health Treatment	
	Neuropsychological Evaluation/Testing	
	Peer Support Services (DHS Approved) - Adult	
	Peer Support Services (DHS Approved) - Youth	
	Psychiatric Rehab	
	Psychiatric Rehab - Clubhouse	
	School-Based Outpatient Site	
	Specialized In-Home Treatment Program (SPIN)	
	Telepsychiatry	
SUBSTANCE USE LEVELS OF CARE		
√	**Level of Care Description (PCPC-ASAM)**	**Medical Assistance Provider Number and Location Code**
	SU Outpatient (1)	
	SU Intensive Outpatient (2.1)	
	SU Partial Hospitalization (2.5)	
	SU Clinically Managed Low-Intensity Residential Services (3.1)	

	SU Clinically Managed, High-Intensity Residential Services (3.5)	
	SU Medically Monitored Intensive Inpatient Services (3.7)	
	SU Medically Monitored Inpatient WM (3.7 WM)	
	SU Medically Managed Intensive Inpatient Services (4)	
	SU Medically Managed Intensive Inpatient WM (4 WM)	
	SU D&A Level of Care Assessment	
	SU Certified Recovery Specialist (CRS)	
	SU TCM (ICM, RC)	
	SU Buprenorphine/Suboxone Services	
	SU Methadone Maintenance	
	SU Vivitrol/Naltrexone Services	
	Tobacco Cessation Treatment	
MISCELLANEOUS LEVELS OF CARE		
√	**Level of Care Description**	**Medical Assistance Provider Number and Location Code**
	Administrative Site Only	N/A
	LAB	
	Mobile Psych Nursing	

Practice Site Address: (Address where services will be rendered)

Address 1:			
Address 2:			
County Code:	**City:**	**State:**	**ZIP Code:**

Telephone Number:	**Fax Number:**	**After Hours Telephone Number:**

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)

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

Contact Person for this Site:	Name and Title:	
	Telephone:	
	Email:	

POPULATION AND SPECIALTY INFORMATION AT THIS SITE

Please identify your clinical interests and populations served by check marking applicable items. Perform Care will put this information in your provider profile and referrals will be made based on your responses.

√	**TREATMENT MODALITIES (Checking any of the boxes below requires that the provider is certified and must provide evidence of certification including copies of certifications or other evidence of certification.)** ☐ **Check here if this section is N/A**
	Cognitive Behavioral Therapy (CBT)
	Dialectical Behavioral Therapy (DBT)
	Eye Movement Desensitization and Reprocessing (EMDR)
	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
√	**TREATMENT MODALITIES/SPECIALIZED POPULATIONS (Checking any of the boxes below requires that the provider has specialized training in the area identified and provider must list the training completed and provide evidence of completed training.)** ☐ **Check here if this section is N/A**
	Biofeedback
	Eating Disorders
	Faith-based Counseling
	Family/Couples Therapy
	Geriatrics/Older Adults (65+)
	Lesbian/Gay/Bi-sexual/Transgender/Questioning (LGBTQ+)
	Pain Management
	Play Therapy
	Problem Sexual Behavior
	SUD – Contingency Management
	SU Co-occurring Enhanced
√	**DIAGNOSIS FOCUS** ☐ **Check here if this section is N/A**
	Anxiety Disorders/Phobias/Panic Disorders
	Attention Deficit Disorders / Oppositional Disorders (ADD/OD)
	Autism/Developmental Disorders
	Co-Occurring (MH/SUD)
	Co-Occurring (MH/ID)
	Depression/Mood Disorder
	Obsessive Compulsive Disorders (OCD)

	Personality Disorders		
	Reactive Attachment Disorder (RAD)/Attachment Issues		
	Sexual Disorders/Dysfunction		
	Trauma/Physical/Sexual Abuse Issues (PTSD)		
√	**ACCESSIBILITY** ☐ **Check here if this section is N/A**		
	Handicap Accessible		
	Wheelchair Accessible		
	Restrooms Accessible to Physically Disabled		
	Deaf/Hard of Hearing Accommodations		
	Blind/Visually Impaired Accommodations		
	Tobacco-Free Facility		
√	**POPULATIONS** ☐ **Check here if this section is N/A**		
	Children (preschool 0-4)		
	Children (5-12)		
	Children (13-17)		
	Adults (18-64)		
	Geriatric (65+)		
√	**LANGUAGES**		
	Spanish		Nepali
	English		Polish
	American Sign Language		Portuguese
	Amharic		Punjabi
	Arabic		Romanian
	Chinese		Russian
	Farsi		Swahili
	French		Syrian
	German		Tagalog
	Hawaiian		Telugu
	Hebrew		Thai

	Hindi		Ukrainian
	Italian		Urdu
	Japanese		Vietnamese
	Korean		Yiddish
	Latin		Yoruba

GEOGRAPHIC COVERAGE/ACCESS

County(ies) in which this Program is located	
County(ies) Served	

Do you believe that you are meeting PA Health Choices access standards as listed below?	**YES**	**NO**
Routine – offered an appointment within 7 days		
Urgent – offered an appointment within 24 hours		
Emergent – offered an appointment within 1 hour		
Accessibility Questions	**YES**	**NO**
Is this site accessible to public transportation?		
Is this site handicapped accessible?		
If this site is an Inpatient or Residential Program, please include the number of beds:		

What are your normal business hours for seeing clients?

Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

CULTURAL COMPETENCY SURVEY

Question	**YES**	**NO**
Does the agency have Policies and Procedures or provide training opportunities that cover areas of cultural diversity and cultural competence to all applicable staff members?		

Corporate Compliance Responsibilities

Question	**YES**	**NO**
Is a Corporate Compliance Officer appointed? (REQUIRED)		
Has the Agency (Practice) adopted a Code of Conduct? (REQUIRED)		
Does the Agency (Practice) have a Corporate Compliance Plan? (REQUIRED)		

Corporate Compliance Officer:	Name and Title:	
	Telephone:	
	Email:	

Quality Contact for this Site/Level of Care:

Quality Contact Information:	Name and Title:	
	Telephone:	
	Email:	

Clinical Staff Overview:

LANGUAGES SPOKEN FLUENTLY BY CLINICAL STAFF **Fluently is defined as able to speak with ease or express effortlessly and correctly.**			
# of Each	**Descriptor**	**Language(s)**	**Service(s)**
	Physician(s)		
	Therapist(s)		
	Behavioral Health Technician (BHT)		
	Behavioral Consultant (BC)		
	Mobile Therapist(s) (MT)		
	Other (list):		

NUMBER OF EACH OF THE FOLLOWING: (Specify the number of clinical staff only – include names on the rosters attached)					
#	**Descriptor**	**#**	**Descriptor**	**#**	**Descriptor**
	Psychiatrist – Board Certified		Psychiatrist – Board Eligible		Psychologist – Doctoral Level
	Psychologist – Masters Level		LCSW or LSW		Lic Professional Counselor (LPC)
	LMFT		Cert Addictions Counselor		MH Counselor – Masters Level

STAFF ROSTERS

(Licensed and Non-Licensed Clinicians at this Service Site)

Providers must have Policy and Procedure in place to assure that employees have appropriate credentials. Per Perform Care policy, members under the age of thirteen (13) must be treated by a Board Certified Psychiatrist with a subspecialty certification in Child & Adolescent Psychiatry. If a facility provides child/adolescent RTF and/or child/adolescent IP services and does not employ the above qualified staff, the facility will be required to submit a statement with the credentialing application which informs Perform Care of the provisions the facility will make to meet this expectation. You may submit this information in an alternate format.

Clinician's Name	Clinician's Highest Level of Education (i.e. BS, MS, PhD)	Clinician's License Number	Clinician's Specialties/Areas of Interest

PROGRAM EXCEPTION ATTESTATION

Submit an updated signed attestation form to the attention of your Provider Relations Representative by January 1 of each year for each Program Exception Service. Failure to submit this attestation may result in suspension of referrals to the program. Program exception services must comply with Federal rules and requirements for Medicaid. DHS/OMHSAS staff approve service descriptions that comply with those requirements. Providers must assure that service delivery is consistent with the DPW/OMHSAS approved service description. Perform Care Quality Improvement Staff will audit records against the service description. Payment made for services not delivered in accordance with the approved service description is subject to repayment.

I, _____ assure that _____ (Program Name) was approved by OMHSAS and deemed compensable using Medical Assistance Identification Number / Service Location Code _____ for _____ County(ies).

I affirm that:		**Initial Here:**
1	I have reviewed the current approved service description against operations and attest that service delivery is occurring in accordance with the DHS/OMHSAS approved service description.	
2	I understand that any change to the service description requires approval by Perform Care, the County(ies) and DHS/OMHSAS. Approval must be in writing.	
3	I certify that documentation of services delivered is in accordance with the service description or, in the absence of such detail, in accordance with 1101.51 of the Medical Assistance Manual.	
4	I certify that clinical staff is receiving appropriate supervision.	
5	I have attached a staff roster reflecting current staff complement in the program and confirm that ratios remain consistent with that defined in the approved service description.	

_____ _____ _____

Agency Director Signature **Agency License Number & Type** **Date**

ATTESTATION OF COMPLIANCE
RELATING TO REQUIRED TELEHEALTH POLICIES

The Office of Mental Health and Substance Abuse Services (OMHSAS) first issued guidance in March 2020 on the temporary use of telehealth for behavioral health providers in response to the COVID-19 public health emergency. In order to allow for continued flexibility and increased access to services, OMHSAS issued updated *Guidelines for the Delivery of Behavioral Health Services Through Telehealth* (Bulletin OMHSAS-21-09) allowing for the continuation of behavioral health services via telehealth. OMHSAS 21-09 was then superseded by the issuance of Bulletin OMHSAS-22-02 - Revised Guidelines for Delivery of BH Services Through Telehealth 7.1.22

Per OMHSAS-22-02, any provider seeking to utilize telehealth for delivering behavioral health services must comply with the following procedures:

- Provider agencies should offer telehealth using equipment that meets all state and federal requirements for the transmission or security of health information and comply with the Health Insurance Portability and Accountability Act (HIPAA).

- Effective 1/1/2024 Provider agencies must obtain the individual's or legal guardian's consent for telehealth and service verification consistent with Act 69 of 1999 Electronic Transactions Act, including having systems in place to ensure that there is an audit trail that validates the signer's identity, and the consent and/or service verification must be included in the medical record.

- Provider agencies should establish and enforce policies for assessing when it is clinically appropriate to deliver services through telehealth.

- Licensed practitioners and provider agencies delivering services through telehealth must have policies that ensure that services are delivered using telehealth only when it is clinically appropriate to do so and that licensed practitioners are complying with standards of practice set by their licensing board for telehealth where applicable.

- Providers using telehealth must maintain written policies for the operation and use of telehealth equipment. Policies must include the provision of periodic staff training to ensure telehealth is provided in accordance with the guidance in this bulletin as well as the provider's established patient care standards.

- Providers must maintain a written policy detailing a contingency plan for transmission failure or other technical difficulties that render the behavioral health service undeliverable. Contingency plans should describe how the plan will be communicated to individuals receiving services.

- The licensed practitioner or provider agency must have policies in place to address emergency situations, such as a risk of harm to self or others.

- Providers who elect to deliver services through telehealth must have a policy that makes available interpretation services, including sign language interpretation, for individuals being served through telehealth.

By signing below, Provider hereby agrees that any behavioral health telehealth services being offered are done so in compliance with OMHSAS-21-09. Provider understands that failure to comply with any of the outlined requirements of OMHSAS-21-09 could result in the denial or recoupment of payment for services.

PROVIDER NAME & ADDRESS

_____

_____

_____

_____

PROVIDER SIGNATURE:

_____ DATE:_____

PARTICIPATION STATEMENT

Please select the Behavioral Health Managed Care Organization to whom you are attesting and submitting 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

_____ Dated (mm/dd/yy)_____/_____/_____

Authorized Signature

_____

Name (Please Print)

_____

Title

For Internal Use Only:

Date application received from Provider: