PerformCare In-Plan Service Expansion Request Form

This in-plan service expansion request form provides PerformCare with important information about each provider's relevant experience and training. All the information provided will be shared with County Oversights for HealthChoices. If it is determined that there is a need for additional providers and / or that a specific network need is met by the services proposed, an invitation to join the network and/or move forward with service expansion will be offered. The review may take up to 45 days to complete. **The in-plan must be typed in in order to be reviewed by PerformCare.**

Please choose the statement that best describes you:

☐ Brand new PerformCare provider (new to PerformCare network)

☐ Brand new PerformCare provider who has a group practice (payment for services will be going towards a group, not an individual).

☐ Individual wanting to join an existing PerformCare credentialed group

☐ Existing PerformCare provider wanting to add an additional location/site

☐ Existing PerformCare provider wanting to add a new level of care

☐ Existing PerformCare provider wanting to add additional PerformCare counties to their contract

☐ A program or practitioner moving within the same county AND expanding their services (number of members they will be able to treat)

☐ OTHER. Describe:

Provider name:		
*** Provider address and phone number where the services will be provided. (If this is a school-based site, please include name of the school):**		
Please verify this is not a home office:	☐ No, this is not a home office	Tax ID number:

Contact name, title, phone number, fax number and email address:	
What county is this service site physically located in?	
If you have, or are a part of a group practice, what is the name of your group?	
What license(s) do you hold? Please include licenses for individuals as well as the facility (if applicable)	
What level of care do you intend to offer? **If providing inpatient services please see additional questions on page 5. *** If providing SU services, your service description must be compliant with ASAM standards for the level of care.** ***If providing ABA Center Based, your service description must be compliant with OMHSAS bulletin: 22-03**	☐ MH OP Therapy ☐ Med Checks ☐ Psych Testing ☐ FQHC ☐ MH Partial ☐ MH IP ☐ SU Medically Managed Intensive IP (4.0) ☐ SU OP (1) ☐ Medication Assisted Treatment ☐ SU LOC Assessment(1) ☐ SU IOP (2.1) ☐ SU Partial (2.5) ☐ SU Managed Low-Intensity Residential (3.1) ☐ SU Clinically Managed Residential (3.5) ☐ SU Medically Monitored Intensive Inpatient Services(3.7) ☐ Medically Monitored Inpatient Withdrawal Management (3.7WM) ☐ Medically Managed Inpatient Withdrawal Management (4WM) ☐ MAT for ☐ OUD and/or ☐ AUD ☐ Intend to provide services via Telehealth (Must be in compliance with OMHSAS 22-02) ☐ Other - please list:

IBHS			
☐ IBHS Individual	☐ IBHS ABA	☐ IBHS Group ☐ ABA Group ☐ Non-ABA Group	☐ IBHS 1:1 Center-Based ☐ Individual Center-Based ☐ ABA Center-Based

Describe the needs analysis or market analysis completed to support need for the service:	
Medical Assistance number for proposed site:	MA Number: If no MA number, has application been submitted? ☐ Yes (date submitted) ☐ No
Do you have a CAQH number?	☐ Yes CAQH #: ☐ No
What PerformCare county(ies) do you intend to serve (accept members from)? (check all that apply)	☐ Franklin and Fulton counties (TMCA) ☐ Capital Area (CABHC) (Cumberland, Dauphin, Lancaster, Lebanon and Perry)
Is the treatment site located in what is reasonably considered a rural area?	☐ Yes ☐ No
What ages do you intend to serve? (check all that apply)	☐ Children (0-4) ☐ Adults (18-64) ☐ Children (5-12) ☐ Geriatrics (65+) ☐ Adolescents (13-17)
How many PerformCare members do you expect to serve?	
Are you a Medicare approved provider?	

Do you incorporate evidence-based practices in treatment? Describe:	
List any evidence-based practices /areas of specialty/certifications not included on the population specialty form. If certified, provide a copy of the certification, and provide any evidence of specialized training	Please complete the population specialty form and return with the in-plan application. Use this section to list any practice interests/areas of specialty/certifications not included on the population specialty form.
Do you provide trauma informed care? **If so, provide copies of certification or evidence of training in trauma informed care.**	
*** Are there any other Medicaid enrolled providers at your service location? If you answer yes to this question, please list the names of these practitioners. If you are part of a group, this would be any providers that are NOT part of your group.**	

****The facility is a private psychiatric hospital of more than 16 bed serving adults aged 21-65? (For inpatient services only)**	☐ Yes ☐ No
****The facility is a substance abuse non-hospital residential facility of more than 16 beds serving adults aged 21-65?**	☐ Yes ☐ No

☐ By checking here, I verify that the information on this form is accurate. Date Submitted:

- **Resume/CV attached for individuals/groups (REQUIRED) –** ☐ **Yes** ☐ **N/A for facilities only**
- **Population Specialty form attached (REQUIRED) for all providers/levels of care –** ☐ **Yes, it is attached.**
- **Service description attached?** ☐ **Yes** ☐ **No**

  ***If the service description attached is OMHSAS/DDAP approved, please attach copy of approval notice.**

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.)**
	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.)**
	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**
	Anxiety Disorders/Phobias/Panic Disorders
	Attention Deficit Disorders / Oppositional Disorders (ADD/OD)
	Autism/Developmental Disorders
	Co-Occurring (MH/SUD)
	Dually Diagnosed (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**
	Handicap Accessible
	Wheelchair Accessible
	Restrooms Accessible to Physically Disabled
	Deaf/Hard of Hearing Accommodations
	Blind/Visually Impaired Accommodations
	Tobacco-Free Facility

√	Please note any languages spoken by clinical staff in your practice or agency where an interpreter wouldn't be needed.		
	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

CULTURAL RESPONSIVENESS (DEI) SURVEY

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

Corporate Compliance Responsibilities:

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

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

Sole practitioners assume this responsibility when accepting State and Federal funds.

I certify that the information provided in this document is correct. I understand that any information contained in this document that subsequently is found to be false, could result in denial or termination of enrollment in the PerformCare network.

*****FOR INTERNAL USE ONLY*****

INTERNAL /INITIAL FEEDBACK of IN-PLAN SERVICE EXPANSION REQUEST FORMS

Provider Name: **Level of Care:**

Contract (s) Requested: ☐ **TMCA** ☐ **CABHC**

County(ies) where office(s) located:

PerformCare staff:

☐ **TMCA** Name of staff completing: _____ Date: _____

☐ Proceed with in-plan process ☐ VETO in-plan process – DO NOT PROCEED

Comments:

☐ **CABHC** Name of staff completing: _____ Date: _____

☐ Proceed with in-plan process ☐ VETO in-plan process – DO NOT PROCEED

Comments:

QUALITY IMPROVEMENT (QOCC's):

Name of staff completing: _____ Date: _____

☐ No - QOCC referrals on file ☐ Yes – QOCC referrals on file

Comments:

CONTRACTING (OON's):

Name of staff completing: _____ Date: _____

☐ No - OON's on file ☐ Yes - OON's on file

Comments:

CLINICAL:

Name of staff completing: _____ Date: _____

☐ Agree to proceed with in-plan process ☐ Disagree to proceed with in-plan process (include reason in comments)

Comments:

PROVIDER RELATIONS/ACCOUNT EXECUTIVES:

Name: _____

Date: _____ ☐ Proceed with in-plan process ☐ VETO in-plan process – DO NOT PROCEED

Comments:

Name: _____

Date: _____ ☐ Proceed with in-plan process ☐ VETO in-plan process – DO NOT PROCEED

Comments:

Name: _____

Date: _____ ☐ Proceed with in-plan process ☐ VETO in-plan process – DO NOT PROCEED

Comments:

Name: _____

Date: _____ ☐ Proceed with in-plan process ☐ VETO in-plan process – DO NOT PROCEED

Comments:

****For Internal Use Only****

PerformCare Provider Credentialing Application Request Analysis

Number of similar providers located in the county/counties – adequacy of network as evidenced by GeoAccess Mapping – any information that may suggest wait times outside standard.

PerformCare recommendation:

County/Oversight decision –

☐ TMCA

☐ Agree with PerformCare recommendation ☐ Disagree with PerformCare recommendation

Comments:

☐ CABHC

☐ Agree with PerformCare recommendation ☐ Disagree with PerformCare recommendation

Comments**:**