Ancillary Data Form Community Mental Health Center/ Substance Use Treatment Center/ ABA Services

Please use this checklist as a guide when completing the requirements to become a participating provider with Point32Health, the parent organization of Harvard Pilgrim Health Care and Tufts Health Plan.

Please select applicable plans for which you would like to be credentialed.

Email this completed application and required documents to provider_information_dept@point32health.org.

Providers expressing an interest in joining our network will be credentialed and enrolled in all of our plans upon securing a contract. For further information on our plans, visit the Our Plans page on the provider website at www.point32health.org/provider/network-plans/our-plans.

Federal regulations require that providers who render services to Medicaid members are screened by and enrolled with the appropriate state Medicaid agency. This requirement applies to providers who participate in Medicaid lines of business.

- **RI providers:** Complete this screening and enrollment process via the Rhode Island Executive Office of Health and Human Services (EOHHS) provider portal.
- **MA providers:** Complete this screening and enrollment process via the MassHealth website. For more information, refer to this FAQ.

By submitting this form, I hereby attest I have completed the screening and enrollment process.

Please note that, consistent with state requirements, Rhode Island providers requesting to join our Commercial network must also become participating providers in our Rhode Island Medicaid network for the Tufts Health RITogether product.

Provider eligibility criteria

Organizations licensed by the state as Behavioral Health Clinics are eligible to apply for consideration as contracted behavioral health care providers for Point32Health.

Required credentialing documentation

- ☐ A completed Ancillary Data Form Community Mental Health Center/Substance Use Treatment Center/ABA Services Application
- ☐ A completed and signed W-9 Form
- ☐ Copy of state license (*if applicable*)
- ☐ Copy of Accreditation Certification or State site visit within the last three years (*if not accredited*)
- ☐ A Federally Required Disclosures Form (*applicable to MA & RI only*)
  Note: *Although a MassHealth form, it can be completed for both MA & RI Facilities*

Accreditation

At the time of credentialing, MA and RI ABA providers must be accredited by Autism Commission on Quality (ACQ), Jade/Behavioral Health Center of Excellence (BHCOE), or Global Autism Project Accreditation. This requirement will be extended to NH, ME and VT providers as of Jan. 1, 2028.

If your facility is accredited:

- ☐ Copy of the most recent accreditation certificate which includes the effective date and expiration date (e.g., The Joint Commission (TJC), The Commission on Accreditation of Rehabilitation Facilities (CARF), Community Health Accreditation Program (CHAP), Urgent Care Association of America (UCAOA), etc.)
- ☐ Also provide the following, if applicable, to your accreditation status:
  - ☐ Decision report/letter
  - ☐ Written progress report
  - ☐ Letter from accreditation agency removing any corrected recommendations/deficiencies (*if applicable*)

If your facility is NOT accredited:

- ☐ Provide the most recent applicable state survey report, Department of Public Health (DPH), CMS or Department of Mental Health (DMH)
- ☐ Follow-up letter of acceptance from the DPH/DMH (for corrective action plans) or in lieu of the survey report, a letter from the DPH/DMH or applicable state agency which shows that the facility was reviewed and indicates that all deficiencies have been corrected and it passed inspection

Insurance

☐ The clinic must maintain professional liability insurance in the amount of $1 million per incident, and $3 million in the aggregate per year covering all clinicians included in the agreement.

Articles of incorporation

☐ A copy of the Clinic's Articles of Incorporation or similar documents submitted to the state or local authorities in order to register the group with appropriate governmental units.

General information

Missing information will delay your application.

Contract/Legal Entity Name

DBA/Practice Name (*if applicable*)

NPI

Type of Provider: ☐ Community Mental Health Center ☐ Substance Use Treatment Center ☐ ABA Service Provider

Participating in Medicare? YES ☐; Medicare PTAN # NO ☐

Participating in MassHealth/Medicaid? YES ☐; PID/SL (for existing MassHealth providers) NO ☐

Participating in Rhode Island Medical Assistance Program (Medicaid)? YES ☐ NO ☐

Are you currently utilizing interoperable Electronic Health Records? ☐ YES ☐ NO
(*certified by Office of the National Coordinator, 2015 Edition Cures Update*)

Primary practice address Phone

Street City, State, ZIP

Email Fax

Service hours: Mon Tue Wed

Thu Fri Sat Sun

Handicap access? YES ☐ NO ☐

Are translation services available? YES ☐ NO ☐

Languages other than English at this location

Secondary practice address Phone

Street City, State, ZIP

Email Fax

Service hours: Mon Tue Wed

Thu Fri Sat Sun

Handicap access? YES ☐ NO ☐

Are translation services available? YES ☐ NO ☐

Languages other than English at this location

☐ Check here for additional addresses and attach a separate sheet.

Mailing information

Corporate affiliated providers with different names and locations need to submit separate applications.

Mailing address Phone

Street City, State, ZIP Fax

Corporate affiliation (*if different*) Phone

Street City, State, ZIP Fax

Managed by

Please explain in detail any name changes that have occurred in the past 3 years and attach appropriate documentation:

Practice information

President/CEO

Office Mgr/Contact person

Please provide the contact information for the person we should contact if we have any questions about the information on this form.

Phone Fax

Email

Payment information

Payee NPI Tax ID #

To whom should checks be made payable?

Payment address Phone

Street City, State, ZIP Fax

Please enclose a copy of your W-9 form (request for taxpayer ID). Payee name and tax ID# must match information on your W-9.

Levels of care provided *Check all that apply.*

Level of care applicability varies by plan. Please see the key on the right. If a plan is not noted, the level of care is applicable for all products.

Key:

- Tufts Health Direct
- Tufts Health One Care
- Tufts Health Plan Senior Care Options (SCO)
- Tufts Health Together

- Acute Treatment Services (ATS) ASAM Level 3.7
- Adult Mobile Crisis Intervention
- Applied Behavioral Analysis Services (ABA)
  - In Home
  - Center Based
- Clinical Stabilization Services (CSS) ASAM Level 3.5
- Community Based Acute Treatment (CBAT) ● ●
- Community Crisis Stabilization
- Community Support Program – Homeless Individuals (CSP-HI) ● ● ●
- Community Support Program – Justice Involvement (CSP-JI) ● ● ●
- Community Support Program – Standard (CSP) ● ● ● ●
- Community Support Program – Tenancy Preservation Program (CSP-TPP) ● ● ●
- Dual Diagnosis Intensive Outpatient Program
- Dual Diagnosis Partial Hospitalization Program
- Early Intensive Behavioral Intervention (EIBI)
- Eating Disorder Intensive Outpatient Program
- Eating Disorder Partial Hospitalization Program
- Electroconvulsive Therapy (ECT)
- Family Support and Training (FS&T) for Children and Adolescents
- Individualized Treatment and Stabilization (IT&S) Tier 1 ● ●
- Individualized Treatment and Stabilization (IT&S) Tier 2 ● ●
- In-Home Behavioral Services for (IHBS) Children and Adolescents
- In-Home Therapy (IHT) for Children and Adolescents
- Intensive Care Coordination (ICC) for Children and Adolescents
- Medication Assisted Treatment (MAT)
- Methadone Treatment
- Outpatient Behavioral Health Program
- Outpatient Detoxification Program
- Peer Recovery Coach ● ● ● ●
- Program for Assertive Community Treatment ● ● ●
- Psychiatric Day Treatment ● ● ●
- Psychiatric Intensive Outpatient Program
- Psychiatric Partial Hospitalization Program
- Recovery Support Navigation ● ● ●
- Residential Rehabilitation Services (RRS) ASAM Level 3.1 ● ● ●
- Structured Outpatient Addiction Program (SOAP)
- Substance Use Disorder Intensive Outpatient Program
- Substance Use Disorder Partial Hospitalization Program
- Therapeutic Mentoring for Children and Adolescents
- Youth and Transitional Age Youth Detox and Stabilization ●

Americans with Disabilities Act compliance *Check all that apply.*

- Staff receives ADA-compliance training
- Practice can accommodate people who are physically disabled (e.g., accessible parking, wheelchair access to building)
- Practice allows wheelchair access to exam rooms
- Practice can accommodate people who are intellectually/cognitively disabled (e.g., on-site staff to explain instructions)
- Practice can accommodate people who are blind/visually impaired (e.g., service animals allowed, Braille directions available)
- Practice can accommodate people who are deaf/hard of hearing (e.g., American Sign Language or written instruction available)
- Practice is accessible by public transportation (e.g., bus, subway or commuter rail)

Certification, authorization and release

Contract/Legal Entity Name

DBA/Practice Name (*if applicable*)

In submitting this application for credentialing (or recredentialing) by Harvard Pilgrim Health Care (collectively "Plan") / Tufts Associated Health Maintenance Organization, Inc., Total Health Plan, Inc., or any Tufts Health Plan affiliate (as defined in your written agreement to provide services to Tufts Health Plan members) (collectively "Plan") I understand that it is the Provider's responsibility to produce the required information for the proper evaluation of its application and that failure to produce this information will prevent its application from being reviewed and acted upon. The undersigned hereby acknowledges that he or she is authorized and empowered to complete this application and enter into contracts on behalf of the Provider. By submission of this application for membership in the Plan Provider Network, the undersigned hereby:

1. Certifies under pains and penalties of perjury that the information contained herein, including all supporting materials, is true and complete to the best of his/her knowledge and belief. The Provider understands that its application will be reviewed based upon the information it has provided and other information obtained by Plan in accordance with its credentialing program. The Provider further understands that information which is found to be false could result in a denial or termination of Provider's network privileges.
2. Acknowledges and agrees that Plan or its agents may solicit information from past and former associates, health care organizations and any other relevant sources and review documents which Plan, in its discretion, deems relevant in assessing Provider's qualification for membership in the Plan provider network.
3. Authorizes the release of all such relevant information by any individual or organization and release from liability Plan and any such individuals or organizations which in good faith and without malice provide information bearing on the Provider's qualifications for the Plan provider network and/or credentialing status.
4. Authorizes the licensing agencies in any state in which the Provider is or has been licensed, to release information to Plan regarding any licensure information, any pending or final disciplinary action, and any other information relevant to the Provider's professional competence or status.
5. Agrees that all employed and/or contracted clinical staff and associates have been appropriately credentialed consistently with all applicable laws, requirements and standards.
6. Authorizes and requests Provider's professional liability insurance carrier to release information regarding any claim or action for damages pending or closed during the previous ten years, whether or not there has been a final disposition.
7. Agrees to notify Plan as soon as Provider becomes aware of any event which might reasonably affect Provider's Plan credentialing status, including the initiation of any disciplinary action by any certification or accreditation entity, any health care facility or regulatory agency.
8. Understands that it may not provide healthcare services to Plan members until it is credentialed and contracted by Plan.
9. Authorizes and releases from liability Plan for the good faith disclosure of credentialing information by Plan to the extent required by law, regulations, court order or other standards or requirements applicable to Plan.

Authorized Representative's Signature

Date

Authorized Representative's Name (*Please Print*)

Authorized Representative's Title

CLEAR FORM