

ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

Date Issued **11/23**

Page **1**

CHAPTER Administrative		CHAPTER 01	SECTION 003	SUBJECT 0006
SECTION Provider Management		SUBJECT Provider Registry Process		
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I. APPLICATION:

- ☐ SCCCMHA Board
- ☐ SCCCMHA Provider & Sub-Contractors
- ☒ Direct Operated Programs
- ☒ Community Agency Contractors
- ☒ Residential Programs
- ☒ Specialized Foster Care

II. PURPOSE STATEMENT:

St. Clair County Community Mental Health Authority (SCCCMHA) shall maintain a provider registry through an application and review process.

III. DEFINITIONS:

- A. Provider Registry: Listing of current and potential providers available to provide specific contracted services. Existing providers have already submitted the Organization Application with additional required information about the organization and have been privileged to provide identified services and have signed a contract. Potential providers have submitted a letter requesting to become a provider of specific type of service(s).

IV. STANDARDS:

- A. The provider registry process will follow the process outlined in the Provider Registry Process Flowchart (Exhibit A).

V. PROCEDURES:

Provider

1. Submits a request/letter to become part of the SCCCMHA Provider Network.

Chief Executive Officer and Staff

2. Discusses request/letter at Provider Network Management and/or Leadership Team meeting to determine if an immediate service need exists in area(s) of specialty.

CHAPTER Administrative		CHAPTER 01	SECTION 003	SUBJECT 0006
SECTION Provider Management		SUBJECT Provider Registry Process		

3. Notifies Contract Manager of the decision of the Leadership Team to proceed or not with contacting the provider and adding them to the Provider Network Registry.

Administrative Support/Contract Management Staff

4. Forwards the “Organization Application” and “Conflict of Interest Attestation” with instructions to the provider using sample letter (Exhibit B) if an immediate/emergency need for services is identified and SCCCMHA will potentially be contracting with provider.
5. Notifies provider of no immediate service need or gap in services indicating to the provider they will be placed on the Provider Registry using sample letter (Exhibit C).

Provider

6. Submits completed “Organization Application” and “Conflict of Interest Attestation” and any additionally requested contract provider materials/information.

Administrative Support/Contract Management Staff

7. Reviews all applications and materials for completeness. Requests provider clarify and/or submit additional information.
8. Forwards the Organization Application to SCCCMHA Credentialing Committee and the Conflict of Interest Attestation to the assigned contract management staff for processing.
9. Proceed with developing contract with provider following policy #01-003-0021 Contract Management.

Administrative Support Service Staff/Designee

10. Adds provider to Provider Network Registry. Should future service needs be identified, policy # 01-003-0016 Procurement and Provider Selection Process will be followed.
11. Informs provider of Provider Network Registry status using sample letter (Exhibit C).

Chief Executive Officer

12. Provides the SCCCMHA Board, upon request, a periodic status report on Provider Registry (Exhibits D and E).

Provider

13. Informs SCCCMHA of any changes to Organization Application information.

CHAPTER Administrative		CHAPTER 01	SECTION 003	SUBJECT 0006
SECTION Provider Management		SUBJECT Provider Registry Process		

VI. REFERENCES:

None Available

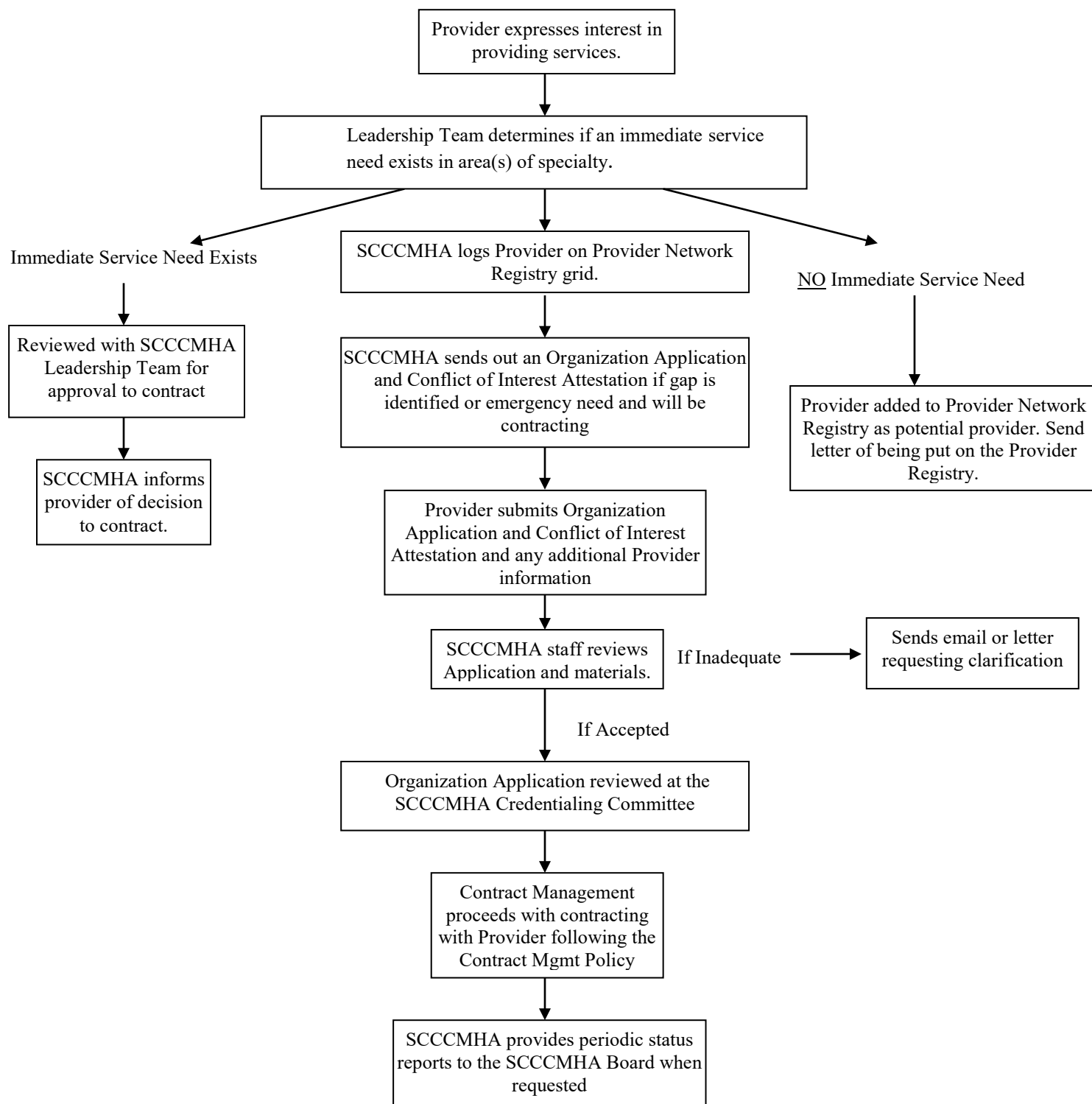
VII. EXHIBITS:

- A. Provider Registry Process Flowchart
- B. Sample Letter #1
- C. Sample Letter #2
- D. Provider Registry Status Grid
- E. Current Provider Panel Status - Expanded Services Grid

VIII. REVISION HISTORY:

Dates issued 10/98, 10/00, 07/03, 6/06, 06/08, 06/10, 03/12, 07/13, 07/14, 07/15, 07/16, 09/17, 09/18, 09/19, 11/20, 11/21, 11/22.

St. Clair County Community Mental Health Services

PROVIDER REGISTRY PROCESS

(Date)

(Provider Name)

(Provider Agency/Street Address)

(Provider City, State, Zip)

Dear (Provider Name):

Thank you for your interest in providing services to the residents of St. Clair County.

To register as a potential provider, you must submit an Organization Application for approval. An Application has been included. Please complete and forward to my attention.

Along with the completed Application, the following is also requested:

- A completed IRS W-9 tax identification form
- Your agency's Organizational Chart, indicating which individuals have the legal authority to bind the agency for purposes of proposals and contracting.
- Listing of Board members, indicating terms and expiration dates.
- Accreditation/Certification, include copy for verification
- Listing of Employees, including copies of staff licenses/certifications/registrations
- Three (3) professional references that include a contact person and telephone number.

You will receive formal notification on your registry status once we have had a chance to review your application and accompanying materials. Notice of your status should be received by you within 30 days.

If you have any questions, please do not hesitate to contact me at (810) 966-(XXXX).

Sincerely,

Provider Network Coordinator

cc: Provider File
Attachment

(Date)
(Provider Name)
(Provider Agency/Street Address)
(Provider City, State, Zip)

Dear (Provider Name):

Thank you for your interest in providing services to the residents of St. Clair County.

OPTION 1

At this time you will be registered as a potential provider for our network. Your registry status entitles you to receive information on service acquisition. Should we determine that a provider(s) is needed for the services(s) you indicated interest in, a formal selection process will be used. Only after otherwise qualifying through a further application process and after the issuance of a Request for Proposal and official provider selection, will your agency be added to our network.

OPTION 2

(Your agency's/your) Application has inadequate or incomplete information and can not be accepted at this time. Your Application will be re-considered if you are able to correct the deficiencies or provide any missing information indicated below, and it is resubmitted by _____.

1. _____
2. _____

If any of the information submitted with your Application changes, please forward the changes to this office as soon as possible.

OPTION 3

(Your agency's/your) Application for Provider Registration has been rejected. Based upon the information submitted, we will not be adding you to our registry.

If you have any questions, please feel free to call (contact) at (810) 966-(XXXX).

Sincerely,

Provider Network Coordinator
cc: Chief Executive Officer
Program Director
Support Services Director
Provider Registry File

St. Clair County Community Mental Health Services

EXHIBIT D

PROVIDER NETWORK REGISTRY STATUS

Provider (Contact Person/Address/Services Specialty)	Date Letter/ Request Received	Date Materials Sent/ Due Back	Date Materials Received by CMH	Describe Any Follow-up Action Taken	Recommended for: Acceptance – Contract; Acceptance – Registry; or Rejection	Update Changes/ Other	Provider Materials Sent

CURRENT PROVIDER NETWORK PANEL STATUS – EXPANDED SERVICES

Current Providers/ New Services	Request to Expand Services Rec'd	Request to Update Application Sent/Due Back	Updates Received	Follow-up	Recommend for Expansion	Mgmt Planning Decision	Provider Materials Sent