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| A blue and white sign with black text  Description automatically generated with medium confidence | NEW MEMBER APPLICATION |

Thank you for your interest in joining the Ohio Behavioral Healthcare Provider Network (OBHPN) -

**Application for Network Membership**

Please complete and return this application to Katy Smith at [Katy.Smith@shcare.net](mailto:Katy.Smith@shcare.net).

The OBHPN Board will consider your application. Completion of the application is not a guarantee of acceptance. If accepted, we will contact you with the appropriate corporate documents for completion.

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| Organization Name: | Click or tap here to enter text. | | |
| Address: | Click or tap here to enter text. | | |
| Tax ID Number: | Click or tap here to enter text. | | |
| NPI Number(s) | Click or tap here to enter text. | | |
| Corporate Owner/ Affiliation: | Click or tap here to enter text. | | |
| Contact Name: | Click or tap here to enter text. | | |
| Contact Email: | Click or tap here to enter text. | | |
| Contact Phone: | Click or tap here to enter text. | | |
| CEO and #Email | Click or tap here to enter text. | | |
| How many unique clients does your organization serve annually? | | | Click or tap here to enter text. |
| Does your organization serve both adult and pediatric populations? | | | Yes No |
| Does your organization provide MH services? If yes, specify age ranges.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Yes No |
| Does your organization provide AOD services? If yes, specify age ranges.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Yes No |
| What percentage of your clients served are SPMI (severe and persistent mental illness)? | | | Fewer than 25%  Greater than 50%  Greater than 75% |
| Which EMR(s) does your organization use? | | | Click or tap here to enter text. |
| Does your organization use Clinisync? If yes, which functions?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Yes  No |
| Is your organization accredited by one of the following bodies? If other, please specify. | | | CARF  The Joint Commission  COA  Other |
| Is or/has your organization been a CCBHC grant recipient under SAMHSA? | | | Yes  No |
| Does your organization provide primary care services directly? | | | Yes  No |
| Does your organization provide primary care through outside affiliation/contract? | | | Yes  No |
| If yes, please describe your model below: | | | |
| Click or tap here to enter text. | | | |
| If your organization provides primary care, which of the following describes you best? | | | FQHC  FQHC look alike  RHC  Other |
| Which of the following BH services does your organization directly provide? If other, please specify.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Which of these services does your organization provide via a contract with another provider? Please specify.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Counseling  Case management  Medication Management  24/7 Crisis Intervention  Day Treatment  Homeless Services  Housing  Peer Support  Employment  Residential  MAT/MOUD  Prevention  Other |
| Please list the geographic areas your organization covers (counties and part of counties) | | | |
| Click or tap here to enter text. | | | |
| **Mandatory Participation Criteria**: Please indicate your ability to participate in network contracting and quality requirements (required of subcontracting agents): | | | |
| * Organization will participate in at least 80% of negotiated contracts. | | Yes No | |
| * Organization will comply with all OBHPN quality program requirements. | | Yes No | |
| * Members of organization will be required to actively participate in OBHPN Board committees and subcommittees. | | Click or tap here to enter text. | |