

State of Alaska Department of Health

Division of Behavioral Health

NEW PROVIDER APPLICATION

Mailing address: 3601 C Street, Suite 878, Anchorage, AK 99503

Fax 907-269-3623

1.	Agency Name:	Date:	
2	Insert the physical location i.e., street address for the location the agency will be operating at [7AAC 70.030(b)(3)]:		
3	Insert the mailing address for the agency:	Same as above <input type="checkbox"/>	
4	Insert the headquarter location:	Same as above <input type="checkbox"/>	
5	Who will be the point of contact? Name:	Phone:	E-mail:
6	What is the target date to begin services at this location?		
7	Please indicate the service area the location will be located within [7AAC 70.030(b)(2)]:		
8	The agency will provide services to which population (check all that apply): <input type="checkbox"/> Adults w/ MH <input type="checkbox"/> Adults w/ SUD <input type="checkbox"/> Youth w/ MH <input type="checkbox"/> Youth w/ SUD		
9	Are you seeking DBH Department Approval (DA) for the purposes of billing Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No		
10	Projected number of recipients annually who will receive services: <input type="checkbox"/> 0-100 <input type="checkbox"/> 101-500 <input type="checkbox"/> 501-1000 <input type="checkbox"/> 1001-2000 <input type="checkbox"/> 2001+		
11	Indicate the service category(s) that will be delivered [7AAC 70.030(a)(1)(A)]: <input type="checkbox"/> Clinic (MH) <input type="checkbox"/> Rehab (SUD) <input type="checkbox"/> Withdrawal Management (ASAM Level) <input type="checkbox"/> Residential SUD (ASAM Level)		
12	I understand that the agency must be Nationally Accredited within two years from the date the department issued the provisional approval. If department approval is awarded [7AAC 70.150], what National Accreditation Agency will accredit the location & services? <input type="checkbox"/> The Joint Commission <input type="checkbox"/> The Commission on Accreditation of Rehabilitation Facilities (CARF) <input type="checkbox"/> The Council on Accreditation (COA)		
13	Do you understand that your agency must collect and report the statistics, service data, and other information requested by the department [7AAC 70.100(a)(4)]? <input type="checkbox"/> Yes <input type="checkbox"/> No		
14	Upon successful completion of Departmental Approval all staff must provide a Background Check approval letter from the Background Check Unit (BCU).		
15	Provide copy of letter received from the Background Check Unit that the background check process has begun.		
16	List of all employees and positions (no resumes) and organizational chart.		
17	Completed Provider Attestation Form		
18	Completed Self-Evaluation Form		
19	If providing behavioral health <u>clinic</u> services, such as psychotherapy, psych. testing, med. management, etc. please attach the documented formal agreement with the physician for the purpose of providing general direction and direct clinical services [7AAC 70.100(a)(3)]. <input type="checkbox"/> Yes, I have attached the agreement <input type="checkbox"/> No I do not have an agreement with a physician <input type="checkbox"/> Not applicable		

Certification Statement:

I certify that the responses in this request and the information in the attached documents are accurate, complete, and current. I understand the information may be verified by Division of Behavioral Health staff upon on-site evaluations.

Printed Name: _____
 (Administrator or Authorized Person)

Signature: _____

Date: _

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Follow-up Required: