Appendix A

Application to Become an SEFBHN Qualified Provider

Name of Prospective Provider: Click or tap here to enter text.

Address: Click or tap here to enter text.

Phone #: Click or tap here to enter text.

Contact Person: Click or tap here to enter text.

Agency Representative with Signature Authority: Click or tap here to enter text.

**I - The following criteria are non-negotiable in order to move forward with becoming an SEFBHN Qualified Provider. A “Yes” response to either of these questions will result in your application being denied.**

1. Are you or is your agency on the Florida Department of Children and Families Convicted Vendor List?  Yes No
2. Are you or is your agency on the excluded entities listing maintained by the Federal Government System for Award Management? Yes No

If no – attach an original signed copy of the Certification Regarding Debarment and Suspension.

1. Are you or is your agency excluded from Florida Medicaid or Medicare? Yes No
2. Have you or your agency ever had a provider number with Florida Medicaid or Medicare revoked? Yes No

**II - The following criteria will be reviewed by SEFBHN staff as assigned by the Chief Operating Officer (COO). A recommendation to approve or disapprove the application will be made to the COO and the final decision will be made by the Chief Executive Office. If an application is not approved the applicant will have the opportunity to remediate the information found to be insufficient by resubmitting their application.**

1. Explain and describe you or your agency’s experience and commitment to providing services to persons with mental health, or substance abuse disorders. How does your agency provide recovery oriented services to persons with mental health and/or substance abuse disorders and their families? Include a description of the Evidence Based Practices your agency uses and the qualifications of staff to utilize them.

Click or tap here to enter text.

1. Describe you or your organization and its current infrastructure to include the following information
2. Readiness and capability to acquire an additional program
3. Experience in taking on and implementing new projects/programs in a short time frame
4. Fiscal Health – How many months of working capital do you operate on
5. Experience in providing services in the SEFBHN service delivery area of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties
6. Experience in providing service in Florida

Click or tap here to enter text.

1. Describe the types of services you propose to offer within the Southeast Florida Behavioral Health Network. How are the services you provide Person Centered? Include the population to be served and location of services

Click or tap here to enter text.

1. Do you have any current or previous contracts with any other Florida Managing Entity? If yes, include the following information. Provide documentation from the Managing Entity.
2. Name of the Managing Entity
3. Type of services provided in the contract
4. Amount of Contract
5. Beginning and end date of Contract
6. Outcomes – Did you meet your performance measures and is the contract in good standing. If the contract is expired did it end on good terms

Click or tap here to enter text.

1. Have you ever had a contract with any funder terminated for cause? If yes, provide a detailed response to include who the funder was, the dates of service and termination, the reasons for the termination and whether the funder (provide documentation from funder) would consider contracting with your agency in the future.

Click or tap here to enter text.

1. What licenses do you or your agency currently hold or that you have applied for and are pending? Attach copies of licenses and/or applications

Click or tap here to enter text.

1. Have you ever had a license terminated for cause or had a license not renewed upon application? If yes, provide a detailed response to include who the licensing authority was, the date of termination, the reasons for the termination and whether the licensing authority (provide documentation from licensing authority) would consider issuing a license for your agency in the future.

Click or tap here to enter text.

1. Are you or your agency a Medicaid Provider or do you or your agency have a pending application to become a Medicaid Provider for behavioral health services? Indicate which services you are approved to provide. Attach applicable documentation. If you are currently not enrolled as a Medicaid Provider – what plans do you have to do so.

Yes No Application Pending

Click or tap here to enter text.

1. Is your agency currently Accredited by or do you have a pending application with a National Accrediting Body such as Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (JCAHO). If so – attach a copy of your Certificate of Accreditation or documentation of a pending application.

Yes  No  Application Pending

1. Indicate your status as a **For Profit** or **Not For Profit** Agency. Note that there is very limited funding for **For Profit** Agencies and contracts will only be considered with **For Profit** Agencies based on very specific needs in which the services to be provided are of an emergent nature or not readily available from a **Not For Profit** Agency.

Click or tap here to enter text.

**III – The following applies to previous SEFBHN providers who had a contract terminated for cause by SEFBHN.**

1. Attach documentation that all findings that resulted in termination of your contract have been rectified. This can include but is not limited to change in board composition, a new physical location, an audit indicating sound financial health, new licenses issued, certification acquired, and positive performance in contractual relationships with other funders. The decision to approve a provider previously terminated for cause will be made by the CEO who will take all information provided in this application under advisement.

**IV- Attestation – include the following statement in your application. The application will be rejected without this statement.**

“I Click or tap here to enter text., do hereby attest that the information submitted in this application to become a qualified SEFBHN provider is true, accurate and complete to the best of my knowledge and I understand that any falsification or omission may result in said application being denied.”

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Signature Date