APPENDIX 1 (Professional Provider Agreement Application)

Complete all applicable boxes, and put N/A in any boxes left blank.

Attach the following:

IRS W-9 Copy of Professional Liability Insurance CLIA Certification (If applicable)

Legal name: (As registered with the S	ecretary of State)						
DBA/Directory listing name: (If applicable)							
Office contact name:		Email addr	066.				
Office contact name: Email address:							
Contract Signature of Authority (v	vho will sign the	Email addr	ess:				
contract?):							
Phone:		Fax:					
Website address:							
Is practice female-owned?	Yes 🗌 No [
(Optional)							
Is practice minority-owned? (Optional)	Yes \(\Boxed{\omega} \mathbb{No} \([
FQHC?	Yes No [
RHC?	Yes No [
CMHC?	Yes No [
Pediatric Only?	Yes No [
Women Only?	Yes No [
Adults Only?	Yes No [
Make checks payable to (Box 33 of C	CMS 1500 form):						
Legal Name (must have an orga		ption)					
☐ DBA Name (must have an organ	izational NPI for this op	tion)					
☐ Individual Provider							
Federal tax ID	Organizational N	PI #:	Organiza	tional Medicare #:			
Organizational Medicaid #:							
Billing/remit Address:							
County:							
Billing contact name:	Billing phone	\ <u>"</u>		Billing fax:			
	29 p.1.0110	·•					
Billing contact email address:							
Billing Format CMS 1500 UB0	4 🗌						
Directory: Yes No	_ _						

1

APPENDIX 1 (Continued)

Complete for each <u>PRACTICE/SITE location</u> included in this Agreement.

Please copy this page if necessary in order to complete for each practice/site location.

(1- Primary) Do you have multiple sites? Yes ☐ No ☐ Practice Site location name:									
Add	Address:								
Cou	ınty:								
NPI	1			TIN			Phone:		Fax:
	Site specific Medicaid ID#			Enrollment limit?		Yes □ No □		If Yes, list maximum # of Medicaid Members	
Offi			s of ope	eration for each	day			T	<u> </u>
!	Mon `	AM/PM	to	AM/PM		Fri	AM/PM	to	AM/PM
l	Tues	AM/PM	to	AM/PM		Sat	AM/PM	to	AM/PM
!	Wed	AM/PM	to	AM/PM		Sun	AM/PM	to	AM/PM
	Thurs	AM/PM	to	AM/PM					
etc.) are Are Do y Do y indiv	ADA Compliance: Is there an ADA accessible approach (e.g., ramps, stability, curbs, stairs, width, etc.) to the entrance of your building/office, with accessible parking spaces that are identified with signage? Are any of the parking spaces van-accessible? Do you have an accessible examination room for individuals with disabilities? Yes No Do No Do you have accessible medical equipment to accommodate examining individuals with disabilities? Are you able to effectively communicate with individuals who have hearing, vision, speech or cognitive disabilities?								
(2)	(2) Practice/site location name:								
Add	ress:								
Cou	inty:								
NPI	1	1	ΓΙΝ			Phone:		Fax	x :

	ent limit?	Yes 🗌	No 🗌	ma	Yes, list eximum # of edicaid Members		
Office Hours: (add vour hour	s of op	peration for each	dav of the we	eek)		
Mon	AM/PM	to	AM/PM	Fri	AM/PM	to	AM/PM
Tues	AM/PM	to	AM/PM	Sat	AM/PM	to	AM/PM
Wed	AM/PM	to	AM/PM	Sun	AM/PM	to	AM/PM
Thurs	AM/PM	to	AM/PM				
etc.) to the entrar are identified with Are any of the pa Do you have an a Do you have acc individuals with d	accessible app nce of your buil h signage? arking spaces v accessible exam cessible medica disabilities? effectively comm	Iding/of ran-acc minatio Il equip municat	on room for individence ment to accommode te with individuals	ole parking spa uals with disab	oilities?	Yes	□ No □ □ No □ □ No □ □ No □ □ No □
(3) Practice/site	; iocanon na	ic.					
Address: County:							
	TIN			Phone:		Fa	x:
County:			nt limit?	Phone:	No 🗆	If Y	x: /es, list aximum # of edicaid Members
County: NPI: Site specific Me ID#	edicaid En	rollmer		Yes 🗆		If Y	res, list
County: NPI: Site specific Me ID#	edicaid En	rollmer	nt limit? Deration for each	Yes 🗆		If Y	res, list
County: NPI: Site specific Me ID# Office Hours: (a	edicaid Eni	rollmer	peration for each	Yes □	eek)	If \\ma	es, list eximum # of edicaid Members
County: NPI: Site specific Me ID# Office Hours: (a	edicaid Eni add your hour AM/PM	s of op	peration for each AM/PM	Yes day of the we	eek) AM/PM	If \\max_Me	Yes, list aximum # of edicaid Members
County: NPI: Site specific Me ID# Office Hours: (a Mon Tues	edicaid Eni add your hour AM/PM AM/PM	s of op	peration for each AM/PM AM/PM	Yes day of the we	AM/PM	If \ ma Me	Yes, list eximum # of edicaid Members AM/PM AM/PM

	ccessible examination	on room for indivic	luals with disabilities?	Yes □ No □				
Do you have accessible medical equipment to accommodate examining Yes ☐ No ☐ individuals with disabilities?								
Are you able to effectively communicate with individuals who have hearing, vision, speech or cognitive disabilities?								
APPENDIX 1	(Continued)							
included in this Agservices.	greement, and indic	cate <u>all site locat</u>	ions where practitione					
Please	copy this page if nec	essary in order to	complete for each individ	lual practitioner.				
Full name:		Date of birth:	Degree/licensure:	Practicing specialty:				
Subspecialty:								
Medicare ID #:	Medicaid ID #:	Individual NPI a 1500 form):	#: (Box 24J of the CMS	CAQH#:				
Additional langua	ages spoken:		Accepting new pa	itients: Yes ☐ No ☐				
Interpretive services provided: Yes No								
interpretive servi	Provider gender (optional): Female Male							
•	• •							
Provider gender	• •		es 🗌 Date:	No 🗆				
Provider gender Has completed c	Male ultural competency d by: (list OBH, Colo	training? Yo	es Date: er) – attach certificate of	_				
Provider gender Has completed compl	Male ultural competency d by: (list OBH, Colo	training? Yourado Access, other	_	_				
Provider gender Has completed compl	Male ultural competency d by: (list OBH, Colo training	training? Your ado Access, others pages:	er) – attach certificate of	_				
Provider gender Has completed compl	Male ultural competency d by: (list OBH, Colo training ution(s) from previou	training? Your ado Access, others is pages:	er) – attach certificate of	completion for non-				
Provider gender Has completed compl	Male ultural competency d by: (list OBH, Colo training ution(s) from previou	training? Your training? Your training? Your training? Your training? Your training? Your training? You training?	er) – attach certificate of capacity? Yes cilities? Yes	No No				
Provider gender Has completed compl	Male ultural competency d by: (list OBH, Colo training ution(s) from previou	training? Your ado Access, others is pages:	er) – attach certificate of	completion for non-				

Individual NPI #: (Box 24J of the CMS 1500 form):

CAQH#:

Medicare ID #:

Medicaid ID #:

Additional languages spoken (list al	l):	Accepting new pat	tients: Yes ☐ No ☐					
Interpretive services provided: Yes No Languages:								
Provider gender (optional): Female Male								
Has completed cultural competency	training? Yes	☐ Date:	No 🗌					
Training provided by: (list OBH, Colo Colorado Access training	Training provided by: (list OBH, Colorado Access, other) – attach certificate of completion for non-							
Practice site location(s) from previou	s pages:							
Is provider practicing only in an inpa			No 🗌					
Are services provided only in nursir	ng or hospital facilit	ies? Yes	No □					
Full name:	Date of birth: D	egree/licensure:	Practicing specialty:					
ruii name.	Date of birth.	egree/licensure.	Practicing specialty.					
Subspecialty:								
Medicare ID #: Medicaid ID #:	Individual NPI #: (I 1500 form):	Box 24J of the CMS	CAQH #:					
Additional languages spoken:		Accepting new pa	tients: Yes \(\) No \(\)					
Interpretive services provided: Yes	s No							
Provider gender (optional): Fem	ale □							
Has completed cultural competency		Date:	No 🗌					
Training provided by: (list OBH, Colo Colorado Access training Practice site location(s) from previou	orado Access, other)	_						
`,'								
Is provider practicing only in an inpa	<u> </u>	<u> </u>	No 🗌					
Are services provided only in nursir Does any other Individual have an C	· .		No □ No □					
in Provider's business?	wherein or could) III.G. GSL 165	J 140 🖂					
If your answer is YES, please list all su			• •					
Include each person's name, address, indicate the title (e.g. chief executive or see the definition of "persons with an or included. Attach additional pages as no	fficer, owner) and if a ownership or control i	in owner, the percent	of ownership. Please					

Name	Title	% of ownership (if applicable)	Address	DOB	SSN				
	Corporation have	e an Ownership c	or Control	Yes 🗌 No	o 🗌				
Interest in Prov									
If your answer is YES, please list all corporations with an ownership or control interest in the applicant. Include the Tax Identification Number (TIN), the percent of ownership in the applicant, the primary business address, every business location, and P.O. Box address(es). Attach additional pages as needed.									
Name of	TIN	% of ownership	Primary	Every Business	PO Box				
Corporation		(if applicable)	Business	Locations	Addresses				
			Address						

For purposes of the above Questions, "Person/Corporation with an ownership or control interest" means a person or corporation that:

- a) Has an ownership interest totaling 5 percent or more in Provider;
- b) Has an indirect ownership interest equal to 5 percent or more in Provider;
- c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in Provider;
- d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by Provider if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- e) Is an officer or director of Provider that is organized as a corporation; or
- f) Is a partner in a Provider that is organized as a partnership?

Attestation:

All information provided on this application or in connection with this application is complete, truthful and accurate to the best of Provider's knowledge.

Provider further agrees to notify Colorado Access in a timely manner of any changes to the information provided on the application, including any Medicare and Medicaid sanctions or remedies imposed by the State.

Provider further certifies that the medical and/or clinical staff is legally and professionally qualified for the positions to which they are appointed and that the organization credentials its individual practitioners.

Signature:	
Print Name:	
Title:	
Organization (if applicable):	
Date:	

APPENDIX 1 (Professional Provider Agreement Application)

Complete all applicable boxes, and put N/A in any boxes left blank.

Attach the following:

IRS W-9 Copy of Professional Liability Insurance CLIA Certification (If applicable)

Legal name: (As registered with the Secretary of State)								
DBA/Directory listing name: (If applicable)								
Office contact name:	Email address:							
Contract Signature of Authority (who will sign the contract?):	Email address:							
Phone:	Fax:							
Website address:								
Is practice female-owned? (Optional)	Yes □ No □							
Is practice minority-owned? (Optional)	Yes □ No □							
Ages seen in your practice:								
0-3 Yes □ No □								
4-11 Yes □ No □								
12-17 Yes □ No □								
18+ Yes □ No □								
Make checks payable to (Box 33 of CMS 1500 form): Legal Name (must have an organizational NPI for this option) DBA Name (must have an organizational NPI for this option) Individual Provider								
Federal tax ID	Organizational NPI #:							
Organizational Medicaid #:								
Billing/remit Address:								
County:	Organizational Medicare #:							

illing contact name: Billing phone:								
Billing contact email address:								
Billing Format CMS 1500 UB04 Directory: Yes No								
							_	
			APPENDIX 1 (Con	tinued)				
Com	plete for eac	h <u>PF</u>	RACTICE/SITE location	included in	n this Agree	ement	: .	
Please co			cessary in order to comp sites? Yes □	lete for each No □	n practice/sit	e loca	tion.	
Practice Site loca		libie	sites: Tes	NO [_]				
Address:								
Addi 000.								
County:								
NPI:			TIN		Phone:		Fax:	
Office Hours: (add	d your hours	of o	peration for each day	of the week	()			
Mon `	AM/PM	to	AM/PM	Fri	AM/PM	to	AM/PM	
Tues Wed	AM/PM AM/PM	to	AM/PM AM/PM	Sat Sun	AM/PM AM/PM	to	AM/PM AM/PM	
Thurs	AM/PM	to	AM/PM	Suli	AIVI/FIVI	to	AIVI/PIVI	
ADA Compliance: Is there an ADA ac		roach	n (e.g., ramps, stability, o	curbs, stairs	, width,			
etc.) to the entranc	e of your bui		office, with accessible p			Yes	□ No □	
are identified with s Are any of the park	•	an-a	ccessible?			Yes	□ No □	
	•		tion room for individuals	with disahili	tios?	Yes		
Do you have all ac	CCSSINIC CXA	iiiiai	non room for marviadals	with disabili	แบง :	169		
Do you have acces individuals with dis		l equ	ipment to accommodate	examining		Yes	□ No □	
Are you able to effe speech or cognitive	•		cate with individuals who	have hearir	ng, vision,	Yes	□ No □	

Continued on next page

(2)	Practice/site	e location nan	ne:					
Add	dress:							
Coı	ınty:							
NPI	:	7	ГΙΝ		Phone:		Fa	x:
Offi				peration for each da		•	I .	
	Mon _	AM/PM	to	AM/PM	Fri	AM/PM	to	AM/PM
	Tues	AM/PM	to	AM/PM	Sat	AM/PM	to	AM/PM
	Wed	AM/PM AM/PM	to	AM/PM	Sun	AM/PM	to	AM/PM
	Thurs		to	AM/PM				
Is the		accessible app		n (e.g., ramps, stability office, with accessible	•		es	□ No □
Are	any of the pa	arking spaces v	/an-ad	ccessible?		`	′es	□ No □
	you have an a abilities?	accessible trea	atmen	t room or office for inc	dividuals wit	h Ŋ	′es	□ No □
	•	effectively comi		cate with individuals w s?	rho have hea	aring,	′es	□ No □
(3)	Practice/site	e location nam	ne:					
Add	dress:							
Coı	ınty:							
NPI	:	TIN	1		Phone:		Fa	x:
Offi	ce Hours: (a	dd your hour	s of c	pperation for each da	ay of the we	eek)		
	Mon	AM/PM	to	AM/PM	Fri	AM/PM	to	AM/PM
 	Tues	AM/PM	to	AM/PM	Sat	AM/PM	to	AM/PM
	Wed	AM/PM	to	AM/PM	Sun	AM/PM	to	AM/PM
Щ_	Thurs	AM/PM	to	AM/PM				
Is the etc.)	ADA Compliance: Is there an ADA accessible approach (e.g., ramps, stability, curbs, stairs, width, etc.) to the entrance of your building/office, with accessible parking spaces that are identified with signage? Are any of the parking spaces van-accessible? Yes No							
Do	•	•		t room or office for inc	dividuals wit	h Y	⁄es	
	•	effectively comi		cate with individuals w s?	rho have hea	aring,	′ es	□ No □

APPENDIX 1 (Continued)

Please complete for each <u>individual licensed practitioner</u> (physicians and non-physician practitioners) included in this Agreement, and indicate <u>all site locations</u> where practitioner will be providing services.

Please copy this page if necessary in order to complete for each individual practitioner.

				1					
Full name:		Date of birth:	Degree/licensure:	Practicing specialty:					
Subspecialty:									
Medicare ID #:	Medicaid ID #:		#: (Box 24J of the CMS	CAQH#:					
	ı	1500 form):							
Additional langua	iges spoken:		Accepting new par	tients: Yes ☐ No ☐					
•	ces provided: Yes								
Provider gender ((optional): Fema Male	ale 🗌							
Has completed cu	ultural competency	training? Ye	es 🗌 Date:	No 🗆					
Training provided	by: (list OBH, Colo	rado Access, othe	er) – attach certificate of	completion for non-					
Colorado Access ti			,	,					
To the site less	· / \ f mention	. = -							
Practice site loca	tion(s) from previous	s pages:							
FII nama:		Data of hirth:	Decree/licensure:	Dreatising angolalty:					
Full name:		Date of birth:	Degree/licensure:	Practicing specialty:					
Full name:		Date of birth:	Degree/licensure:	Practicing specialty:					
Full name: Subspecialty:		Date of birth:	Degree/licensure:	Practicing specialty:					
		Date of birth:	Degree/licensure:	Practicing specialty:					
Subspecialty:									
	Medicaid ID #:	Individual NPI #	Degree/licensure: #: (Box 24J of the CMS	Practicing specialty: CAQH #:					
Subspecialty:	Medicaid ID #:								
Subspecialty: Medicare ID #:		Individual NPI # 1500 form):	#: (Box 24J of the CMS	CAQH#:					
Subspecialty: Medicare ID #:	Medicaid ID #:	Individual NPI # 1500 form):		CAQH#:					
Subspecialty: Medicare ID #: Additional langua	ages spoken (list all	Individual NPI # 1500 form):	#: (Box 24J of the CMS	CAQH#:					
Subspecialty: Medicare ID #: Additional langua Interpretive service Languages:	ages spoken (list all	Individual NPI # 1500 form):	#: (Box 24J of the CMS	CAQH#:					
Subspecialty: Medicare ID #: Additional langua	ages spoken (list all ces provided: Yes optional): Female	Individual NPI # 1500 form):	#: (Box 24J of the CMS	CAQH#:					
Subspecialty: Medicare ID #: Additional langua Interpretive service Languages:	ages spoken (list all	Individual NPI # 1500 form):	#: (Box 24J of the CMS	CAQH#:					
Subspecialty: Medicare ID #: Additional langua Interpretive service Languages: Provider gender (continuous)	ages spoken (list all ces provided: Yes optional): Female	Individual NPI # 1500 form):): No	#: (Box 24J of the CMS	CAQH#:					
Subspecialty: Medicare ID #: Additional langua Interpretive servic Languages: Provider gender (continuous)	ages spoken (list all ces provided: Yes optional): Female Male ultural competency	Individual NPI # 1500 form): I): No training? Y	#: (Box 24J of the CMS Accepting new pat	CAQH#:					
Subspecialty: Medicare ID #: Additional langua Interpretive servic Languages: Provider gender (continuous)	ages spoken (list all ces provided: Yes optional): Female Male ultural competency	Individual NPI # 1500 form): I): No training? Y	#: (Box 24J of the CMS Accepting new pate)	CAQH#:					
Subspecialty: Medicare ID #: Additional langua Interpretive servic Languages: Provider gender (completed cumulations) Training provided Colorado Access to	ages spoken (list all ces provided: Yes optional): Female Male ultural competency d by: (list OBH, Coloraining	Individual NPI # 1500 form): I): No training? Y rado Access, other	#: (Box 24J of the CMS Accepting new pate)	CAQH#:					
Subspecialty: Medicare ID #: Additional langua Interpretive servic Languages: Provider gender (completed cumulations) Training provided Colorado Access to	ages spoken (list all ces provided: Yes optional): Female Male ultural competency	Individual NPI # 1500 form): I): No training? Y rado Access, other	#: (Box 24J of the CMS Accepting new pate)	CAQH #:					

Full name:		Date of birth	: Degree/li	icensure:	Practic	ing specialty:			
Subspecialty:									
Medicare ID #: Medicaid ID #: Individual NPI #: (Box 24J of the CMS 1500 form):						CAQH #:			
Additional languages spoken: Accepting new patients: Yes \(\sum \) No \(\sum \)									
Interpretive serv	rices provided: Y	es No							
Provider gender		emale 🗌 ale 🗌							
Has completed of	cultural competen	cy training?	Yes Dat	e:	No	D			
Training provide Colorado Access	ed by: (list OBH, Cotraining	olorado Access, c	ther) – attach	certificate of	completic	on for non-			
Practice site loc	ation(s) from previ	ous pages:							
in Provider's bu		-			No	_			
	YES, please list all								
	son's name, addres e.g. chief executive								
	of "persons with a								
included. Attach a	additional pages as	needed.							
Name		% of ownership (if applicable)	Address	DOB		SSN			
Does any other	Corporation have	an Ownership o	r Control	Yes	No				
Interest in Provi				. 55 🗀					
	YES, please list all								
	dentification Number, every business lo								
needed.	, every business ic	ocalion, and F.O.	DUX addiess(es). Allacii du	uilionai p	ayes as			
Name of Corporation	TIN	% of ownership (if applicable)	Primary Business Address	Every Bu Location		PO Box Addresses			

For purposes of the above Questions, "Person/Corporation with an ownership or control interest" means a person or corporation that:

- a) Has an ownership interest totaling 5 percent or more in Provider;
- b) Has an indirect ownership interest equal to 5 percent or more in Provider;
- c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in Provider;

- d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by Provider if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
- e) Is an officer or director of Provider that is organized as a corporation; or
- f) Is a partner in a Provider that is organized as a partnership?

Attestation:

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Provider further agrees to notify Colorado Access in a timely manner of any changes to the information provided on the application, including any Medicare and Medicaid sanctions or remedies imposed by the State.

Provider further certifies that the medical and/or clinical staff is legally and professionally qualified for the positions to which they are appointed and that the organization credentials its individual practitioners.

Signature:	
Print Name:	
Title:	
Organization (if applicable):_	
Date:	

Behavioral Health Specialty

Please indicate which speciality population you work with below:			
	Children (12 and younger)		Foster Care
	Adolescents (13 to 18)		Seniors (65 and older)
Please check only the top 3 speciality(s) of your practice below:			
	Adoption		Learning disabilities
	AIDS/HIV		Life transitions
	Alzheimer's/dementia		Men's issues
	Animal-assisted		Mood disorders
	Anxiety/panic		Neuropsychiatry
	ADD/ADHD		Neuropsychology
	Autism spectrum		Obesity
	Bipolar disorder		Obsessive compulsive disorders
	Brain injury (TBI)		Parenting issues
	Child Abuse		Personality disorders
	Children of alcoholics		Phobias
	Chronic pain or illness		Postpartum
	Compulsive behaviors		Psychological testing/assessment
	Conduct disorder		Psychosis
	Criminal justice		Psychosomatic illness
	Cultural issues		Queer/Questioning
	Depression		Relationship issues
	Developmental disorders		Relinquishment counseling
	Disruptive behavior disorders		Reproductive
	Dissociative disorders		Schizophrenia
	Divorce/custody		Self-harm/self-injury
	Domestic violence		Sexual harassment
	Eating disorders		Sexual issues
	Elder abuse		Sleep/insomnia
	End-of-life		Spiritual concerns
	Family therapy		Stress management
	Gender identity issues		Substance Use Disorder
	Grief and loss		Trauma/PTSD
	Impulse control		Violent offenders
	Intellectual disabilities		Women's issues
	Intimacy issues		