Routine Additional Service Request Form

For the addition of new services and related sites as applicable for currently contracted providers

To be completed by the Provider Agency requesting service/site addition.

Please fax or email completed Additional Service Request Forms to your assigned Network Specialist upon initial verification of capacity/service need.

Provider Name: ______________________ Application Date: ______________

Services Requested to Provide: ______________________________

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Section I

Corporate Information
Please review the following and make any corrections to the information about your agency, if needed.

Legal Name of Organization
(as used for tax reporting purposes): ______________________________

Federal Tax ID#: ______________________________

Organization Address

Street: ______________________________ County: ______________

City: ______________________ State: __________ ZIP: __________

National Accreditation (Complete if applicable.)

Status: Applied and Processed Accreditation

Accrediting Organization:

Date Accredited: ______________ Date Accredited Until: ______________ Number of Years Accredited: ______________

Primary Contact: ______________________ Primary Contact's Title: ______________________

Primary Contact's Email: ______________________________

Office Phone: ______________________ Mobile: ______________________

Fax: ______________________ Pager: ______________________

Executive Director: ______________________ Clinical/Medical Director: ______________________

National Provider Identifier#:
(Please provide a list of NPI #s for each site you are applying for on this application.)

Taxonomy Code(s):
(Please provide a list of the taxonomy codes for the services you intend to render at each site which you are requesting.)

☐ Yes ☐ No Is this change currently reflected in NC Tracks?
If no, attach the Provider Enrollment Form or MCR Submission screenshot
Note: *Requests for updates that do not appear in NC Tracks must be accompanied by a Provider Enrollment Form or MCR Screenshot for the request to be approved.*

Section II: Site Enrollment for Specific Service(s)

Facility/Site Specific Information:
A facility/site is a physical location where supervision and/or management of services occur.
If your Organization operates more than one facility/site, copy and complete this section ***for each facility/site****.*

Facility/Site Name: ____________________

Address: ____________________ County: ____________________

City: ____________________ State: ____________________ ZIP: ____________________

Hours: ____________________ Phone: ____________________ Fax: ____________________

Facility Medicaid #: ____________________ Facility NPI #: ____________________

Taxonomy Codes associated with the
NPI #(s) provided for the requested site: ____________________

Information about the Facility/Site Director/Supervisor

Facility/Site Director's Name: ____________________

Education: ____________________ Credentials: ____________________

☐ Yes ☐ No Have you ever completed a Cardinal Innovation Application for services in the past?

If Yes, what year? ____________________

Outcome? ____________________

Complete this section for each service that the Agency is seeking to provide and for each site.
(Make copies of this section if needed.)

1. Is this facility/site licensed by? (If Yes, attach a copy of the license.)

   ☐ Yes ☐ No DHSR: License #: ____________________ State: ____________________

   ☐ Yes ☐ No DSS: License #: ____________________ State: ____________________

   ☐ Yes ☐ No Other: Type: ____

   License #: ____________________ State: ____________________

2. If you are applying to provide a service, which does not require licensure, submit a completed Self Study of Core Rules.

   ☐ Yes ☐ No Completed Self Study is attached.

3. Is this facility/site staffed and equipped to serve: (This question is not optional. Check either Yes or No)

   ☐ Yes ☐ No Physically Handicapped?
   ☐ Yes ☐ No Deaf & Hearing Impaired?
   ☐ Yes ☐ No Blind/Visually Impaired?
   ☐ Yes ☐ No Foreign Languages? (Specify): ____________________
   ☐ Yes ☐ No Behaviorally Disruptive?
   ☐ Yes ☐ No Sexually Aggressive?

4. **Coverage:** Indicate what arrangements you make to cover consumer emergency situations during nights, weekends, and holidays (skip if you are requesting enrollment for Diagnostic Assessment only):

   ____
   ____
   ____
   ____
   ____

5. **Physician Coverage:** Indicate what arrangement you have made or are planning to make to cover your Organization for consumers who need psychiatric evaluation or psychiatric medication. List psychiatrist/physician who will see your consumers:

   Name: ____________________ Phone: ____________________

   Name: ____________________ Phone: ____________________

   Name: ____________________ Phone: ____________________

6. Do you have a manmade, natural disaster, or act of God crisis/disaster plan?
   ☐ Yes ☐ No If Yes, please attach.

7. Since time of initial application/contract, has the agency/facility received any of the following:
   (If Yes, please attach verification.)

   ☐ Yes ☐ No License?
   ☐ Yes ☐ No Accreditation?
   ☐ Yes ☐ No Sanctions?

8. Cardinal Innovations is interested in a clear understanding of each agency's organizational qualifications as it relates to services or disability group. Please provide a detailed description of the following items:

   a. Agency Description including mission and Philosophy/vision
   b. Describe the Agency's expertise with services provided and priority populations. This should include how the Agency has developed their overall expertise in the areas of service delivery, access to training and ongoing use of consultation, which will assure adherence to the service definition.
   c. Describe how the Agency has developed and maintained the expertise of the Agency in service delivery area requested and priority populations. This answer should be very specific and describe how supervision is done, including the credentials of staff and management. If the service is a nationally recognized best practice, please include what the Agency does to assure fidelity to model.
   d. Please describe any local, state, or national recognition that the Agency has received for the service area and all national accreditations.
   e. If National Accreditation is required for the service, please submit your Agency's Strategic
   f. Plan to achieve this within the timelines established.
   g. If peer certification is required for the service, please describe how the Agency will achieve this.
   h. Define what steps if any your Agency has taken to achieve cultural competency.
   i. Description of how your Agency will operationalize or has operationalized the new service.
   j. Please submit results of any client satisfaction surveys and if you are a new Agency, a detailed plan and timeline of how this will be obtained including the types of questions and frequency to be administered.

9. List all services that you are requesting to provide. The services must be listed according to the North Carolina Department of Health & Human Services Division of Mental Health, Developmental Disabilities, and Substance Abuse MH/DD/SA Services Definitions (ex. not group home but (ex.) supervised living moderate). Information to be documented, per service includes:
   a. State Classification of the Service;
   b. Consumer capacity;
   c. Ages to be served;
   d. Disability Population to be served;
   e. Screening and assessment process;
   f. Admission criteria;
   g. Discharge criteria;
   h. Please include the proposed job descriptions of the staff for the service(s).
   i. Minimum qualifications of staff for the service;
   j. Staffing pattern;
   k. Sample of the staffing schedule for PSR, Residential, Day Treatment, Day and Night Services that demonstrates staffing at the ration required by the State Service Definitions;
   l. Description of the initial competency training program for staff that is to be offered as required by the specific service definition. This should include specifics on the training curriculum, who will provide the training, and how competencies will be determined.
   m. Sample of documentation that is required for the service definition;
   n. On call support system (clinical);
   o. On call support system (medical);
   p. Are the services within thirty (30) miles of Consumers in Cardinal Innovations catchment area?

10. Include information related to the Agency's use of person centered and/or recovery models of service. Please include specific examples of how this is demonstrated on a day¬ to-day basis.

11. Cardinal Innovations will schedule an on-site service visit to review policies and procedures, personnel, training, medication (residential facility), facility (residential facility), and medical records. (This question is not applicable for an existing contracted site)

Authorization to File Additional Service(s) Endorsement Application

To the best of my knowledge, my Agency is able to meet all requirements necessary to apply for additional services. I am submitting the attached Additional Services Endorsement Application, which, to my knowledge, is a true and complete representation of the requested materials.

Authorized Signature: ______________________________ Date: ______________

Title: ____