GEORGIA COLLABORATIVE ASO
Behavioral Health Letter of Intent

Note: Information must be typed with all fields completed. If a field does not apply, indicate "NA". Handwritten documents will NOT be accepted.

Please return the following checklist and applicable documents to:

Georgia Collaborative Enrollment
P.O. Box 56324
Atlanta, GA 30343

Letter of Intent Checklist:

☐ Certificate of Attendance at the most recent Behavioral Health Open Enrollment Forum

☐ Complete Letter of Intent form

☐ Complete Service Location Addendum(s)

☐ Copy of a fully executed contract to verify a minimum of one year of same/similar service delivery during the most recent 12 months

☐ Copy of last two years agency business Tax Returns or audited financials

☐ Agency Bank Statements – business statements for previous 6 months

☐ Verification of Tax ID number *(IRS Form 147C or Form CP575A)*

☐ IRS Exempt Letter *(Non-profit applicants only)*

☐ IRS Form 990 *(Non-profit applicants only)*

☐ Three Professional Reference Letters

☐ Copy of "DBA" or trade name Registration *(if applicable)*

☐ Copy of the Current Georgia Secretary of State registration

☐ Copy of County/City Business license or permit for each site or documentation from municipality stating a Business license or permit is not required

☐ Drug Abuse Treatment and Education Program (DATEP) License *(Core Benefit Package & Substance Abuse applicants only)*

☐ Narcotics Treatment Program License *(Medication Assisted Treatment (MAT) applicants only)*

☐ DEA Controlled Substance Registration Certificate *(Medication Assisted Treatment (MAT) applicants only)*

☐ SAMSHA Opioid Treatment Provider Certification Letter *(Medication Assisted Treatment (MAT) applicants only)*

☐ Accreditation Certificate/Award Letter

☐ Current resume of:

- Clinical Director *(CORE Services Benefit Packet Applicants Only)*
- Owner
- Chief Executive Officer (CEO) and/or Director

The Georgia Collaborative ASO

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I. GENERAL INFORMATION

A. Georgia Agency Information

Agency Legal Name:
_____

DBA/Trade Name:
_____

Address:
_____

City: _____ County: _____ State: ____ Zip Code (9 Digits): _____

Phone #: _____ TAX ID#:_____

DUNS Number, if applicable: _____ Fiscal Year End:_____

Mailing Address *(if different)*:
_____

City: _____ County: _____ State: ____ Zip Code (9 Digits): _____

Website Address of Agency: www._____

Person completing this application / Title: _____

Phone: _____ Email: _____

B. Executive Leadership/Management

Chief Executive Officer:
_____

Phone: _____ E-mail: _____

Behavioral Health Clinical Director: *(Core Benefit Package Applicants)*
_____

Phone: _____ E-mail: _____

Agency Contact Name: _____ Title: _____

Phone: _____ Email: _____

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C. Corporate Information

Please complete if agency is part of a corporate system:

Corporate Name:

_____

Corporate Address:

_____

City: _____ County: _____ State: ____ Zip Code (9 Digits): _____

Mailing Address *(if different)*:

_____

City: _____ County: _____ State: ____ Zip Code (9 Digits): _____

D. Business Classification

Please Check only one box for Ownership and only one box for Status.

1. Ownership: ☐ Private ☐ Public ☐ Government Program

2. Status: ☐ For-Profit ☐ Not-for-Profit

E. Accreditation

This organization is accredited by one or more of the following:

☐ The Joint Commission (TJC)

Certificate No. _____ Effective Date:_____ Expiration Date:_____

☐ Commission on Accreditation of Rehabilitation Facilities (CARF)

Certificate No. _____ Effective Date:_____ Expiration Date:_____

☐ Council On Accreditation (COA)

Certificate No. _____ Effective Date:_____ Expiration Date:_____

☐ Council on Quality and Leadership (CQL)

Certificate No. _____ Effective Date:_____ Expiration Date:_____

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II. SERVICE LOCATION ADDENDUM

Complete one page per service location.

A. Service Location:

Site Name:_____

Address Line 1: _____

Address Line 2: _____

City, State, ZIP (9 Digit): _____

Phone Number: _____

B. Billing Address:
(Please confer with your Billing Dept.)

Address Line 1: _____

Address Line 2: _____

City, State, Zip (9 Digit): _____

Phone Number: _____

C. Counties Requested:

Counties requested must be within a 50-mile radius of the service location. Only counties that are approved are eligible for service.

D. Accessibility:

This service location is:

☐ Yes ☐ No - Accessible by Public Transportation

☐ Yes ☐ No - Americans with Disabilities Act Compliant

E. Healthcare Facility Regulation (HFR) Permits/Licenses:

This site is licensed by Healthcare Facility Regulation (HFR) as a (include a copy of the license:)

☐ Drug Abuse Treatment and Education Program (DATEP) License:

Permit No. _____ Effective Date: _____ Expiration Date: _____

☐ Narcotics Treatment Program (NTP) License:

Permit No. _____ Effective Date: _____ Expiration Date: _____

☐ Not Required

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F. Services Requested Grid
Select the services and applicable age group being requested.

SERVICES REQUESTED AT LOCATION *(PLEASE SELECT APPLICABLE AGE GROUP)*	CHILD & ADOL (4-17)	ADULT (18+)
CORE BENEFIT PACKAGE		
SUBSTANCE ABUSE INTENSIVE OUTPATIENT (SAIOP)		
AMBULATORY SUBSTANCE ABUSE DETOXIFICATION		
ASSERTIVE COMMUNITY TREATMENT (ACT)		
COMMUNITY SUPPORT TEAM (CST)		
INTENSIVE CASE MANAGEMENT (ICM)		
INTENSIVE CUSTOMIZED CARE COORDINATION (IC3) *[Must be deemed a Care Management Entity via Community Based Alternatives for Youth (CBAY) and Children's Health Insurance Program Reauthorization Act (CHIPRA)]*		
INTENSIVE FAMILY INTERVENTION (IFI)		
MEDICATION ASSISTED TREATMENT (MAT)		
MENTAL HEALTH PEER SUPPORT PROGRAM		
ADDICTIVE DISEASES PEER SUPPORT PROGRAM		
PEER SUPPORT – WHOLE HEALTH AND WELLNESS *(Groups and Individual)*		
PARENT PEER SUPPORT *(Group and Individual)* *(Must be a* Tier I, Tier II+, or has *3 or more years providing Parent/Youth Peer support through a Medicaid mechanism (e.g. CBAY etc.)*		
YOUTH PEER SUPPORT *(Group and Individual)* *(Must be a* Tier I, Tier II+, or has *3 or more years providing Parent/Youth Peer support through a Medicaid mechanism (e.g. CBAY etc.)*		
PSYCHOSOCIAL REHABILITATION PROGRAM		
TASK ORIENTED REHABILITATION SERVICES (TORS) *(Must be state funded supported employment provider)*		

Attestation Statement:
My signature below indicates that all of the information provided above, and in any attachments to this application document, is complete and correct to the best of my knowledge.

Name: _____ Title: _____

Signature: _____ Date: _____

III. PROVIDER PROFILE QUESTIONS

PLEASE ATTACH A DETAILED EXPLANATION FOR ANY QUESTIONS BELOW THAT WERE ANSWERED "YES"

A. Please answer the following questions regarding your organization's **programs:**

1. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had its professional liability or malpractice insurance refused, revoked, declined or accepted on special terms in the past five (5) years? ◯ Yes ◯ No

2. Has any government agency suspended, revoked, or taken other action against the organization's license to practice or to conduct business in the past five years, or taken such an action in the past five years against any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee? (To include Medicaid /Medicare) ◯ Yes ◯ No

3. Have any accreditations or memberships in professional organizations been revoked, reduced, denied, or suspended by others or voluntarily given up by the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, in the past five years, or are any actions now under way which may lead to such sanctions? ◯ Yes ◯ No

4. Has any Owner, Managing Employee, officer, or shareholder of the organization **ever** been convicted of a crime, excluding minor traffic misdemeanors? ◯ Yes ◯ No

5. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, **ever** been previously denied acceptance into, disenrolled from, or withdrawn from GA DBHDD or GA Collaborative ASO network participation? ◯ Yes ◯ No

6. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had any settled claims or judgments relating to sexual misconduct or civil rights violations in the past five years? If **Yes**, enter the total number: _____ ◯ Yes ◯ No

7. In the past five years, has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had any settled claims or judgments relating to any other matter not disclosed in the response to Question 6 above? If **Yes**, enter the total number:_____ ◯ Yes ◯ No

8. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, been a defendant in five (5) or more lawsuits within the **past five (5) years?** If **Yes**, enter the total number: _____ ◯ Yes ◯ No

9. Does the organization hire, continue to employ, or contract with individuals listed on the Office of Inspector General's List of Excluded Individuals/Entities (to include owners, officers, employees, subcontractors, and others identified in §1128)? ◯ Yes ◯ No

10. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, filed for Bankruptcy in the past five years? ◯ Yes ◯ No

IV. PARTICIPATION STATEMENT

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) requires that services be provided according to the service guidelines and that the agency will operate in accordance with applicable standards, rules and regulations and policies.

By signing below, I hereby certify and attest that my staff, agents, contractors, subcontractors, billing agent(s) and I have reviewed and agree to comply with the terms and conditions set forth in the applicable DBHDD and Department of Community Health (DCH)/ Medicaid Provider manuals.

I understand and acknowledge that the policies and procedures manuals are amended (generally on a quarterly basis) when either Department finds it necessary or appropriate to do so, and that it is my responsibility to check periodically for any revisions pertaining to the delivery of or reimbursement for services rendered to eligible individuals.

I further understand that failure to abide by either Department's (DBHDD or DCH) policies and procedures will result in adverse actions including, but not limited to the denial of claims, monetary recoupment, termination, suspension of payments, and reduction of reimbursement.

I certify and attest that I have reviewed the entire contents of the completed application and that the information provided is accurate and complete. I understand that inaccurate, incomplete or omitted data may lead to sanctions against me.

Under applicable state and federal laws, I do hereby affirm that I am the authorized agent to complete this document and that the information contained herein this document is complete, true, and correct to the best of my knowledge. I understand that material misrepresentation and/or falsification of any information contained herein shall result in the immediate removal of further consideration for participation.

_____
Agency Name

_____ Date (mm/dd/yy): _____/_____/_____
Authorized Signature

_____
Name (Please Print)

_____
Title