



# WRAPAROUND MILWAUKEE PROVIDER NETWORK - CREDENTIALING

PHONE: (414) 257-8108

9201 WATERTOWN PLANK ROAD, MILWAUKEE, WI 53226

FAX: (414) 257-7575

January - 2009

Dear Applicant,

Thank you for your interest in joining the Wraparound Milwaukee Provider Network. As a provider in the Wraparound Network, you will be able to provide pre-authorized services to youth enrolled in Wraparound Milwaukee, including court order and REACH youth. You will also be afforded the opportunity to provide services through Children's Community Health Plan (CCHP). Additional information about CCHP can be found by visiting their website at <http://www.childreuschp.com>.

In order to process your application, you must be affiliated with an AODA or Behavioral Health agency or be an Independently Licensed Practitioner that is already providing services for or in the process of becoming a vendor for Wraparound Milwaukee. Wraparound Milwaukee expedites the processing of all Universal Applications. However, it is extremely important that you review your Universal Applications for accuracy and completeness in order to avoid a delay in the processing of your Universal Application. The time frame for completing the Universal Application review varies from several weeks to several months. Applicants may begin accepting referrals from Wraparound Milwaukee following receipt of written confirmation that they have successfully completed Wraparound Milwaukee's credentialing process.

No practitioner will be excluded from becoming a Wraparound Milwaukee provider based on gender, race, religion, age, disability, sexual orientation, ethnic origin or client population served.

In the event that your request to become a provider is denied, you have the right to appeal the decision in writing within fourteen (14) days of formal notice of denial. The written appeal should include all supporting documentation in favor of the applicant's reconsideration for the Wraparound Milwaukee Provider Network. The Credentialing Committee reviews appeals within 60 days from the receipt of the additional documentation. A written response to the appeal is issued within 30 days of appeal decision. Once enrolled, should a suspension, reduction, or termination of privileges occur as the result of a practice violation, the practitioner will have the right to appeal the decision in accordance with Wraparound Milwaukee Policies and Procedures and Milwaukee County Ordinances. In compliance with NCQA (National Committee for Quality Assurance) standards, Wraparound Milwaukee reports Credentialing Committee denial and revocation of practitioner privileges to the National Practitioner Data Bank. Additional information about the appeal process can be obtained from the Wraparound Milwaukee 2009-2010 Credentialing/Recredentialing plan, which is available on our web site at <http://www.county.milwaukee.gov>.

A current State of Wisconsin Medicaid Number and National Provider Identifier is required of all applicants. All personal information contained in the Universal Application is kept confidential. Your social security number and date of birth are used to assist in properly identifying you when obtaining insurance and education verification information. Be sure to provide your complete work history (see instructions contained with the Universal Application). Work gaps greater than "30 days" require a written explanation. Masters prepared, non-licensed practitioners must attach a copy of the 3000-hour letter issued to them by the State of Wisconsin permitting practice in a Licensed Mental Health clinic.

Tips for completing the Universal Application and other relevant information is available to you on the AODA and Behavioral Health Practitioner Credentialing page of our website at <http://www.county.milwaukee.gov>. You may also direct questions to Wraparound Milwaukee Provider Network staff at 414-257-8108.

Jeannine P. Maher  
Provider Network Coordinator  
Wraparound Milwaukee

# UNIVERSAL APPLICATION

Modified by Wraparound Milwaukee and used with the permission of the Medical Society of Milwaukee County and the coalition of integrated health care delivery systems and other physician organizations.

**INSTRUCTIONS:** Applicant must fill out the application in its entirety and include all required documentation in accordance with the instructions given in the application cover letter. Failure to do so will result in the return of the application to the applicant and will delay processing. Questions about the status of an application should be directed to Theresa Randall, Wraparound Milwaukee Provider Network at 414-257-8108.

**No individual will be excluded from participating in Wraparound Milwaukee's credentialing process on the basis of gender, race, religion, age, disability, sexual orientation, ethnic origin or client population served.**

<b>PERSONAL INFORMATION</b> <span style="float: right; color: red; font-weight: normal;">(ALL APPLICANTS – Complete Pages 1 and 2)</span>		
Last Name	First Name	Middle Name or Middle Initial
Other Names By Which You Have Been Known Professionally	Degree	Social Security Number
Home Street Address		Home City/State/Zip
Home Phone Number (Include Area Code)	City Wide Pager (Include Area Code)	Answering Service (Include Area Code)
Preferred E-Mail Address for professional correspondence	Citizenship	If not a US Citizen, specify status & Visa #
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth City/State
Birth Country	Languages Spoken by Applicant	Ethnic Origin (optional)
Spouse's Name (optional)	Emergency Contact Information (optional) Phone: e-mail address	Marital Status (optional) <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single
<b>OFFICES: List all practice sites, identify a primary, mailing and billing address.</b>		
<b>Office #1</b>		
Office Name  <span style="color: red; font-weight: normal; display: block; text-align: center;">(ALL APPLICANTS)</span>		Check all applicable boxes: <input type="checkbox"/> Primary Office <input type="checkbox"/> Secondary Office <input type="checkbox"/> Mailing Address <input type="checkbox"/> Billing Address
Office Street Address		
Office City, State and Zip Code		Start and End Dates (Month & Year)
Office Phone 1 (Include Area Code)	Office Phone 2 (Include Area Code)	Office Fax (Include Area Code)
Languages Spoken at this Office	Office Site Tax ID	Office Contact/Office Manager
<b>Office #2</b>		
Office Name		Check all applicable boxes: <input type="checkbox"/> Primary Office <input type="checkbox"/> Secondary Office <input type="checkbox"/> Mailing Address <input type="checkbox"/> Billing Address
Office Street Address		
Office City, State and Zip Code		Start and End Dates (Month & Year)
Office Phone 1 (Include Area Code)	Office Phone 2 (Include Area Code)	Fax (Include Area Code)
Languages Spoken at this Office	Office Site Tax ID	Office Contact/Office Manager

<b>Office #3</b>		
Office Name		Check all applicable boxes: <input type="checkbox"/> Primary Office <input type="checkbox"/> Secondary Office <input type="checkbox"/> Mailing Address <input type="checkbox"/> Billing Address
Office Street Address		
Office City, State and Zip Code		
Office Phone 1 (Include Area Code)		
Office Phone 2 (Include Area Code)		Office Fax (Include Area Code)
Languages Spoken at this Office		Office Site Tax ID
		Office Contact/Office Manager

<b>Type of Practice:</b>	<input type="checkbox"/> Primary Care	<input type="checkbox"/> Specialist
<b>Accepting New Patients:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Communications Available:</b>	<input type="checkbox"/> TTY –Teletypewriter	<input type="checkbox"/> Sign Language

**SPECIALTIES**

Specialty (AODA / AODA & Psychotherapist Psychotherapist Psychologist Psychiatry / Child Psychiatry)	Primary	Secondary	Board Certified (Yes or No)		Name of Board (if applicable)	Year Certified	Last Re-Certified	Expiration Date
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

**ID NUMBERS**

State License: *List all current and past state licenses.*

State of Licensure	Number	Type	Expiration Date

*Non-Licensed - Master Prepared Practitioners (NOTE: \$10.00 Fee Assessed for Education Verification)*

**Date 3000 Hour Psychotherapy Letter Issued:** \_\_\_\_\_ *Include copy of 3000 hour letter with application*

Other ID Numbers

Type of Number	Number	Expiration Date (where applicable)
DEA Number		
UPIN Number		
ECFMG Number (Foreign Medical Graduate) <i>Please also include a copy</i>		
Medicare Provider Number		
Medicaid Provider Number		
National Provider ID Number		

**HOSPITAL & ASC AFFILIATIONS: NEW APPLICATIONS:** List all hospitals, ambulatory surgery centers and medical offices where you have ever had an affiliation or where you have an application in process. Indicate affiliation status (Active, Courtesy, Provisional, Temporary, etc.) Begin with current affiliations and then list past affiliations. Enter additional affiliations on a separate sheet of paper and attach to the application. Do not include Residency or Internship information in this area. **REAPPOINTMENT:** List hospitals where you have had an affiliation at any time in the past two years. Include current affiliation status.

**(PHYSICIANS AND PSYCHOLOGISTS WHEN APPLICABLE)**

<b>Name</b>		Start and End Dates (Month & Year)
Street Address		City, State and Zip Code
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Affiliation Status
<b>Name</b>		Start and End Dates (Month & Year)
Street Address		City, State and Zip Code
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Affiliation Status
<b>Name</b>		Start and End Dates (Month & Year)
Street Address		City, State and Zip Code
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Affiliation Status
<b>Name</b>		Start and End Dates (Month & Year)
Street Address		City, State and Zip Code
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Affiliation Status
<b>Name</b>		Start and End Dates (Month & Year)
Street Address		City, State and Zip Code
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Affiliation Status
<b>Name</b>		Start and End Dates (Month & Year)
Street Address		City, State and Zip Code
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Affiliation Status
<b>Name</b>		Start and End Dates (Month & Year)
Street Address		City, State and Zip Code
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Affiliation Status
<b>Name</b>		Start and End Dates (Month & Year)
Street Address		City, State and Zip Code
Phone Number (Include Area Code)	Fax Number (Include Area Code)	Affiliation Status

**EDUCATION AND TRAINING**  
**(ALL APPLICANTS)**

**Medical Education or Professional School**

<b>Name of Institution</b>			Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Degree Obtained

<b>Name of Institution</b>			Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Degree Obtained

**Internship**

<b>Name of Institution</b>		<b>Program</b>	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Program Director

<b>Name of Institution</b>		<b>Program</b>	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Program Director

**Residency**

<b>Name of Institution</b>		<b>Program</b>	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Program Director

<b>Name of Institution</b>		<b>Program</b>	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Program Director

<b>Name of Institution</b>		<b>Program</b>	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Program Director

<b>Fellowship</b>			
<b>Name of Institution</b>		<b>Program</b>	Start & Finish Dates (Month & Year)
Street Address		City	State      Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address	Program Director
<b>Name of Institution</b>		<b>Program</b>	Start & Finish Dates (Month & Year)
Street Address		City	State      Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address	Program Director
<b>Name of Institution</b>		<b>Program</b>	Start & Finish Dates (Month & Year)
Street Address		City	State      Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address	Program Director

***ADDITIONAL FORMAL TRAINING, such as Preceptorships, etc.:***  
***(ALL APPLICANTS)***

<b>Name of Institution</b>		<b>Program</b>	Start & Finish Dates (Month & Year)
Street Address		City	State      Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address	Program Director
<b>Name of Institution</b>		<b>Program</b>	Start & Finish Dates (Month & Year)
Street Address		City	State      Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address	Program Director

***CLINICAL TEACHING APPOINTMENTS:*** *List current and previous clinical teaching appointments.*  
***(ALL APPLICANTS)***

<b>Name of Institution</b>		<b>Rank</b>	Start & Finish Dates (Month & Year)
Street Address		City	State      Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address	Program Director
<b>Name of Institution</b>		<b>Faculty Rank</b>	Start & Finish Dates (Month & Year)
Street Address		City	State      Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address	Program Director

**MILITARY EXPERIENCE:** List all military experience that has occurred since completion of medical or professional school. **(PHYSICIANS)**

<b>Name of Institution</b>		<b>Rank</b>	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Supervisor's Name
<b>Name of Institution</b>		<b>Faculty Rank</b>	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Supervisor's Name

**PRACTICE AFFILIATION / WORK HISTORY** List all practice history (past & present) that has occurred since completion of medical or professional school. Explain all gaps of 30 days or more in next section. **(ALL APPLICANTS)**

<b>Name of Institution</b>		<b>Job Title</b>	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Supervisor's Name
<b>Name of Institution</b>		<b>Job Title</b>	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Supervisor's Name
<b>Name of Institution</b>		<b>Job Title</b>	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Supervisor's Name
<b>Name of Institution</b>		<b>Job Title</b>	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Supervisor's Name
<b>Name of Institution</b>		<b>Job Title</b>	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Supervisor's Name
<b>Name of Institution</b>		<b>Job Title</b>	Start & Finish Dates (Month & Year)	
Street Address		City	State	Zip
Phone Number (Include Area Code)	Fax Number (Include Area Code)	E-Mail Address		Supervisor's Name



**DISCLOSURE QUESTIONS**

If you answer "YES" to questions numbered 2 through 18, please provide details on a separate page. Include a copy of any order or settlement where applicable.

1.	Have there ever been, or are there currently, any professional or work-related claims, settlements or judgments against you, your employer, or other third party, even if not resulting in monetary damages, or have you received any notice of "Intent to File"? <b>IF YOU ANSWER "YES," PLEASE PROVIDE DETAILED INFORMATION ON THE ENCLOSED PROFESSIONAL LIABILITY ACTION EXPLANATION FORM.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever had any professional liability insurance coverage voluntarily or involuntarily canceled, declined or modified (i.e., reduced limits, restricted coverage), or has any renewal ever been refused, or have you voluntarily given up coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Have you ever been denied, or have you voluntarily or involuntarily given up, membership, or renewal of membership, or been subject to any disciplinary action in any hospital, IPA, HMO, PHO, PPO, managed care organization or professional society, or is any such action pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have your clinical privileges or employment at any hospital or healthcare institution been voluntarily or involuntarily limited, suspended, revoked, not renewed, or subject to probationary or other disciplinary conditions, or have proceedings toward any of those ends been instituted or recommended by a hospital administration, medical staff or committee or governing board?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Has your request for any specific clinical privileges been voluntarily or involuntarily denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation been recommended by a medical staff or committee or governing board?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Have you ever had any previous or pending challenges to, or voluntarily or involuntarily relinquished any medical staff membership, clinical privilege(s), professional license(s), or narcotics registration as the result of any investigation or disciplinary action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have you ever been disciplined by any State Board of Medical Examiners, or by any Professional Conduct Board, or have you ever been reprimanded, or fined by any state or federal agency that disciplines physicians or allied health professionals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Have you ever been reprimanded, censured, excluded, suspended or disqualified by Medicare, Medicaid, CLIA or any other health plan for which you provide services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Have you ever received notice of a proposed or actual exclusion from any health care program funded in whole or part by the federal government or any state health care program, including Medicare or Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Has your Drug Enforcement Agency or other controlled substances authorization ever been voluntarily or involuntarily denied, revoked, suspended, reduced or not renewed, or have proceedings toward any of those ends been instituted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Has your specialty board certification or eligibility ever been voluntarily or involuntarily denied, revoked, relinquished, not renewed, suspended, reduced, or have any proceedings toward any of those ends been instituted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Has your authorization to practice in any jurisdiction (state or county) ever been voluntarily or involuntarily revoked, suspended, or subject to probation or any conditions or limitations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Have you ever been convicted of, or pleaded guilty or no contest to, a felony, serious or gross misdemeanor, or any crime or municipal violation, involving dishonesty, assault or sexual misconduct or abuse, or abuse of controlled substances or alcohol, or are charges pending against you for any such crimes by information, indictment or otherwise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	To your knowledge, has any information pertaining to you ever been reported to the National Practitioner Data Bank (NPDB)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Will practicing to the fullest extent of your licensure, qualifications, and privileges, with or without reasonable accommodation, in any way pose a risk of harm to your patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	In the past five years, up to, and including the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Have you ever been court-martialed, investigated, sanctioned, reprimanded or cautioned by a hospital or other healthcare facility of any military agency, been involuntarily terminated or forced to resign, or have you resigned voluntarily while under investigation or threat of sanction from a hospital or healthcare facility of any military agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	If you perform clinical research, have you ever had any clinical research study terminated involuntarily, been asked to terminate a clinical research study before it was completed or had any other discipline or sanctions with respect to your clinical research?	<input type="checkbox"/> Yes <input type="checkbox"/> No

(Continue to page 9)

19.	Is your professional liability insurance current? (Please read this question carefully)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> in residency/ fellowship
20.	Do your professional liability insurance amounts meet state minimum requirements? (Please read this question carefully)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> in residency/ fellowship

I understand and agree that the burden of producing adequate information in a timely manner and for resolving doubts is my responsibility.

I understand and agree that the application will not be processed until the application is deemed complete by the healthcare organization. It is my responsibility to provide a "complete" application.

I certify that the information in this document and any attached documents is true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after staff membership/privileges or network participation has been awarded to me, may lead to suspension or termination of that membership/privileges and/or participation.

Print Practitioner Name: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Stamped Signatures are NOT Acceptable*

**Professional Liability Action Explanation Form (ALL APPLICANTS)**

This form **must be completed if you answered "yes" to question #1** on the Disclosure Questions of the Practitioner Application Form.

Please complete this form if there have ever been, or currently are, any professional or work-related claims, settlements or judgments against you, your employer, or other third party, even if not resulting in monetary damages or if you have received any notice of "Intent to File." All questions must be answered completely. If additional sheets are required, please photocopy this page prior to completing. Please provide us with a separate sheet for each malpractice action. In order to maintain HIPAA compliance please remove all patient identifiers (i.e. name, DOB) from submitted documents.

P l e a s e   P r i n t

Date of Alleged Incident

Date Suit Filed

Docket Number

City/State of Incident

Your Relationship to Patient (Attending Practitioner, Surgeon, Assistant Surgeon, Consultant, etc.)

Additional Named Defendant(s)

Liability Carrier When Incident Occurred

Allegation

Claim Status

OPEN – If open, amount being sought

CLOSED – If closed, indicate method of closing

Dismissal

Settlement

Judgment

Amount of settlement or judgment

Summarize the circumstances giving rise to the action. If the action involves patient care, describe a narrative that provides your care and treatment of the patient. If additional space is necessary, attach adequate clinical detail to allow proper evaluation by a committee of physicians. Include 1) condition and diagnosis at time of incident, 2) dates and description of treatment rendered and 3) condition of patient subsequent to treatment. In order to maintain HIPAA compliance please remove all patient identifiers (i.e. name, DOB) from submitted documents. *Please print.*

SUMMARY

**Consent to Release Information (ALL APPLICANTS)**  
**Verification of Education and Professional Training or Affiliations**

**Consent to Release Information**

I understand that this Consent to Release Information is made in connection with Physician/Practitioner contracting, credentialing, or recredentialing activity conducted by the Milwaukee County Behavioral Health Division (MCBHD)–Wraparound Milwaukee Program.

**I hereby authorize the Milwaukee County Behavioral Health Division-Wraparound Milwaukee Program, the MCBHD Medical Staff Office and/or their representatives to consult with all** persons, entities or institutions for purposes of evaluating my professional training, experience, character, conduct, ethics, judgment, **qualifications and competence**; and I consent to the release and communication of such information and documents to the Milwaukee County Behavioral Health Division–Wraparound Milwaukee Program, **MCBHD Medical Staff Office and their representatives. I further authorize the Milwaukee County Behavioral Health Division-Wraparound Milwaukee Program, the MCBHD Medical Staff Office, MCBHD Human Resources and/or their representatives to conduct any and all Caregiver, criminal and/or other required background checks, in connection with this application.**

I hereby authorize agencies contacted by the Milwaukee County Behavioral Health Division–Wraparound Milwaukee Program, **MCBHD Medical Staff Office and their representatives in connection with this application** to release such information regarding education, professional training, and/or professional competence and qualifications to representatives of the Milwaukee County Behavioral Health Division–Wraparound Milwaukee Program, **MCBHD Medical Staff Office and/or their representatives**, and I understand in doing so I am waiving my confidentiality rights to this information. I release and hold harmless from liability all persons, entities, and institution when in good faith and without malice for acts performed in gathering or exchanging information related to this credentialing or recredentialing process. This release and hold harmless provision applies to all persons, entities and institutions who provide and/or receive information as part of the Milwaukee County Behavioral Health Division–Wraparound Milwaukee Program credentialing or recredentialing process, which may include information related to a past or present physical and/or mental condition, including substance abuse, alcohol dependency and mental health information.

I further authorize the release of information obtained by the Milwaukee County Behavioral Health Division–Wraparound Milwaukee Program in connection with Physician/Practitioner contracting, credentialing, or recredentialing activity to the Children’s Community Health Plan and any other health care organizations with which the Milwaukee County Behavioral Division–Wraparound Milwaukee Program may enter into a credentialing/recredentialing agreement.

**Acknowledgement:** I acknowledge in making this application that my affiliation with the Milwaukee County Behavioral Health Division is only in connection with Physician/Practitioner contracting with the Milwaukee County Behavioral Health Division–Wraparound Milwaukee Program and that with this application I am not being considered for appointment and/or privileges as a member of the Milwaukee County Behavioral Health Division Medical Staff Organization.

A photocopy of this consent shall be as effective as an original when presented.

Print Practitioner Name: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent to Release Information (ALL APPLICANTS)  
Verification of Professional Liability Insurance**

Copy and completed this form for each Insurance Carrier used in the last 5 years.

**Consent to Release Information**

I understand that this Consent to Release Information is made in connection with Physician/Practitioner contracting, credentialing, or recredentialing activity conducted by the Milwaukee County Behavioral Health Division – Wraparound Milwaukee Program.

I hereby authorize the Milwaukee County Behavioral Health Division–Wraparound Milwaukee Program and its representatives to contact and consult with the **Insurance Carrier identified below** with which I have affiliated, have used for liability insurance or who may have information relevant to my professional liability insurance and/or malpractice insurance claims history.

I release and hold harmless from liability all persons, entities, and institution when in good faith and without malice for acts performed in gathering or exchanging information related to this credentialing or recredentialing process. This release and hold harmless provision applies to all persons, entities and institutions who provide and/or receive information as part of the Milwaukee County Behavioral Health Division–Wraparound Milwaukee Program credentialing or recredentialing process.

I further authorize the release of information obtained by the Milwaukee County Behavioral Health Division–Wraparound Milwaukee Program in connection with Physician/Practitioner contracting, credentialing, or recredentialing activity to the Children’s Community Health Plan and any other health care organizations with which the Milwaukee County Behavioral Health Division–Wraparound Milwaukee Program may enter into a credentialing/recredentialing agreement.

I, the undersigned, authorize

\_\_\_\_\_  
Name of Insurance Carrier

\_\_\_\_\_  
Street Address of Insurance Carrier

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Policy Number

to send verification of my professional liability coverage, to include dates of coverage, amounts of coverage and any limitations in coverage to the **Milwaukee County Behavioral Health Division–Wraparound Milwaukee** who will hereinafter be a Certificate Holder and as such is to be notified of the amount of my current and any future coverage and/or changes to my insurance status.

Print Practitioner Name: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**BACKGROUND INFORMATION DISCLOSURE INSTRUCTIONS**

The Background Information Disclosure form (HFS64) gathers information as required by the Wisconsin Caregiver Background Check Law to help employers and governmental regulatory agencies make employment, contract, residency, and regulatory decisions. Complete and return the entire form and attach explanations as specified by employer or governmental regulatory agency.

**CAREGIVER BACKGROUND CHECK LAW**

In accordance with the provisions of Chapters 48.685 and 50.065 of the Wis. Stats., for persons who have been convicted of certain acts, crimes or offenses:

1. The Department of Health and Family Services (DHFS) may not license, certify or register the person or entity (Note: Employers and Care Providers are referred to as “entities”);
2. A county agency may not certify a child care or license a foster or treatment foster home;
3. A child placing agency may not license a foster or treatment foster home or contract with an adoptive parent applicant for a child adoption;
4. A school board may not contract with a licensed child care provider; and
5. An entity may not employ, contract with, or permit persons to reside at the entity.

A list of barred crimes and offenses requiring rehabilitation review is available from the regulatory agencies or through the Internet at <http://dhfs.wisconsin.gov/caregiver/StatutesINDEX.HTM>.

**THE CAREGIVER LAW COVERS THE FOLLOWING EMPLOYERS/CARE PROVIDERS (REFERRED TO AS “ENTITIES”)**

Programs Regulated Under Chapter 48, Wis. Stats.	Treatment Foster Care, Family Child Care Centers, Group Child Care Centers, Residential Care Centers for Children and Youth, Child Placing Agencies, Day Camps for Children, Family Foster Homes for Children, Group Homes for Children, Shelter Care Facilities for Children, and Certified Family Child Care.
Programs Regulated Under Chapters 50, 51, and 146, Wis. Stats.	Emergency Mental Health Service Programs, Mental Health Day Treatment Services for Children, Community Mental Health, Developmental Disabilities, AODA Services, Community Support Programs, Community Based Residential Facilities, 3-4 Bed Adult Family Homes, Residential Care Apartment Complexes, Ambulance Service Providers, Hospitals, Rural Medical Centers, Hospices, Nursing Homes, Facilities for the Developmentally Disabled, and Home Health Agencies – including those that provide personal care services.
Others	Child Care Providers contracted through Local School Boards

**THE CAREGIVER LAW COVERS THE FOLLOWING PERSONS**

- Anyone employed by or contracting with a covered entity who has access to the clients served, except if the access is infrequent or sporadic and service is not directly related to care of the client.
- Anyone who is a Child Care Provider who contracts with a School Board under Wisconsin Statute 120.13 (14).
- Anyone who lives on the premises of a covered entity and is 10 years old or over, but is not a client (“non-client resident”).
- Anyone who is licensed by DHFS.
- Anyone who has a foster home licensed by DHFS.
- Anyone certified by DHFS.
- Anyone who is a Child Care Provider certified by a county department.
- Anyone registered by DHFS.
- Anyone who is a board member or corporate officer who has access to the clients served.

**FAIR EMPLOYMENT ACT**

Wisconsin’s Fair Employment Law, Chapters 111.31-111.395, Wis. Stats., prohibits discrimination because of a criminal record or pending charge; however, it is not discrimination to decline to hire or license a person based on the person’s arrest or conviction record if the arrest or conviction is substantially related to the circumstances of the particular job or licensed activity.

**PERSONALLY IDENTIFIABLE INFORMATION:** This information is used to obtain relevant data as required by the provisions set forth by the Wisconsin Caregiver Background Check Law. Providing your social security number is voluntary, however your social security number is one of the unique identifiers used to prevent incorrect matches. For example, the Department of Justice uses social security numbers, names, gender, race, and date of birth to prevent incorrect matches of persons with criminal convictions. The Department of Health and Family Services’ Caregiver Misconduct Registry uses social security numbers as one identifier to prevent incorrect matches of persons with findings of abuse or neglect of a client or misappropriation of a client’s property.

## BACKGROUND INFORMATION DISCLOSURE (BID)

Completion of this form is required under the provisions of Chapters 48.685 and 50.065 of the Wis. Stats. Failure to comply may result in a denial or revocation of your license, certification or registration; or denial or termination of your employment or contract. Refer to the instructions (HFS-64A) on page 1 for additional information. Providing your social security number is voluntary, however your social security number is one of the unique identifiers used to prevent incorrect matches.

### PLEASE PRINT YOUR ANSWERS.

Check the box that applies to you.

Employee / Contractor (Including new applicant)

Household member/lives on premises - but not a client

Applicant for a license or certification or registration (including continuation or renewal)

Other – specify:

**NOTE:** If you are an owner, operator, board member, or non client resident of a Division of Quality Assurance (DQA) regulated facility, complete the BID, HFS-64, and the Appendix, HFS-69, and submit both forms to the address noted in the Appendix instructions.

Name - First and Middle	Name – Last	Position Title (Complete only if you are a prospective employee or contractor, or a current employee or contractor.)		
Any other names by which you have been known (including maiden name)		Birth Date	Gender (M / F)	Race
Address			Social Security Number(s)	
Business Name and Address of Employer or Care Provider (Entity)				

<b>Section A - ACTS, CRIMES AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION</b>	<b>YES</b>	<b>NO</b>
1. Do you have any criminal charges pending against you or were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?  ➤ If <b>Yes</b> , list each crime, when it occurred or the date of the conviction, and the city and state where the court is located. You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.		
2. Were you ever found to be (adjudicated) delinquent by a court of law on or after your 10 <sup>th</sup> birthday for a crime or offense? (NOTE: A response to this question is only required for group and family day care centers for children and day camps for children.)  ➤ If <b>Yes</b> , list each crime, when and where it happened, and the location of the court (city and state). You may be asked to supply additional information including a certified copy of the delinquency petition, the delinquency adjudication, or any other relevant court or police documents.		
3. Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect? A response is required if the box below is checked: <input type="checkbox"/> (Only employers and regulatory agencies entitled to obtain this information per sec. 48.981(7) are authorized to, and should, check this box.)  ➤ If <b>Yes</b> , explain, including when and where it happened.		
4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client?  ➤ If <b>Yes</b> , explain, including when and where it happened.		
5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client?  ➤ If <b>Yes</b> , explain including when and where it happened.		
6. Has any government or regulatory agency (other than the police) ever found that you <b>abused an elderly person</b> ?  ➤ If <b>Yes</b> , explain, including when and where it happened.		
7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients?  ➤ If <b>Yes</b> , explain, including credential name, limitations or restrictions, and time period.		

Section B – OTHER REQUIRED INFORMATION	YES	NO
1. Has any government or regulatory agency ever limited, denied or revoked your license, certification or registration to provide care, treatment or educational services? ➤ If <b>Yes</b> , explain, including when and where it happened.		
2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility? ➤ If <b>Yes</b> , explain, including when and where it happened and the reason.		
3. Have you been discharged from a branch of the US Armed Forces, including any reserve component? ➤ If <b>Yes</b> , indicate the year of discharge: _____ ➤ Attach a copy of your DD214 if you were discharged within the past 3 years.		
4. Have you resided outside of Wisconsin in the last 3 years? ➤ If <b>Yes</b> , list each state and the dates you lived there		
5. Have you had a caregiver background check done within the last 4 years? ➤ If <b>Yes</b> , list the date of each check, and the name, address and phone number of the person, facility or government agency that conducted each check.		
6. Have you ever requested a rehabilitation review with the Wisconsin Department of Health and Family Services, a county department, a private child placing agency, school board, or DHFS designated tribe? ➤ If <b>Yes</b> , list the review date and the review result. You may be asked to provide a copy of the review decision.		
<b>A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.</b>		

I understand, under penalty of law, that the information provided above is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a forfeiture of up to \$1000.00 and other sanctions as provided in HFS 12.05 (4), Wis. Adm. Code.

<b>SIGNATURE</b>	Date Signed
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Please complete the attached regarding your office availability and after hours coverage arrangements.

**Primary Office Location**

Clinic Hours			Practitioner Specific Hours		
	AM	PM		AM	PM
Monday			Monday		
Tuesday			Tuesday		
Wednesday			Wednesday		
Thursday			Thursday		
Friday			Friday		
Saturday			Saturday		

Name(s) of Partners/Associates: \_\_\_\_\_

Practitioner(s) who share call who are not part of your practice group:

Name and Professional Status: \_\_\_\_\_

Address: \_\_\_\_\_

**Secondary Office Location**

Clinic Hours			Practitioner Specific Hours		
	AM	PM		AM	PM
Monday			Monday		
Tuesday			Tuesday		
Wednesday			Wednesday		
Thursday			Thursday		
Friday			Friday		
Saturday			Saturday		

Name(s) of Partners/Associates: \_\_\_\_\_

Practitioner(s) who share call who are not part of your practice group:

Name and Professional Status: \_\_\_\_\_

Address: \_\_\_\_\_

**COVERAGE ARRANGEMENTS**

Please provide detailed after hours coverage for each of your affiliate agencies, to include coverage when you are on vacation and days you are not located at a Wraparound Network agency.

# WRAPAROUND MILWAUKEE CHILDREN'S COMMUNITY HEALTH PLAN OPTION AGREEMENT

To: Wraparound Milwaukee Provider Network

- I wish to **OPT IN** with the Children's Community Health Plan (CCHP) under the Wraparound Milwaukee Fee-for-Service Agreement.

I understand that the CCHP fee schedule, authorization procedures and payment procedures will apply to all services provided to CCHP enrollees.

I further understand that all of the conditions and requirements identified in the Wraparound Milwaukee Fee-for-Service Agreement apply to services provided to CCHP enrollees. In addition, I agree to comply with all CCHP policies and procedures as outlined in the CCHP Provider Manual.

- I **DO NOT** wish to **OPT IN** with the Children's Community Health Plan (CCHP) under the Wraparound Milwaukee Fee-for-Service Agreement.

**PLEASE PRINT**

Physician/Clinician Name: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physician/Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return to Theresa Randall ■ Wraparound Milwaukee Provider Network  
9201 Watertown Plank Road  
Wauwatosa, WI 53226  
Fax 414-257-7575 ■ Phone 414-257-8108**

**CHILDREN'S COMMUNITY HEALTH PLAN  
RELEASE AND IMMUNITY FROM LIABILITY**

**Release and Immunity**

I extend absolute immunity to, and release from any and all liability and agree not to sue Children's Community Health Plan (CCHP) any of their authorized representatives and any third parties, as defined below, for any actions, recommendations, reports, statements, communications or disclosures involving me, which are made, taken or received by CCHP, any of their authorized representatives and any third parties acting in good faith in the course of review or evaluation of my provision of services in this application for health plan participation. Such review, evaluation and action shall include but not be limited to the following:

- ⇒ matters or inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and
- ⇒ periodic reappraisals undertaken for recertification for participation status or any other disciplinary action;
- ⇒ hearings and appellate review;
- ⇒ hospital, organizational and medical staff quality assurance;
- ⇒ utilization reviews;
- ⇒ any other matter that might directly or indirectly have an effect on my competence, on patient care or on the orderly operation of CCHP.

The term "third parties" means all individuals from whom information has been requested or received by CCHP.

**Affirmation**

I represent that information provided in or attached to this application is accurate and complete. I understand that a condition of this application is that any misrepresentation or misstatement on, or omission from this application, whether intentional or not, may be cause for automatic and immediate rejection of this application and may result in the denial of participation.

In the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner, CCHP shall notify the practitioner in writing within two weeks of the discrepancy. The applicant shall have 30 days to correct erroneous information submitted by other parties and/or to correct his/her own information or the processing of his/her application will be terminated.

I agree that if approved as a provider, I will participate as a member of the Children's Hospital and Health System, Inc. Organized Health Care Arrangement for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996.

**Duration of Consent and Release**

By applying for participation status, I accept all conditions, authorizations and releases set forth in this Consent and Release regardless of whether or not I am approved as a provider, and intend to be legally bound thereby. These authorizations, releases and conditions shall be irrevocable so long as I am an applicant for participation status at CCHP.

\_\_\_\_\_  
Practitioner Signature (*Stamped Signatures Are Unacceptable*)

\_\_\_\_\_  
Date

Wraparound Milwaukee obtained permission to use the Universal Application developed by the Medical Society of Milwaukee County to use Universal Application (copyright 2003). This document is a modification of the Medical Society of Milwaukee County Universal Application.