Vaya Health

Provider Nomination Form

Request for nomination

Complete this form if you are requesting to enroll as a new provider or seeking to expand the sites/services offered by your practice in the Vaya Health provider network.

Please provide the date of this request in the space below.

Date of request: _____

Provider information

Legal organization name: _____

Provider type:

- ☐ Agency
- ☐ Group practice
- ☐ CABHA
- ☐ Agency/licensed facility
- ☐ Facility only (for example, PRTF only)
- ☐ Licensed independent practitioner (LIP)

Request type:

- ☐ New in-network provider contract → Complete sections A and D
- ☐ In-network provider adding a new site → Complete sections A, B and D
- ☐ In-network provider adding a new service → Complete sections A, C and D

Submit this completed and signed request for nomination form to Vaya at the following address:

Vaya Health
Provider Network Development
200 Ridgefield Ct. Suite 206
Asheville, NC 28806
ProviderInfo@vayahealth.com

Section A: All providers

Basic information

Primary address: _____

City, state, ZIP: _____

Primary contact: _____

Email: _____

Phone: _____

Organization website: _____

Executive director: _____

Proposed site street address: _____

Proposed site city, state, ZIP: _____

Count(ies) to be served: _____

Tax ID: _____

Have any of owner/managers ever owned or operated, in whole or in part, any other provider agency?

☐ Yes ☐ No

If yes, list name of individual(s) and provider agency(ies):

_____

Sanctions history

Has the provider or organization ever been sanctioned, placed on probation or lost accreditation or certification?

☐ Yes ☐ No

If yes, attach an explanation of circumstances and how it or they was/were resolved.

Accreditation

Is this organization accredited?

☐ Yes ☐ No

If yes, provide name of accrediting body:

_____

Liability history

Does the applicant have an acceptable liability history with no history of insurance liability claims for the past five (5) years?

☐ Yes ☐ No

If no, attach detailed information.

An unacceptable liability history is defined as:
Within the five-year period immediately preceding the date of the agency/applicant's application, one or more legal actions resulted in:

- At least one (1) judgment, or;
- One (1) settlement in an amount over $50,000 or more, or;
- Two (2) or more settlements in an aggregate amount of $50,000 or more; or
- As of the date of the agency/applicant's application, there are legal actions pending.

Other MCO contracts

Does the applicant have any current contracts with other Medicaid managed care organizations (including LME/MCOs or out-of-state MCOs), or had any such contracts in the past three (3) years?

Alliance Behavioral Health	☐ Yes	☐ No
Cardinal Innovations	☐ Yes	☐ No
CenterPoint	☐ Yes	☐ No
ECBH	☐ Yes	☐ No
Partners Behavioral Health	☐ Yes	☐ No
Sandhills Center	☐ Yes	☐ No
Trillium	☐ Yes	☐ No
Vaya/Smoky Mountain	☐ Yes	☐ No
Other	☐ Yes	☐ No

If "other," name of MCO: _____

Financial information

Does the applicant have:

1. A minimum of one (1) month working capital or line of credit? *(Please attach financial statement supporting response.)*

   ☐ Yes ☐ No

2. Any tax liens?

   ☐ Yes ☐ No

3. Infrastructure to monitor all financial information of the agency, including debt-to-income ratio?

   ☐ Yes ☐ No ☐ N/A (LIP only)

4. A compliant electronic medical record (EMR) system that supports management of authorization and billing functions and meets meaningful use standards?

   ☐ Yes ☐ No ☐ N/A (LIP only)

   List EMR currently being utilized: _____

Crisis response

Does the applicant maintain or contract for a 24/7 crisis response phone line? ☐ Yes ☐ No

If yes, list phone number: _____

Service information

Attach written documentation from a community stakeholder or give written rationale supporting the need for the service(s) you provide:

- Specialty services (e.g., DBT, faith-based, trauma-focused CBT):

_____

- List evidence-based practices being used to provide the requested services:

_____

Complete the following for all services requested:

Service description	Service code	NPI#	Taxonomy #	Medicaid/ IPRS (state) funding

Attach additional pages if needed.

Section B: In-network provider adding a new site/change of address

Requested effective date: _____

Which of the following would you like to request? ☐ Add a site ☐ Change address

(Only one request may be submitted per page. This page may be duplicated if necessary to submit multiple requests. Ensure that this section is specific to the sites that you want to add with a specific MCO.)

Address type: ☐ Mailing address ☐ Billing address
☐ Service site Address ☐ Administrative address

Provide the following information for all address/site changes:

NEW ADDRESS (if applicable):

_____	_____	_____	_____	_____
Street/P.O. Box	City	State	ZIP+4	County

OLD ADDRESS:

_____	_____	_____	_____	_____
Street/P.O. Box	City	State	ZIP+4	County

Phone number: _____ **Fax number:** _____

Hours of operation:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Provide the following information for all service site changes:

Site/facility name: _____ **Site NPI:** _____

Site/facility director name: _____

Site/facility director's education: _____

Site/facility director's credentials: _____

Arrangements for emergency coverage after hours: _____

(*911 and ER will not be accepted.)*

Population(s) served: ☐ I/DD ☐ MH ☐ SU

Ages served: ☐ Child/adolescent ☐ Adult ☐ Geriatric

Are telepsychiatry services provided at this location? ☐ Yes ☐ No

Complete the following for all services requested:				
Service description	**Service code**	**NPI#**	**Taxonomy #**	**Medicaid/ IPRS (state) funding**
Attach additional pages if needed				

Is this facility/site licensed by:

DHSR? ☐ Yes (*attach copy of license)* ☐ No License number: _____ State: _____

DSS? ☐ Yes (*attach copy of license)* ☐ No License number: _____ State: _____

Other? ☐ Yes (*attach copy of license)* ☐ No Type: _____

License number: _____ State: _____

Since the time of initial application for licensure, has the applicant received any sanctions?

☐ Yes (*attach a detailed explanation)* ☐ No

What accommodations/specialties does this location provide? *(Check all that apply)*

Wheelchair access ☐
Gender-specific women's SU services ☐
Interpreter for the hearing-impaired ☐
Accommodations for vision-impaired ☐
Staff cross-trained across disability areas ☐
Culturally diverse staff ☐
Organization staff who are bi/multi-lingual ☐
at this location
Language(s): _____

Staff trained in cultural diversity ☐
Serve blind/visually impaired members ☐
Serve sexually aggressive members ☐
Serve behaviorally disruptive members ☐
Teletypewriter (TTY) for the hearing-impaired ☐
Other: (Describe below) ☐
_____
_____

Other interpreter (contracted services) for ☐
non-English speaking members available
at this location
Language(s): _____

Languages supported *(Check all languages that are spoken or supported at this location.)*

☐ Arabic ☐ English ☐ Hindi ☐ Korean ☐ Portuguese ☐ American Sign Language
☐ Armenian ☐ French ☐ Italian ☐ Persian ☐ Russian ☐ Other: _____
☐ Chinese ☐ German ☐ Japanese ☐ Polish ☐ Spanish ☐ Other: _____

Note: Vaya is required to conduct an on-site review of basic health, safety and records storage compliance prior to approving an initial request for credentialing.

Are licensed practitioners at this location? ☐ Yes ☐ No

Licensed practitioners must be credentialed with the LME/MCO before providing services to the MCO's members. To initiate credentialing for licensed practitioners and associates (provisionally licensed) practitioners not yet credentialed by the MCO, refer to the Vaya credentialing instructions at http://vayahealth.com/providers/credentialing/.

Section C: In-network provider adding a new service

Which of the following would you like to request?

☐ New service at existing site ☐ New service at new site

Requested effective date: _____

Ensure that this section is specific to the services that you want to add with a specific MCO.

Funding type: ☐ Medicaid ☐ IPRS/state-funded

Provide the following for all service changes:

Site/facility name: _____

_____	_____	_____	_____	_____
Street/P.O. Box	City	State	ZIP+4	County

Site NPI: _____ Phone number: _____ Fax number: _____

Hours of operation:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Arrangements for emergency coverage after hours: _____

(*911 and ER will not be accepted.)*

Population(s) served: ☐ I/DD ☐ MH ☐ SU ☐ Medicaid ☐ IPRS

Ages served: ☐ Child/adolescent ☐ Adult ☐ Geriatric

Complete the following for all services requested:

Service description	Service code	NPI#	Taxonomy #	Medicaid/ IPRS (state) funding

Licensing and accreditation

Is the organization accredited? ☐ Yes ☐ No ☐ N/A (if not required)

If no, and national accreditation is required for the service, please provide your agency's strategic plan to achieve accreditation within the timelines established:

Organization	Accredited?	Years accredited	Expiration date
CARF	☐ Yes ☐ No		
COA	☐ Yes ☐ No		
CQL	☐ Yes ☐ No		
Joint Commission	☐ Yes ☐ No		
Other:	☐ Yes ☐ No		

Is this facility/site licensed by:

DHSR? ☐ Yes (*attach copy of license)* ☐ No License number: _____ State: _____

DSS? ☐ Yes (*attach copy of license)* ☐ No License number: _____ State: _____

Other? ☐ Yes (*attach copy of license)* ☐ No Type: _____

License number: _____ State: _____

Since the time of initial application, has the applicant received any sanctions?

☐ Yes (*attach a detailed description)* ☐ No

Are licensed practitioners at this location? ☐ Yes ☐ No

Licensed practitioners must be credentialed with Vaya before providing services to Vaya's members. To initiate credentialing for licensed practitioners and associate (provisionally licensed) practitioners not yet credentialed by Vaya, refer to the credentialing instructions at http://vayahealth.com/providers/credentialing/.

Section D: Signature and Attestation

By signing below, I hereby certify that all of the information and attachments provided herein are true and accurate to the best of my knowledge. I further understand that any false or misleading information may be cause for denial or termination of any and all agreements with Vaya Health (Vaya). I understand that the purpose of this request is to obtain nomination by Vaya for enrollment and credentialing. **Submission of this request does not guarantee the issuance of a credentialing application, nor does the receipt of an application or approval of credentialing guarantee the issuance of a contract.**

I further signify my willingness for Vaya to verify all information presented in this request and to provide additional information, if needed, to verify accuracy of the information contained therein. I agree to provide any additional information upon request to verify information and address issues of concern prior to the approval of this request. I also consent for Vaya to interview any individuals who may have information related to this request or the qualification(s) related to the applicant/organization.

Finally, I attest that I am not aware of any conflict of interest existing between Vaya and the applicant.

_____ _____

Print name Print title

_____ _____

Signature of legally authorized representative Date

Submit this completed, signed Request for Nomination Form to Vaya Health:

Vaya Heath
Provider Network Development
200 Ridgefield Court, Suite 206
Asheville, NC 28806
ProviderInfo@vayahealth.com

Office Use Only

Recommendation: ☐ Approve ☐ Deny Date of decision: _____

Denial reason: ☐ Approve ☐ Need not substantiated ☐ Not in good standing

☐ Deny selection and retention criteria not met ☐ Other: _____