



New Provider Enrollment Form Attachment A/B

Please attach a W9 and return by email to OhioContracting@Centene.com Or use the submit button at the bottom of this page.

Buckeye Health Plan requires all providers to utilize CAQH for credentialing. If you do not utilize the Global Authorization option in CAQH, it is critical that you grant BHP authorization to access your data.

If more than 5 providers or 5 locations are in a group a Roster will be accepted containing the same information. If additional space is needed, or all the below information cannot be provided in a single document, please submit a separate form.

Please complete one Provider Data Form (page 1) for each new provider in the practice.		
Location Forms are on pages 2-6. Please complete one Location Form (pages 2-6) for each office location for the provider.		
How many locations does the provider work at under this tin:		Date Completing:
Contact Information		
Credentialing Contact:	Credentialing Phone Number:	
Credentialing E-mail:	Credentialing Fax Number:	
Group Information		
Group Name:	Group NPI:	
Group Tax ID Number:		
Billing Office Address:		
Billing Office City:	State:	Zip:
Billing Office Phone Number:	Billing Office Phone Fax:	
Provider Information		
Provider First Name:	Middle:	Last Name:
Provider DOB:	Provider SSN:	
OH Medicaid Number:	DEA Number:	
State License Number:	Licensed State:	
Individual NPI#:	Provider Type: (MD, DO, etc.):	
Primary Specialty:	Secondary Specialty:	
Applying <input type="checkbox"/> PCP <input type="checkbox"/> Behavioral Health Only as: <input type="checkbox"/> Specialist <input type="checkbox"/> Behavioral Health and Medical	Work in a Federally Qualified Health Center for this Tax ID: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospital Based and practice exclusively in an inpatient setting: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is provider accepting new patients: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the provider have any gender limitation on patients?		Gender Limits:
Does the provider have any Age limitations on patients?		Age Limits:
Is Provider Affiliated with a PHO: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is provider registered with CAQH: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, CAQH Provider ID:	
Please list any non-English languages spoken by provider:		
Has provider received any Cultural Competency Training: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please list if Cultural Training includes any of the following:		
<input type="checkbox"/> African American <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Deafness <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Chronic Illness <input type="checkbox"/> Blindness <input type="checkbox"/> Homelessness <input type="checkbox"/> Physical Disabilities <input type="checkbox"/> Serious Mental Illness		
Please list Specialized Training completed: (Behavioral Health Providers must complete Section C at the end of this form.)		
Signature		
Date:		
Typed Name:		

All fields on this form are required. If information does not apply please indicate N/A in the space provided.

Clear form to start a new application

Submit Once All Pages Are Completed

Provider Location Form

Location 1

Please complete a Location Form for each Practice Location.

Group Name:								
Practice Location Name:				Group Tax ID Number:				
Primary Office	Street No	Direction	Street Name			Suffix	Suite	
Primary Office City:				State:	Zip:	County:		
Primary Office Phone Number:				Primary Office Fax Number:				
PCP: <input type="checkbox"/> Yes <input type="checkbox"/> No		Capacity:						
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
	To	To	To	To	T	To	To	
	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed
	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs
	Does the location offer telehealth services?				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Does the location have access to Language Line Services?				<input type="checkbox"/> Yes <input type="checkbox"/> No				
Does the location offer translation services for written materials?				<input type="checkbox"/> Yes <input type="checkbox"/> No				
Does the location offer non-English languages, either spoken by the provider, office personnel or offered onsite by skilled medical interpreters?				<input type="checkbox"/> Yes <input type="checkbox"/> No				
If above question is yes, please list which non-English languages are provided at this location:								

ADA Information

<p>Does your office meet ADA Parking Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -Adequate, marked accessible (handicap) parking (1 in 25 or 10% of total spaces) that serve people with mobility disabilities. -At least 1 space that is van accessible available in your parking lot. -An access aisle next to each marked space. 		<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Does your office meet Restroom Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -Restroom large enough to accommodate a patient who uses an adult wheelchair or scooter. -The entry doors to the restrooms are at least 36" wide, and easy to open. -The toilet door or stall have a minimum clear opening of 32". -The top of the toilet seat 17-19" from the floor. -Grab bars behind and to the wall side of the toilet. -At least one open space (at least 42") to the side of the toilet. -The soap and towel dispensers 48" or less from the floor. 		<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Does your office meet Exam Room Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -At least one exam room available via an accessible route (no less than 36" wide) with an entry door at 32" clear opening with a minimum of 30" by 48" clear approach next to an examination table for transfer from a wheelchair. -Staff members trained to assist with transfers on/off of examination table. 		<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Does your office meet Equipment Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -Access to a wheelchair scale. -Access to a height adjustable exam table. 		<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Does your office meet Route Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -The route of travel to the building stable, firm and slip resistant and at least 36" wide. 		<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Does your office meet Interior Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -If there are stairs at the main entrance, is there a ramp or lift or is there an alternative accessible entrance. -An entry door at least 34" wide with a push pad or easy assist system. -Elevators located on an accessible route with care control buttons designated with both raised characters and Braille symbols that are no higher than 54" from the floor, with audible signals for the up and down direction or verbal enunciators and doors and cabs with the appropriate dimensions. 		<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Is the provider's location on an accessible public transportation route?</p>		<p>Bus <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
		<p>Train <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Provider Location Form Location 2

Please complete a Location Form for each Practice Location.

Group Name:								
Practice Location Name:				Group Tax ID Number:				
Primary Office Address:	Street No	Direction	Street Name			Suffix	Suite	
Primary Office City:			State:	Zip:	County:			
Primary Office Phone Number:				Primary Office Fax Number:				
PCP: <input type="checkbox"/> Yes <input type="checkbox"/> No		Capacity:						
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
	To	To	To	To	To	To	To	
	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed
	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs
	Does the location offer telehealth services?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the location have access to Language Line Services?						<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does the location offer translation services for written materials?						<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does the location offer non-English languages, either spoken by the provider, office personnel or offered onsite by skilled medical interpreters?						<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If above question is yes, please list which non-English languages are provided at this location:								

ADA Information

Does your office meet ADA Parking Recommendations, Including ALL of the following: -Adequate, marked accessible (handicap) parking (1 in 25 or 10% of total spaces) that serve people with mobility disabilities. <input type="checkbox"/> Yes <input type="checkbox"/> No -At least 1 space that is van accessible available in your parking lot. -An access aisle next to each marked space.					
Does your office meet Restroom Recommendations, Including ALL of the following: -Restroom large enough to accommodate a patient who uses an adult wheelchair or scooter. <input type="checkbox"/> Yes <input type="checkbox"/> No -The entry doors to the restrooms are at least 36" wide, and easy to open. -The toilet door or stall have a minimum clear opening of 32". -The top of the toilet seat 17-19" from the floor. -Grab bars behind and to the wall side of the toilet. -At least one open space (at least 42") to the side of the toilet. -The soap and towel dispensers 48" or less from the floor.					
Does your office meet Exam Room Recommendations, Including ALL of the following: -At least one exam room available via an accessible route (no less than 36" wide) with an entry door at 32" clear opening with a minimum of 30" by 48" clear approach next to an examination table for transfer from a wheelchair. <input type="checkbox"/> Yes <input type="checkbox"/> No -Staff members trained to assist with transfers on/off of examination table.					
Does your office meet Equipment Recommendations, Including ALL of the following: -Access to a wheelchair scale. <input type="checkbox"/> Yes <input type="checkbox"/> No -Access to a height adjustable exam table.					
Does your office meet Route Recommendations, Including ALL of the following: -The route of travel to the building stable, firm and slip resistant and at least 36" wide. <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does your office meet Interior Recommendations, Including ALL of the following: -If there are stairs at the main entrance, is there a ramp or lift or is there an alternative accessible entrance. <input type="checkbox"/> Yes <input type="checkbox"/> No -An entry door at least 34" wide with a push pad or easy assist system. -Elevators located on an accessible route with care control buttons designated with both raised characters and Braille symbols that are no higher than 54" from the floor, with audible signals for the up and down direction or verbal enunciators and doors and cabs with the appropriate dimensions.					
Is the provider's location on an accessible public transportation route?	<table style="width: 100%; border: none;"> <tr> <td style="border: none;">Bus</td> <td style="border: none;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="border: none;">Train</td> <td style="border: none;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	Bus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Train	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bus	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Train	<input type="checkbox"/> Yes <input type="checkbox"/> No				



Provider Location Form

Location 3

Please complete a Location Form for each Practice Location.

Group Name:							
Practice Location Name:				Group Tax ID Number:			
Primary Office Address:	Street No	Direction	Street Name			Suffix	Suite
Primary Office City:			State:	Zip:	County:		
Primary Office Phone Number:				Primary Office Fax Number:			
PCP: <input type="checkbox"/> Yes <input type="checkbox"/> No		Capacity:					
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	To	To	To	To	To	To	To
	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed
	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs
Does the location offer telehealth services?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the location have access to Language Line Services?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the location offer translation services for written materials?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the location offer non-English languages, either spoken by the provider, office personnel or offered onsite by skilled medical interpreters?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
If above question is yes, please list which non-English languages are provided at this location:							

ADA Information

<p>Does your office meet ADA Parking Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -Adequate, marked accessible (handicap) parking (1 in 25 or 10% of total spaces) that serve people with mobility disabilities. <input type="checkbox"/> Yes <input type="checkbox"/> No -At least 1 space that is van accessible available in your parking lot. -An access aisle next to each marked space. 	
<p>Does your office meet Restroom Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -Restroom large enough to accommodate a patient who uses an adult wheelchair or scooter. <input type="checkbox"/> Yes <input type="checkbox"/> No -The entry doors to the restrooms are at least 36" wide, and easy to open. -The toilet door or stall have a minimum clear opening of 32". -The top of the toilet seat 17-19" from the floor. -Grab bars behind and to the wall side of the toilet. -At least one open space (at least 42") to the side of the toilet. -The soap and towel dispensers 48" or less from the floor. 	
<p>Does your office meet Exam Room Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -At least one exam room available via an accessible route (no less than 36" wide) with an entry door at 32" clear opening with a minimum of 30" by 48" clear approach next to an examination table for transfer from a wheelchair. <input type="checkbox"/> Yes <input type="checkbox"/> No -Staff members trained to assist with transfers on/off of examination table. 	
<p>Does your office meet Equipment Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -Access to a wheelchair scale. <input type="checkbox"/> Yes <input type="checkbox"/> No -Access to a height adjustable exam table. 	
<p>Does your office meet Route Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -The route of travel to the building stable, firm and slip resistant and at least 36" wide. <input type="checkbox"/> Yes <input type="checkbox"/> No 	
<p>Does your office meet Interior Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -If there are stairs at the main entrance, is there a ramp or lift or is there an alternative accessible entrance. <input type="checkbox"/> Yes <input type="checkbox"/> No -An entry door at least 34" wide with a push pad or easy assist system. -Elevators located on an accessible route with care control buttons designated with both raised characters and Braille symbols that are no higher than 54" from the floor, with audible signals for the up and down direction or verbal enunciators and doors and cabs with the appropriate dimensions. 	
<p>Is the provider's location on an accessible public transportation route?</p> <p style="font-size: small;">(Rev. 03/2018) Page 4 of 9</p>	<p>Bus <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Train <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

All fields on this form are required. If information does not apply please indicate N/A in the space provided.



Provider Location Form

Location 4

Please complete a Location Form for each Practice Location.

Group Name:								
Practice Location Name:					Group Tax ID Number:			
Primary Office Address:		Street No	Direction	Street Name			Suffix	Suite
Primary Office City:				State:	Zip:	County:		
Primary Office Phone Number:				Primary Office Fax Number:				
PCP: <input type="checkbox"/> Yes <input type="checkbox"/> No			Capacity:					
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
	To	To	To	To	To	To	To	
	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed
	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs
	Does the location offer telehealth services? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Does the location have access to Language Line Services? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Does the location offer translation services for written materials? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Does the location offer non-English languages, either spoken by the provider, office personnel or offered onsite by skilled medical interpreters? <input type="checkbox"/> Yes <input type="checkbox"/> No								
If above question is yes, please list which non-English languages are provided at this location:								

ADA Information

<p>Does your office meet ADA Parking Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -Adequate, marked accessible (handicap) parking (1 in 25 or 10% of total spaces) that serve people with mobility disabilities. <input type="checkbox"/> Yes <input type="checkbox"/> No -At least 1 space that is van accessible available in your parking lot. -An access aisle next to each marked space. 	
<p>Does your office meet Restroom Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -Restroom large enough to accommodate a patient who uses an adult wheelchair or scooter. <input type="checkbox"/> Yes <input type="checkbox"/> No -The entry doors to the restrooms are at least 36" wide, and easy to open. -The toilet door or stall have a minimum clear opening of 32". -The top of the toilet seat 17-19" from the floor. -Grab bars behind and to the wall side of the toilet. -At least one open space (at least 42") to the side of the toilet. -The soap and towel dispensers 48" or less from the floor. 	
<p>Does your office meet Exam Room Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -At least one exam room available via an accessible route (no less than 36" wide) with an entry door at 32" clear opening with a minimum of 30" by 48" clear approach next to an examination table for transfer from a wheelchair. <input type="checkbox"/> Yes <input type="checkbox"/> No -Staff members trained to assist with transfers on/off of examination table. 	
<p>Does your office meet Equipment Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -Access to a wheelchair scale. <input type="checkbox"/> Yes <input type="checkbox"/> No -Access to a height adjustable exam table. 	
<p>Does your office meet Route Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -The route of travel to the building stable, firm and slip resistant and at least 36" wide. <input type="checkbox"/> Yes <input type="checkbox"/> No 	
<p>Does your office meet Interior Recommendations, Including ALL of the following:</p> <ul style="list-style-type: none"> -If there are stairs at the main entrance, is there a ramp or lift or is there an alternative accessible entrance. <input type="checkbox"/> Yes <input type="checkbox"/> No -An entry door at least 34" wide with a push pad or easy assist system. -Elevators located on an accessible route with care control buttons designated with both raised characters and Braille symbols that are no higher than 54" from the floor, with audible signals for the up and down direction or verbal enunciators and doors and cabs with the appropriate dimensions. 	
<p>Is the provider's location on an accessible public transportation route?</p>	
Bus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Train	<input type="checkbox"/> Yes <input type="checkbox"/> No

All fields on this form are required. If information does not apply please indicate N/A in the space provided.

Provider Location Form Location 6

Please complete a Location Form for each Practice Location.

Group Name:								
Practice Location Name:				Group Tax ID Number:				
Primary Office Address:		Street No	Direction	Street Name			Suffix	Suite
Primary Office City:				State:	Zip:	County:		
Primary Office Phone Number:				Primary Office Fax Number:				
PCP: <input type="checkbox"/> Yes <input type="checkbox"/> No			Capacity:					
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
	To	To	To	To	To	To	To	
	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	<input type="checkbox"/> Closed	
	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24	<input type="checkbox"/> Open 24 Hrs	<input type="checkbox"/> Open 24 Hrs	
	Does the location offer telehealth services? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Does the location have access to Language Line Services? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Does the location offer translation services for written materials? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Does the location offer non-English languages, either spoken by the provider, office personnel or offered onsite by skilled medical interpreters? <input type="checkbox"/> Yes <input type="checkbox"/> No								
If above question is yes, please list which non-English languages are provided at this location:								

ADA Information

Does your office meet ADA Parking Recommendations, Including ALL of the following: -Adequate, marked accessible (handicap) parking (1 in 25 or 10% of total spaces) that serve people with mobility disabilities. -At least 1 space that is van accessible available in your parking lot. -An access aisle next to each marked space.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your office meet Restroom Recommendations, Including ALL of the following: -Restroom large enough to accommodate a patient who uses an adult wheelchair or scooter. -The entry doors to the restrooms are at least 36" wide, and easy to open. -The toilet door or stall have a minimum clear opening of 32". -The top of the toilet seat 17-19" from the floor. -Grab bars behind and to the wall side of the toilet. -At least one open space (at least 42") to the side of the toilet. -The soap and towel dispensers 48" or less from the floor.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your office meet Exam Room Recommendations, Including ALL of the following: -At least one exam room available via an accessible route (no less than 36" wide) with an entry door at 32" clear opening with a minimum of 30" by 48" clear approach next to an examination table for transfer from a wheelchair. -Staff members trained to assist with transfers on/off of examination table.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your office meet Equipment Recommendations, Including ALL of the following: -Access to a wheelchair scale. -Access to a height adjustable exam table.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your office meet Route Recommendations, Including ALL of the following: -The route of travel to the building stable, firm and slip resistant and at least 36" wide.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your office meet Interior Recommendations, Including ALL of the following: -If there are stairs at the main entrance, is there a ramp or lift or is there an alternative accessible entrance. -An entry door at least 34" wide with a push pad or easy assist system. -Elevators located on an accessible route with care control buttons designated with both raised characters and Braille symbols that are no higher than 54" from the floor, with audible signals for the up and down direction or verbal enunciators and doors and cabs with the appropriate dimensions.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the provider's location on an accessible public transportation route? <small>(Rev. 09/2020) Page 6 of 9</small>	Bus <input type="checkbox"/> Yes <input type="checkbox"/> No Train <input type="checkbox"/> Yes <input type="checkbox"/> No

All fields on this form are required. If information does not apply please indicate N/A in the space provided.

Section C - Provider Specialty Profile

Treatment Expertise/Specialties

Please select the types of services you offer, including the disorders you treat and the modalities you practice. (Check those that apply)

NOTE: Please submit evidence of certificates or transcripts that account for the associated trainings in the treatment modalities and/or disorders selected below.

Certification	
<input type="checkbox"/> Art Therapy	<input type="checkbox"/> Positive Behavior Support
<input type="checkbox"/> Center of Excellence	<input type="checkbox"/> SBIRT
<input type="checkbox"/> Emergency Services Provider	<input type="checkbox"/> Targeted Case Management (TCM) Certificate
<input type="checkbox"/> Lead Behavior Analysis Therapist	<input type="checkbox"/> Trauma Informed Care
Settings/Populations Treated	
<input type="checkbox"/> Adolescents	<input type="checkbox"/> Homelessness
<input type="checkbox"/> Adults	<input type="checkbox"/> Men
<input type="checkbox"/> Blind/Visually Impaired	<input type="checkbox"/> Mobile Crisis
<input type="checkbox"/> Children	<input type="checkbox"/> Nursing Home
<input type="checkbox"/> Community Based	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Deaf/Hearing Impaired	<input type="checkbox"/> Serious Emotional Disturbance
<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Serious Mental Illness
<input type="checkbox"/> Emotionally Disturbed	<input type="checkbox"/> Severe Persistent Mentally Ill
<input type="checkbox"/> Gay/Lesbian	<input type="checkbox"/> School Based
<input type="checkbox"/> Geriatric	<input type="checkbox"/> Telemedicine
<input type="checkbox"/> Hospital Based	<input type="checkbox"/> Women
<input type="checkbox"/> Home Based	<input type="checkbox"/> Young Children
Treatment Modalities/ Approaches	
<input type="checkbox"/> Applied Behavioral Analysis (ABA)	<input type="checkbox"/> Group Therapy
<input type="checkbox"/> Addictive Disorders	<input type="checkbox"/> Geriatric Psychiatry
<input type="checkbox"/> Adolescent Psychotherapy	<input type="checkbox"/> Gestalt
<input type="checkbox"/> Adolescent Sex Offender	<input type="checkbox"/> Hypnosis
<input type="checkbox"/> Adolescent Psychiatry	<input type="checkbox"/> Intensive Family Intervention
<input type="checkbox"/> Adoption Issues	<input type="checkbox"/> Individual Therapy
<input type="checkbox"/> Alcohol/SA Treatment	<input type="checkbox"/> Intensive Outpatient
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Intake Assessment
<input type="checkbox"/> Art Therapy	<input type="checkbox"/> Medication Management
<input type="checkbox"/> Attachment Therapy	<input type="checkbox"/> Methadone/Suboxone
<input type="checkbox"/> Behavioral Therapy	<input type="checkbox"/> Mood Disorders
<input type="checkbox"/> Brief Therapy	<input type="checkbox"/> Neuropsychological Testing
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Neuro-Linguistic Programming (NLP)
<input type="checkbox"/> Chemical Dependency Assessment	<input type="checkbox"/> Outcomes Oriented Therapy
<input type="checkbox"/> Child Parent Psychotherapy (CCP)	<input type="checkbox"/> Parent Child Interaction Therapy (PCIT)
<input type="checkbox"/> Child Psychological Testing	<input type="checkbox"/> Play Therapy
<input type="checkbox"/> Child Psychiatry	<input type="checkbox"/> Psychological Testing
<input type="checkbox"/> Christian Counseling	<input type="checkbox"/> Psychoanalytic Therapy
<input type="checkbox"/> Client Centered Therapy	<input type="checkbox"/> Psychodynamic Therapy
<input type="checkbox"/> Cognitive Rehab Therapy	<input type="checkbox"/> Psychopharmacology

<input type="checkbox"/> Cognitive Therapy	<input type="checkbox"/> Pain Management
<input type="checkbox"/> Community Support Program	<input type="checkbox"/> Rationale Emotive Therapy
<input type="checkbox"/> Community Support Program for the	<input type="checkbox"/> Relapse Prevention
<input type="checkbox"/> Couples Therapy	<input type="checkbox"/> Relationship Disorders
<input type="checkbox"/> Crisis Intervention/Stabilization	<input type="checkbox"/> Sensory Processing/Integration
<input type="checkbox"/> Critical Incident Debriefing	<input type="checkbox"/> Sexual Compulsions/Addictions
<input type="checkbox"/> Dialectical Behavioral Therapy	<input type="checkbox"/> Sex Therapy
<input type="checkbox"/> Developmental Evaluation	<input type="checkbox"/> Solution Empowerment Therapy
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Stress Management
<input type="checkbox"/> ECT	<input type="checkbox"/> Tobacco
<input type="checkbox"/> EMDR	<input type="checkbox"/> Tobacco Cessation
<input type="checkbox"/> Evaluation/Assessment	<input type="checkbox"/> Trauma Focused Cognitive Behavioral Therapy
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Trauma Informed Care (TIC)
<input type="checkbox"/> Family Systems	<input type="checkbox"/> Trust Based Relational Intervention (TBRI)
<input type="checkbox"/> Gay/Lesbian/Bisexual	<input type="checkbox"/> Weight Management
Disorders/Iss	
<input type="checkbox"/> Addictive Medicine	<input type="checkbox"/> Impulse disorders
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Infertility
<input type="checkbox"/> Addictive Disorders	<input type="checkbox"/> Inpatient Attending
<input type="checkbox"/> Adjustment Disorder	<input type="checkbox"/> Inpatient Consult MD
<input type="checkbox"/> Adolescent Behavior Disorders	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Adoption Issues	<input type="checkbox"/> Medical Evaluation
<input type="checkbox"/> Adult ADD	<input type="checkbox"/> Medical Illness/Chronic Illness
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Men Issues
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Mood Disorders
<input type="checkbox"/> Anxiety/Panic Disorder	<input type="checkbox"/> Marital Issues
<input type="checkbox"/> Attachment Disorder	<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Autism/Asperger's	<input type="checkbox"/> Obsessive Compulsive Disorder
<input type="checkbox"/> Bipolar Disorders	<input type="checkbox"/> Oppositional Defiant Disorder
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Organic Mental Disorder
<input type="checkbox"/> Christian/Spiritual	<input type="checkbox"/> Parenting Issues
<input type="checkbox"/> Chronic Pain/Pain Management	<input type="checkbox"/> Personality Disorders
<input type="checkbox"/> Crisis Stabilization	<input type="checkbox"/> Post-Partum Disorder
<input type="checkbox"/> Cultural Issues	<input type="checkbox"/> PTSD
<input type="checkbox"/> Child/Parent Bonding	<input type="checkbox"/> Panic Disorder
<input type="checkbox"/> Co-occurring Disorders	<input type="checkbox"/> Phobias
<input type="checkbox"/> Cognitive Disorder	<input type="checkbox"/> Physical Abuse
<input type="checkbox"/> Concussion	<input type="checkbox"/> Reactive Attachment Disorder
<input type="checkbox"/> Criminal Offenders	<input type="checkbox"/> Relapse Prevention
<input type="checkbox"/> Dementia Disorders	<input type="checkbox"/> Sexual/Physical Abuse (Adults)
<input type="checkbox"/> Development Disorders	<input type="checkbox"/> Sexual/Physical Abuse (Children)
<input type="checkbox"/> Disruptive Behavior	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Dissociative Disorder	<input type="checkbox"/> Serious/Persistent Mental Illness
<input type="checkbox"/> Separation/Divorce	<input type="checkbox"/> Sexual Disorders
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Sexual Dysfunction
<input type="checkbox"/> Dual Diagnosis	<input type="checkbox"/> Sexual Abuse/Incest
<input type="checkbox"/> Depression	<input type="checkbox"/> Sleep Disorder
<input type="checkbox"/> Disabled	<input type="checkbox"/> Step/Blended Families

<input type="checkbox"/>	Eating Disorders	<input type="checkbox"/>	Stress Management
<input type="checkbox"/>	Equine Assisted Therapies	<input type="checkbox"/>	Self-Injury
<input type="checkbox"/>	Family Dysfunction	<input type="checkbox"/>	Sexual Offender
<input type="checkbox"/>	Feeding Disorders	<input type="checkbox"/>	Substance Abuse
<input type="checkbox"/>	Gay/Lesbian/Bisexual	<input type="checkbox"/>	Suicide
<input type="checkbox"/>	Gender Identity Issues	<input type="checkbox"/>	Tobacco Cessation
<input type="checkbox"/>	Grief/Loss/Bereavement	<input type="checkbox"/>	Women Issues
<input type="checkbox"/>	Head Trauma	<input type="checkbox"/>	Work Related Problems
<input type="checkbox"/>	Home Visits		