Initial Provider Data Form

For Credentialing Purposes – Group and Solo providers only.
*(**Not needed for Facility based clinicians**.)*

To begin the credentialing process, please complete **all** required information on this form.
****An email address is required**
All MA providers treating Medicaid members 21 and under, must provide CANS certification number.

Date	**Group/Solo Name:** Transformations hope for today's families LLC		****Email Address:**	
Last Name:		**First Name:**	**Middle Initial:**	
DOB:	**Social Security # :**	**Tax ID:** 61-1351752	**Office Phone:** (502) 899-5411	**Office Fax:** (502) 899-5411
Office Street Address: 4010 Dupont Circle			**Suite:** 582	
City: Louisville	**State:** KY		**County:** Jefferson	**Zip:** 40207
License type: (MD, LICSW, CSW, PHD, LMHC, etc.):		**CANS # :** MA only NA		**License # :**
Are you Board Certified? Yes ☐ No ☑		**If yes, Board Name:**		
Are you registered with CAQH? Yes ☑ No ☐		**If yes, CAQH Provider ID:**		
Contact Person: Teresa Lloyd		**Contact #:** (502) 905-9494		

***Note:** Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation.*

Please mail complete information packet, including signed Contracts
Attention: Credentialing

Beacon Health Strategies
500 Unicorn Park Drive Suite 401
Woburn, MA 01801

BEACON HEALTH STRATEGIES

Beacon Health Strategies
Provider Directory Questionnaire for Disability Competency
Page 1: SITE INFORMATION

Please provide all of the following information for each location.
(Attach extra sheets if necessary.)

Date: 6/5/14	**Beacon Provider ID #:** pending
Provider Name: Transformations	**Corporate Name:** Transformations hope for today's families LLC
Federal Tax Identification Number: 61-1351752 (Please attach a W-9 tax form indicating practice's legal name and tax identification number)	**Site NPI #:** 1427229483
Site Address: 4010 Dupont Circle Suite 582	**City/State/Zip:** Louisville KY 40207
Phone Number: (502) 899-5411	**Fax Number:** (502) 899-5411
Email Address: tlloyd@transformationsllc.net	**TTY Number:**

Hours: Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8 am to 5pm	8 am to 5 pm	8 am to 5pm	8am to 5 pm	8am to 5pm	varies according to need	

Billing Address: 4010 Dupont Circle Suite 582	**Billing Phone:** (502) 899-5411	**Billing Fax:** (502) 899-5411

Currently accepting New Patients? Yes ☑ No ☐	**Medicare Licensed?** Yes ☐ No ☑ **Medicare #:** none
Accessible by Public Transportation? Yes ☑ No ☐	**Handicapped Accessible?** Yes ☑ No ☐
Do you treat: **Individuals?** Yes ☑ No ☐	**Families?** Yes ☑ No ☐ **Couples?** Yes ☑ No ☐

Please indicate the date of next available opening for:	Adult	Adolescent	Child
Intake Appointment	6/6/14	6/6/14	6/6/14
Urgent Visit	6/6/14	6/6/14	6/6/14
Medication Evaluation/Mgmt.			

Please indicate services provided to each of the following:

☑ Adult	☑ Geriatric	☑ Adolescent	☑ Child
☑ therapy ☐ meds	☑ therapy ☐ meds	☑ therapy ☐ meds	☑ therapy ☐ meds

Executive Director Name/Address: Laura Krebs Lewis 4010 Dupont Cir Suite 582 Louisville KY 40207	**Email Address/Phone/Fax:** lkrebslewis@transformationsllc.net/502-899-5411/502/899/5411
Mental Health Program Contact Name/Address: Teresa Lloyd 4010 Dupont Cir Suite 582 Louisville KY 40207	**Email Address/Phone/Fax:** tlloyd@transformationsllc.net/502-899-5411/502/899/5411
Substance Abuse Program Contact Name/Address: Teresa Lloyd 4010 Dupont Cir Suite 582 Louisville KY 40207	**Email Address/Phone/Fax:** tlloyd@transformationsllc.net/502-899-5411/502/899/5411
Claims/Billing Contact Name/Address: Renee Klein 4010 Dupont Cir Suite 582 Louisville KY 40207	**Email Address/Phone/Fax:** office@transformationsllc.net/502-899-5411/502/899/5411
Credentialing Contact Name/Address: Teresa Lloyd 4010 Dupont Cir Suite 582 Louisville KY 40207	**Email Address/Phone/Fax:** tlloyd@transformationsllc.net/502-899-5411/502/899/5411
Contracting Contact Name/Address: Teresa Lloyd 4010 Dupont Cir Suite 582 Louisville KY 40207	**Email Address/Phone/Fax:** tlloyd@transformationsllc.net/502-899-5411/502/899/5411
Intake Coordinator Contact Name/Address: Lisa Coleman 4010 Dupont Cir Suite 582 Louisville KY 40207	**Email Address/Phone/Fax:** lcoleman@transformationsllc.net/502-899-5411/502/899/5411
Office Manager Contact Name/Address: Renee Klein 4010 Dupont Cir Suite 582 Louisville KY 40207	**Email Address/Phone/Fax:** office@transformationsllc.net/502-899-5411/502/899/5411
Drug/Patient Safety Contact Name/Address: Laura Krebs Lewis 4010 Dupont Cir Suite 582 Louisville KY 40207	**Email Address/Phone/Fax:** lkrebslewis@transformationsllc.net/502-899-5411/502/899/5411
Contact Name/Address for Authorization Letters: Renee Klein 4010 Dupont Cir Suite 582 Louisville KY 40207	**Email Address/Phone/Fax:** office@transformationsllc.net/502-899-5411/502/899/5411
Authorization Letter Email: office@transformationsllc.net	**Mailing Address:** **Phone/Fax:** **(Should Authorization letters go to this fax? Yes ☑ No ☐)**

Beacon Health Strategies/Chartered Health Plan
Provider Directory Questionnaire for Disability Competency
Page 2: SITE-SPECIFIC ACCOMMODATIONS

Please provide the following additional information for each Beacon in-network location. (Attach extra sheets if necessary.) This information will be made available to members for referral purposes.

Provider Name: Transformations hope for today's families LLC	
Site Name: Transformations	
Alternate Site Address (if different location is used just for handicapped access, indicate name, proximity, address and address, e.g., VFW, across the street, 18 Main St.):	**City/State/Zip:** 4010 Dupont Circle Suite 582 Louisville KY 40207

Check all that apply in the boxes below:

Professional Experience & Capabilities:

- ☐ Cultural Diversity
  # of staff _____
- ☐ Disabled Populations
  # of staff _____
- ☐ Domestic Violence
  # of staff _____
- ☐ Dual Diagnosis (mental health/substance abuse)
  # of staff _____
- ☐ Home Visits
  # of staff _____
- ☐ Sexual Abuse
  # of staff _____

Physical Accessibility:

- ☑ Wheelchair accessible public transit routes
- ☑ Designated handicapped parking
- ☑ Passenger pick-up and drop-off zone
- ☑ Home Visiting
- ☑ Building access ramp
- ☑ Walkway free of stairs and obstacles
- ☑ Wheelchair accessible office entrance / reception area
- ☑ Wheelchair accessible treatment space
- ☑ Wheelchair accessible lavatory
- ☐ All services available on ground level
- ☑ Elevator / Lift
- ☐ Saff experienced with wheelchair transfer techniques

Communication & Scheduling:

- ☐ TTY/ TDD (Telephone Typewriter/ Telephone Device for the Deaf)
- ☑ Flexible appointment times, including evenings and/or weekends
- ☐ Patient information in Braille
- ☑ Patient information in large print
- ☐ Staff fluent in American Sign Language (# of staff _____)
- ☐ Staff fluent in languages other than English (# of staff _____)

After-Hours Accessibility:

- ☐ Answering service with one or more clinicians on call 24 x 7
- ☑ Beeper/direct number given to members to reach clinician on-call 24 x 7
- ☐ Other (specify):

Attach Extra Sheets if Needed.

BEACON HEALTH STRATEGIES

Beacon Health Strategies
Provider Directory Questionnaire
CLINICIAN INFORMATION FORM

Please copy and complete this entire form for each clinician.

Facility Name: Transformations		Facility Beacon ID#: pending
Address: 4010 Dupont Circle Suite 582	Tax ID:	Accepting new referrals? Yes No
Clinician First:	Clinician Last:	Middle Initial:
Gender: Male ☐ Female ☑	Date of Birth:	Clinician License #: / Clinician NPI #:
Medicaid ID#: 7100267430	Medicare#: none	Taxonomy:
CANS (MA Only): Not Applicable		

Licensure:

☐ MD	☐ PHD	☐ CSAC	☐ LCSW	☐ LICSW	☐ RN
☐ DO	☐ LMFT	☐ PSYD	☐ CADAC	☐ MSNCS	☐ RNCS / CNS
☐ LMHC	☐ LMSW	☐ NP	☐ LPC	☐ Other (specify):	

Ethnicity:

☐ African American	☐ Asian	☐ Caucasian	
☐ Latino / Hispanic	☐ Native American	☐ Other (specify):	

Language(s):

☐ American Sign Language	☐ Cambodian	☐ English	☐ French
☐ Haitian Creole	☐ Laotian	☐ Portuguese	☐ Russian
☐ Spanish	☐ Vietnamese	☐ Other (specify)	

Specialties: Please indicate top 10 areas of expertise. **Shaded** specialties require submission of attached **Specialty Verification Form**. To qualify as "disability competent" in RI, at least one asterisked (*) specialty must be checked.

☐ **Abuse (Physical)**	☐ Cultural Diversity*	☐ Methadone
☐ **Abuse (Sexual)** *	☐ DBT (**Please include certification**)	☐ Mood Disorders
☐ Acupuncture Detoxification	☐ Depression	☐ **Neuropsychological Testing**
☐ Addiction Psychiatry	☐ DID/MPD	☐ OCD
☐ **Addictions/ Substance Abuse**	☐ Disabilities – Developmental / MR *	☐ Pastoral Counseling
☐ ADHD	☐ Disabilities – Hearing Impaired *	☐ Personality Disorders
☐ Adolescents	☐ Disabilities – Learning *	☐ **Post Partum Depression**
☐ Adoption	☐ Disabilities – Physical *	☐ Psychiatry & Neurology
☐ Adult	☐ Disabilities – Visually Impaired *	☐ Psychiatry
☐ Affective Disorders	☐ **Domestic Violence** *	☐ **Psychological Testing**
☐ Alzheimer/Dementia	☐ Dual Diagnosis (MH/SA) *	☐ Psychology
☐ Ambulatory Detoxification	☐ EAP	☐ Psychopharmacology
☐ Anger Management	☐ **Eating Disorder**	☐ Psychotherapy
☐ Anxiety Disorder	☐ ECT	☐ Psychotic Disorders
☐ Applied Behavioral Analysis	☐ EMDR (**Please include certification**)	☐ PTSD
☐ **Autism Spectrum Disorders** *	☐ Family	☐ Refugees
☐ Bariatric Counseling	☐ **Fire-Setting**	☐ School Based
☐ Bereavement	☐ **Forensic**	☐ **Sex Offenders**
☐ Borderline Personality Disorder	☐ Gambling	☐ Sexual Addictions
☐ Certified Drug/Alcohol Counselor	☐ Gay/Lesbian/Bisexual	☐ Sexual Disorders
☐ Certified Social Worker	☐ Gender Identity	☐ Sexual Dysfunction
☐ **Child Abuse**	☐ **Geriatric**	☐ Sleep Disorders
☐ Child Oppositional Defiant	☐ Group Therapy (**Please Specify Type**): domestic violence and adolescents	☐ SPMI (Severe & Persistently Mentally Ill)
☐ Child Psychiatry	☐ Head Injury	☐ Suboxone/ Buprenorphine
☐ Child Psychopharmacology	☐ HIV/AIDS	☐ Terminal Illness
☐ Child/ Pediatric	☐ Home Visits *	☐ Transgender
☐ Chronic Pain	☐ Homeless/Outreach	☐ Veteran's Issues
☐ Cognitive/Behavioral Therapy	☐ Immigrant Populations	☐ Victim Awareness
☐ Couples	☐ Low Income Populations *	☐ Women
☐ CSN (Children w/Special Health Care Needs)	☐ Men	

Beacon Health Strategies
Provider Directory Questionnaire

SPECIALTY VERIFICATION FORM

Please copy and complete this entire form for each clinician.

Providers who have indicated specialties in **Abuse (Physical), Abuse (Sexual), Addictions/Substance Abuse, Autism Spectrum Disorders, Child Abuse, Domestic Violence, Fire-Setting, Forensics, Geriatrics, Neuropsychological Testing, Post Partum Depression, Psychological Testing** or **Sex Offenders** must attest to the following criteria:

- Independent licensure.
- 10-20 hours of documented training (continued education, etc) in past 1-2 years (and/or internship or postdoctoral fellowship in specialty)
- 200 hours of direct clinical contact in past 5 years
- Access to (*check one or both of the following*):
  - ☐ supervision with a professional in the field.
  - ☐ supervision with a peer supervision group.
- Access to a prescribing provider (network or out-of-network).

Providers who have indicated a specialty in **Eating Disorders**, please answer the following questions:

1) What percentage of your practice involves eating disorders? 0% %
2) Are you a member of a state or national Eating Disorders provider network? If so, please indicate which organization(s):_____
3) Are you familiar with best practices in the eating disorder area, including familiarity with the recent "Carlat Psychiatry Report, Oct 2007?" ____
4) Are you prepared to do the necessary collateral work required for this population? (Work with this population requires coordination and collaboration with client's medical provider, dietician, family therapist, etc.) _____

Attestation Statement

The undersigned hereby certifies that the above information requested by BEACON HEALTH STRATEGIES, LLC is truthful, correct and complete in all respects, and the undersigned further understands that the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as a participating physician with BEACON HEALTH STRATEGIES, LLC. The undersigned hereby agrees to notify BEACON HEALTH STRATEGIES, LLC of any changes in the above information.

_____ _____

Signature (Original Signature Required) **Date**

_____

Printed name/Title