FAIRFAX-FALLS CHURCH
COMMUNITY POLICY & MANAGEMENT TEAM
Children's Services Act
FY2017 Provider Application

* This document is **FILLABLE**. To complete the application, fill in the blanks with the requested information. Attach additional sheets if needed. Attach all requested supplemental documents.

Provider Name:					
Business Address:					
City:		State		Zip	
Phone Number:			Fax No.		
EIN:					
Mailing Address (if different from above)					
City:		State		Zip	
Agency Director:			Title		
E-mail:			Phone		
Primary Billing Contact:			Title		
E-mail:			Phone		
Current Fairfax-Falls Church CSA Provider:	Yes No		**Nonprofit Agency**	Yes No	
Attach an organization chart for all services offered through this application.					
If your company is a subsidiary of another company, complete the following:					
Parent Company:			Phone		
Business Address:					
City:			State		
EIN:					
CEO			Phone		

Provider Narrative: (provide a brief description of the organization, including mission and the history of the organization.)	

Licensure and Accreditation

Licensure: List each license issued by the State (do not include individual clinician licenses)				
Type of License			Issuing Entity:	
Date of issue		Expiration Date		Attach copy of License
Type of License			Issuing Entity:	
Date of issue		Expiration Date		Attach copy of License
Type of License			Issuing Entity:	
Date of issue		Expiration Date		Attach copy of License
Accreditation: List each certification and/or accreditation held by the organization				
Type of accreditation/ certification:			Issuing Entity:	
Date of issue		Expiration Date		Attach copy of certification
Type of accreditation/ certification:			Issuing Entity:	
Date of issue		Expiration Date		Attach copy of certification
Type of accreditation/ certification:			Issuing Entity:	
Date of issue		Expiration Date		Attach copy of certification

Fairfax County is an Equal Opportunity Employer that does not discriminate on the basis of race, color, sex, creed, religion, national origin, age, disability, genetic information, veterans' status or disabled veterans' status.

Medicaid Enrollment	
Virginia Medicaid (Magellan) Provider Number:	
Medicaid Eligible Services Offered:	☐ Treatment Foster Care ☐ Residential Treatment Services, Level A, B or C ☐ Outpatient Services ☐ Intensive In Home Services ☐ Mental Health Support Services ☐ Behavior Therapy/Modification
Liability Insurance Provider (Provide verification)	
Private Insurance Accepted: (List Third Party Payers)	

Facility/Service Locations					
If applicable, include information regarding all locations at which services may be provided of awarded an Agreement for the Purchase of Services. Use additional pages if necessary					
Facility Name:					
Facility Address:					
City:		State		Zip	
Phone Number:		Fax No.			
Mailing Address (if different from above)					
City:		State		Zip	
Facility/Program Director:		Title			
E-mail:		phone			

Department of Administration for Human Services
Contracts & Procurement Management
12011 Government Center Parkway, Suite 738
Fairfax, VA 22035
Phone: 703-324-5630 Fax: 703-324-7339 TTY: 711
http://www.fairfaxcounty.gov/admin/cm/

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Primary Billing Contact:		Title			
Facility/Service Location					
Facility Name:					
Facility Address:					
City:		State		Zip	
Phone Number:		Fax No.			
Mailing Address (if different from above)					
City:		State		Zip	
Facility/Program Director:		Title			
E-mail:		Phone			
Primary Billing Contact:		Title			
E-mail:		Phone			

Application Checklist: Before signing and submitting this application, the signature authority has reviewed and the following documents are attached:

- ☐ Completed Application
- ☐ Accord Certificate of Insurance
- ☐ Organizational Chart for offered programs
- ☐ Program description and offered services.
- ☐ Copies of licenses for each service and location
- ☐ Verification of accreditation
- ☐ Completed Individual Clinician Qualifications supplement for **ALL** offered clinicians with resumes and licensure verification.
- ☐ W-9

All of the information in this application is accurate and truthful. This application is submitted with the intent to enter into an Agreement for the Purchase of Services as a Provider of Services with the Fairfax-Falls Church CPMT.

_____
Signature of Authorized Individual and Date

_____
Title

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