

MHMRA of Harris County
PROVIDER APPLICATION FOR ECI PROGRAM

A. General Information

Last Name		First Name		Middle Initial	Professional Designation or Title
Preferred Mailing Address Line 1			Preferred Mailing Address Line 2		
City		State	Zip	Telephone	
Social Security Number (REQUIRED)		Date of Birth (REQUIRED)	Sex	MHMRA CONTRACT ID NUMBER (INTERNAL USE ONLY)	

B. Primary Office Information

Make checks payable to (must match tax ID owner name on file with IRS for the EIN listed below)					Type of Corporation
Billing Address Line 1			Billing Address Line 2		
City		State	Zip	Telephone	
Employer Identification Number (EIN)		W-9 on file (submit form if blank)		Your Medicare/UPIN Number	Your Medicaid Number

Hours available to provide services:

Monday		Tuesday		Wednesday		Thursday		Friday	
From	To	From	To	From	To	From	To	From	To

Identify any foreign language(s) or sign language that you speak fluently in treating patients (select no more than 5):

<input type="checkbox"/> Arabic (AR)	<input type="checkbox"/> Chinese (CH)	<input type="checkbox"/> Farsi (FA)	<input type="checkbox"/> French (FR)	<input type="checkbox"/> German (GE)
<input type="checkbox"/> Hebrew (HE)	<input type="checkbox"/> Hindi (HI)	<input type="checkbox"/> Italian (IT)	<input type="checkbox"/> Japanese (JA)	<input type="checkbox"/> Korean (KO)
<input type="checkbox"/> Laotian (LA)	<input type="checkbox"/> Portuguese (PO)	<input type="checkbox"/> Russian (RU)	<input type="checkbox"/> Sign Language (SL)	<input type="checkbox"/> Spanish (SP)
<input type="checkbox"/> Vietnamese (VI)	<input type="checkbox"/> Tagalog (TA)	<input type="checkbox"/> Other (specify): _____		

C. Referral Information

Identify the percentage of your practice time dedicated to the following patient population:

Population	% of Practice
Toddler (birth to 2)	
Child (3 – 6)	
Adolescent (7-18)	
Adult (18-65+)	

D. License/Certification Information

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PROFESSIONAL LICENSE(S): List below your current professional license(s). To expedite credentialing, submit a copy of your current state license.

Board Name	Certificate #	Cert. Date	Exp. Date

E. Malpractice (Professional Liability) Insurance

List below your current malpractice carrier. Enclose a copy of your current policy certificate and/or declarations page showing the coverage limits and dates of coverage.

Current Carrier (Name and Certificate Number)	Policy Number	Dates of Coverage	Coverage Limits

In the space provided below, list the name and address of the malpractice carrier who has provided coverage for you for the most recent five (5) year period. **If there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.**

Carrier (Name and Address)	Policy Number	Dates of Coverage	Reason for Changing Carriers

F. Education Information

Educational Institution (include name and complete address)	Degree	From (mm/yy)	To (mm/yy)
Undergraduate			
Graduate School			
Internship			

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CONTINUING EDUCATION: List any continuing education seminars/workshops you have attended in the past 24 months. Please attach copy of CEU certificate(s) of completion or you may attach a copy of your Accredited Continuing Education Agency's Report, if applicable.

Course Subject	Sponsoring Organization (Name and Address)	Date Completed (mm/dd/yy)	# of CEUs Awarded

G. Work History

List below all work history for a five (5) year period beginning with the current. **Please explain fully any gaps of six months or more on a separate sheet of paper.** A current Curriculum Vitae (must specify month and year) may be submitted.

From (Month/Year)	To (Month/Year)	Description of Activities

H. Attestation

NOTE: If "YES" is checked, **please explain fully** on a separate sheet. Documentation is required if you have malpractice claims pending or settled in the past five (5) years (include any settlements/adjudication's, original complaint and final disposition). Your signed statement regarding the alleged incident will suffice for pending cases.

1. **Health Status:** Do you currently have any physical, mental, or emotional condition which may impair your ability to render the professional services which are the subject of this application?..... Yes No
 - a. Do you currently use illegal drugs or abuse drugs or alcohol?..... Yes No

2. **Insurance Coverage:** Has your malpractice (professional liability) insurance coverage ever been denied, canceled, or non-renewed or initially refused upon application?..... Yes No

3. **License:** Has your professional license in any state ever been revoked, suspended, placed on probation, conditional status, or limited?..... Yes No
 - a. Have you ever voluntarily surrendered your license?..... Yes No
 - b. Are formal charges pending against you at this time? Yes No

4. **Professional Membership(s):** Has your membership in any professional society or association ever been canceled, revoked, or censured?..... Yes No

5. **Medicare/Medicaid:** Have you ever been fined, had an arrangement suspended, been expelled from

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- participation or had criminal charges brought against you by Medicare or Medicaid?..... Yes No
6. **Criminal Offenses:** Have you ever been convicted of a felony or involved in charges relating to moral or ethical turpitude?..... Yes No
- a. Have you ever been named as a defendant in any criminal proceeding?..... Yes No
7. **Board Discipline:** Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county; state or national professional society hospital medical or clinical staff)?..... Yes No
8. **Malpractice Action:** Has any malpractice action against you been brought or settled in the last 5 years or has there been any unfavorable judgment(s) against you in a malpractice action?..... Yes No
- a. To your knowledge, is any malpractice action against you currently pending?..... Yes No
9. **Federal or State Compliance:** Do you have the ability to comply with relevant state/federal regulations? Yes No
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- a. Have you ever been held in abeyance or barred from the award of a federal or state contract? Yes No
- b. Have you ever been delinquent or in unfavorable standing for state tax, pursuant to the Texas Business Corporation Act, Texas Civil Statutes, Article 2.45? Yes No

I hereby attest that the information above is true and correct.

 Signature

 Date (mm/dd/yy)

PARTICIPATION STATEMENT

I fully understand that if any matter stated in this application is or becomes false, MHMRA ECI (EARLY CHILDHOOD INTERVENTION) Program will be entitled to terminate my provider agreement for breach. All information submitted by me in this application is warranted to be true, correct and complete.

I authorize MHMRA ECI (EARLY CHILDHOOD INTERVENTION) Program to consult with the National Practitioners Data Bank, state licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Council for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character and moral and ethical qualifications, and I also authorize all of them to release such information to Client. I release MHMRA ECI (EARLY CHILDHOOD INTERVENTION) Program and its employees and all those whom MHMRA ECI (EARLY CHILDHOOD INTERVENTION) Program contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I consent to the release by any person to MHMRA ECI (EARLY CHILDHOOD INTERVENTION) Program of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualification, including any information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

 Signature of Applicant

Date (mm/dd/yy): ____ / ____ / ____

 Name (Please Print)