PRACTITIONER EMPLOYMENT ASSISTANCE\SUPPORTED EMPLOYMENT APPLICATION

PROVIDER IDENTIFICATION			
Last Name:	First Name:	Middle Name:	
Social Security Number (SSN)- Required:		Date of Birth: __________/___________/__________	
Contact Person:		Email:	
Medicaid #1:		Medicare #1:	
PROVIDER TYPE			
Supported Employment: __Supported Employment (S.281)			
PRIMARY OFFICE /SERVICE ADDRESS			
Practice Location Name:			
Address Line 1:			
Address Line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:	Primary Contact:	
Administrator (Full Name):			
Does Provider bill from this address? ☐ Yes ☐ No			
Does this office meet ADA accessibility requirements? ☐ Yes ☐ No			
Check all that apply: Handicap Accessible: ☐ Building ☐ Parking ☐ Restroom Services for Disabled: ☐ Text Telephone ☐ American Sign Language ☐ Mental/Physical Impairment Accessible by Public Transportation: ☐ Bus ☐ Subway ☐ Regional Train			
PROFESSIONAL EDUCATION			
Undergraduate /High School	City	State	
Degree Received	Date of Graduation		
WORK HISTORY			

Please attach a copy of your current resume that shall include your documented experience providing services to people with disabilities within a professional setting, including number of years of experience.

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BILLING INFORMATION			
Name (Billing Name)			
Address Line 1:			
Address Line 2:			
City:	State:	ZIP:	Phone:

SECONDARY OFFICE /SERVICE ADDRESS (Attach separate sheet of paper for additional practice locations)			
Practice Location Name:			
Address Line 1:			
Address Line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:	Primary Contact:	
Administrator (Full Name):			
Does Provider bill from this address?	☐ Yes ☐ No		
Does this office meet ADA accessibility requirements?	☐ Yes ☐ No		

Check all that apply:

Handicap Accessible:	☐ Building	☐ Parking	☐ Restroom
Services for Disabled:	☐ Text Telephone	☐ American Sign Language	☐ Mental/Physical Impairment
Accessible by Public Transportation:	☐ Bus	☐ Subway	☐ Regional Train

BILLING INFORMATION			
Name (Billing Name)			
Address Line 1:			
Address Line 2:			
City:	State:	ZIP:	Phone:
Social Security Number (SSN):		Date of Birth:	

LICENSURE:			
State:	Date of License:	License Number:	Expiration Date:
State:	Date of License:	License Number:	Expiration Date:

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GENERAL AND PROFESSIONAL LIABILITY INSURANCE	
General Liability Coverage	
Current Carrier Name:	
Policy Number:	Coverage Type: ☐ Occurrence Based ☐ Claims Based
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $
Professional Liability Coverage	
Current Carrier Name:	
Policy Number:	Coverage Type: ☐ Occurrence Based ☐ Claims Based
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $

ATTESTATION AND INFORMATION RELEASE AUTHORIZATION

All information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify Amerigroup of any changes thereto. I understand that this application does not entitle me to participation in Amerigroup. By applying for appointment as an Amerigroup Participating Provider, I authorize the Plan, its medical director and appropriate representatives to consult with administrators and members of other institutions where I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by Amerigroup, its medical director and appropriate representatives of all records and documents, excluding medical records of nonmembers of Amerigroup's Plans, that may be material to an evaluation of any professional qualifications and competence to carry out the requested duties, as well as my moral and ethical qualifications for Participating Provider status with Amerigroup. I consent and agree that Amerigroup will complete a criminal history background check to determine if I have any history of felony convictions, including adjudication withheld on a felony, plea or nolo contendere to a felony or entry into a pretrial for a felony. I hereby release Amerigroup and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release any individuals and organizations from any liability that provide information to Amerigroup or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the Provider Agreement between me and Amerigroup, as such terms may be applicable to me.

I understand that as an applicant for participation in Amerigroup, I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from Amerigroup, I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the Credentialing Committee, if they so request. I further understand that I may appeal the Committee's decision either in writing or by appearance before the Credentialing Committee, if they so request.

Printed Name: ____ Date:________________________

Signature: ____ Title:________________________

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Employee Assistance (EA) Supported Employment (SE) Applicants Only

Please answer the following questions:

1. **Education and Training:** a. Do you have a bachelor's degree in rehabilitation, business, marketing, or a related human services field and have six months of documented experience providing services to people with disabilities in a professional or personal setting? b. Do you have an associate's degree in rehabilitation, business, marketing, or a related human services field and one year of documented experience providing services to people with disabilities in a professional or personal setting? c. Do you have a high school diploma or GED, and two years of documented experience providing services to people with disabilities in a professional or personal setting?	a. □ Yes □ No b. □ Yes □ No c. □ Yes □ No
2. Have you ever been convicted of, pled guilty to or pled nolo contendere to any felony in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a professional? If yes, please explain below. (You may use a separate sheet of paper if necessary) ____ ____ ____ ____ ____ ____	□ Yes □ No
3. Have you ever been convicted of, pled guilty to or pled nolo contendere to any felony in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that is alleged fraud, and act of violence, child abuse, or a sexual offense or sexual misconduct? If yes, please explain below. (You may use a separate sheet of paper if necessary) ____ ____ ____ ____ ____ ____	□ Yes □ No
3. Have you ever been indicted in any civil or criminal suit? If yes, please explain below. (You may use a separate sheet of paper if necessary) ____ ____ ____ ____ ____	□ Yes □ No

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4. Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)	□ Yes □ No
5. Do you use any chemical substances that would in any way impair or limit your ability to practice the functions of your job with reasonable skill and safety?	□ Yes □ No
6. Are you unable to perform the essential functions of a practitioner in your area of practice even w reasonable accommodation?	□ Yes □ No
7. **Knowledge of State Requirements:** The rendering service practitioner must be knowledgeable of the following: a. Acts that constitute abuse, neglect, or exploitation of a member, as defined in 40 TAC Chapter 705, Subchapter A; b. Reports suspected abuse, neglect, or exploitation as instructed; c. Adheres to applicable state laws when providing transportation, and d. May not be a spouse, legally responsible for person or employment supervisor of the member who receives the service.	a. □ Yes □ No b. □ Yes □ No c. □ Yes □ No d. □ Yes □ No

ATTACHMENTS

Please submit all applicable documents from the list below with your completed and signed application. Failure to provide this information will prohibit Amerigroup from completing your credentialing and/ or contracting process.

□ Copy of current resume