

Provider Application Instructions:

Thank you for applying to become a DCS vendor! We look forward to reviewing your materials so that we can consider partnering with you to provide services to our population. In order to make this process most efficient, we request that you submit your materials electronically either:

- Via email to Elvie Newcomb (Elvie.Newcomb@tn.gov) and Shannon Patterson (Shannon.M.Patterson@tn.gov)
- Mail a flash drive with these attachments to:
 - TN Department of Children's Services
 - Attn.: Elvie Newcomb or Shannon Patterson
 - 315 Deaderick Street
 - UBS Tower, 10th Floor
 - Nashville, TN 37243

Application materials to return:

- Eight page application form including signature
 - Name this file as PROVIDER Application.pdf (Ex. Counselors R Us Application.pdf)
- W-9 tax form
 - Name this file as PROVIDER W9.pdf (Ex. Counselors R Us W9.pdf)
- Additional attachments per service type (see table below)

The following table shows which materials are required for each service and the preferred file names. Where sample reports are required, please redact all reports, removing identifying information.

Section 1 – Behavioral Health		
Service Type	Submission Materials	Preferred File Name
Anger Management/Conflict Resolution*	Submission material required is a Program Summary/Description -Indicate the evidence-based approach used	PROVIDER Anger mgt.pdf
Alcohol and Drug Assessment	Submission material required is a recent (within the last year) redacted sample report conducted by a licensed Mental Health Professional (Master's or above) or LADAC either Level I or II.	PROVIDER A and D report.pdf
Alcohol and Drug Treatment*	Submission material required is a Program Summary/Description -Indicate the evidence-based approach used	PROVIDER A and D description.pdf
Assessment for Children with Sexual Behavior Problems (Ages 12 and under)	Submission material required is a recent (within the last year) redacted sample report conducted by a licensed Mental Health Professional (Master's or above)	PROVIDER Child SBP report.pdf
Intensive In-Home Family Services*	Submission material required is a Program Summary/Description -Indicate the evidence-based approach used	PROVIDER in home.pdf
Mental Health Assessment	Submission material required is a recent (within the last year) redacted sample report conducted by a licensed or licensure-track Mental Health Professional (Master's or above)	PROVIDER Mental Health Assessment.pdf
Mental Health Case Management	Submission material required is a Program Summary/Description	PROVIDER Case mgt.pdf

Parenting Capacity Assessment	Submission material required is a recent (within the last year) redacted sample report conducted by a licensed Mental Health Professional (Master's or above)	PROVIDER Parenting Capacity.pdf
Neuropsychological Assessment - Child	Submission material required is a recent (within the last year) redacted sample report conducted by a TN Licensed Psychologist	PROVIDER Neuropsych Child.pdf
Neuropsychological Assessment - Adult	Submission material required is a recent (within the last year) redacted sample report conducted by a TN Licensed Psychologist	PROVIDER Neuropsych Adult.pdf
Psychosexual Assessment - Adolescent (Ages 13-17)	Submission material required is a recent (within the last year) redacted sample report conducted by a licensed or licensure-track Mental Health Professional (Master's or above)	PROVIDER Psychosexual Adol.pdf
Psychosexual Assessment - Adult (Ages 18 and up)	Submission material required is a recent (within the last year) redacted sample report conducted by a licensed or licensure-track Mental Health Professional (Master's or above)	PROVIDER Psychosexual Adult.pdf
Psychological Assessment - Child/Youth	Submission material required is a recent (within the last year) redacted sample report conducted by a TN Licensed Psychologist or independently Licensed Psychological Examiner	PROVIDER Psychological Child.pdf
Psychological Assessment - Adult	Submission material required is a recent (within the last year) redacted sample report conducted by a TN Licensed Psychologist or independently Licensed Psychological Examiner	PROVIDER Psychological Adult.pdf
Psychoeducational Assessment	Submission material required is a recent (within the last year) redacted sample report conducted by a TN Licensed School Psychologist, a Licensed Psychologist or an independently Licensed Psychological Examiner	PROVIDER Psychoed.pdf
Psychotherapy or Counseling*	Submission material required is a Program Summary/Description -Indicate the evidence-based approach used	PROVIDER Therapy.pdf
Therapy or Counseling for Sex Offender Treatment	Submission material required is a Program Summary/Description	PROVIDER Therapy SO.pdf

Section 2 – Alcohol and Drug Testing		
Service Type	Submission Materials	Preferred File Name
Fingernail Analysis	Redacted Report, Lab Status and Details	PROVIDER Fingernail.pdf
Hair Analysis	Redacted Report, Lab Status and Details	PROVIDER Hair.pdf
Medical Review of Drug Screen	Redacted Report, Lab Status and Details	PROVIDER Med Review.pdf
Urine Analysis	Redacted Report, Lab Status and Details	PROVIDER Urine Analysis.pdf
Extended Panel Urine Analysis	Redacted Report, Lab Status and Details	PROVIDER Extended Urine.pdf

Section 3 – Other Services		
Service Type	Submission Materials	Preferred File Name
Homemaker Services	Submission material required is a Program Summary/Description	PROVIDER Homemaker.pdf
Interpreter	Submission material required is a Program Summary/Description	PROVIDER Interpreter.pdf
Parent Education/Class	Submission material required is a Program Summary/Description	PROVIDER Parent Ed/Class.pdf
Prevention and Diversion Case Management Services**	Submission material required is a Program Summary/Description -Indicate the evidence-based and/or evidence-informed approach used	PROVIDER Case Mgt.pdf
Sitter Services	Submission material required is a Program Summary/Description	PROVIDER Sitter.pdf
Tutoring	Submission material required is a Program Summary/Description	PROVIDER Tutoring.pdf

Program summaries include the following:

- **An overview of the program used**
- **The frequency and duration of sessions**
- **The location(s) and setting(s) in which the services are provided**

Provider Application

Provider Information

I. Contact Information

Enter the provider's name and all contact information below. If multiple locations are involved, please include attachment with all additional locations and the service types for each.

Name of Organization

Address

City

State

Zip

Contact Name

Contact Phone

Contact Fax

Contact E-mail

II. Business Information

A. Select the appropriate box below of the business type:

Sole Proprietorship

Partnership

Limited Liability Partnership

Limited Liability Company

Corporation

Other Incorporated Entity, eligible to do business in Tennessee (please explain below.)

B. Select the provider's incorporation status:

Not-for-profit

For-profit

Governmental

Other (Please explain below.)

C. Is the business considered a small business according to the Tennessee Department of Treasury?

Yes

No

To qualify as a small business, a company must be a business type listed in Section B above and be located in and maintain operations in Tennessee with annual gross receipts of less than \$4,000,000.

- D. Indicate below how long the business has been in existence.

- E. List and explain below any complaint filed against this business and/or its employees.

- F. Please provide the names of up to three businesses, insurance entities (medical or behavioral), or government entities to which you are currently providing services or that you have provided services. If no such names can be obtained, explain below.

Business and Personnel Documentation

III. Attachments:

- A. Service Checklist

- B. Regional Structure

- C. Direct Contact Staff Roster

IV. Staff Qualifications and Professional Licensure

- A. Providers and their employees, interns, volunteers, and if applicable, subcontractors, must have and maintain all appropriate Tennessee licenses and/or certifications required to provide the services offered.

- B. All professional licenses and/or certifications held must be current and in good standing. Providers submit license numbers for all licensed personnel so that they can be verified on the State of Tennessee website.

- C. When an employee, intern, volunteer, and if applicable, subcontractor, is on licensure track, a statement of the license pursued is required and the supervision guidelines provided by the applicable licensing board will be followed. Furthermore, information regarding the person providing clinical supervision must be submitted, including that person's license(s), certification(s), malpractice/professional liability insurance, and that person's legal name, and if different, the name on the documents submitted.

- D. Upon approval, all direct service staff, will complete applicable background check(s) and provide results to DCS on form CS-0687- Background Check Checklist and form CS-0741 - Data Base Search Results. Providers are required to notify DCS if the individual provider, an employee, intern, volunteer, or if applicable, subcontractor working with DCS clients commits any malfeasance during the period the provider is approved to provide services. Notifications must be made promptly and sent to the Regional Fiscal Director and Regional Administrator.

V. Approval

Approval of service type(s) and rates are valid for two (2) years from the date of approval. Being an approved provider does not guarantee the utilization of said services by any DCS region. The Department will consider all monitoring information and any reported concerns in the assessment of provider performance.

VI. Disapproval and Withdrawal of Approval Status

The Department reserves the right to disapprove any application for a provider that fails to meet the qualifications specified in this application. The Department reserves the right to withdraw approval at any time if a provider fails to meet the qualifications, or for cause.

VII. Certification

I certify, under penalty of perjury, that all of the information provided above and submitted with this application is true and correct to the best of my knowledge. I also certify that all persons providing services approved through this process have had/will have and passed all applicable background checks, as required, prior to delivery of any services.

Printed Name

Title

Signature

Date