Children, Youth & Family Network
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PRELIMINARY APPLICATION

Provider or Agency Name: _____

Office Address: _____ Phone: _____

City, State, Zip: _____ FAX: _____

Mailing Address
(If different from above): _____

_____

Administrative Contact: _____ Email: _____

Type of Organization: ☐ Association ☐ Private Practice ☐ Corporation

☐ Other: _____

Payor Source(s) Accepted: ☐ Insurance *(List which policies):* _____

☐ Sliding Scale ☐ Other: _____

Tax Status: ☐ Non-Profit ☐ For-Profit ☐ Other: _____

1. Type of Practice Model:

☐ Independent Provider ☐ Single-Site Clinic Model ☐ Multiple-Site Clinic Model

☐ Community-Based Organization ☐ Other: _____

2. Describe the type of services your organization provides: _____

_____

_____

_____

_____

For CYFN Use Only

Service Codes			
	A = Mental Health Services B = Mentoring C = In-home Counseling D = Alcohol/Substance Abuse E = Respite Care	F = Behavioral Management G = Day Treatment H = Life Skills I = Emergency Shelter/Care J = Parent/Family Support & Training	K = Child Care L = MHS/Medication Support M = Faith-Based Counseling N = Case Management / Brokerage O = MHS/Crisis
Service Codes:			

C:\WINDOWS\Desktop\Culled Pieces\Preliminary Application.doc
Revised: 5/20/02

1. Has there been a malpractice claim filed against you, your organization or any employee relating to the provision of mental health, chemical dependency or any other services in which settlement or disposition resulted in a payment of $10,000 or greater during the last five (5) years?

   ☐ Yes *(If yes, please attach a confidential listing of each claim filed.)*

   ☐ No

2. Has your organization or any employee been sanctioned, placed on probation, or lost accreditation, licensure or certification status during the last five (5) years?

   ☐ Yes *(If yes, please attach a description of the nature and reasons for the sanction(s).)*

   ☐ No

3. CYFN will conduct site visits as part of their review of your organization. Please indicate whether or not you have the following on file:

a)	List of key official/officers:	☐ Yes	☐ No	☐ N/A
b)	Organizational By-Laws:	☐ Yes	☐ No	☐ N/A
c)	Articles of Incorporation:	☐ Yes	☐ No	☐ N/A
d)	Verification of Tax Status:	☐ Yes	☐ No	☐ N/A
e)	Personnel Records of all staff, which include: all relevant licenses, credentials, degrees and work experience:	☐ Yes	☐ No	☐ N/A
f)	Relevant licenses, certifications and insurance:	☐ Yes	☐ No	☐ N/A
g)	Policies and Procedures that include (but not limited to) the following:	☐ Yes	☐ No	☐ N/A
i)	Description of services delivered:	☐ Yes	☐ No	☐ N/A
ii)	Intake Procedures:	☐ Yes	☐ No	☐ N/A
iii)	Assessment process:	☐ Yes	☐ No	☐ N/A
iv)	Protocol for emergency situations:	☐ Yes	☐ No	☐ N/A
v)	Complaints and grievance procedures:	☐ Yes	☐ No	☐ N/A
vi)	Quality Improvement Plan:	☐ Yes	☐ No	☐ N/A
vii)	System for medical document storage, maintenance and disposal:	☐ Yes	☐ No	☐ N/A
viii)	Utilization Management Plan:	☐ Yes	☐ No	☐ N/A
ix)	Personnel policies, including procedures for conducting employee back-round checks, including DOJ and FBI fingerprinting:	☐ Yes	☐ No	☐ N/A

4. What type of computer set-up do you have?

   a. Internet Connection: ☐ None ☐ Dial-In Modem ☐ High Speed Connection

   b. Web Browser *Internet Explorer 5.5:* ☐ Yes ☐ No

   c. Email Address: ☐ Yes ☐ No

   d. Number of computer stations with this capability: _____

5. Can you have electronic funds deposited into your bank account? ☐ Yes ☐ No

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Service/Program Information

Type of Provider: ☐ Mental Health Care Agency *(Please complete **Section 1** and **Section 2**. Agencies with multiple sites/programs, please submit one completed copy of this page for each.)*

☐ Independent Provider *(Please skip **Section 1** and continue on to **Section 2**)*

Section 1

Program Name: _____ Site Address: _____

Contact Person: _____ _____

Contact Telephone: _____ _____

Supervising Manager: _____ Program RU #: _____

1.1 Type of program: ☐ Outpatient Clinic ☐ Day Treatment ☐ School-Based

☐ In-Home ☐ Other: _____

1.2 List the number of practitioners at your site(s) accordingly:

	PhD	MD	LCSW	MFT	Intern	Masters	Bachelors	Other
Full Time								
Part Time								

Section 2

2.1 List any ethnic populations your staff can claim professional cultural competency: _____

2.2 Other than English, list any languages your staff can claim professional fluency: _____

2.3 List the specific services provided: _____

2.4 What geographic area does your service cover? _____

2.5 List relevant zip codes: _____

2.6 How long before a referred client would have their initial appointment? _____

2.7 Do you have 24-hour emergency coverage, 7 days a week? ☐ Yes ☐ No

2.8 List your hours of operation, including evenings and weekends: _____

Service/Program Information

Section 3

3.1 To help us better understand your organization or private practice, please include your Mission Statement or philosophy of care below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3.2 Please describe how your organization's Mission Statement and program of services support the *System of Care Initiative* goals and principles and the *wraparound* philosophy of care. *(For details on this philosophy, please refer to the handout,* ***Wraparound Principles****.)*

_____

_____

_____

_____

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_____

_____

_____

_____

I acknowledge that to the best of my knowledge, the foregoing information is true and accurate. Furthermore, I understand that any information that is found to be intentionally misleading or false may be grounds for exclusion from the CYFN provider network.

_____ _____
Signature of Authorized Individual *Date*

_____
Title

Please return this completed form to:

Children, Youth and Family Network
Provider Relations
3247 Mission Village Drive
San Diego, CA 92123