County Rural Offices of Social Services
PROVIDER NETWORK APPLICATION

Provider: _____ Date: _____
Address: _____
_____

Contact Name: _____

Check all that are applicable:

_____ currently licensed by the State of Iowa
List licensed services: _____
_____ currently accredited by State of Iowa
List accredited services: _____
_____ currently enrolled as a Medicaid provider
List Medicaid services you provide: _____
_____
_____ have a current accreditation by a recognized state/national accrediting body
List accrediting body: _____
_____ currently have a contract with "host" county
List county name(s): _____

Check all populations that your agency currently serves:

_____ Persons with Mental Illness or Chronic Mental Illness
_____ Persons with Mental Retardation
_____ Persons with other Developmental Disabilities
_____ Persons with Brain Injuries

Do you serve persons under the age of 18? _____ Yes _____ No

Please attach the following to this application:

-a brief provider organizational history,
-a list of any specialized training, education, or skills that your staff possess that may be unique to your organization,
-a copy of proof/certificate of insurance, licensure, or accreditation (as applicable)
-a copy of current rates that have been approved by your host county
-a list of name, address, and phone numbers of three references (including at least one county)

As the authorized representative of the provider, I swear that all information provided is accurate to my best ability, that our agency and staff will have no financial or other conflict of interest in providing services to CROSS clients.

Provider Signature: _____
Title: _____