



**Provider Name** \_\_\_\_\_

**Date** \_\_\_\_\_

Dear Applicant:

Enclosed you will find the Access to Recovery - Iowa (ATR) Provider Application and W-9 which must be completed for inclusion as a provider in the ATR network. Please refer to the ATR Provider Manual for policies, procedures and requirements regarding the ATR program. After completing the Provider Application and W-9, please ensure all required documentation is included when submitting your application. The checklist below will assist you in completing the application packet:

**Checklist**

- Documentation requirements as outlined in Section V of the ATR Provider Application
- Liability insurance verification (organization or sole practitioner)
- List of board of directors or governing body members, and name of chairperson
- Organization's certificate, endorsement, license, registration, or accreditation documentation related to ATR covered services (include all satellite locations)
- Provider Application
- W-9

Please complete and mail the required materials and documents along with your application. If you have any questions regarding the application process, please call **1-866-923-1085**. Information regarding ATR is also available on our website: [www.idph.state.ia.us/atr](http://www.idph.state.ia.us/atr).

Sincerely,

Access to Recovery – Iowa Staff



## Access to Recovery - Provider Application

### Instructions

Please type or print legibly and mail completed application and required attachments to:

**Iowa Department of Public Health  
 Division of Behavioral Health  
 Access to Recovery – Iowa Provider Application  
 321 E. 12<sup>th</sup> Street  
 Des Moines, IA 50319**

- Thoroughly complete all applicable sections
- Retain a copy of the completed application and attachments for your files
- **If you need any assistance completing this application, please call IDPH at: 1-866-923-1085**

#### **I. Applicant Information:**

Organization name:	Tax ID Number:
Name and title of organization’s director/leader:	County:
Mailing address:	Physical address:
Main phone number:	Fax number:
ATR contact person:	
ATR contact phone number:	
E-mail address:	
What services does your program provide?	
How do you determine if staff and volunteers are qualified and appropriate to serve clients?	

Note any criteria that would prohibit a staff member or volunteer from providing services to or having contact with clients.

Select if your organization:

- offers American Sign Language interpretation
- has a location near public transportation
- has handicapped parking

- is handicapped accessible
- offers services in languages other than English.  
If so, what language(s)?

**II. Disclosures:**

Complete only if your organization is not certified by, endorsed by, licensed by, registered with, or otherwise accredited by or affiliated with an authority accepted by IDPH, consistent with the qualification requirements of the ATR Provider Manual.

Has your organization or an employee or volunteer ever lost a professional certification or licensure for misconduct, failure to maintain required standards, or any other reason?

- Yes  No

*If yes, please explain.*

Is your organization or an employee or volunteer facing any pending or threatened litigation?

- Yes  No

*If yes, please explain.*

Has an employee or volunteer ever been convicted of a felony?

- Yes  No

*If yes, please explain.*

**III. Type of Organization:**

Place a check mark in the box that best describes your organization.

- Faith-Based  
(organization founded on a particular religion or spiritual belief)

Type of religious denomination:

- Community-Based  
(not Faith-Based)

Please indicate type (select all that apply):

- Non-profit
- For-profit
- Grassroots (organizations with annual operating budgets of \$500,000 or less)
- Other:

**IV. Information System Requirements:**

- Organization has Windows Internet Explorer 6.0 or higher

<b>V. ATR Covered Services:</b> Check the services your organization is applying to provide.	
<b>ATR Covered Services</b>  (see ATR – Iowa Provider Manual <u>Appendix A</u> Service Descriptions, Rates, and Qualifications)	<b>Documentation Requirements</b>  (please check that the following information is included in the application packet)
<b>Care Coordination</b>	
<input type="checkbox"/> <b>Care Coordination</b> On-going, face-to-face or telephone meetings with client, conducted as needed to coordinate and support client access to, participation in, and continuation in ATR covered services. Care Coordination also includes the following ATR covered services: <ul style="list-style-type: none"> <li>• <b>Sober Living Activities:</b> participation in an organized recreational or social event for recovering persons, and</li> <li>• <b>Supplemental Needs:</b> community services or material items that directly link to a client’s recovery but are not ATR covered services.</li> </ul> <b>For previous ATR Care Coordination providers requesting to offer this service, please include your final ATR II GPRA Follow-up rate.</b>	<input type="checkbox"/> Copy of current substance abuse program license, or deemed status documentation, <b>OR</b> <input type="checkbox"/> Documentation of experience during the 12 consecutive months immediately prior to the date of application in providing referrals, linkages, and coordination of multiple services  <input type="checkbox"/> ATR II GPRA Follow-up Rate    % _____
<b>Recovery Support Services</b> Providers of Care Coordination may also be eligible to provide Recovery Support Services.	
<input type="checkbox"/> <b>Child Care</b> Childcare for the client’s dependent children (under 14 yrs) while the client is attending, or going to or from, treatment or ATR covered services.	<input type="checkbox"/> Copy of current childcare license and/or registration certificate <input type="checkbox"/> Liability insurance verification
<input type="checkbox"/> <b>Co-Pays</b> Out-of pocket fees assessed to clients receiving substance abuse treatment services at IDPH Block-grant funded providers that are at or below 200% of the Federal Poverty Level Guidelines.	<input type="checkbox"/> Copy of current substance abuse program license, or deemed status documentation <input type="checkbox"/> Documentation of IDPH Block-grant funded status
<input type="checkbox"/> <b>Dental Services</b> Dental procedures, including exams, dentures, extraction, fillings, x-rays, and other necessary procedures specifically related to the client’s substance abuse.	<input type="checkbox"/> Copy of current license consistent with licensure standards as established in Iowa Code chapters 147, 153, 272C and Administrative Code chapter 650, <b>OR</b> <input type="checkbox"/> Organization approving the service must meet the qualifications to provide ATR Care Coordination
<input type="checkbox"/> <b>Drug Testing</b> A laboratory test to collect and analyze urine, blood, hair, or saliva, to determine whether a client is using, or has used, alcohol or other drugs administered by a licensed substance abuse treatment provider.	<input type="checkbox"/> Copy of current substance abuse program license
<input type="checkbox"/> <b>Housing Assistance</b> Short-term housing in a safe and recovery-oriented environment for clients with no other recovery housing alternatives. Housing may be provided in a facility for individuals in recovery, in a licensed halfway house, or in a facility providing related services in the community.	<input type="checkbox"/> Copy of organizational status (e.g. 501c3) <input type="checkbox"/> Copy of current substance abuse program license or deemed status documentation <input type="checkbox"/> Documentation of occupancy permit <input type="checkbox"/> Evidence of 12 months prior experience providing this service <input type="checkbox"/> Liability insurance verification

<input type="checkbox"/> <b>Integrated Therapy</b> Face-to-face individual, family or group therapy with the client to address concurrent mental health and substance abuse disorders.	<input type="checkbox"/> Copy professional licensure <input type="checkbox"/> Copy of substance abuse certification <input type="checkbox"/> Liability insurance verification
<input type="checkbox"/> <b>Life Skills Coaching</b> Individual coaching with clients to develop the skills that help individuals make informed decisions, communicate effectively, and develop coping and self-management skills that may assist their recovery.	<input type="checkbox"/> Documentation of experience providing referrals, linkages, and coordination of multiple services <input type="checkbox"/> Evidence of 12 months prior experience providing this service
<input type="checkbox"/> <b>Medical Evaluation Services for Pharmacological Interventions and Psychotropic Medications</b> Medical evaluation to determine client appropriateness for placement on a pharmacological intervention and/or psychotropic medication	<input type="checkbox"/> Documentation of qualifications that the organization delivering this service meets all state/federal guidelines and licensure requirements for providing medical evaluation services for pharmacological interventions and/or psychotropic medications <input type="checkbox"/> Organization approving the service must meet the qualifications to provide ATR Care Coordination
<input type="checkbox"/> <b>Pharmacological Interventions</b> Assistance provided to clients ages 18 and over to purchase prescription pharmacological medications used only for the treatment of substance addiction	<input type="checkbox"/> Documentation of qualifications to administer / prescribe pharmacological interventions
<input type="checkbox"/> <b>Recovery Calls</b> Weekly telephone meetings between the ATR client and an employee or volunteer using an established tool to discuss routine recovery issues following discharge from substance abuse treatment services.	<input type="checkbox"/> Copy of curriculum and training <input type="checkbox"/> Documentation of employee or formal volunteer relationship <input type="checkbox"/> Liability insurance verification
<input type="checkbox"/> <b>Recovery Peer Coaching</b> Face-to-face meetings between the client and a Recovery Peer Coach to support and sustain recovery from a peer perspective.	<input type="checkbox"/> Copy of curriculum and training <input type="checkbox"/> Documentation of employee or formal volunteer relationship <input type="checkbox"/> Liability insurance verification
<input type="checkbox"/> <b>Spiritual Counseling</b> Face-to-face counseling with the client to address spiritual issues that can support recovery.	<input type="checkbox"/> Copy of certificate, license or other spiritual leadership documentation, <b>OR</b> <input type="checkbox"/> Documentation of Native American tribal endorsement as a spiritual healer, <b>OR</b> <input type="checkbox"/> Documentation of active relationship with local religious body, <b>OR</b> <input type="checkbox"/> Copy of professional licensure with documentation of experience / education <input type="checkbox"/> Evidence of 12 months prior experience providing this service <input type="checkbox"/> Liability insurance verification
<input type="checkbox"/> <b>Transportation – Bus</b> Transportation by bus to and from an activity related to the client’s recovery.	<input type="checkbox"/> Organization approving the service must meet the qualifications to provide ATR Care Coordination
<input type="checkbox"/> <b>Transportation –Cab</b> Transportation by cab to and from an activity related to the client’s recovery.	<input type="checkbox"/> Organization approving the service must meet the qualifications to provide ATR Care Coordination

**Behavioral Health Services for Active Military and National Guard Personnel At/Above 201% FPL Only**  
 Providers of Care Coordination and Recovery Support Services may also be eligible, if appropriately credentialed, to provide Behavioral Health Services.

<input type="checkbox"/> <b>Mental Health Therapy</b> Face-to-face individual therapy with the client to address a mental health condition that negatively impacts the client's recovery efforts.	<input type="checkbox"/> Copy of professional licensure <input type="checkbox"/> Liability insurance verification
<input type="checkbox"/> <b>Substance Abuse Treatment - Assessment</b> The process in which a client is evaluated as to their strengths, weaknesses, problems, and needs for the purpose of defining a course of treatment.	<input type="checkbox"/> Copy of current substance abuse program license, or deemed status documentation
<input type="checkbox"/> <b>Substance Abuse Treatment - Continuing Care</b> An organized service delivered by addiction professionals or addiction credentialed clinicians, which provides on-going supportive counseling for individuals who have completed substance abuse treatment.	<input type="checkbox"/> Copy of current substance abuse program license, or deemed status documentation
<input type="checkbox"/> <b>Substance Abuse Treatment - Extended Outpatient</b> An organized service, delivered in a variety of settings, in which treatment staff provide professionally directed evaluation and treatment of substance related disorders.	<input type="checkbox"/> Copy of current substance abuse program license, or deemed status documentation
<input type="checkbox"/> <b>Substance Abuse Treatment - Halfway House</b> An organized service delivered by addiction professionals which provides addiction treatment services at least 5 hours per week in a 24 hour setting.	<input type="checkbox"/> Copy of current substance abuse program license, or deemed status documentation
<input type="checkbox"/> <b>Substance Abuse Treatment - Intensive Outpatient Treatment</b> An organized service delivered by addiction professionals or addiction credentialed clinicians, which provides a planned regimen of treatment, consisting of regularly scheduled sessions within a structured program.	<input type="checkbox"/> Copy of current substance abuse program license, or deemed status documentation
<input type="checkbox"/> <b>Substance Abuse Treatment - Residential</b> An organized service delivered by addiction professionals or addiction credentialed clinicians, which provides a 24-hour live-in, seven-day-a-week substance abuse treatment program providing a structured recovery environment to support recovery from substance related disorders.	<input type="checkbox"/> Copy of current substance abuse program license, or deemed status documentation

<b>VI. Satellite Facility Information (include additional sheets if needed):</b>	
Facility name (if different):	Facility phone number:
Facility address:	County:
ATR contact person:	ATR contact phone number:
<b>Services provided at this location:</b>	
<input type="checkbox"/> Care Coordination	<input type="checkbox"/> Recovery Calls
<input type="checkbox"/> Child Care	<input type="checkbox"/> Recovery Peer Coaching
<input type="checkbox"/> Co-Pays	<input type="checkbox"/> Spiritual Counseling
<input type="checkbox"/> Dental Services	<input type="checkbox"/> Substance Abuse – Assessment
<input type="checkbox"/> Drug Testing	<input type="checkbox"/> Substance Abuse – Continuing Care
<input type="checkbox"/> Housing Assistance	<input type="checkbox"/> Substance Abuse – Extended Outpatient
<input type="checkbox"/> Integrated Therapy	<input type="checkbox"/> Substance Abuse – Halfway House
<input type="checkbox"/> Life Skills Coaching	<input type="checkbox"/> Substance Abuse – Intensive Outpatient
<input type="checkbox"/> Medical Evaluation Services	<input type="checkbox"/> Substance Abuse – Residential
<input type="checkbox"/> Mental Health Therapy	<input type="checkbox"/> Transportation – Bus
<input type="checkbox"/> Pharmacological Interventions	<input type="checkbox"/> Transportation – Cab

<b>Satellite Facility Information (include additional sheets if needed):</b>	
Facility name (if different):	Facility phone number:
Facility address:	County:
ATR contact person:	ATR contact phone number:
<b>Services provided at this location:</b>	
<input type="checkbox"/> Care Coordination	<input type="checkbox"/> Recovery Calls
<input type="checkbox"/> Child Care	<input type="checkbox"/> Recovery Peer Coaching
<input type="checkbox"/> Co-Pays	<input type="checkbox"/> Spiritual Counseling
<input type="checkbox"/> Dental Services	<input type="checkbox"/> Substance Abuse – Assessment
<input type="checkbox"/> Drug Testing	<input type="checkbox"/> Substance Abuse – Continuing Care
<input type="checkbox"/> Housing Assistance	<input type="checkbox"/> Substance Abuse – Extended Outpatient
<input type="checkbox"/> Integrated Therapy	<input type="checkbox"/> Substance Abuse – Halfway House
<input type="checkbox"/> Life Skills Coaching	<input type="checkbox"/> Substance Abuse – Intensive Outpatient
<input type="checkbox"/> Medical Evaluation Services	<input type="checkbox"/> Substance Abuse – Residential
<input type="checkbox"/> Mental Health Therapy	<input type="checkbox"/> Transportation – Bus
<input type="checkbox"/> Pharmacological Interventions	<input type="checkbox"/> Transportation – Cab

**In the event that an application is incomplete or additional documentation is requested by IDPH in order to complete the process, the applicant has 30 days from the date of the request to provide all of the additional documentation or the application will be discarded.**

**Upon acceptance of your application, IDPH will issue a Cooperative Agreement for the provision of the services you identified. The duties, rights and obligations of the parties to this agreement shall be governed by the Cooperative Agreement Documents, which include the Special Conditions, General Conditions and Application. The General Conditions effective October 1, 2009, are posted on the Department’s Web site under *Funding Opportunities*: [www.idph.state.ia.us](http://www.idph.state.ia.us)**

**By signing below, I certify that the information provided in this application and attachments, is correct and true to my knowledge.**

\_\_\_\_\_  
(Signature of Applicant Representative)

\_\_\_\_\_  
(Title or Position)

\_\_\_\_\_  
(Date)

<b><i>For IDPH office use only:</i></b>	
Date application received by IDPH:	<input type="checkbox"/> Application approved
ATR Project Director Signature:	<input type="checkbox"/> Application pending Reason:
	<input type="checkbox"/> Application denied
Date:	Reason:

# IOWA DEPARTMENT OF PUBLIC HEALTH

## INSTRUCTIONS FOR COMPLETING SUBSTITUTE W-9/VENDOR UPDATE FORM

If you are requesting payment from IDPH as an entity other than an individual, this form should be completed by your business office, treasurer, or accountant.

In order for the State of Iowa to pay you and to comply with the Internal Revenue Service (IRS) regulations on reporting these payments, we need the following information. **Failure to provide this information will result in withholding of payment.**

The IRS states: "Taxpayer Identification Numbers (TINs) are used to associate and verify amounts reported to the IRS with corresponding amounts on tax returns." The TIN for individuals is the social security number. For other recipients, it is the Employer Identification Number (EIN), except for sole proprietors. Sole Proprietors may enter their EIN; however, the IRS prefers you use your SSN.

It is important to obtain the correct TIN of vendors. The IRS penalty for payments made by IDPH to incorrect TIN numbers is \$50 per occurrence. This penalty will be passed on to you, if incorrect information is provided on the attached form.

The attached Substitute W-9/Vendor Update Form should be completed using the following guidelines:

**Individual: Complete Box A**

- Check yes next to [I] - Individual
- Social Security Number
- First & Last Name
- Address

**Sole Proprietor: Complete Box A**

- Check yes next to [S] – Sole Proprietor
- Social Security Number or EIN
- First & Last Name (person who holds the SS#)
- Doing Business as (DBA) (if different than First & Last Name)
- Address

**All Others: Complete Box B**

- Check appropriate classification (as filed with IRS)
- Employer Identification Number (EIN) that you received from the IRS
- Phone & Fax Numbers
- Legal Name of Firm (this must be exactly as you have filed with the IRS)
- Doing Business As (DBA):

**Complete this line only if the name under which you are conducting business is different than the legal name listed above.** Example: If another firm has agreed that you may operate under its EIN, you would complete the names as follows:

Metro Hospital (this is the legal name)  
DBA Metro EMS

- Address

If you are unsure of the correct Employer Identification Number, classification, or legal name, please contact your accountant or Iowa Department of Revenue and Finance Taxpayer Services at 515-281-3114 or 1-800-367-3388.

**All Substitute W-9/Vendor Updates Forms must be signed and dated by the individual or by a representative of the company.** The completed form can be mailed, faxed or returned as an attachment to an e-mail to the person or program requesting the information. The e-mail must contain a note that the individual sending the e-mail is a representative of the company.

For assistance in filling out this form, please contact Diane Anderson at 515-281-7225  
IDPH (2/7/03)

