



**PROVIDER SERVICES NETWORK
RETURNING PARTNER APPLICATION**

| | | |
|---|-----------|-----------|
| Agency/Service Provider Name: | | |
| Business Address: | | |
| City: | State | Zip |
| Phone Number: | Fax No. | |
| EIN: | | |
| Mailing Address (if different from above) | | |
| City: | State | Zip |
| Website Address: http://www . | | |
| Principal Owner: | | Title |
| Email: | | Dir. Dial |
| Agency Director: | | Title |
| E-mail: | | Dir. Dial |
| Primary Billing Contact: | | Title |
| Current Cuyahoga County Contractor: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Nonprofit Agency <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If your agency is a subsidiary of another agency, complete the following: | | |
| Parent Agency: | | Phone |
| Business Address: | | |
| City: | State | Zip |
| Contact | Dir. Dial | |

Please check the applicable boxes and complete the information below

All services and rates will remain the same

Delete the following service(s):

| SERVICE CODE | SERVICE NAME | CTSOC Use Only |
|--------------|--------------|----------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Add the following service (s) from the Provider Services Description List

| SERVICE CODE | SERVICE NAME | PROPOSED UNIT RATE | LOCATION OF SERVICE (Please indicate the location of where the service will take place (i.e. home of client, library, recreational center, business location, etc.) | CTSOC Use Only |
|--------------|--------------|--------------------|--|----------------|
| | | | | |
| | | Rate: \$ | | |
| | | Unit: | | |
| | | Rate: \$ | | |
| | | Unit: | | |
| | | Rate: \$ | | |
| | | Unit: | | |
| | | Rate: \$ | | |
| | | Unit: | | |
| | | Rate: \$ | | |
| | | Unit: | | |
| | | Rate: \$ | | |
| | | Unit: | | |
| | | Rate: \$ | | |
| | | Unit: | | |

Add the following **NEW** Service(s) **not** previously offered in the existing Provider Services Description List

| NAME OF SERVICE | BRIEF DESCRIPTION OF SERVICE (If more space is needed, please feel free to attach additional documentation) | PROPOSED RATE | LOCATION OF SERVICE (Please indicate the location of where the service will take place (i.e. home of client, library, recreational center, business location, etc.) | CTSOC Use only |
|-----------------|--|---------------|--|----------------|
| | | | | |
| | | Rate:\$ | | |
| | | Unit: | | |
| | | Rate: \$ | | |
| | | Unit: | | |
| | | Rate: \$ | | |
| | | Unit: | | |
| | | Rate: \$ | | |
| | | Unit: | | |

Application Process Steps

1. Returning providers complete, sign and submit the PSN Returning Partner application and attachments in **hard copy** to the CTSOC office.
2. The CTSOC office reviews applications and (a) returns incomplete submissions; or (b) notifies applicants of acceptance for processing; or (c) contacts applicants for additional information.
3. Returning providers must submit a W-9, State of Ohio DMA form, Campaign Contribution Certification form, proof of insurance, any other required forms, and sign a CTSOC PSN Memorandum of Understanding. Basic instructions, current guidelines and forms can be accessed at www.cuyahogatapestry.org.

I certify that all of the information contained in this application is true and accurate and that the agency and any person providing services to Cuyahoga Tapestry System of Care comply with all accrediting, certifications and licensure requirements to provide the proposed services. By signing and submitting this application and its attachments, I understand and agree to all requirements for participation in the Cuyahoga Tapestry System of Care Provider Services Network. I understand that information contained in this application and its attachments is subject to periodic verification without notice; that any misrepresentation on this form may result in a failure to qualify or disqualification from participation in the Cuyahoga Tapestry System of Care Provider Services Network.

Authorized Signature: _____

Title: _____ Date: _____

CHECKLIST

- | | |
|--|---|
| <input type="checkbox"/> Completed and signed application | <input type="checkbox"/> IRS W-9 form |
| <input type="checkbox"/> State of Ohio DMA form | <input type="checkbox"/> Campaign Contribution Certification form |
| <input type="checkbox"/> Proof of insurance | <input type="checkbox"/> Updated background checks |
| <input type="checkbox"/> Additional Documentation: References, professional licenses, and credentials if applicable. | |
| <input type="checkbox"/> Copy of Business License – State of Ohio Certification from Ohio Secretary of State (www.sos.state.oh.us) | |