mhs health wisconsin

Credentialing Application

Facility, Ancillary, and Clinic/Center

ADDITIONAL FACILITY PRACTICE LOCATIONS

Location _____ of _____

Location Name _____

Address _____

Phone _____ Fax _____

Psychiatric / Mental Health Services *(Mark all services and ages that apply.)*

	Child	Adolescent	Adult	Geriatric
☐ Inpatient	☐	☐	☐	☐
☐ Partial (PHP)	☐	☐	☐	☐
☐ IOP	☐	☐	☐	☐
☐ Residential	☐	☐	☐	☐
☐ Observation	☐	☐	☐	☐
☐ Other _____	☐	☐	☐	☐
☐ Other _____	☐	☐	☐	☐

Substance Use Disorder / Chemical Dependency Services *(Mark all services and ages that apply.)*

	Child	Adolescent	Adult	Geriatric
☐ Inpatient	☐	☐	☐	☐
☐ Partial (PHP)	☐	☐	☐	☐
☐ IOP	☐	☐	☐	☐
☐ Residential	☐	☐	☐	☐
☐ Observation	☐	☐	☐	☐
☐ Other _____	☐	☐	☐	☐
☐ Other _____	☐	☐	☐	☐

☐ Methadone services offered ☐ Suboxone services offered

ECT Offered ☐ Inpatient ☐ Outpatient

Genders treated ☐ Male ☐ Female

I/P Beds (Mental Health) _____ # I/P Beds (Substance Use) _____

Accessibility and Hours for this Location

Languages Spoken *(Check all that apply)*

☐ English ☐ Spanish ☐ Hmong ☐ Burmese ☐ Rohingya
☐ Somali ☐ Russian ☐ Ukrainian ☐ Arabic ☐ Pashto
☐ Hindi ☐ German ☐ Polish ☐ Italian ☐ French
☐ Swahili ☐ Yiddish ☐ Vietnamese ☐ Korean ☐ Laotian
☐ Chinese Mandarin ☐ Other _____

☐ Wheelchair accessible

☐ Open at least 5 days per week

Daily Hours *(Check all the days that apply and add daily hours of operation.)*

	Time Open		Time Close			Time Open		Time Close	
☐ Monday	_____	a.m.	_____	p.m.	☐ Friday	_____	a.m.	_____	p.m.
☐ Tuesday	_____	a.m.	_____	p.m.	☐ Saturday	_____	a.m.	_____	p.m.
☐ Wednesday	_____	a.m.	_____	p.m.	☐ Sunday	_____	a.m.	_____	p.m.
☐ Thursday	_____	a.m.	_____	p.m.					

Please complete a new form for each of your locations and submit with your application.

Email: mhs-wipdm@mhswi.com
Mail: MHS Health Wisconsin, Attn: Provider Data Management, 115 S. 84th Street, Suite 350, Milwaukee, WI 53214