NORTHERN LAKES COMMUNITY MENTAL HEALTH
New Provider Request Form

Consumer Name: _____ Date of Birth: _____
Gender: _____ Case Manager/Worker Name: _____
Operations Manager/Chief Population Officer Name: _____

Reason for request of services (please note the scope, duration and intensity as well as the specific codes required):

_____
_____
_____
_____
_____
_____
_____

Type of Service Requested:

_____

- ☐ Specialized Residential Services
- ☐ Community Living Services
- ☐ Supported Independent Living Services
- ☐ In Home Services-adult
- ☐ In Home Services-child
- ☐ Other:_____
- ☐ Cost:_____

Name of Requested Provider:

Address:

_____

City, St, Zip

_____

Phone:

_____

Contact Person: _____

Date services need to be started: _____
Operations Manager /CPO review: ☐ APPROVED ☐ DENIED
Reason for denial: _____

Date given to Network Management Committee for review: _____
Has the requested provider completed an application? _____
Do we have a current contract with this Provider? _____
Do we need a contract amendment for the services needed? _____
Have we reached our capacity for this type of service with our current contract Providers?

_____
Do we need a new contract? _____
Will this contract be for this consumer only, _____**or** will we use this Provider for other consumers? _____
Network Management Committee review: ☐ APPROVED ☐ DENIED
Reason for denial: _____
Recommended alternative: _____

Date given to Contract Manager: _____