MACOMB COUNTY
COMMUNITY MENTAL HEALTH

Macomb County Community Mental Health Provider Profile Application

ALL INFORMATION IS REQUIRED TO BE COMPLETED AND IS SUBJECT TO VERIFICATION

CORPORATE INFORMATION	Corporate/Legal Name: Belle Meade AFC		
	Organization/DBA Name: Belle Meade AFC		
	Organization Mailing Address: 36270 Bordman Rd		
	City: Richmond	State: MI	Zip + 4 code: 48062
	Billing Address (if different than mailing)		
	Phone: (810) 392-2884	Fax: (586) 261-1282	E-Mail: rclark@bellemeadeafc.com

ADMINISTRATIVE INFORMATION	Chief Administrative Officer: Randy Clark	
	Chief Financial Officer: Randy Clark	
	Chief Medical Officer: Dan Clark	
	Chief Clinical Manager: Dan Clark	
	Respondent for Recipient Rights Complaints: Mary Lessard	
	Business Manager: Mary Lessard	
	Contract Primary Contact Person: Randy Clark	E-mail: rclark@bellemeadeafc.com
		Phone: (586) 405-8710
	Contract Secondary Contact Person: Stephanie Cook	E-mail: scook@bellemeadeafc.com
		Phone:
	Clinical Director/Supervisor: Dan Clark	E-mail: jclark@bellemeadeafc.com
	Location: Belle Meade AFC	Phone: (810) 523-1033
	Clinical Director/Supervisor:	*E-mail:*
	Location:	Phone:
	Clinical Director/Supervisor:	E-mail:
	Location:	Phone:
BILLERS	Biller (Needs EMR Access): Stephanie Cook	E-mail: scook@bellemeadeafc.com
	Location: Belle Meade AFC	Phone: (586) 255-8874
	Biller (Needs EMR Access):	E-mail:
	Location:	Phone:

OFFSHORE BILLERS		
	Offshore Billing Organization Name N/A	
	Biller (Needs EMR Access):	E-mail:
	Location:	Phone:
	Biller (Needs EMR Access):	E-mail:
	Location:	Phone:

TYPE OF PROGRAM *(Please check ALL that apply)*

- ___ Assertive Community Treatment
- ✓ Assistance w/Challenging Behavior
- ___ Children's Waiver
- ___ Children's Residential
- ___ Case Management Services
- ✓ Community Living Supports (✓ MI or ✓ DD)
- ___ Crisis Residential (Adult or Child)
- ___ Crisis Services
- ___ Day Program
- ___ Family Support Services (___ MI or ___ DD)
- ___ Habilitative Waiver Services
- ___ Home Based Services
- ___ Intensive Crisis Stabilization Services
- ___ O.T. ___ P.T. ___ SP & L
- ___ Out of County Services
- ___ Peer Delivered or Operated Services
- ___ Psychiatric Hospital (Adult or Child)
- ___ Psycho-Social Rehabilitation Programs
- ___ Respite Services
- ✓ Skill Building Services (✓ MI or ✓ DD)
- ✓ Specialized Residential Services
- ✓ Supported Independent Program (SIP)
- ___ Wrap Around Services
- ___ Other (specify):
- ___ SUD Withdrawal Management
- ___ SUD Residential Treatment
- ___ SUD Outpatient
- ___ SUD IOP
- ___ SUD MAT
- ___ SUD Outpatient
- ___ SUD Prevention
- ___ SUD Recovery Home
- ___ SUD Peer Recovery Coach
- ___ SUD Recovery Center

TYPE OF ORGANIZATION *(Please check one)*

___ Federal ___ State ___ County	___ City ✓ Private Non-profit ___ Privately Owned	___ Corporation Partnership LLC/LLP

Parent Corporation or Owner of Organization: Belle Meade Foundation		
Street Address: 36270 Bordman Rd.		
City: Richmond, M	State: MI	Zip code: 48062
Telephone: (810) 392-2884	Fax: (586) 201-1282	
Name and Title of Corporate Executive Officer: Randall Clark, Admin		

TAX ID

Important Note: *All programs listed in this application must correspond to the Tax Identification Number (TIN) and Payee listed below. If there is more than one TIN, an additional application must be completed. Providers need to submit copy of Federal W-9.*

TAX ID		
	TIN: 38-3359722	Payee: Belle Meade AFC
	Medicaid # (if applicable):	Agency NPI # (if applicable):
	Medicare # (if applicable):	

LICENSE/CERTIFICATES

Is the organization state licensed/certified: ✓ Yes ____ No

(Please attach a current copy of all Licenses and Certificates)

Type: Adult Grp Home	License/Certification #: AM500073448	Exp. Date: 6/29/2023
Type:	License/Certification #:	Exp. Date:

Type:	License/Certification #:	Exp. Date:
Type:	License/Certification #:	Exp. Date:

ACCREDITATION/CERTIFICATION
(Please attach a current copy of all Accreditation Award Letters or Certificates)

		Yes	No	N/A	Exp. Date
ACCREDITATION/CERTIFICATION	Has the organization been reviewed and accredited by JCAHO/NCQA?			✓	
	Has the organization been reviewed and accredited by CARF/COA?			✓	
	Has the organization been reviewed and accredited by MDHHS?			✓	
	Has the organization been approved or certified by Medicaid?			✓	
	Has the organization been approved or certified by Medicare?			✓	
	Please indicate any other accreditation/certifications:				

INSURANCE
*(Please attach a current copy of the policy face sheet with limits and expiration dates listing coverage for organization sites. **ALL ADDRESSES** must be listed.)*

LIABILITY/INSURANCE INFORMATION	Company Name of Liability Carrier:	Houston Casualty	
	Policy Number:	H21S520208	
	LIMITS:	Per Occurrence: $ 1,000,000	Aggregate: $ 3,000,000
	DATES:	Effective Date: 3/7/21	Expiration Date: 3/7/22
	Company Name of Liability Carrier:		
	Policy Number:		
	LIMITS:	Per Occurrence:	Aggregate:
	DATES:	Effective Date:	Expiration Date:

ORGANIZATION PROFILE
(Please complete this section. Your responses need to cover the past five (5) calendar years plus current year to the present. If a question does not apply to your organization, you may check "N/A" (Not Applicable.)

	Yes*	No	N/A
Has the organization's state license/certification ever been revoked, suspended, or limited?		✓	
Is there action pending to suspend, revoke, or limit the organization's state license/certification?		✓	
Has the organization's accreditation status ever been revoked, suspended, or limited?		✓	
Is there action pending to revoke, suspend, or limit the organization's accreditation status?		✓	
Has the organization ever had sanctions imposed by Medicare and/or Medicaid?		✓	
Has the organization ever been denied professional liability insurance or has its insurance ever been canceled or denied renewal?		✓	

Has the organization ever been a defendant in any lawsuit in regard to the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000 or more?		✓	
Has the organization had any malpractice claims in regard to the practice of mental health or substance abuse treatment?		✓	

**Note: If you have answered "yes" to any of the above questions, please provide the current status and details on a separate sheet of paper. Please include the following: description of incident, correspondence with state licensing boards, and/or a detailed description of any litigation, including settlements, court awards, etc. Please feel free to include a personal summary of the events; however, your application cannot be processed without the necessary official documentation.*

ADMITTING PRIVILEGES FOR PSYCHIATRIC HOSPITALIZATION (if applicable)
Please list all Physicians/Psychiatrists who have admitting privileges at your organization. ✓ N/A

Provider Last Name	Provider First Name	License

PROGRAM PROFILE
Your organization may have more than one location identified on page one of this application. If so, please photocopy this page (page THREE), plus pages FOUR and FIVE, and complete for each program service.

HOURS OF OPERATION (e.g., 8:30 am - 8:00 pm)	Mon.	Tue.	Wed.	Thur.	Fri.	Sat.	Sun.
	12am-12am	12am-12am	12am-12am	12am-12am	12am-12am	12am-12am	12am-12am

TREATMENT STAFF ROSTER – CREDENTIALS
Please identify the person in your organization responsible for ensuring staff have and maintain appropriate credentials:

Staff Responsible for Credentialing	Phone Number	Email Address
Mary Lessard	(810) 392-2884	mlessard@bellemeadecafe.com

AGE GROUP AND GENDER
Please check (✓) the groups for which this program provides services.

Child/Adolescent (0 -17)		Adult (18 - 59)		Senior (60 and over)	
___ Female	___ Male	✓ Female	✓ Male	✓ Female	✓ Male

Please respond to the following questions regarding the service address(es):	Yes	No
Does this service address comply with ADA (American's w/Disabilities Act) regulations?	✓	
Is this service address accessible by public transportation (within 0.5 mile)?	✓	
List all HMOs, other health insurance organizations and other related entities with which you have a provider agreement and/or are able to bill for Mental health Services (attach additional pages if necessary). Please list Health Program Name, Effective date and Expiration date for each agreement.		