STATE OF TENNESSEE

DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Credentialing Application for Dental Services and/or Anesthesia Service

Provider qualification specified in the Home and Community –Based Services (HCBS) waivers for providers of Dental services require the provider (owner) to be a dentist (individual, group, or dental service agency) licensed to practice in Tennessee (TDH Rules 0460-1 and 0460-2) . For dental anesthesia, the provider must be a dentist, nurse anesthetist, or anesthesiologist licensed in Tennessee**.**

Part I: General Instructions

1. All questions regarding services should be directed to:

   Provider Enrollment Coordinator
   Phone: (615) 532-6530
   E-Mail: DIDDProvider.Application@tn.gov

2. Please return the original application and one (1) copy.

3. Please follow the format of the application (form) and answer the questions in the order they are asked. Attachments should be included at the end of the applicable section.

4. Once approved, the Department of Intellectual and Developmental Disabilities (DIDD) may enter into a provider agreement with you or your business to provide services.

5. The applicant may be required to provide additional information or additional references at the request of the Department of Intellectual and Developmental Disabilities (DIDD).

6. It is the policy of the Department of Intellectual and Developmental Disabilities (DIDD) to prohibit discrimination on the basis of race, color, religion, national or ethnic origin, sex, age, disability, or political affiliation, or in the admission or access to, or treatment or employment in, its program, services or activities.

7. The Department of Intellectual and Developmental Disabilities (DIDD) reserves the exclusive right to approve or deny an application.

Please include the following when returning this application:

- Copy of your license and any specialty qualifications
- Copy of your Declarations Page or Evidence of Coverage page for your insurance.
- Intellectual /Developmental Disabilities experience (Not a requirement for approval)

STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Credentialing Application for Dental Services and/or Anesthesia Service

Please type or print all of the information requested on this application. Incomplete applications cannot be accepted and will be returned for completion.

ORGANIZATIONAL INFORMATION

1. Name of Business

_____

2. Name of Business in Tennessee (if different from #1 above)

_____

3. Has any business owner, non-profit organization board member, or the executive director ever provided services to persons with intellectual, developmental, or other types of disabilities or mental illness in Tennessee using the name listed in the provider application or using a different name? If yes, attach a statement specifying the person's name(s) and providing details.

4. Mailing Address

_____

City _____State _____ Zip Code _____

5. Phone Number _____Fax Number _____

6. Business E-Mail _____ Web Site Address _____

7. Organization Type ☐ Not-for-Profit organization ☐ For Profit organization

8. Type of Business
   ☐ Sole Proprietorship
   ☐ Partnership
   ☐ Limited Partnership
   ☐ Limited Liability Corporation
   ☐ Other: _____
   _____

Optional

Business Ownership: (Check One Only)	Ownership Ethnicity: (Check One Only)
☐ G Government Owned ☐ E Race/Ethnic ☐ N Non-Minority Owned ☐ W Female Owned ☐ P Non-Profit Background (Minority Owned)	☐ A Asian ☐ B African American ☐ H Hispanic ☐ I Native American Indian ☐ C Caucasian ☐ O Other

9. Personal information: Please provide the information indicated in the tables below.

NAME OF OWNER(s)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	TELEPHONE NUMBER

NAME OF EXECUTIVE DIRECTOR(S) (if currently identified)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	TELEPHONE NUMBER

NAME OF CHAIRMAN OF THE BOARD (if applicable)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	TELEPHONE NUMBER

Please provide at least three (3) letters of reference from individuals who may be contacted regarding your professional services and skills. Provide at least one (1) who has known applicant for at least five (5) years.

Which DIDD Tennessee region(s) do you propose to provide Dental Services and /or Anesthesia Service?

Region: ☐ Middle ☐ East ☐ West

Dental and Anesthesia: Please list appropriate information in I, II, and III for all Employees and Subcontractors. *Make copies of this sheet if you have additional names*

I. LICENSES – Held in Tennessee and /or other states.

Name	State	**License Number**	**Expiration Date**	**Social Security Number**	Date of Birth
1.					
2.					
3.					
4.					
5.					
6.					

II. OFFICE INFORMATION: For each Employee and or Subcontractor their Office Information

If you have additional offices, please include this information on a separate attachment.

1. PRIMARY OFFICE	**SECONDARY OFFICE**
Name of Practice _____	Name of Practice _____
Street Address _____	Street Address _____
_____	_____
City State Zip	City State Zip
Telephone Number (__) _____	Telephone Number (__) _____

Fax Number (__) _____ Fax Number (__) _____

E-mail Address _____ E-mail Address_____

2... PRIMARY OFFICE **SECONDARY OFFICE**

Name of Practice _____ Name of Practice _____

Street Address _____ Street Address _____

_____ _____

City State Zip City State Zip

Telephone Number (__) _____ Telephone Number (__)_____

Fax Number (__)_____ Fax Number (__)_____

E-mail Address _____ E-mail Address_____

3. PRIMARY OFFICE **SECONDARY OFFICE**

Name of Practice _____ Name of Practice _____

Street Address _____ Street Address _____

_____ _____

City State Zip City State Zip

Telephone Number (__) _____ Telephone Number (__)_____

Fax Number (__)_____ Fax Number (__)_____

E-mail Address _____ E-mail Address_____

III. PROFESSIONAL INFORMATION

Dental and Anesthesia: for all Employees and or Subcontractors listed.

A. Does your office comply with the Center for Disease Control and Prevention? (CDC) Guidelines on Infection Control Practices for Tennessee Dentistry? ☐ Yes ☐ No
(If NO. please provide an explanation on a separate sheet of paper.)

B. Have you ever been involved in a malpractice suit or claim? ☐ Yes ☐ No
(If YES, please provide an explanation on a separate sheet of paper and and include dates, nature of suit, amount of settlement, and the name and address of the professional liability insurer involved.)

C. Do you have any experience with persons with intellectual disabilities or persons with developmental disabilities? (Not a requirement.) ☐ Yes ☐ No

IV. MALPRACTICE INSURANCE

In order to be approved by DIDD you are required to provide proof of professional liability (malpractice) insurance. So that this requirement might be fulfilled, please complete the Authorization Form included on page 8. This authorization permits your carrier/agent to provide us with copies of future renewals; thereby eliminating the need for you to do so. **Also, please enclose a copy of the declaration page of your policy.**

AUTHORIZATION FORM TO INSURANCE CARRIER/AGENT

I hereby authorize the below named insurance carrier/agent to provide a copy of the declaration page of my current professional liability (malpractice) insurance to The State of Tennessee Department of Intellectual and Developmental Disabilities (DIDD). The insurance carrier/agent is also to provide DIDD with a copy of each yearly renewal of this policy and in the event of cancellation, a copy of the cancellation notice.

Name of Insurance Carrier/Agent_____

Policy Number _____

Street Address_____

City _____ State _____ Zip Code _____

( )_____
Telephone Number

I certify that the information given in this application is correct and complete to the best of my knowledge. I am aware that should investigation show any falsification, my organization will not be considered as a potential provider of DIDD services. I hereby authorize the State of Tennessee to make all necessary investigations concerning the applicant. I further authorize and request each former employer, educational institution, or organization (including law enforcement agencies) to provide all information that may be sought in connection with this application.

The individual or business will carry adequate and appropriate general liability, professional liability, and workers compensation insurance for the protection of clients, staff, facilities, and the general public

Title: _____

Signature:_____

Business Name: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the State Board to any health care facility, health maintenance organization or professional organization with whom I have had employment, practice, association or privileges, to release information to the State of Tennessee Department of Intellectual and Developmental Disabilities (DIDD) regarding my professional skills, any pending or final disciplinary action or malpractice action, and any other information relevant to my character of professional competence. I authorize and request my professional liability (malpractice) insurance carrier to release information to The State of Tennessee, DIDD regarding any claims or actions for damages pending or closed, whether or not a final disposition. Further, I authorize such carrier to provide evidence of professional liability coverage to The State of Tennessee DIDD upon its request. I release from liability: a) any person or entity who, in good faith and without malice, provides information to The State of Tennessee DIDD for the purpose of evaluating this application; and b) The State of Tennessee DIDD for their acts performed in good faith and without malice in connection with evaluating this application.

Title: _____

Signature:_____

Business Name: _____