PrimeWest HEALTH™

Community First Services and Supports (CFSS) Application

Please submit this application only if you are providing services for members enrolled in PrimeWest Health.

Forms must be downloaded before they can be filled out and submitted. To download a form, right-click on the name of the form, choose "Save target as…" (in Internet Explorer) or "Save link as…" (in Chrome and Firefox), select a folder on your computer to save it to, and click the "Save" button. After the form has finished downloading, navigate to the folder it was saved to and double-click it to open it in Adobe Reader. If you do not have Adobe Reader, you can download it here.

LEAVE NOTHING BLANK
Please enter all information. If the question does not apply, enter NA. ***Incomplete applications will be returned.***

1. ☐ New hire ☐ Rehire
2. Has this individual maintained continuous employment with your agency since this background study was completed? ☐ Yes ☐ No Employment end date _____
3. First name _____ Middle initial ____ Last name _____
4. Maiden/former/other name(s) _____
5. Gender ☐ M - Male ☐ F - Female ☐ X - Unspecified or Another Gender Identity ☐ U - Undisclosed
6. Race and/or Ethnicity - The following information is optional. If you provide it, PrimeWest Health may utilize race and/or ethnicity information in provider directories or in internal resources to help members make informed choices and/or to help ensure that our network of providers is adequate to meet the needs of our members.

   ☐ American Indian or Alaska Native
   ☐ Asian
   ☐ Black or African American
   ☐ Hispanic or Latino
   ☐ Middle Eastern or North African
   ☐ Native Hawaiian or Other Pacific Islander
   ☐ White
   ☐ Other (please specify) _____
   ☐ Prefer Not to Say

   Providing race and/or ethnicity information on the credentialing application is entirely optional and refusal to provide this information will not subject you to adverse treatment. This information will not be considered in making any decisions regarding your credentialing.

   Check here if you do not wish for your race and/or ethnicity to be displayed in provider directories: ☐
7. Date of birth _____ 8. Social Security number _____
9. UMPI number _____
10. Current employer name _____ Start date of employment _____

    Address _____

    City _____ State _____ Zip _____
11. Office phone number _____ 12. Fax number _____
13. Federal tax ID number _____ 14. UMPI facility (employer) number _____
15. Will you be providing services to PrimeWest Health members? ☐ Yes ☐ No

    If "yes," provide effective date: _____

Continued on next page

16. Do you speak a language other than English with sufficient fluency that you would be able to provide care to a patient who only spoke that language? ☐ Yes ☐ No

    If "yes," what language(s)? _____

17. Include a photocopy of your background clearance letter or NetStudy confirmation form if you had a DHS background study done and have been continuously employed as a CFSS provider. If you have not been continuously employed as a CFSS provider, complete a new DHS background study on NetStudy and mail, email, or fax it to the address below.

18. Please send the application and background clearance letter or NetStudy confirmation form to PrimeWest Health via mail, email, or fax:

    Attn: Credentialing
    PrimeWest Health
    3905 Dakota St
    Alexandria, MN 56308

    Fax: **1-320-335-5313**
    Email: **credentialing@primewest.org**

I have reviewed and certify that the information provided is true and correct to the best of my knowledge. I will notify PrimeWest Health of any additions and/or changes to the information. By signing this, I acknowledge that I have read and understand the application.

Agency personnel: _____

Agency signature _____

Title_____

Date _____

OR

Name _____

Signature _____

Date _____