March 1, 2017

Mental Health Crisis Center
825 J St
Lincoln, NE, 68502-3749

Fax: (402) 441-8624
Email Address: setherton@lancaster.ne.gov

Dear Credentialing Contact,

This letter is being sent to you as a part of our recredentialing activities for our network facilities. We consider accurate and up to date credentialing documents to be a vital part of maintaining a quality network. The information requested is required in order to comply with Optum and/or OptumHealth Behavioral Solutions of California (Optum), Joint Commission and NCQA standards. Your participation in this process helps ensure your continued good standing in our network. We are asking for information that will help confirm that we are referring our members to you in the most appropriate way and that we are making full use of the services you offer. Additionally, the information you provide will help ensure the accuracy of claims payment.

The need to keep this information current in our files means that we will approach you to request this documentation throughout the life of the contract between our two entities. These requests can be expected approximately every 36 months. We understand that complying with this request can be time consuming, but it is required in order to allow us to continue to refer members to your programs and allow you to remain in the Optum network. Please provide the following documents within 30 days from the above date:

- A copy of facility's current license(s) for each contracted location
- A copy of facility's Professional and General liability insurance certificate(s)
- A copy of the facility's National accreditation, if applicable
- W-9
- Disclosure of Ownership Form – if attached
- Secure Fax Number

In addition, enclosed you will find the Site/Level of Care Update form. Please indicate any new programs you may have added since our last contract negotiations. Please take a moment to indicate any changes, as this information is a vital part of our ability to maximize your referral base. You will also find a detailed description of the above re-credentialing documents we are requesting.

If you have any questions at all or there is anything we can do to assist you in providing us with the requested documentation please feel free contact us. Please call Optum Behavioral Network Services at 9522052818. Thank you for taking the time to comply with this request.

Please return the requested information within 30 days to the email address OR to the attention of the undersigned at the fax number listed below.

Sincerely,

Alison Dittbrenner
Facility Recredentialing Associate

RETURN DOCUMENTS TO:

Email: optumbh.facilities@optum.com
Fax: (877) 771-1267

Optum Facility Tracking Number FAC000039900

Optum
Facility / Level of Care Update and Attestation Form

Please make updates directly to this form, sign attestation and return to Optum along with requested credentialing documents. Thank you.

Facility Name:	Mental Health Crisis Center
Federal Taxpayer Name:	Lancaster County of Nebraska
Federal Tax ID Number:	476006482
Primary Address:	825 J St Lincoln, NE, 68508-2958
Billing Address:	825 J St Lincoln, NE, 68508-2958

Medicare	**Medicaid**
093627	47600648227
093627	10025784800

Facility Address and Program Details

825 J St
Lincoln, NE, 68508-2958

Wheelchair Accessibility: Yes X No ___

Program	Desc I, II	Revenue Cd	CPT/ HCPC Cd	Length/ Frequency I	Length/ Frequency 2	Gender
MH Acute Inpatient Adult	Medicaid Rate Only	0124		24 hours/7 Days/Week		Both
MH Inpatient Adult		0124		6 Hours/Day	5 Days/Week	Both
MH Inpatient Adult	Medicaid Rate Only	0124		24 Hours/7 Days/Week		Both
J2315 Naltrexone Depot 1mg	Medicaid Rate Only		J2315			Both
J1630 Injection - Haloperidol - up to 5mg	Medicaid Rate Only		J1630			Both
J2680 Injection - Fluphenazine Decanoate - up to 25mg	Medicaid Rate Only		J2680			Both
J3490 MH Unclassified Drug	Medicaid Rate Only		J3490			Both
J2426 Paliperidone Palmitate 1mg	Medicaid Rate Only		J2426			Both
J1942 - MH Injection Aripiprazole Lauroxil up to 1mg	Medicaid Rate Only		J1942			Both
J0401 MH Injection-Aripiprazole Extended Release	Medicaid Rate Only		J0401			Both
J2794 Risperidone 5mg	Medicaid Rate Only		J2794			Both
J1631 Injection - Haloperidol Decanoate - per 50mg	Medicaid Rate Only		J1631			Both
S0166 Injection - Olanzapine 2.5mg	Medicaid Rate Only		S0166			Both

Contracting Contact Person:

Name: Scott Etherton

Title: Director

Phone: (402) 441-6329

Clinical Contact Person:

Name: Sarah Price

Title: Managed Care Coordinator

Phone: (402) 441-8217

Please sign and date:

I hereby certify that all responses and information provided in this recredentialing documentation submitted to Optum is complete, true, and correct to the best of my knowledge and belief. I further certify that the Facility is in good standing with all applicable federal and state licensing agencies and all required licenses are current and free of sanction. I warrant that I have the authority to sign this Facility Update Form on behalf of the entity for which I am signing in a representative capacity.

OPTUM
MALPRACTICE QUESTIONNAIRE

Facility Name: Mental Health Crisis Center Tax ID# 476006482

Address: 825 J St Lincoln, NE 68508

As part of our due diligence, we promise our customers that we will be certain that any facility we choose for our network provides a safe environment with high-quality treatment. We must have a statement in our file which shows we have looked into issues that may affect our membership. Please complete this form and return it with your application. Note: Your application for inclusion in our network will not be considered until the information requested has been received in full.

I. *If there have been no claims filed, or claims settled as described, please indicate this with your signature below:*

This confirms that during the past five years the facility has not entered into a settlement disposition of $100,000 for any malpractice claim and that there are no claims currently pending settlement.

_____ _____

Signature *Date*

_____

Title

II. *Should the facility have settled any claim for $100,000 or more during the past five years, and/or have any pending claims, please make copies of this questionnaire and complete one for each claim. In order to give us more information regarding the malpractice suit(s) mentioned in your application, the following questions must be answered. Answers must include all details requested. In order to protect your patient's confidentiality, we ask that you please do not state their name(s) on this questionnaire or any supplemental attachments.*

1. Title of Suit _____

2. Date Filed _____

3. What are the specific malpractice charges/allegations?

4. Indicate your position in the case in relation to plaintiff and to any codefendants.

5. Provide a brief clinical summary of the case including details of the treatment such as presenting complaints, assessment, diagnosis, medications prescribed, nature of clinical interactions, length of stay, details of discharge, etc.

6. What is your response to the allegations?

7. Disposition: ( ) Pending ( ) Settled

If settled, provide the following information:

Date of Settlement _____ *( ) In Court ( ) Out of Court*

Total Amount of Settlement _____ *Amount Attributable to You* _____

8. Please Attach a copy of the original complaint with the settlement and/or court documents.

Please white-out your patient's name to protect their confidentiality.

9. Describe any actions you have taken and how your Policies and Procedures have changed as a result of this claim.

This confirms that the information given above is true and complete.

_____ _____

Signature *Date*

_____

Title

SUBSTITUTE FORM W-9

IMPORTANT TAX DOCUMENT

Request for Taxpayer Identification Number

As part of the contracting process we are requesting that you complete this Substitute Form W-9. We are required by law to obtain this information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to 31% federal income tax backup withholding. Also, if you do not provide us with this information, you may be subject to a $50 penalty imposed by the Internal Revenue Service under Section 6723 of the Internal Revenue Code.

A. Taxpayer Name:
(To whom the check is payable)

Lancaster County of Nebraska
(A legal entity name if a corporation or partnership)

Doing Business As (DBA):
(A division name if a corporation or the name of the business if a sole proprietor)

Mental Health Crisis Center

B. Taxpayer Address

555 South 10th St

Lincoln NE, 68508

C. Taxpayer Identification Number:

1. Corporation

(List employer identification number)

2. Partnership

(List employer identification number)

3. Sole Proprietorship

(List social security number or employer identification number)

4. Tax Exempt Entity

(List employer identification number)

5. Other - Please Explain

Government 47-6006482

D. Effective Date of Taxpayer Name & TIN:

E. Form Completed By:

(Print name)

F. Signature:

(Signature)

G. Today's Date:

H. Daytime Phone Number:

PLEASE NOTE: INFORMATION REPORTED ON LINES A, B and C MUST BE CONSISTENT WITH DATA ON FILE WITH THE IRS AND SOCIAL SECURITY ADMINISTRATION.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 9/27/2016

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER UNICO Group, Inc. 1128 Lincoln Mall Suite 200 Lincoln, NE 68508	**CONTACT NAME:** UNICO Group, Inc. **PHONE (A/C, No, Ext):** 402-434-7200 **FAX (A/C, No):** 402-434-7272 **E-MAIL ADDRESS:**
	INSURER(S) AFFORDING COVERAGE — **NAIC #** **INSURER A :** Landmark American Insurance Company **INSURER B :** Continental Western Insurance Company **INSURER C :** Midwest Employers Casualty Company **INSURER D :** **INSURER E :** **INSURER F :**
INSURED Mental Health Crisis Center of Lancaster County 2201 South 17th Street Lincoln NE 68502	

COVERAGES **CERTIFICATE NUMBER:** 32052879 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	✓ **COMMERCIAL GENERAL LIABILITY** ☐ CLAIMS-MADE ☑ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☐ PRO-JECT ☐ LOC ☐ OTHER:			LHC759591	9/30/2016	9/30/2017	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 50.000 $ 5,000 $ 1,000,000 $ 3,000,000 $ 3,000,000
B	**AUTOMOBILE LIABILITY** ✓ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY			2375674-35	9/30/2016	9/30/2017	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
	☐ **UMBRELLA LIAB** ☐ OCCUR ☐ **EXCESS LIAB** ☐ CLAIMS-MADE ☐ DED ☐ RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
C	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N ☐ N / A **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below			EWC008646	9/30/2016	9/30/2017	✓ PER STATUTE ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000
A	Medical Professional Liability Claims-Made Form			LHC759591	9/30/2016	9/30/2017	$1,000,000 Each Claim $3,000,000 Aggregate Retro Date: 07/14/1986	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

D) Public Officials Liability - Gemini Insurance Company - PEM0000049-02 - 9/30/2016-9/30/2017 - $4,750,000 Each Occurrence and Aggregate $250,000 Retention

CERTIFICATE HOLDER

eBHIN
1645 N Street
Lincoln NE 68508

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

(LIN) Tom Champoux

carf INTERNATIONAL

November 25, 2015

Scott E. Etherton
Mental Health Crisis Center of Lancaster County
2201 South 17th Street, Suite 200
Lincoln, NE 68502

Dear Mr. Etherton:

It is my pleasure to inform you that Mental Health Crisis Center of Lancaster County has been issued CARF accreditation based on its recent survey. The Three-Year Accreditation applies to the following program(s):

Crisis Stabilization: Mental Health (Adults)

This accreditation will extend through October 31, 2018. This achievement is an indication of your organization's dedication and commitment to improving the quality of the lives of the persons served. Services, personnel, and documentation clearly indicate an established pattern of conformance to standards.

The survey report is intended to support a continuation of the quality improvement of your organization's program(s). It contains comments on your organization's strengths as well as any consultation and recommendations. A quality improvement plan (QIP) demonstrating your organization's efforts to implement the survey recommendation(s) must be submitted within the next 90 days to retain accreditation. The QIP form is posted on Customer Connect (*customerconnect.carf.org*), CARF's secure, dedicated website for accredited organizations and organizations seeking accreditation. Please log on to Customer Connect and follow the guidelines contained in the QIP form.

Your organization should take pride in achieving this high level of accreditation. CARF will recognize this accomplishment in its listing of organizations with accreditation and encourages your organization to make its accreditation known throughout the community. Communication of the accreditation to your referral and funding sources, the media, and local and federal government officials can promote and distinguish your organization. Enclosed are some materials that will help you publicize this achievement.

Your organization's complimentary accreditation certificate will be sent separately. You may use the enclosed form to order additional certificates.

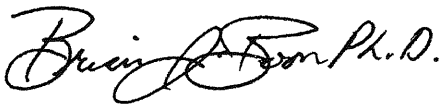
If you have any questions regarding your organization's accreditation or the QIP, you are encouraged to seek support from Mary Hanna by email at mhanna@carf.org or telephone at (888) 281-6531, extension 7068.

CARF International Headquarters
6951 E. Southpoint Road
Tucson, AZ 85756-9407, USA

www.carf.org

CARF encourages your organization to continue fully and productively using the CARF standards as part of its ongoing commitment to accreditation. CARF commends your organization's commitment and consistent efforts to improve the quality of its program(s) and looks forward to working with your organization in its ongoing pursuit of excellence.

Sincerely,



Brian J. Boon, Ph.D.
President/CEO

Enclosures

Department of Health and Human Services
Division of Public Health
Licensure Unit
301 Centennial Mall South, P O Box 94986
Lincoln, NE 68509-4986

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
CERTIFIES THAT

Mental Health Crisis Center Of Lancaster County

MEETS STATUTORY REQUIREMENTS AS A
MENTAL HEALTH CENTER
Lic # MHC108

Services	Total Licensed Beds
IN-PATIENT	16

SEAL

Thomas L. Williams, MD, Chief Medical Officer
Director, Division of Public Health
Department of Health and Human Services

EXPIRES
2/28/2018

Cut on heavy line and place on license.

FACILITY NAME: Mental Health Crisis Center Of Lancaster County
ADDRESS: 825 J STREET, LINCOLN, NE 68508

This is to verify that your MENTAL HEALTH CENTER is licensed through the date indicated on the above renewal card. Place the renewal card in the lower left hand corner of your original license.

Please notify this office at the address listed above of any change in name, address, or ownership.