

Rocky Mountain Health Plans Behavioral Health Provider Demographic Tool

Please complete a form for each provider in your practice.

Provider Information				
Date:	Tax ID:			
Group Name:	Group NPI:			
Provider Name:	Individual NPI:			
Practice Phone:	Practice Fax:			
Practice Website URL (if applicable):	Email Address:			
For the following sections, please select all answers that apply.				
Provider currently accepts new Health First Colorado (Colorado's Medicaid Program) Members? <input type="checkbox"/> Yes <input type="checkbox"/> No Accepts CHP+ Members: <input type="checkbox"/> Yes <input type="checkbox"/> No Currently Accepts New CHP+ Members: <input type="checkbox"/> Yes <input type="checkbox"/> No Practice/Provider accepts Mental Health Certifications? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Populations Served: <input type="checkbox"/> Pediatric only <input type="checkbox"/> Adult only <input type="checkbox"/> Both Pediatric & Adult <input type="checkbox"/> Adolescents <input type="checkbox"/> Families <input type="checkbox"/> Couples <input type="checkbox"/> Senior Adults				
Provider Type: <input type="checkbox"/> Psychiatrists <input type="checkbox"/> Child Psychiatrists <input type="checkbox"/> Psychiatric Prescriber <input type="checkbox"/> Adult mental health <input type="checkbox"/> Pediatric mental health <input type="checkbox"/> Substance use disorder				
Specialization / Area of Expertise <input type="checkbox"/> Anxiety <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Eating Disorders <input type="checkbox"/> Gender Identity & Sexual Orientation <input type="checkbox"/> Grief <input type="checkbox"/> Intellectual & Developmental Disabilities <input type="checkbox"/> Mood Disorder <input type="checkbox"/> PTSD <input type="checkbox"/> Severe & Persistent Mental Illness <input type="checkbox"/> Sexual Assault <input type="checkbox"/> Substance Use Disorder				
<input type="checkbox"/> Provider / practice is a safe space provider for LGBTQIA+ clients.* <small>*A provider whose practice provides an affirming and welcoming culture and environment for Members who identify as LGBTQIA+. This means that providers actively affirm and work with clients struggling with life challenges around their gender or sexuality identity and/or that the Member is in a place that supports them regardless of their identity as they work through other life challenges.</small>				
Is your practice able to provide services via telehealth? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Office Hours				
Monday	Tuesday	Wednesday	Thursday	Friday
After Hours Appointment Availability <input type="checkbox"/> After-hours (outside 8 am – 5 pm M – F) <input type="checkbox"/> Weekends				
Average Appointment Wait Times Non-urgent / regular Appointments (Non-acute care) <input type="checkbox"/> 1-3 calendar days <input type="checkbox"/> 4-7 calendar days Other: _____				

Emergency Care Appointments

By Phone: Within 15 minutes after initial contact Yes No Other: _____

In Person: Within 1 hour 1-2 hours Other: _____

Follow Up Appointments after Emergency Department and/or Hospital Discharge

1-3 calendar days 4-7 calendar days Other: _____

Linguistic Diversity

Skilled Medical Interpreter American Sign Language Spanish Chinese Vietnamese Other: _____

Accommodations for People with Physical Disabilities

Accessible building (ramps, doorways, hallways, bathrooms) Accessible exam room(s) (allows for wheelchair maneuvering and transfer)

Accessible medical equipment (e.g., adjustable-height exam tables, patient lifts, wheelchair scale)

Staff Training Received

Disability Competent Care Training Cultural Competency Training

COVID-19

Has COVID-19 impacted your practice in any of the following ways? (Please select all that apply.)

Office closure Limited hours Loss of staff

Is there any additional information, questions or concerns you would like to share with RMHP?

As the situation continues to evolve, we will provide updates on the following webpage: www.rmhp.org/i-am-a-provider/covid-19-resources

Signature _____

Date _____

Please return the completed and signed form by email, fax, or mail.

Email

providersurvey@rmhp.org

Fax

970-244-7957

Mail

Rocky Mountain Health Plans
Attention: Provider Network Management
2775 Crossroads Blvd.
Grand Junction, CO 81506



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