Employee Name: ____________________
Date of Completion: ____________________

PRACTITIONER APPLICATION

Network Enrollment and Credentialing

Complete as a new employee or when re-credentialing.

☐ SUD Provider ☐ PIHP ☐ ACCESS/UM

☐ GHS ☐ Lapeer CMH ☐ Sanilac CMH ☐ St. Clair CMH ☐ Other

Section I. Practitioner Profile

(To be completed by applicant)

Name of Practitioner Seeking Privileges: ____

Former Last Name (if applicable): ________________________ Date of Birth: _________________

Title and Department: ____

Name of Organization you work for: ____

Address of Organization you work for: ____

Organization Phone Number: ________________ Supervisor Name: _________________________

Email Address: ____________________ Date of Hire: _________________________

Degree: _________________________ NPI Number: ______________________

Licensure: _______________________ License Number: ____________________ Exp. Date: ____________

Certification: ____ Exp. Date: ____________

Certification: ____ Exp. Date: ____________

Current Credentialing Status: ☐ Provisional ☐ Probationary ☐ Full ☐ N/A - Current Term Dates: ______________

Applying for: ☐ Provisional ☐ Full ☐ Re-Credentialing *(Term shall be determined by Credentialing Committee)*

Target Populations you are seeking privileges to serve within the Region 10 PIHP Provider Network

☐ Children (0-3 years) ☐ Children w/Intellectual/Developmental Disabilities (4-17 years)

☐ Children w/ Serious Emotional Disturbance (4-17 years)

☐ Children with Substance Use Disorder

☐ Adults w/ Intellectual / Developmental Disabilities

☐ Adults with Mental Illness

☐ Adults with Substance Use Disorder

☐ Co-occurring Disorders (MH/SUD)

Review/Revision Date: ____________

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Cultural Competencies and Linguistic Capabilities

Do you speak a language other than English that can assist non-English speaking individuals within the agency you are providing services? ☐ YES ☐ NO

If you answered 'YES', please identify the language(s): ______________

Do you have any cultural or ethnic specialties you would like identified? ☐ YES ☐ NO

If you answered 'YES', please list them here and identify your specialty qualifications.

Section II. Privileges Requested

(To be completed by applicant)

I am seeking privileges to perform services as (check all that apply):

☐	Psychiatrist	☐ MD ☐ DO
☐	Physician, Non-Psychiatrist	☐ MD ☐ DO
☐	Psychologist	☐ LP
☐	Physician Assistant	☐ PA-C
☐	Nurse Practitioner	☐ APRN-BC ANP ☐ FNP ☐ PedNP ☐ APRN-BE NHNP ☐ PsychNP
☐	Therapist/Clinician, Psychologist Limited License	☐ LPC ☐ LMFT ☐ LLP ☐ LMSW ☐ LLPC* ☐ LLMFT* ☐ TLLP* ☐ LLMSW* *May only provide services under the supervision of LMSW, LLP, LPC or LLMFT
☐	Supports Coordinator/ Case Manager	☐ LBSW ☐ SST ☐ LLBSW* *May only provide services under the supervision of LMSW
☐	Psychiatric Nurse	☐ MA ☐ MSN in Psych ☐ RN
☐	Registered Nurse, BSN	☐ BSN ☐ RN ☐ LPN
☐	Occupational Therapist	☐ OTR
☐	Occupational Therapy Assistant	☐ COTA
☐	Physical Therapist	☐ PTR
☐	Physical Therapy Assistant	☐ PTA
☐	Speech Pathologist or Audiologist	☐ SLP
☐	Registered Dietician	☐ RD

<u>Other Certifications</u>

PRACTITIONER APPLICATION
Network Enrollment and Credentialing
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☐	Substance Abuse Treatment Specialist	☐CADC ☐ CADC- M ☐ CAADC ☐ CCS ☐ CCS-M ☐CCJP ☐Development Plan ☐ CCDP ☐CCDP-D
☐	Non-Credentialed Staff	
☐	Qualified Behavioral Health Professional (QBHP)	
☐	Qualified Mental Health Professional (QMHP)	
☐	Qualified Intellectual Disability Professional (QIDP)	
☐	Certified Peer Support Specialist (PSS)	
☐	Children's Mental Health Professional (CMHP)	
☐	Family Psychoeducation	☐ Successful completion of Certified Training
☐	Peer Recovery Coach (SUD)**	☐ CPRM ☐ Certified Recovery Coach (CRC) ☐ MDHHS Certification ☐ CCAR Completion
☐	Certified in SUD Prevention	☐ CPC-R ☐ CPC-M ☐ CPS-R ☐ Development Plan ☐CHES
☐	Gender Competent	
☐	Communicable Disease Trainer	☐HAPIS
☐	Parent Management Training – Oregon Model	☐PMTO
☐	Infant Mental Health Certification	☐IMH
☐	Trauma Focused CBT	☐TFCBT
☐	Board Certified Behavioral Analyst (BCBA)	
☐	Board Certified Aide Behavioral Analyst (BCaBA)	

**Peer Recovery Coach Attestation: This is to be completed when applying for peer recovery coach privileges.

☐ I am in peer recovery
☐ I have a High School Diploma or equivalent
☐ I am in stable recovery
☐ I am actively working in a recovery program E.g.) Twelve-step, church/spiritual, other recovery support group
☐ I have completed the Connecticut Community for Addiction Recovery (CCAR) training, MDHHS Recovery Coach training, or a MCBAP Certification for Certified Peer Recovery Mentor.

Section III. Privileging Questionnaire

(To be completed by applicant)

1. Are you now, or have you ever been, involved in any malpractice suit, including arbitration?
   ☐Yes ☐No
2. Has any malpractice claim settlement, without litigation or arbitration, ever been paid by you or on your behalf? ☐Yes ☐No
3. With regard to each of the following, have you ever been involuntarily denied, removed, suspended, penalized, not renewed, placed under probation, subjected to disciplinary action, or otherwise limited or curtailed; or have you voluntarily relinquished any of the items below in anticipation of any of these actions; or any adverse actions pending?
   a. Clinical Privileges ☐Yes ☐No
   b. State License ☐Yes ☐No
   c. Specialty Board Certification ☐Yes ☐No
   d. DEA Registration or other applicable narcotic regulation ☐Yes ☐No

e. Hospital staff membership or privileges ☐Yes ☐No
f. Other health care organization staff membership or privileges ☐Yes ☐No
g. Professional organization membership ☐Yes ☐No
h. Medicare, Medicaid or other government program participation ☐Yes ☐No
i. HMO, PPO, or other prepaid health plan participation ☐Yes ☐No
j. Professional liability insurance ☐Yes ☐No

4. Have you ever been discharged (terminated) from any position in a healthcare or substance use disorder organization (e.g. hospital, nursing home, CMH, Inpatient state facility, nonprofit agency, etc.)? ☐Yes ☐No
5. Other than traffic violations, have you had a misdemeanor conviction in the last 5 years? ☐Yes ☐No
6. Have you ever had a felony conviction? ☐Yes ☐No
7. Have you ever been investigated, reprimanded, sanctioned, or fined by any state or local agency? ☐Yes ☐No
8. Are you an owner partner or investor; or do you have a business (financial) interest in a clinical laboratory, diagnostic or testing center; or do you have other involvement with the provision of health services or pharmaceuticals? ☐Yes ☐No
9. Do you currently have independent malpractice insurance? ☐Yes ☐No
   a. If yes, please provide a copy of your malpractice insurance including the coverage limit and dates of coverage.
10. Are you currently able to perform all necessary functions of the position that is requested to be privileged and credentialed? ☐Yes ☐No
11. Do you attest that you have no present/current illegal drug or unprescribed medication use? ☐Yes ☐No

If you answered "Yes" to any question(s) # 1- # 8, please attach a signed and dated explanation for confidential review by the privileging entity.

Section IV. Attestation

(To be completed by applicant and signed by applicant supervisor)

Practitioners are expected to have training, education, and experience appropriate to their position and responsibilities. Applicants are required to maintain information in their personal training file for specialized training (courses, seminars, conferences, clinical experience) which would qualify them to provide clinical treatment in that specific skill area and should be prepared to present this information upon request. These records should also be on file in their credentialing file at the Provider Organization. Some competencies or skills do not require specific training or education but may be acquired through experience, for example, foreign language skills or knowledge of a particular cultural group.

PRACTITIONER APPLICATION
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By signing below I attest that I understand that I am applying to be appointed to provide specialty services within **PIHP Provider Network** and that my clinical work may be subject to Federal, State, PIHP, and/or CMH performance and compliance reviews, and that I have the training, education and experience necessary to provide these services.

By signing below I attest that I have reviewed the **Mission and Values** statements and **Code of Conduct** as contained in the Corporate Compliance Program and/or Credentialing and Privileging Policy and agree to adhere to these ethical standards of practice and agree to comply with all stated values and guided principles.

By signing below I attest that the information contained herein is correct and complete.

Signature of Applicant:____________________________ **Date:**____________________

Supervisor Recommendation: ☐Approve ☐Disapprove

Signature of Supervisor:____________________________ **Date:**____________________

*A designated supervisor is mandatory for Peer Specialists/Certified Recovery Coaches, TLLPs, LLMSWs, LLBSWs, LLPCs; CMHPs, SATSs other than supervisors and SATPs; and Case Managers or Supports Coordinators who are not QMHPs or QIDPs.

*Designated Clinical Supervisor: ______________________ Degree: ____________________
PLEASE PRINT

*Designated Child MH Supervisor: ______________________ Degree: ____________________
PLEASE PRINT

*A Designated supervisor is mandatory for all staff providing services under a MCBAP Development Plan-Counselor or Development Plan-Supervisor.

*Designated MCBAP Supervisor: ____________________ Certification: ____________________
PLEASE PRINT

Review/Revision Date: _____________

PRACTITIONER APPLICATION
Network Enrollment and Credentialing
Complete as a new employee or when re-credentialing.

Section V. Committee Determination

(To be completed by the approving committee or designee only)

After review of the practitioner's application, the Privileging & Credentialing Committee recommends:

☐ Full Privileges of the practitioner for all services as outlined in this application.
☐ Provisional Privileges of the practitioner.
☐ Probationary Privileges.
☐ Limitation of Services Requested.
☐ Privileges Revoked or Denied.

For the following target populations:

☐ Children (0-3 years) ☐ Children w/Intellectual/Developmental Disabilities (4-17 years)

☐ Children w/ Serious Emotional Disturbance (4-17 years) ☐ Children with Substance Use Disorder

☐ Adults w/ Intellectual / Developmental Disabilities ☐ Adults with Mental Illness

☐ Adults with Substance Use Disorder ☐ Co-occurring Disorders (MH/SUD)

☐	Psychiatrist	☐ MD ☐DO
☐	Physician, Non-Psychiatrist	☐ MD ☐DO
☐	Psychologist	☐ LP
☐	Physician Assistant	☐ PA-C
☐	Nurse Practitioner	☐ APRN-BC ANP ☐ FNP ☐ PedNP ☐ APRN-BE NHNP ☐ PsychNP
☐	Therapist/Clinician, Psychologist Limited License	☐ LMSW ☐ LLMSW* ☐ LLP ☐ TLLP* ☐ LPC ☐ LLPC* ☐ LLMFT* ☐ LMFT *May only provide services under the supervision of LMSW, LLP, LPC or LLMFT
☐	Supports Coordinator/ Case Manager	☐ LBSW ☐ LLBSW* ☐ SST *May only provide services under the supervision of LMSW
☐	Psychiatric Nurse	☐ MA ☐ MSN in Psych ☐ RN
☐	Registered Nurse, BSN	☐ BSN ☐ RN ☐LPN
☐	Occupational Therapist	☐ OTR
☐	Occupational Therapy Assistant	☐ COTA
☐	Physical Therapist	☐ PTR
☐	Physical Therapy Assistant	☐ PTA
☐	Speech Pathologist or Audiologist	☐ SLP
☐	Registered Dietician	☐ RD
☐	Substance Abuse Treatment Specialist	☐CADC ☐ CADC- M ☐ CAADC ☐ CCS ☐ CCS-M ☐CCJP ☐Development Plan ☐ CCDP ☐CCDP-D
☐	Non-Credentialed Staff	
☐	Qualified Behavioral Health Professional (QBHP)	
☐	Qualified Mental Health Professional (QMHP)	

Employee Name: ______________________
Date of Completion: ______________________

PRACTITIONER APPLICATION
Network Enrollment and Credentialing
Complete as a new employee or when re-credentialing.

☐	Qualified Intellectual Disability Professional (QIDP)	
☐	Certified Peer Support Specialist (PSS)	
☐	Children's Mental Health Professional (CMHP)	
☐	Family Psychoeducation	☐ Successful completion of Certified Training
☐	Peer Recovery Coach (SUD)**	☐ CPRM ☐ Certified Recovery Coach (CRC) ☐ MDHHS Certification ☐ CCAR Completion
☐	Certified in SUD Prevention	☐ CPC-R ☐ CPC-M ☐ CPS-R ☐ Development Plan ☐CHES
☐	Gender Competent	
☐	Communicable Disease Trainer	☐HAPIS
☐	Parent Management Training – Oregon Model	☐PMTO
☐	Infant Mental Health Certification	☐IMH
☐	Trauma Focused CBT	☐TFCBT
☐	Board Certified Behavioral Analyst (BCBA)	
☐	Board Certified Aide Behavioral Analyst (BCaBA)	

If privileges are being revoked, denied or the practitioner is placed on provisional or probationary status, attach a separate document to the application that outlines rationale for decision.

Recommended Term: _________________ To: _________________

Credentialing Committee / Designee Signature: ______________________________ *Date:* ______________________

Credentialing Committee / Designee Name Printed: ______________________________

ATTACHMENT A – Primary Source Verification

(TO BE COMPLETED BY PROVIDER ORGANIZATIONS HUMAN RESOURCE DEPARTMENT OR DESIGNEE)

Name of Practitioner:	Contract Provider:
Degree: College/University: Degree Completion Date: __/____	Verification Source: Verified By: Date:
Licensure: Expiration Date:	Verification Source: Verified By: Date:
Certification: Expiration Date:	Verification Source: Verified By: Date:
Certification: Expiration Date:	Verification Source: Verified By: Date:
Employee has undergone a satisfactory criminal background check. **must be completed initially and at least every 2-years after* ☐ Yes ☐No	Verification Source: Verified By: Date:

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Item	Verification
Satisfactory disciplinary status with regulatory board or agency verified? ☐ Yes ☐No	Verification Source: http://w3.lara.state.mi.us/free Verified By: Date:
Free of Medicare/Medicaid Sanctions: ☐ Yes ☐No **must be done initially and monthly on-going*	Verification Source: http://exclusions.oig.hhs.gov AND http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-16459--,00.html Verified By: Date:
Satisfactory National Practitioner Databank/Healthcare Integrity and Protection Data Bank (NPDB/HIPDB) query ☐ Yes ☐No	Verification Source: www.npdb.hrsa.gov Verified By: Date:
Satisfactory work history review of at least previous five years, or review of full history for those with less than five years' experience? ☐Yes ☐No	Verification Source: Verified By: Date:

I attest that I have completed the Primary Source Verification as indicated above for the employee indicated.

______________________________ ____________
HR Designee Signature **Date**

______________________________ ____________
Training Designee Signature **Date**