ORGANIZATION APPLICATION

Network Enrollment and Privileging / Credentialing

☐ **SUD Provider** ☐ **CMHSP** ☐ **Sub-Contract Provider of CMHSP** ☐ **PIHP**

Note**: If the organization has multiple locations with which the PIHP contracts, an additional location form is needed for **each location

(Complete as a new organization or when re-applying)

Current Privileging Status: ☐ Provisional ☐ Probationary ☐ Full ☐ N/A

Current Term (if applicable): _____

Start Date: _____ End Date: _____

Applying For: ☐ Provisional ☐ Full ☐ Re-Privileging

Section I. Organizational Profile

(Sections I. – V. To be completed by the organization applying for network enrollment both initially and at the time of re-application)

Organization Name: _____

DBA (if applicable): _____ Group Affiliation (if applicable): _____

NPI Number of Location: _____

Organization Web Address: _____

Organization Primary Mailing Address: _____

Organization Primary Phone: _____ Fax: _____ Hours of Operation: _____

Primary Point of Contact Name: _____ Contact Number: _____

Organization Accepting New Beneficiaries: ☐ YES ☐ NO

Facility is ADA Compliant: ☐ YES ☐ NO

If yes, please specify if the office / facility has the following equipment to accommodate individuals with physical disabilities:

☐ Wheelchair(s) ☐ Ramp(s) ☐ Elevator(s) ☐ Accessible Bathroom(s)
☐ Other: _____

Specific linguistic capabilities within your agency: ☐ ASL ☐ Language Interpretation Services

☐ Non-English Languages (if your organization maintains non-English languages spoken, please specify those languages): _____

Specific Cultural capabilities within your agency: ☐ Sexual Orientation ☐ Gender Competency
☐ Age-Specific Competencies ☐ Race ☐ Religious / Spiritual Beliefs
☐ Ethnic Background(s) (if your organization maintains specific ethnic background(s), please specify those):

_____

☐ Other: _____

Provider has ensured staff have completed Cultural Competency Training: : ☐ YES ☐ NO

Independent PCP Facilitator(s) (***Mental Health Service Providers only***): _____

Section II. Organizational Licensing and Certification

Accreditation Type: ☐ TJC ☐ CARF ☐ COA ☐ ACHC ☐ NCQA ☐ N/A ☐ Other: _____

Note: You must provide the organization accreditation letter, accreditation report as well as accreditation corrective action plan(s) and the status of the action plan(s).

Organization Type: ☐ For Profit ☐ Not for Profit ☐ Partnership ☐ Private ☐ Public ☐ Government
☐ Limited Liability Corp. (LLC) ☐ Other: _____

Certification and Licensing *(check all that apply)*:

☐ MDHHS Certification if the organization is not accredited – Expiration Date: _____

☐ MDHHS Certification Waived if accredited – Expiration Date: _____

☐ MDHHS Certification Pending – Expiration Date: _____

☐ MDHHS Designated Women's Specialty Service Provider

☐ LARA Licensure Obtained – License Number: _____

Licensing Type(s): _____ Expiration Date: _____

☐ LARA Licensed Integrated Treatment Provider – Expiration Date: _____

☐ MDHHS ASAM LOC Designation(s) (List all MDHHS LOC Designation(s)

ASAM LOC: _____ ☐ Adult ☐ Children

ASAM LOC: _____ ☐ Adult ☐ Children

ASAM LOC: _____ ☐ Adult ☐ Children

**If the organization has additional certification(s), license(s) and/or ASAM LOC Designation(s), please include this information on an additional page. Copies of license(s) and/or certification(s) are to be submitted with this application.*

Section III. Organizational Managing Employees

Managing Employees: List all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operations of Provider Entity (e.g. general manager, business manager, administrator or director, executive officer, chief operating officer, chief financial officer, medical director, clinical program director, corporate compliance officer etc.), including the name, phone number, email, and title.

(Attach additional sheet(s) as necessary)

Name	Phone Number	Email	Title

Name	Phone Number	Email	Title

Section IV. Organizational State and Federal Regulatory Status Attestation

- This organization is in good standing with all State regulatory bodies: ☐ YES ☐ NO
  - If no, provide written explanation on a separate page.
- This organization is in good standing will all Federal Regulatory bodies: ☐ YES ☐ NO
  - If no, provide written explanation on a separate page.
- This organization has active Federal or State sanctions: ☐ YES ☐ NO
  - If yes, provide written explanation on a separate page.
- This organization has active Federal or State Disbarments: ☐ YES ☐ NO
  - If yes, provide written explanation on a separate page.
- This organization has had a malpractice lawsuit and/or judgement within the last ten (10 years): ☐ YES ☐ NO
  - If yes, provide written explanation on a separate page.
- This organization has been excluded from Medicare/Medicaid participation: ☐ YES ☐ NO
  - If yes, provide written explanation on a separate page.
- This organization maintains liability insurance: ☐ YES ☐ NO
  - If yes, provide copy with submission of this application

Attestation:

The signature below indicates that the statement and indications made in Section I, II, III and IV are accurate and true. The below signature is that of an authorized representative within your organization.

Print Name: _____ *Title:* _____

Signature: _____ *Date:* _____

Section V. Provider Services

Indicate the services you are requesting privileges to provide within your organization under subcontract for CMHSP/SUD within the scope of your practice.

***SUD** Contracted Provider: If you are seeking privileges for SUD services only, please only complete table **E**.*

***CMHSP / CMHSP** Contract Provider: Please indicate all items that apply within tables **A-D**.*

A. Mental Health Services – CMHSP / CMHSP Contracted Provider	
☐ ACT – Assertive community Treatment	☐ Integrated Dual Disorders (Fidelity Tested)
☐ Assessment and Evaluation	☐ Medication Administration
☐ Behavioral Management Review	☐ Medication Review
☐ Child Therapy	☐ Nursing Facility Mental Health Monitoring
☐ Clubhouse Psychosocial Rehabilitation Program	☐ Occupational Therapy
☐ Community Psychiatric Inpatient	☐ Outpatient Partial Hospitalization
☐ Community Living Supports	☐ Peer-Directed & Operated Support Services
☐ Crisis Interventions	☐ Personal Care in Specialized Residential Settings
☐ Crisis Observation Care	☐ Personal Emergency Response System (PERS)
☐ Crisis Residential Services	☐ Physical Therapy
☐ Dialectic Behavior Therapy (Certified Team)	☐ Prevention Services
☐ Electroconvulsive Therapy	☐ Respite Care
☐ Enhanced Medical Equipment and Supplies	☐ Skill Building Assistance
☐ Enhanced Pharmacy	☐ Speech, Hearing, and Language
☐ Environmental Modifications	☐ Supported Employment
☐ Family Therapy	☐ Supports Coordination
☐ Family Training	☐ Targeted Case Management
☐ Fiscal Intermediary	☐ Transportation
☐ Health Services	☐ Treatment Planning
☐ Home Based Services	☐ Wraparound Facilitation
☐ Housing Assistance	☐ Telemedicine
☐ Individual/Group Therapy	
☐ Inpatient Psychiatric Hospital – State Facility Admission	

B. Habilitation Supports Services	
☐ Assistive Technology	☐ Out of Home Pre-Vocational Services
☐ Community Living Supports	☐ Personal Emergency Response System (PERS)
☐ Enhanced Medical Equipment and Supplies	☐ Private Duty Nursing
☐ Enhanced Pharmacy	☐ Respite Care
☐ Environmental Modifications	☐ Supported Employment
☐ Family Training	☐ Supports Coordination
☐ Out of Home Non-Vocational Habilitation	
C. Children's Services	
☐ Assessments	☐ Home Care Training, Non-Family
☐ Behavioral Management Review	☐ Individual/Group Therapy
☐ Community Living Supports	☐ Massage Therapy
☐ Environmental Modifications	☐ Medication Review
☐ Family Therapy	☐ Occupational Therapy
☐ Family Training	☐ Non-Family Training
☐ Health Services	☐ Respite Care
☐ Targeted Case Management	
D. Serious Emotional Disturbance Services	
☐ Community Living Supports	☐ Child Therapeutic Foster Care
☐ Family Home Care Training	☐ Therapeutic Overnight Camp
☐ Family Support Training	☐ Transitional Services
☐ Therapeutic Activities	☐ Wraparound Services
☐ Respite Care	☐ Home Care Training – Non-Family
E. Substance Use Disorder Services	
☐ Recovery Housing	☐ Peer Delivered Services (Recovery Coaching)
☐ Early Intervention Services	☐ Residential Services
☐ Individual Assessment Services	☐ Sub – Acute Detoxification Services
☐ Medication Assisted Treatment Services	☐ Outpatient Care Services
☐ Women's Specialty Services*	☐ Psychiatric Services
☐ Gender Competent Services*	☐ Adolescent Treatment Services
☐ Intensive Outpatient	

**Substance Use Disorder Women's Specialty and Gender Competent services must meet criteria specified within Region 10 SUD Women's Specialty Services and Gender Competent Programs Policy (05.03.06).*

Section VI. PIHP Review and Recommendation

(This section is to be completed by a PIHP / CMHSP Network Manager or Designee)

I have reviewed the application as well as documents submitted by the organization. I, or a designee, have done a due diligence review of all information and find the statements submitted by the organization to be true and accurate.

☐ YES ☐ NO

If no, note area(s) of concern that have been identified on a separate sheet of paper and attach to application.

After review of this information, I Recommend:

☐ Full Privileges
☐ Provisional Privileges
☐ Probationary Privileges
☐ Limitations of Services Requested
☐ Privileges be Revoked/Denied

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

I recommend the following term (if applicable):

Start: _____ Expiration: _____

Network Manager / Designee Signature: _____ *Date:* _____

Network Manager / Designee Name Printed: _____

Section VII. Privileging & Credentialing Committee Review and Recommendation

(This section is to be completed by the PIHP / CMH Privileging & Credentialing Committee or Designee)

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

☐ Full Privileges of the provider organization in the Region 10 PIHP Provider Network for all services as outlined in this application.
☐ Provisional Privileges of the provider organization in the Region 10 Provider Network.
☐ Probationary Privileges.
☐ Limitation of Services Requested.
☐ Privileges Revoked or Denied.

If privileges are being revoked, denied or the organization 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: _____