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| **This section for CMHSP or CMHPSM use only:** | | | | | | |
| Application Reviewer: |  | | | | Review Date: |  |
| Application Approved: | Yes:  No: | Term Start: |  | | Term End: |  |
| Reviewer Organization: |  | | | EHR Upload Date: | |  |

Application will be returned with status information if it is not approved or if more information is needed. Re-credentialing applications need to be approved prior to the expiration of the previous application term.

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|  | **Community Mental Health Partnership of Southeast Michigan** |
| **Mental Health Service Provider Network**  **Initial Application / Re-Credentialing Application**  **Application Revised: 5/1/2014** |

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| **SECTION 1: APPLICATION INFORMATION** |

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| **Application (Please select one):** | | | | **Application Date:** |
| Initial Application: |  | Re-Credentialing Application: |  |  |

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| **Application submitted to the following CMHSP within the CMHPSM Region:** | | | | | | | |
| Lenawee |  | Livingston |  | Monroe |  | WCHO |  |

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| **Staff Responsible for Completing this Application:** | | |
| Name | Email | Phone |
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| **Service Panels** | **MI Adult** | **Older Adult w/ SPMI** | **DD Adult** | **DD Child** | **SED Child** | **Co-Occurring: SUD/MI** |
| Agency With Choice Services |  |  |  |  |  |  |
| Applied Behavioral Analyst Services |  |  |  |  |  |  |
| Art Therapy |  |  |  |  |  |  |
| Case Management |  |  |  |  |  |  |
| Crisis Residential |  |  |  |  |  |  |
| Fiscal Intermediary Services |  |  |  |  |  |  |
| Home Based |  |  |  |  |  |  |
| Licensed Residential Supports |  |  |  |  |  |  |
| Occupational Therapy |  |  |  |  |  |  |
| Outpatient Mental Health Services |  |  |  |  |  |  |
| Peer Delivered or Operated Services |  |  |  |  |  |  |
| Psychiatrist |  |  |  |  |  |  |
| Psychologist |  |  |  |  |  |  |
| Psycho-Social Rehabilitation |  |  |  |  |  |  |
| Recreation Therapy |  |  |  |  |  |  |
| Registered Dietician |  |  |  |  |  |  |
| Registered Nurse |  |  |  |  |  |  |
| Respite |  |  |  |  |  |  |
| Respite Camp Services |  |  |  |  |  |  |
| Skill Building |  |  |  |  |  |  |
| Speech Language Pathologist |  |  |  |  |  |  |
| Supported Employment |  |  |  |  |  |  |
| Unlicensed Comm. Living Supports |  |  |  |  |  |  |
| Wrap Around Services |  |  |  |  |  |  |
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| **Any Other Unlisted Services:** |  |  |  |  |  |  |
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| **SECTION 2: ORGANIZATIONAL INFORMATION** |

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| --- | --- | --- | --- |
| **Organization (Complete Billing address only if different than mailing address):** | | | |
| **Legal Name:** |  | **DBA (if different):** |  |
| **Address:** |  | **City:** |  |
| **State:** |  | **Zip Code (ZIP +4):** |  |
| **Main Phone:** |  | **Main Fax:** |  |
| **Billing Add.:** |  | **Billing City:** |  |
| **Billing State:** |  | **Billing (ZIP + 4)** |  |

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| **Organization Type:** | | | | **Organizational Identification Numbers** | |
| **Governmental Entity:** |  | **Corporation:** |  | **Tax ID:** |  |
| **Private Non-Profit:** |  | **Partnership:** |  | **Medicaid #:** |  |
| **Privately Owned:** |  | **LLC/LLP:** |  | **Medicare #:** |  |
| **Other (Describe):** |  | |  | **NPI #:** |  |

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| **Administrative Information (Please fill out as applicable to your organization):** | | |
| **Position** | **Name** | **E-Mail or Phone#** |
| **CEO/Executive Director:** |  |  |
| **Chief Medical Officer:** |  |  |
| **Chief Clinical Manager:** |  |  |
| **Recipient Rights Contact:** |  |  |
| **Claims Contact:** |  |  |
| **Contracts Contact:** |  |  |
| **Compliance/HIPAA Officer:** |  |  |
| **Primary Contact:** |  |  |
| **Secondary Contact:** |  |  |

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| **Please list your organizations board of directors as of this application date:** | | |
| **Last Name** | **First Name** | **Term Expires** |
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| **Notes/Additional Space if more than 12 members:** | | |

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| **If applicable, please list all individuals with an ownership stake in your organization of 5% or greater:** | | |
| **Last Name** | **First Name** | **% Ownership** |
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| **Notes/Additional Space if more than five individuals:** | | |

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| **Within the five years preceding the application date, has the organization:** | **Yes** | **No** | **N/A** |
| **Had a state license or certification revoked?** |  |  |  |
| **Had its accreditation revoked, suspended or limited?** |  |  |  |
| **Had any other license, certification or accreditation revoked?** |  |  |  |
| **Had any sanctions imposed by Medicaid or Medicare?** |  |  |  |
| **Had professional liability insurance canceled, or denied for renewal?** |  |  |  |
| **Had any malpractice claims related to mental health services?** |  |  |  |
| **Organization has been a defendant in a mental health services lawsuit, where an award or settlement exceeded $50,000.00.** |  |  |  |
| **Has the organization’s leadership, board of directors, or owners (if applicable) been listed on any federal or state exclusion or debarment list.** |  |  |  |
| **Does the organization have any pending actions related to any of the above that have yet to be settled or finalized?** |  |  |  |
| ***For any questions in which a “Yes” was indicated please provide a detailed accounting of the incident or incidents and the current status of any situations.*** | | | |

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| **SECTION 3. PROVIDER CONTRACTUAL REQUIREMENTS** |

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| **Provider Accreditation:** | | | |
| **Accreditation Type:** | | **Select:** | **Expiration Date:** |
| TJC/JCAHO: | |  |  |
| CARF: | |  |  |
| COA: | |  |  |
| NCQA: | |  |  |
| Other: |  |  |  |
| Request accreditation waiver, (may serve no more than six consumers concurrently per CMHPSM policy): | | |  |
| ***Please attach your organizations accreditation documentation to this application.*** | | | |

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| **The following insurances are required for paneled providers:** | | |
| **Type:** | **Notes:** | **Check box if Attached:** |
| **Commercial General** | Minimum $1,000,000.00 combined limit per occurrence/claim. |  |
| **Professional Liability** | Minimum $1,000,000.00 combined limit per occurrence/claim. |  |
| **Workers Disability Compensation** | If provider is an employer, if provider is not an employer please attach written assertion of such. |  |
| **Motor Vehicle Liability** | If provider transports consumers, $1,000,000.00 per occurrence combined single limit Bodily Injury and Property Damage. |  |
| ***Please attach documentation of required provider insurances to this application.*** | | |

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| **Provider has expertise, specialized training, or certifications in any of the following: (Please check all that apply)** | | | |
| Adjustment Disorders |  | Motor Skill Disorders |  |
| Anxiety Disorders |  | P.M.T.O. |  |
| Applied Behavioral Analysis |  | Personality Disorders |  |
| Attention & Disruptive Behavior Disorders |  | Physical/ Sexual Abuse |  |
| Communication Disorders |  | Schizophrenia & other Psychotic Disorders |  |
| D.B.T. |  | Sexual & Gender Identity Disorders |  |
| Delirium, Dementia & Other Cognitive Disorders |  | Sleep Disorders |  |
| Developmental Disabilities |  | Somatoform Disorders |  |
| Dissociative Disorders |  | Speech Impaired Consumers |  |
| Eating Disorders |  | Substance Abuse Related Disorders |  |
| Elimination Disorders |  | Tic Disorders |  |
| Factitious Disorders |  | Visually Impaired Consumers |  |
| Hearing Impaired Consumers |  | Other(s): (Please List below) |  |
| Impulse-Control Disorders |  |  |  |
| Learning Disorders |  |  |  |
| Mental Disorders due to General Medical Condition |  |  |  |
| Mood Disorders |  |  |  |
| Motivational Interviewing |  |  |  |

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| **Hours of Service Availability (Identify availability or indicate 24 hours/7 days per week)** | | | | | | | | |
| **Choose:** |  | **SUN** | **MON** | **TUE** | **WED** | **THU** | **FRI** | **SAT** |
|  | **BEGIN:**  **END:** |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | **24 HOUR** | 24 HR | 24 HR | 24 HR | 24 HR | 24 HR | 24 HR | 24 HR |

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| **Organizational Linguistic Capacity** | | |
| Available: | | Number of staff fluent or brief explanation of service capacity: |
| Spanish |  |  |
| French |  |  |
| Arabic |  |  |
| American Sign Language |  |  |
| Others (Please List) | |  |
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| **Special Certifications** |
| Please list all special mental health service certifications the organization and/or its staff members have obtained (Text Box Expands) : |
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| **Organizational References-**Please provide contact information for individuals for at least three, but no more than five separate agencies your organization contracts with to provide mental health services: | | | | |
| # | Agency Name: | Individual Name: | Email Address: | Phone Number: |
| 1 |  |  |  |  |
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| **Section 4. Staff Information Attachments** |

The following attachments are required to be submitted with the application. New panel providers will have the opportunity to complete staff trainings after application is approved and contract is executed. Providers with staff trained under other CMHSP training programs or other training sources may be deemed permissible upon review of training materials or reciprocity standards.

|  |  |  |
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| **Attachment Type:** | **Attached:** | **# of Pages** |
| Attachment A: Staff Credential Review |  |  |
| Attachment B: Staff Background Review |  |  |
| Attachment C: Staff Training |  |  |

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| **Current Staff Responsible for Staff Credential Review:** | | |
| Name | Email | Phone |
|  |  |  |
| **Current Staff Responsible for Criminal Background Checks** | | |
| Name | Email | Phone |
|  |  |  |
| **Current Staff Responsible for Staff Training Documentation** | | |
| Name | Email | Phone |
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| **SECTION 5. PROVIDER CERTIFICATION, RELEASE & SIGNATURE** |

I hereby certify that all information contained in this application, and all its attachments is accurate, complete, and true:

I understand that in making this application to CMHPSM, the organization agrees to the following:

1. Any information contained in this application which subsequently is found to be false could result in denial of my application or termination of participation in the CMHPSM Provider Network;
2. It is the organization’s responsibility to promptly advise the CMHPSM Provider Network of any changes or additions to the information contained in this application;
3. All the information contained in this application or its attachments is subject to CMH investigation and review; only complete applications will be reviewed, a complete application shall include the following:
   1. Application Sections 1-5 completely and accurately filled out.
   2. Attachment A: Primary Credential Review; completed on all staff that will serve CMHPSM consumers, as many copies as needed.
   3. Attachment B: Staff Background Review; completed on all staff that will serve CMHPSM consumers, as many copies as needed.
   4. Attachment C: Staff Training Review; completed on all staff that will serve CMHPSM consumers, as many copies as needed.
   5. Any documentation requested within the application (i.e. accreditation documentation, financial audits, proof of insurances) is attached to the application package.
   6. Any documentation requested by CMHPSM staff during the application process.
4. This is an application only and that submission of this application does not automatically result in participation in the CMHPSM Provider Network; and
5. Acceptance in to the provider network does not guarantee any specific level of utilization or guarantee utilization at all.
6. The information contained in this document provides an initial baseline for monitoring of the contractual requirements between this agency and CMHPSM Provider Network. Information provided could result in adverse contract action including sanction, suspension or termination.
7. The credentialing application will not be the sole resource for obtaining information for contractual requirements. The CMHPSM may also conduct administrative desk and site audits, service site audits, financial reviews, recipient rights visits, and/or any other reviews outlined in the service contract.

We hereby authorize the CMHPSM to consult with administrators and members of the organization and/or institutions which the agency has been or is currently associated with, and others, including past and present malpractice carriers, who may have information bearing on professional competence, character, and ethical qualifications. We further consent to the inspection by representatives of the CMHPSM Provider Network of all documents that may be material to an evaluation of the organization’s professional competence, character, and ethical qualifications.

WE HEREBY RELEASE FROM LIABILITY ALL REPRESENTATIVES OF CMHPSM FOR THEIR ACTS PERFORMED IN GOOD FAITH AND WITHOUT MALICE IN CONNECTION WITH EVALUATING THIS APPLICATION, CREDENTIALS, AND QUALIFICATIONS, AND WE RELEASE FROM ANY LIABILITY ANY AND ALL INDIVIDUALS AND ORGANIZATIONS WHO PROVIDE INFORMATION TO CMHPSM IN GOOD FAITH AND WITHOUT MALICE CONCERNING PROFESSIONAL COMPETENCE, CHARACTER, AND ETHICS. WE HEREBY CONSENT TO THE RELEASE AND EXCHANGE OF INFORMATION RELATING TO ANY DISCIPLINARY ACTION, SUSPENSION, OR CURTAILMENT OF PROFESSIONAL PRIVILEGES AND/OR CLINICAL SERVICES TO THE CMHPSM PROVIDER NETWORK.

1. All applications for participation in the CMHPSM Provider Network shall be reviewed by the CMHPSM. Recommendations for CMHPSM Provider Network participation will be forwarded to the appropriate CMHSP Board, or designee for approval. By signing this, the organization gives consent for verification of the information provided in this application.
2. In the event that the agency, organization, or institution is accepted for participation in the CMH Provider Network, we consent to CMH inspection of our patient records relating to consumers as necessary for its peer and utilization review process.

We understand that if this application is rejected for reasons relating to professional conduct or competence, CMH may report the rejection to the appropriate State licensing board and/or the National Practitioner Data Bank.

To abide by applicable bylaws, rules and regulations, policies and procedures of the CMH Provider Network as in force at the time of this application, and agree to be bound by the terms thereof in all matters related to the consideration of this application.

Acknowledge the organization’s obligation to provide continuous care and supervision to all for whom we have responsibility, and that the organization will seek clinical consultation as necessary to insure the highest quality of consumer care.

That the organization, or designee will be willing to appear before any appropriate committee of CMH with regard to this application.

It is understood that failure to comply with the agreements specified above or providing inaccurate, incorrect, or withholding information on this application will automatically terminate appointment as a provider of behavioral health service in the CMHPSM Provider Network.

|  |  |  |  |
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| **Attestation of Organization CEO or Designated Representative** | | | |
| Signature: |  | | |
| Enter Title: |  | Enter Date: |  |