|  |  |
| --- | --- |
| **Organizational Initial Credentialing Application**  **This section for CMHSP or CMHPSM use only:** | |
| Application Reviewer: |  |
| Date Application Received: |  |
| Application Complete? |  |
| If no, date application returned to applicant: |  |
| Start Date (date completed application is received): |  |
| End Date (when the credentialing decision is sent to the provider): |  |
| Date application was declined, and letter sent stating reasons for it being incomplete: |  |

|  |  |
| --- | --- |
| **Organizational Re-Credentialing Application**  **This section for CMHSP or CMHPSM use only:** | |
| Application Reviewer: |  |
| Date Application Received: |  |
| Application Complete? |  |
| If no, date application returned to applicant: |  |
| Start Date (date completed application is received): |  |
| End Date (when the credentialing decision is sent to the provider): |  |
| Date application was declined, and letter sent stating reasons for it being incomplete: |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | **Community Mental Health Partnership of Southeast Michigan** | | | | | | | | | | |
| **Mental Health Service Provider Network**  **Initial Credentialing Application/Re-Credentialing Application**  **Application Revised: 3/10/2022** | | | | | | | | | | |
| **SECTION 1: APPLICATION INFORMATION** | | | | | | | | | | | | | | | |
| **Mental Health Service Provider:** | | | | | | | | | | | | | | | |
| Name of Organization: | | |  | | | | | | | | | | | | |
| **Application (Please select one):** | | | | | | | | | | | | | | **Application Date:** | |
| Initial Application: | | | |  | | | Re-Credentialing Application: | | | | |  | |  | |
| **Application submitted to the following CMHSP within the CMHPSM Region:** | | | | | | | | | | | | | | | |
| Lenawee |  | Livingston | | | | | |  | Monroe |  | | | Washtenaw | |  |
| **Staff person Responsible for Completing this Application:** | | | | | | | | | | | | | | | |
| Name | | | | | | Email | | | | | Phone | | | | |
|  | | | | | |  | | | | |  | | | | |
| **SECTION 2: ORGANIZATIONAL INFORMATION** | | | | | | | | | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **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)** |  |

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

|  |  |
| --- | --- |
| **Health Plans/Insurance Carriers Agency Participates With:** | |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |
| 5 |  |
| 6 |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CMHSPs/PIHPs-**Please provide contact information for the other CMHSPs/PIHPs in Michigan that you’re currently credentialed with: | | | | |
| # | CMHSP/PIHP Name: | Individual Name: | Email Address: | Phone Number: |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Organizational References-**Please provide contact information for individuals from at least three separate agencies your organization contracts with to provide mental health services: | | | | |
| # | Agency Name: | Individual Name: | Email Address: | Phone Number: |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **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:** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **ADA Compliant Accommodations** | | | |
| Does provider have ADA compliance accommodations at all service facilities that CMHPSM covered individuals would be served within: | Yes: | No: | N/A: |
| Does provider have ADA compliance accommodations at administrative sites: | Yes: | No: | N/A: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Organization’s Licensed Sites:** | |  | |  |
| **Site Name:** | **Address:** | **Licensing #:** | **Licensing Expiration Date:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Other:** |
| **Site Name:** | **Address:** | **Licensing #:** | **Licensing Expiration Date:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Other:** |
| **Site Name:** | **Address:** | **Licensing #:** | **Licensing Expiration Date:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Other:** |
| **Site Name:** | **Address:** | **Licensing #:** | **Licensing Expiration Date:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Other:** |
| **Site Name:** | **Address:** | **Licensing #:** | **Licensing Expiration Date:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Other:** |
| **Site Name:** | **Address:** | **Licensing #:** | **Licensing Expiration Date:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Other:** |
| **Site Name:** | **Address:** | **Licensing #:** | **Licensing Expiration Date:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Other:** |
| **Site Name:** | **Address:** | **Licensing #:** | **Licensing Expiration Date:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Other:** |
| **Site Name:** | **Address:** | **Licensing #:** | **Licensing Expiration Date:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Other:** |
| **Site Name:** | **Address:** | **Licensing #:** | **Licensing Expiration Date:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Other:** |
| **Site Name:** | **Address:** | **Licensing #:** | **Licensing Expiration Date:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Other:** |

\*\*If your agency has more than 10 sites, please include an all-inclusive list along with this application.

|  |  |  |
| --- | --- | --- |
| **Organization’s Sites (not licensed):** | |  |
| **Site Name:** | **Address:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Person centered (ensures accommodations specific to individual’s plan of service)** * **Other:** |
| **Site Name:** | **Address:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Person centered (ensures accommodations specific to individual’s plan of service)** * **Other:** |
| **Site Name:** | **Address:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Person centered (ensures accommodations specific to individual’s plan of service)** * **Other:** |
| **Site Name:** | **Address:** | **ADA Accommodations:**   * **Wide entries** * **Wheelchair access** * **Accessible rooms** * **Accessible bathrooms** * **Grab bars** * **Person centered (ensures accommodations specific to individual’s plan of service)** * **Other:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 been revoked, suspended, or limited?** |  |  |  |
| **Minimum five-year history of professional liability claims resulting in a judgment or settlement, or disciplinary status with regulatory board or agency.** |  |  |  |
| **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.*** | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Provider Delivered Service** | **SMI Adult** | **Older Adult w/ SPMI** | **I/DD/**  **CI Adult** | **I/DD/CI Child** | **SED Child** | **Co-Occurring: SUD/MI** | **Site #s where Service available** |
| Agency With Choice Services |  |  |  |  |  |  |  |
| Applied Behavioral Analysis/Behavior Treatment Services |  |  |  |  |  |  |  |
| Art Therapy (child waiver only) |  |  |  |  |  |  |  |
| Case Management |  |  |  |  |  |  |  |
| Community Living Supports (CLS) unlicensed setting |  |  |  |  |  |  |  |
| Crisis Residential |  |  |  |  |  |  |  |
| Fiscal Intermediary Services |  |  |  |  |  |  |  |
| Home Based |  |  |  |  |  |  |  |
| Licensed Residential Supports |  |  |  |  |  |  |  |
| Music Therapy (child waiver only) |  |  |  |  |  |  |  |
| Occupational Therapy |  |  |  |  |  |  |  |
| Outpatient Mental Health Services |  |  |  |  |  |  |  |
| Overnight Health and Safety Services (CLS) |  |  |  |  |  |  |  |
| 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 |  |  |  |  |  |  |  |
| Wrap Around Services |  |  |  |  |  |  |  |
| **Any Other Unlisted Services:** |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Provider Organization Accreditation:** | | | |
| **Accreditation Type:** | | **Select:** | **Expiration Date:** |
| The Joint Commission: | |  |  |
| CARF: | |  |  |
| COA: | |  |  |
| NCQA: | |  |  |
| BHCOE: | |  |  |
| Other: |  |  |  |
| Organization not currently accredited: | | |  |
| ***Please submit your organization’s accreditation documentation with this application.*** | | | |

|  |  |  |
| --- | --- | --- |
| **The following insurances are required for CMHPSM 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 submit documentation of required provider insurances with this application.*** | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 |

|  |  |  |
| --- | --- | --- |
| **Are staff trained in cultural competency?** | | |
| **Yes** | **No** | **N/A** |
|  |  |  |

| **Organizational Staff Linguistic Capacity** | | |
| --- | --- | --- |
| Available: | | Number of staff fluent or brief explanation of service capacity: |
| Spanish |  |  |
| French |  |  |
| Arabic |  |  |
| Chinese |  |  |
| American Sign Language |  |  |
| German |  |  |
| Other Languages (Please List) | | Number of staff fluent or brief explanation of service capacity: |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 |  |
| Intellectual / Developmental Disabilities |  | Somatoform Disorders |  |
| Dissociative Disorders |  | Speech Impaired Consumers |  |
| Elimination Disorders |  | Substance Abuse Related Disorders |  |
| Factitious Disorders |  | Tic Disorders |  |
| Hearing Impaired Consumers |  | Visually Impaired Consumers |  |
| Impulse-Control Disorders |  | Other(s): (Please List below) |  |
| Learning Disorders |  |  |  |
| Mental Disorders due to General Medical Condition |  |  |  |
| Mood Disorders |  |  |  |
| Motivational Interviewing |  |  |  |

|  |
| --- |
| **Special Certifications** |
| Please list all special mental health service certifications the organization and/or its staff members have obtained (Text Box Expands) : |
|  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Section 4. Debarment Information/Disclosure Statement** | | | | | | | | | |
| **Provider Entity Ownership and/or Board of Directors:** | | | | | | | | | |
| Are there individuals or organizations with a Direct or Indirect Ownership or Controlling Interest of 5% or more in the Provider Entity? Yes No  If yes, list the name, primary address, date of birth (DOB) and Social Security Number (SSN) for each person having an Ownership or Controlling Interest in the Provider Entity of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having an Ownership or Controlling Interest of 5% or greater. (42 CFR §455.104) | | | | | | | | | |
| Type:  Ind. or  Org | Name of Owner: | | Complete Address: | | Ind.: SSN  Org: EIN/TIN | | Ind. Only:  Date of Birth (mm/dd/yyyy) | | % Interest of Entity |
|  |  | |  | |  | |  | |  |
|  |  | |  | |  | |  | |  |
|  |  | |  | |  | |  | |  |
|  |  | |  | |  | |  | |  |
|  |  | |  | |  | |  | |  |
|  |  | |  | |  | |  | |  |
|  |  | |  | |  | |  | |  |
|  |  | |  | |  | |  | |  |
|  |  | |  | |  | |  | |  |
|  |  | |  | |  | |  | |  |
| Does the provider entity have a Board of Directors? Yes No  If yes, list the name, primary address, date of birth (DOB) and Social Security Number (SSN) for each person on the Organization’s Board of Directors. (42 CFR §455.104) | | | | | | | | | |
|  | | | | | | | | | |
| First Name | | Last Name | | Address: | | Date of Birth | | Soc Sec # | |
|  | |  | |  | |  | |  | |
|  | |  | |  | |  | |  | |
|  | |  | |  | |  | |  | |
|  | |  | |  | |  | |  | |
|  | |  | |  | |  | |  | |
|  | |  | |  | |  | |  | |
|  | |  | |  | |  | |  | |
|  | |  | |  | |  | |  | |
|  | |  | |  | |  | |  | |
|  | |  | |  | |  | |  | |

|  |
| --- |
| **Provider Entity Ownership in Other Provider’s Entities:** |

|  |  |  |
| --- | --- | --- |
| Does the disclosing provider entity or any owner of the entity have a direct or indirect ownership or controlling interest in any provider entity contracted with the CMHPSM or its partner CMHSPs?  Yes No  If yes, list the disclosing entity’s name or the individual owner, the name of the provider the preceding has an ownership in and that provider’s TIN/EIN: (42 CFR §455.104). | | |
| Disclosing entity or name: | Name of subcontractor or other provider entity: | Subcontractor or provider entity TIN/EIN: |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **Provider Entity Ownership in Subcontractors:** |

|  |  |  |
| --- | --- | --- |
| Are any of the individuals listed above related to each other? Yes No  If yes, list each of the individual’s full names and their relationship to each other: (42 CFR §455.104) | | |
| Individual: | Type of Relationship: | Individual: |
|  | Spouse  Sibling  Parent/Child  Step or Adoptive Parent/ Child  Aunt or Uncle/Niece or Nephew  Grandparent/Grandchild  Cousins |  |
|  | Spouse  Sibling  Parent/Child  Step or Adoptive Parent/ Child  Aunt or Uncle/Niece or Nephew  Grandparent/Grandchild  Cousins |  |
|  | Spouse  Sibling  Parent/Child  Step or Adoptive Parent/ Child  Aunt or Uncle/Niece or Nephew  Grandparent/Grandchild  Cousins |  |
|  | Spouse  Sibling  Parent/Child  Step or Adoptive Parent/ Child  Aunt or Uncle/Niece or Nephew  Grandparent/Grandchild  Cousins |  |

|  |
| --- |
| **Managing Employees and Agents:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does your organization have any agents or managing employees? Yes No  If yes, provide the name, address, date of birth and social security number of the applicable individuals.  Agent means any person who has been delegated the authority to obligate or act on behalf of a provider. It also means any person who has express or implied authority to obligate or act on behalf of an entity (42 CFR 1001.1001).  Managing employee means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency (for example, CEO, CFO, etc.). | | | | |
| Full Name | Agent or Job Title: | Address: | Date of Birth | Soc Sec # |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| **Sanctions/Exclusions Disclosure:** |

|  |  |  |  |
| --- | --- | --- | --- |
| Does the disclosing entity itself as an organization, or any persons (individual or entity) with an ownership or control interest in the provider/disclosing entity, or an agent, managing employee, officer, consultant, director, co-partner, board member of the provider/disclosing entity who is excluded, suspended, terminated, sanctioned, or debarred, or any adverse legal action taken by the United States Department of Health and Human Services or by any state from participation in any program established under Title XVIII (Medicare), XIX (Medicaid programs), XX (Social Services Block Grants), XXI (State Children’s Health Insurance Program), Title V (Maternal & Child Health Services Block Grant), or any other government-funded program since the inception of these programs?  Yes No  If no skip Section G. If yes, list the name, position (if individual), offense and date of action. | | | |
| Full Name or Entity Name | Position | Offense | Date of Action |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **Criminal Offense Disclosure:** |

|  |  |  |  |
| --- | --- | --- | --- |
| Has the provider/disclosing entity, or any person (individual or entity) with an ownership or control interest in the provider/disclosing entity, or is an agent or managing employee, officer, consultant, director, co-partner, board member, or shareholder of the provider/disclosing entity ever been convicted of a criminal offense related to that person’s involvement in any program established under Titles XIX (Medicaid), XVIII (Medicare), Title XX programs (Social Services Block Grants), Title V (Maternal & Child Health Services Block Grant), or XXI (State Children’s Health Insurance Program) of the Social Security Act since the inception of those programs (42 CFR 455.106)? Yes No  If no, skip this section. If yes, list the name, position (if individual), offense and date of action. | | | |
| Full Name or Entity Name | Position | Offense | Date of Action |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **Other Offense Disclosure:** |

|  |  |  |  |
| --- | --- | --- | --- |
| Including you the provider/disclosing entity, are there any persons (individual or entity) with an ownership or control interest in the provider/disclosing entity, or is an officer, consultant, director, co-partner, board member, shareholder, agent or managing employee of the provider/disclosing entity, who is presently indicted for, or otherwise criminally (felony and/or misdemeanor) or civilly charged by a governmental entity or who has been found guilty, or pled guilty or nolo contendere, or assessed fines or penalties for any of the offenses listed below, under any federal law or in any state, in connection with the delivery of a health care item or service, or with respect to any act or omission in a health care program operated by or financed in whole or in part by any Federal, State, or local government agency?  Yes No  If no, skip this section. If yes, list the name, position (if individual), offense and date of action. | | | |
| Full Name or Entity Name | Position | Offense | Date of Action |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **Provider Entity Attestation:** |

My signature below is my certification that the information in this form is complete and accurate. I will notify the CMHPSM immediately if any information entered into this form changes. I hereby give consent to the CMHPSM to utilize this information to meet its obligations as a pre-paid inpatient health plan within the State of Michigan. I understand that misleading, inaccurate, or incomplete data may result in denial or termination of network participation or contractual relationship with the CMHPSM.

|  |  |
| --- | --- |
| Full Name: | Title: |
| Signature: | Date: |

|  |  |  |
| --- | --- | --- |
| **Sub-Contracting (All sub-contracting arrangements must be disclosed when contracted with the CMHPSM** | | |
| Does your organization currently sub-contract to another entity or independent contractor, any business or service function? | Yes: | No: |
| Does your organization plan to sub-contract to another entity or independent contractor, any portion of service delivery derived from a contract or potential with the CMHSP or CMHPSM? | Yes: | No: |
| Please explain any currently existing or potential sub-contractual arrangements. **Include any Business Associate Agreements (BAA)s**: | | |

|  |
| --- |
| **Section 5. 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.

|  |  |  |
| --- | --- | --- |
| **Application Type Choose One:** | | |
| Initial Application: |  | Re-Credentialing Application: |
| **Initial Application Option(s):** | Organizations submitting a re-credentialing application must submit all staff information attachments at the same time as the main re-credentialing application submission. |
| Organization agrees to submit all staff information attachments upon acceptance in to the CMHPSM network and prior to any service delivery by the provider: |
| **Or:** |
| Organization is submitting all staff information attachments at the time of application submission: |

|  |  |  |
| --- | --- | --- |
| **Staff Information Attachment Type (see Exhibit 1 for requirements):** | **Attached:** | **# Of Pages** |
| Attachment A: Administrative Staff Requirements Review | Yes: |  |
| Attachment B: Aide Level Staff Background Review | Yes: |  |
| Attachment C: Aide Level Staff Training Review | Yes: |  |
| Attachment D: Licensed Clinical Practitioner Background Review | Yes: |  |
| Attachment E: Licensed Clinical Practitioner Training Review | Yes: |  |
| Attachment F: Licensed Clinical Practitioner Credentialing Review | Yes: |  |

|  |
| --- |
| **SECTION 6. 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. For initial applications, application sections 1,2,3,4 & 6 must be answered completely and accurately. Providers new to the CMHPSM network may submit Section 5 upon approved admission into the CMHPSM network. All staff information attachments and the subsequent CMH review, must be completed prior to any service delivery.
   2. For recredentialing applications, the entire application Sections 1-6 must be answered completely and accurately as well as the following applicable attachments:
      1. Attachment A: Administrative Staff Requirements; completed on all staff that will serve CMHPSM consumers.
      2. Attachment B: Aide Level Staff Background Review; completed on all staff that will serve CMHPSM consumers.
      3. Attachment C: Aide Level Staff Training Review; completed on all staff that will serve CMHPSM consumers.
      4. Attachment D: Licensed Clinical Practitioner Background Review; completed on all staff that will serve CMHPSM consumers.
      5. Attachment E: Licensed Clinical Practitioner Training Review; completed on all staff that will serve CMHPSM consumers.
      6. Attachment F: Licensed Clinical Practitioner Credentialing Review; completed on all staff that will serve CMHPSM consumers.
   3. Any documentation requested within the application (i.e., accreditation documentation, financial audits, proof of insurances) is attached to the application package.
   4. 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 into 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 ensure 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.

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

**Exhibit 1**

| Text  Description automatically generated  **Staff Training Requirements**  **R = Required**  **IR = Individually Required by consumer’s IPOS**  **HR = Highly Recommended** | **Administrative &**  **Non-Service Staff** | **Direct Support Professional/aide:** CLS**,** Respite, Skill Building & Sup. Emp. | **Aide Level:** Licensed Residential | **ABA Behavior Technician Staff** | **Clubhouse and**  **Drop-In Staff** | **Licensed Clinical Practitioners\*** | **Initial Requirement** | **Renewal of Requirement** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Basic First Aid & MDHHS Approved In-Person CPR |  | R | R | R | R | R | Prior to Service Delivery | Per Training Body |
| Medication Administration Initial |  | IR | R | IR |  |  | Prior to Service Delivery | N/A, unless lapsed |
| Medication Administration Refresher |  | IR | R | IR |  |  | Prior to Service Delivery | Annual |
| Individualized Training on each Consumer’s CMH IPOS |  | R | R | R |  | R | Prior to Service Delivery | Upon every new or revised IPOS |
| Universal Precautions / Blood-borne Infectious Disease Training |  | R | R | R | R | R | Prior to Service Delivery | Annual |
| Person Centered Planning | R | R | R | R | R | R | Within 30 days of hire | Annual |
| Recipient Rights/Confidentiality Day One Orientation | R | R | R | R | R | R | Within 30 days of hire and prior to service delivery | N/A, eligible only once |
| Recipient Rights/Confidentiality | R | R | R | R | R | R | Within 90 days of hire (in-person) | Annual (online or in-person) |
| Registered Behavior Technician Task List |  |  |  | R |  |  | Prior to Service Delivery | N/A, unless notified |
| LEP Training | R | R | R | R | R | R | Within 60 days of hire | Biennial (Every 2 Years) |
| Cultural Competency | R | R | R | R | R | R | Within 60 days of hire | Biennial (Every 2 Years) |
| Due Process, Grievance and Appeals | R | R | R | R | R | R | Within 90 days of hire | Biennial (Every 2 Years) |
| Medicaid Integrity (HIPAA,HITECH) | R | R | R | R | R | R | Within 90 days of hire | N/A, unless notified |
| Non-aversive techniques training documented in Behavior Treatment Plan |  | IR | IR | IR | IR | IR | Prior to Service Delivery | Per Training Body |
| Emergency Preparedness Training | R | R |  | R | R | R | Within 30 days of hire | Biennial (Every 2 Years) |
| Standards for Community Living Support Services Training (if providing CLS services) |  | R | R |  |  |  | Prior to Service Delivery | Biennial (Every 2 Years) |
| Licensed Residential Training Bundle:  1. Working with People with DD/MI 2. Role of Direct Care Workers 3. Emergency Preparedness 4. Nutrition 5. Health |  |  | R |  |  |  | Within 180 days of hire | N/A, required only once |
| Staff is 18 years of age or older |  | R | R | R | R | R | Prior to Hire Date | N/A |
| Criminal Background Check | HR | R | R | R | R | R | Prior to Hire Date | Annual |
| Recipient Rights Background Check | R | R | R | R | R | R | Prior to Hire Date | N/A |
| Motor Vehicle Driving Record Check (If transporting CMH consumer(s) | IR | IR | IR | IR | IR | IR | Prior to Service Delivery | Annual |

\*Licensed Clinical Practitioners include: BCBA, BCaBA, BSW, Dietician, LN, LMSW, LPN, Massage Therapist, Music Therapist, MSW, Nurse Practitioner, Occupational Therapist, Physical Therapist, Psychiatrist, Psychologist, GBHP, Recreational Therapist, Registered Nurse, Speech Therapist and/or individual identified by MDHHS Provider Qualifications Chart.

Visit <https://www.cmhpsm.org/training> to access the Learnworlds training platform, other regional training materials, and additional information.