|  |
| --- |
| **This section for CMHPSM / SUD Core Provider use only:** |
| Application Reviewer: |       | Receipt of Initial Application |       |
| Application Approved: | Yes: [ ]  No: [ ]  | Reviewer Organization: |       | Date Completed Application Received and Review Began: |       |
| Term Start: |       | Term End: |       | EHR Upload Date: |       |

|  |
| --- |
|  |
| **Substance Use Disorder Service Provider Network****Initial Application / Re-Credentialing Application****Application Revised: 2/6/2023** |
| Please ensure all areas of the application are completed. Applications will be returned with status information if they are incomplete or if more information is needed. Re-credentialing applications need to be approved prior to the expiration of the previous application term.**SECTION 1: APPLICATION INFORMATION**  |
| **Application (Please select one):** | **Application Date:** |
| **Initial Application** | [ ]  | **Re-Credentialing Application** | [ ]  |       |

|  |
| --- |
| **Staff Person Completing 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 Address** |       | **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 #** |       |

|  |
| --- |
| **Organization State Licensing and ASAM Certification Information (Please complete for all service sites):** |
| **Site #** | **Site Address** | **State Licensing #** | **License Expiration Date** | **ASAM LOC(s) Provided**  | **MDHHS ASAM Certification Letter? (Y/N)** |
| **1** |       |       |       |  |  |
| **2** |       |       |       |       |       |
| **3** |       |       |       |       |       |
| **4** |       |       |       |       |       |
| **5** |       |       |       |       |       |

|  |  |
| --- | --- |
| **Items with an asterisk are required**  | **Administrative Contact 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** |       |       |
| **\*Local Appeals Coordinator Contact** |       |       |
| **\*Claims Contact** |       |       |
| **\*Contracts Contact** |       |       |
| **\*Compliance/HIPAA Officer** |       |       |
| **Primary Clinical Contact** |       |       |
| **Secondary Contact** |       |       |
| **Additional Information** |       |

|  |
| --- |
| **Authorization Notification Email:**  |
| **Authorization Notification Email** |       |
| *The CMHPSM electronic health record can provide notifications to a single email address for each provider when authorizations have been added or changed.* |

|  |  |  |  |
| --- | --- | --- | --- |
| **Within the five years preceding the application date:** | **Yes** | **No** | **N/A** |
| *For any questions in which a “Yes” is indicated please attach additional documentation providing a detailed accounting of the incident(s) and the current status of any situations.* |
| **Has the organization had a state license or certification revoked?** | [ ]  | [ ]  | [ ]  |
| **Has the organization had its accreditation revoked, suspended or limited?** | [ ]  | [ ]  | [ ]  |
| **Has the organization had any other license, certification or accreditation revoked?** | [ ]  | [ ]  | [ ]  |
| **Has the organization had any sanctions imposed by Medicaid or Medicare?**  | [ ]  | [ ]  |  |
| **Has the organization had professional liability insurance canceled, or denied for renewal?** | [ ]  | [ ]  |  |
| **Has the organization had any malpractice claims related to substance use disorder services?** | [ ]  | [ ]  |  |
| **Has the organization been a defendant in a substance use disorder 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?** | [ ]  | [ ]  | [ ]  |

|  |
| --- |
| **SUD Service Panels:** |
| **Panel Type** | **Adults** | **Children/****Adolescents** | **Pregnant Women** | **Site #(s) Where Provided** |
| **Assessment** | [ ]  | [ ]  | [ ]  |       |
| **Case Management** | [ ]  | [ ]  | [ ]  |       |
| **Recovery Coaching / Peer Services** | [ ]  | [ ]  | [ ]  |       |
| **Early Intervention ASAM Level 0.5** | [ ]  | [ ]  | [ ]  |       |
| **Psychiatric Services (Co-occurring)** | [ ]  | [ ]  | [ ]  |       |
| **Outpatient ASAM Level 1.0** | [ ]  | [ ]  | [ ]  |       |
| **Medication Management** | [ ]  | [ ]  | [ ]  |       |
| **Intensive Outpatient ASAM Level 2.1** | [ ]  | [ ]  | [ ]  |       |
| **Withdrawal Management ASAM Level 3.7, Medically Monitored Intensive**  | [ ]  | [ ]  | [ ]  |       |
| **Social Detoxification ASAM Level 3.2**  | [ ]  | [ ]  | [ ]  |       |
| **Residential ASAM Level 3.1, Clinically Managed Low Intensity** | [ ]  | [ ]  | [ ]  |       |
| **Residential ASAM Level 3.3, Clinically Managed Population Specific** | [ ]  | [ ]  | [ ]  |       |
| **Residential ASAM Level 3.5, Clinically Managed High Intensity** | [ ]  | [ ]  | [ ]  |       |
| **Long Term Residential ASAM Level 3.7 Medically Monitored Inpatient Withdrawal Management (Residential Withdrawal Management)** | [ ]  | [ ]  | [ ]  |       |
| **Opioid Replacement Therapy (Methadone)** | [ ]  | [ ]  | [ ]  |       |
| **Medication Assisted Treatment (Vivitrol; Suboxone; Other)** | [ ]  | [ ]  | [ ]  |       |
| **Women’s Specialty Services (Designation by MDHHS)** | [ ]  | [ ]  | [ ]  |       |
| **SBIRT** | [ ]  | [ ]  | [ ]  |       |
| **Crisis Intervention** | [ ]  | [ ]  | [ ]  |       |
| **Co-Occurring Capable** | [ ]  | [ ]  | [ ]  |       |
| **Co-Occurring Enhanced** | [ ]  | [ ]  | [ ]  |       |
| **Other Service:**  | [ ]  | [ ]  | [ ]  |       |
| **Other Service:** | [ ]  | [ ]  | [ ]  |       |
| **Other Service:** | [ ]  | [ ]  | [ ]  |       |
| **Other Service:** | [ ]  | [ ]  | [ ]  |       |

|  |
| --- |
| **SECTION 3. PROVIDER CONTRACTUAL REQUIREMENTS** |
| **Provider Accreditation:** |
| *Please attach your organization’s accreditation documentation to this application.* |
| **Accreditation Type** | **Effective Date** | **Expiration Date** |
| **Joint Commission** | [ ]  |       |       |
| **CARF** | [ ]  |       |       |
| **COA** | [ ]  |       |       |
| **NCQA** | [ ]  |       |       |
| **Other:**  |       | [ ]  |       |       |
| **Accreditation waiver from State of Michigan** | [ ]  |  |

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

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

|  |
| --- |
| **Hours of SUD 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 |

|  |
| --- |
| **The following insurances are required for paneled providers:** |
| *Please attach documentation of required provider insurances to this application.* |
| **Type:** | **Notes:** | **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.** | [ ]  |
| **Fidelity Bonding** | **Commercial Insurance policy includes employee dishonesty or employer has documentation of fidelity bonding documentation:** [**LINK**](http://www.mitalent.org/fidelity-bonding-program/) | [ ]  |

|  |
| --- |
| **Provider has expertise, specialized training, or certifications in any of the following: (Please check all that apply)** |
| **Adolescent Substance Use Disorder Services** | [ ]  | **Mood Disorders** | [ ]  |
| **Adjustment Disorders** | [ ]  | **Motivational Interviewing** | [ ]  |
| **Anxiety Disorders** | [ ]  | **Motor Skill Disorders** | [ ]  |
| **Co-Occurring Enhanced Services** | [ ]  | **Personality Disorders** | [ ]  |
| **Co-Occurring Capable Services** | [ ]  | **Physical/ Sexual Abuse** | [ ]  |
| **Criminal Justice (Parolee/Probationer) Population** | [ ]  | **Schizophrenia & other Psychotic Disorders** | [ ]  |
| **D.B.T.**  | [ ]  | **Speech Impaired Consumers** | [ ]  |
| **Delirium, Dementia & Other Cognitive Disorders** | [ ]  | **Substance Abuse Related Disorders** | [ ]  |
| **Developmental Disabilities** | [ ]  | **Trauma-Informed Treatment** | [ ]  |
| **Dissociative Disorders** | [ ]  | **Visually Impaired Consumers** | [ ]  |
| **Eating Disorders** | [ ]  | **Women’s Specific Substance Use Services** | [ ]  |
| **Gambling Disorders** | [ ]  | **Other:**       | [ ]  |
| **Gender Dysphoria** | [ ]  | **Other:**       | [ ]  |
| **Hearing Impaired Consumers** | [ ]  | **Other:**       | [ ]  |
| **Learning Disorders** | [ ]  | **Other:**       | [ ]  |
| **Medication Assisted Treatment** | [ ]  | **Other:**       | [ ]  |

|  |
| --- |
| **Special Certifications for Organization** |
| *Please list all special substance use disorder service certifications the organization has obtained.* |
| **Type of Certification** | **Expiration Date (if applicable)** |
|       |       |
|       |       |
|       |       |

|  |
| --- |
| **Staff Certifications/Licensure** |
| *Please list all special substance use disorder service certifications staff members have obtained.* |
| **Staff Name** | **Type of Certification/License** | **Staff Name** | **Type of Certification/License** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

|  |
| --- |
| **MCBAP Staff Supervision:** |
| *Please identify all Substance Abuse Certified Clinical Supervisor CCS-M or CCS-R staff responsible for supervising all Substance Abuse Treatment Specialists (SATS) and their Supervised Staff members.* |
| *See the most recent PIHP/CMHSP Provider Qualifications Chart here for SUD provider staff requirements:* [*https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting*](https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/Mental-Health/Reporting-Requirements/SFY_2023_Behavioral_Health_Code_Charts_and_Provider_Qualifications.xlsx?rev=f6b6acfa96a14ffd9918ba706ff8d129) |
| **CCS-M/CCS-R Supervisor** | **Supervised Staff & Credentials** | **CCS-M/CCS-R Supervisor** | **Supervised Staff & Credentials** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

|  |
| --- |
| **Organizational Linguistic Capacity:** |
| **Available** | **Number of staff fluent or brief explanation of linguistic service capacity** |
| **Spanish** | [ ]  |       |
| **French** | [ ]  |       |
| **Arabic** | [ ]  |       |
| **American Sign Language** | [ ]  |       |
| **Other:** | [ ]  |       |
| **Other:** | [ ]  |       |
| **Other:** | [ ]  |       |
| **Translation Services** | **Translation service your organization utilizes when necessary** |
| **All languages** |       |

|  |
| --- |
| **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 substance use disorder services.* |
| **#** | **Agency Name** | **Individual Name** | **Email Address** | **Phone Number** |
| **1** |       |       |       |       |
| **2** |       |       |       |       |
| **3** |       |       |       |       |
| **4** |       |       |       |       |
| **5** |       |       |       |       |

|  |
| --- |
| **Section 4. Staff Information Attachments** |
| *The following attachments are required to be submitted with the application.* |
| **Attachment Type:** | **Attached** | **# of Pages** |
| **Attachment A: Clinical Staff Credential Review** | **[ ]**  |  |
| **Attachment B: Clinical Staff Background Review** | **[ ]**  |  |
| **Attachment C: Clinical Staff Training** | **[ ]**  |  |
| **Attachment D: Debarment, Suspension and Exclusion Form**  | **[ ]**  |  |
| **Current Staff Responsible for:** |
| **Task** | **Name** | **Email** | **Phone** |
| **Staff Credential Review** |       |       |       |
| **Criminal Background Checks** |       |       |       |
| **Staff Training Documentation** |       |       |       |
| **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. Attachment D: Organizational Disclosure Statement
	6. Any documentation requested within the application (i.e. accreditation documentation, financial audits, proof of insurances) is attached to the application package.
	7. 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 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 SUD 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/Director or Authorized Representative** |
| **Signature** |       |
| **Title** |       | **Date** |       |