St. Clair County Community Mental Health

Practitioner Application

Network Enrollment and Credentialing

(Complete as a new employee or when re-credentialing)

Section I. Practitioner Profile

First Name: ____________________________ Middle: ________________ Last: ___________________________________

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

Name of Organization: ____

Title in Organization: _________________________________ Program/Dept.: ____________________________________

Address: _______________________________________ Phone: _________________ Email: _________________________

City: _____________________________________ State: _________ Zip: ____________

NPI: ________________________________ Supervisor: _______________________________ Date of Hire: _____________

Please put "N/A" if not applicable:

Licensure: ________________________________ License #: ___________________________ Exp. Date: ______________

Licensure: ________________________________ License #: ___________________________ Exp. Date: ______________

Certification: _________________________________ Exp. Date: ______________

Certification: _________________________________ Exp. Date: ______________

Degree: ______________________________ Degree: ______________________________

*****Please make sure all of the information above is correct and up to date*****

Section II. Privileges Requested

Applying for:

- ○ Provisional
- ○ Full
- ○ Re-Credentialing
- ○ Changing (Privileges/Credentialing)
- ○ Adding Credentials

Current Credentialing Status:

- ○ Provisional
- ○ Probationary
- ○ Full
- ○ N/A

Target Populations you are seeking privileges to serve within the Region 10 PIHP Provider Network: (select all that apply)

- ☐ 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
- ☐ ABA
- ☐ Adults w/ Intellectual/Developmental Disabilities
- ☐ Adults with Mental Illness
- ☐ Adults with Substance Use Disorder
- ☐ Co-Occurring Disorders (MH/SUD)

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):

1st Language: ____________________ 2nd Language: ____________________ Other Language: ____________________

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:

____

____

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

☐ Psychiatrist	☐ MD ☐ DO
☐ Physician, Non-Psychiatrist	☐ MD ☐ DO
☐ Psychologist	☐ LP
☐ Nurse Practitioner	☐ APRN-BC ANP ☐ APRN-BE NHNP ☐ FNP ☐ PsychNP ☐ PedNP
☐ Therapist/Clinician, Psychologist Limited License	☐ LMSW ☐ LLMSW* ☐ LLP ☐ TLLP* ☐ LPC ☐ LLPC* ☐ LLMFT* ☐ LMFT ☐ Master Level Graduate* *Write In:* ______________________ ***May only provide services under the supervision of LMSW, LLP, LPC, or LLMFT**
☐ Bachelors in Human Services	*Write In:* ______________________
☐ Masters in Human Services	*Write In:* ______________________
☐ Bachelors in Non-Human Services	
☐ Psychiatric Nurse	☐ MA ☐ MSN in Psych ☐ RN
☐ Case Manager/Support Coordinator	☐ LBSW ☐ LLBSW* ☐ SST ***May only provide services under the supervision of LMSW**
☐ Physician Assistant	☐ PA-C
☐ Nurse	☐ BSN ☐ RN ☐ LPN
☐ Occupational Therapist	☐ OTR
☐ Occupational Therapy Assistant	☐ COTA
☐ Physical Therapist	☐ PTR
☐ Physical Therapy Assistant	☐ PTA
☐ Speech Pathologist or Audiologist	☐ SLP
☐ Registered Dietitian	☐ RD
☐ Substance Abuse Treatment Specialist	☐ CADC ☐ CCS-M ☐ CADC-M ☐ CCJP ☐ CAADC ☐ CCDP ☐ CCS ☐ CCDP-C ☐ Development Plan
☐ Non-Credentialed Staff	
☐ Intern	Dates: ______________________ Supervisor & Program: ______________________
☐ Qualified Behavioral Health Professional (QBHP)	***QBHP** – **Must** be physician or **licensed practitioner** (i.e., SWK, Psychologist) **w/ specialized training AND 1 year work experience** in assessing & treatment children w/ ASD **OR Master's degree in MH field** or **BACB approved degree w/ 1 year work experience** in assessing & treating children w/ ASD and **MUST work UNDER a BCBA.**

☐ Qualified Mental Health Professional (QMHP)	***QMHP** – **Minimum of 1 year work experience** with the **MI population.**
☐ Qualified Intellectual Disability Professional (QIDP)	***QIDP** – **Minimum of 1 year work experience** with the **I/DD population**.
☐ Certified Peer Support Specialist (PSS)	
☐ Children's Mental Health Professional (CMHP)	***CMHP** – For **Master Level Staff**, **a minimum of 1 year work experience** with SED and/or I/DD children. For **Bachelor Level Staff**, **a minimum of 3 years SUPERVISED experience** with SED and/or I/DD children (EXCEPTION for BCBA or BCaBA or Psychologist in ABA Practice)
☐ 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 ☐ PTC
☐ Infant Mental Health Certification	☐ IMH
☐ Trauma Focused CBT	☐ TF-CBT
☐ Board Certified Behavioral Analyst	☐ BCBA
☐ Board Certified Aide Behavioral Analyst	☐ BCaBA

Section III. Privileging Questionnaire

(To be completed by Peer Recovery Coach Applicants)

****Peer Recovery Coach Practitioner Attestation:**

☐ 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 groups)
☐ I have completed the Connecticut Community for Addiction Recovery (CCAR) training, MDHHS Recovery Coach training, or a MCBAP Certification for Certified Peer Recovery Mentor

To be completed by all applicants:

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 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 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 malpractice coverage either independently or through the agency with whom you are seeking privileges?
   ○ Yes ○ No

   a. What is the coverage amount? _________________________

   b. Dates of coverage: _______________ thru _______________

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 un-prescribed, medication use?
    ○ Yes ○ No

****If you answered "Yes" to question(s) 1-8 and/or "No" to question(s) 10-11, please attach a signed and dated explanation for confidential review by the privileging entity.****

12. I attest that I have completed and attached form #01-1305 Region 10 PIHP Conflict of Interest.
    ○ Yes ○ No

If no, please provide an explanation: ____

FOR NEW EMPLOYEES ONLY, who are Master Level or Bachelor Level Staff MUST ANSWER, all others do NOT answer the following question:

13. I attest that I have signed the Minimum Year Work Experience Attestation form and that I have at least 1 year work experience for the following populations:

    a. Intellectual Disability Population (QIDP) ○ Yes ○ No

    b. Mental Illness Population (QMHP) ○ Yes ○ No

    c. Children's Population (CMHP) ○ Yes ○ No
    *(**Note:** Bachelor Level staff **MUST** have 3 years of SUPERVISED children work experience)*

Section IV. Attestation

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.

By signing below, I attest that I understand that I am applying to be appointed to provide specialty services within the **PIHP Provider Network** and that my clinical work may be subjected 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. I 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.

____ ______________________

Applicant Signature Date

Supervisor Recommendation: ☐ Approve ☐ Disapprove

____ ______________________

*Supervisor Signature Date

***Designated supervisors are required for some credentials. See below and sign as applicable.**

*A designated supervisor is mandatory for Temporary LLPs, Limited LMSWs, Limited LBSWs, Limited LPCs; CMHPs, SATS other than supervisors and SATPs; and Case Managers or Support Coordinators who are not QMHPs or QIPDs, Peer Specialists and Certified Recovery Coaches.

*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: ______________________________ Degree: ____________________
(please print)

Section V. Committee Decision

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

The Privileging and Credentialing Committee has reviewed this application and recommends a credentialing status of:

○ Provisional
○ Probationary
○ Full
○ Re-Credentialing
○ Does Not Recommend *(provide rationale)*

For the following target population(s):

☐ 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
☐ ABA
☐ Adults w/ Intellectual/Developmental Disabilities
☐ Adults with Mental Illness
☐ Adults with Substance Use Disorder
☐ Co-Occurring Disorders (MH/SUD)

You are granted **provisional privileges** in the identified credentials below, not to exceed 150 days, from this effective date:

Provisional Start Date: ___________________ **Provisional** End Date: ___________________

____ ______________________

Chairman or Designee Signature Date

Privileges Approved:

☐ Psychiatrist	☐ MD ☐ DO
☐ Physician, Non-Psychiatrist	☐ MD ☐ DO
☐ Psychologist	☐ LP
☐ Nurse Practitioner	☐ APRN-BC ANP ☐ APRN-BE NHNP ☐ FNP ☐ PsychNP ☐ PedNP
☐ Therapist/Clinician, Psychologist Limited License	☐ LMSW ☐ LLMSW* ☐ LLP ☐ TLLP* ☐ LPC ☐ LLPC* ☐ LLMFT* ☐ LMFT ☐ Master Level Graduate* *Write In:* ________________________________ ***May only provide services under the supervision of LMSW, LLP, LPC, or LLMFT**
☐ Bachelors in Human Services	*Write In:* ________________________________
☐ Masters in Human Services	*Write In:* ________________________________
☐ Bachelors in Non-Human Services	
☐ Psychiatric Nurse	☐ MA ☐ MSN in Psych ☐ RN
☐ Case Manager/Support Coordinator	☐ LBSW ☐ LLBSW* ☐ SST ***May only provide services under the supervision of LMSW**
☐ Physician Assistant	☐ PA-C
☐ Nurse	☐ BSN ☐ RN ☐ LPN
☐ Occupational Therapist	☐ OTR
☐ Occupational Therapy Assistant	☐ COTA

☐ Physical Therapist	☐ PTR
☐ Physical Therapy Assistant	☐ PTA
☐ Speech Pathologist or Audiologist	☐ SLP
☐ Registered Dietitian	☐ RD
☐ Substance Abuse Treatment Specialist	☐ CADC ☐ CCS-M ☐ CADC-M ☐ CCJP ☐ CAADC ☐ CCDP ☐ CCS ☐ CCDP-C ☐ Development Plan
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☐ Board Certified Behavioral Analyst	☐ BCBA
☐ Board Certified Aide Behavioral Analyst	☐ BCaBA

Credentialing Committee Chairperson/Designee signature below verifies credentialing and privileging of the above-named staff.

Full/Recredentialing Start Date: ___________________ **Full/Recredentialing** End Date: ___________________

____ ________________________

Chairman or Designee Signature Date

Section VI. Primary Source Verification

(to be completed by Provider Organization's Human Resource Department or Designee)

Name of Practitioner:	Contract Provider:
Degree: College/University: Degree Completion Date:	Verification Source: Verified By: Date:
Licensure: Exp. Date:	Verification Source: Verified By: Date:
Certification: Exp. Date:	Verification Source: Verified By: Date:
Certification: Exp. Date:	Verification Source: Verified By: Date:
Employee has undergone a satisfactory criminal background check: ***must be completed initially and annually.** ○ Yes ○ No	Verification Source: Verified By: Date:
Satisfactory disciplinary status with regulatory board or agency verified: ○ Yes ○ No	Verification Source: LARA Licensing Search Verified By: Date:
Free of Medicare/Medicaid Sanctions: ***must be done initially and monthly ongoing.** ○ Yes ○ No	Verification Source: OIG Exclusion Database and MDHHS List of Sanctioned Providers Verified By: Date:
Satisfactory National Practitioner Databank/Healthcare Integrity and Protection Data Bank (NPDB/HIPDB) query: ○ Yes ○ No	Verification Source: National Practitioner Databank 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:
Employee has completed the Organization's Cultural Diversity and Corporate Compliance Trainings as required by the CMHSP/PIHP: ○ Yes ○ No	Verification Source: Verified By: Date:

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

____ ____________________

HR Dept. Designee Signature Date

☐ All required trainings completed.

____ ____________________

Training Dept. Designee Signature Date