|  |
| --- |
| **Sections I – III:**To be completed by the organizational provider at the time of initial network application for enrollment and credentialing, or at the time of the biennial re-credentialing. **Section IV:**To be completed by the contract manager as applicable.**Section V:**To be completed by the Credentialing Committee as applicable. |

**Section I:**

**ORGANIZATION INFORMATION**

Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DBA {if applicable}: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Locations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Locations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Locations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If additional locations are needed, please attach a separate piece of paper.

Primary Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Agency Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Agency Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**KEY EXECUTIVE STAFF**

Administrator/CEO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief Operating Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Program Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recipient Rights Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section II:**

**ORGANIZATIONAL PROFILE**

 **Choose One:**

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ | For Profit | ☐ | Not for Profit |
| ☐ | Partnership | ☐ | Government |
| ☐ | Limited Liability Company (LLC) | ☐ | Designated Collaborating Organization (DCO) |
| ☐ | Other: |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Accreditation**(Check all that apply) | Start Date | Expiration Date |
| ☐ | TJC |  |  |
| ☐ | CARF |  |  |
| ☐ | COA |  |  |
| ☐ | ACHC |  |  |
| ☐ | Other: |  |  |

**Submission of the following Accreditation material is required:**
Accreditation Letter
Accreditation Report
Accreditation Correction Action Plan/Status

|  |  |  |  |
| --- | --- | --- | --- |
|  | **MDHHS Certification Status**(Check all that apply) | Start Date | Expiration Date |
| ☐ | MDHHS Certification Obtained(Required if not Accredited) |  |  |
| ☐ | MDHHS CertificationWaived (if Accredited) |  |  |
| ☐ | MDHHS Certification Pending |  |  |
| ☐ | MDHHS Licensure Obtained(SUD Provider) |  |  |
| ☐ | MDHHS Licensed Integrated Treatment Service Provider |  |  |
| ☐ | Designated Women’s Specialty Services Provider |  |  |

**Section II:**

**ORGANIZATIONAL PROFILE – continued**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Licensure** | Type | Prevention/Treatment | Start Date | Expiration Date |
| Michigan Substance Use Licensure☐ Yes☐ No |  |  |  |  |
|  |  |  |  |
|  |  |  |  |  |

**Submission of a copy of the current licensure is required.**

**State and Federal Regulatory Status – Agency Attestation:**

|  |  |
| --- | --- |
| Good Standing with all **State** Regulatory Bodies | ☐ Yes ☐ NoIf no, please provide written explanation. |
| Good Standing with all **Federal** Regulatory Bodies | ☐ Yes ☐ NoIf no, please provide written explanation. |
| Does this Agency currently have any Federal or State Sanctions active? | ☐ Yes ☐ NoIf yes, please provide a written explanation listing any sanctions. |
| Does this Agency currently have any Federal or State Program Disbarments? | ☐ Yes ☐ NoIf yes, please provide a written explanation listing any disbarments. |
| Does this organization have ownership or controlling interest in the provider organization? | ☐ Yes ☐ NoIf yes, please provide a written explanation. |

If additional documentation is needed, please attach a separate document and indicate above.

**Attestation:**

The signature below indicates that the statements and indications made in Section I and II are accurate and true.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Organization Legal Representative Name (Print) Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Organization Legal Representative Signature Date

**Section III:**

**NETWORK ENROLLMENT INFORMATION**

**Agency Service Type:**

Indicate the service categories you want your Agency to be enrolled and credentialed in under the subcontract for CMHSP/SUD within the scope of your practice.

Check all that apply:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ☐ | Mental Health Services | ☐ | Intellectual/Developmental Disability Services | ☐ | Licensed Substance Use Services |
| ☐ | Integrated Treatment Services (MH/SUD) | ☐ | Other: |

**Target Populations:**

Indicate what services you are requesting “privileges” to provide within the **Provider Network**, under subcontract for CMHSP/SUD within the scope of your practice.

Check all that apply:

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ | Children Diagnosed with Serious Emotional Disturbance | ☐ | Children Diagnosed with Substance Use Disorder |
| ☐ | Children Diagnosed with Intellectual/Developmental Disability (4 to 17 years) | ☐ | Adults Diagnosed with Substance Use Disorder |
| ☐ | Women with SUD who are pregnant, parenting, or working to regain custody of their children | ☐ | Infants Diagnosed with Mental Illness(0 to 3 years) |
| ☐ | Adults Diagnosed with Mental Illness | ☐ | Adults Diagnosed with Intellectual/Developmental Disability |
| ☐ | Other: |

**Section III:**

**NETWORK ENROLLMENT INFORMATION – continued**

**Provider Network Services:**

Indicate what services you are requesting “privileges” to provide within the Provider Network, under subcontract for CMHSP/SUD within the scope of your practice.

***CMHSP:*** *Please indicate all items that apply within Boxes A-D only.*

***SUD:*** *Please indicate all items that apply within Box E only.*

|  |
| --- |
| **A. Mental Health – State Plan/1915(i)SPA Services** |
| ☐ ACT – Assertive Community Treatment | ☐ Inpatient Psychiatric Hospital – State Facility |
| ☐ Assessment and Evaluation | ☐ Integrated Dual Disorders (Fidelity Tested) |
| ☐ Behavioral Management Review | ☐ Medication Administration |
| ☐ Child Therapy | ☐ Medication Review |
| ☐ Clubhouse Psychosocial Rehabilitation | ☐ Nursing Facility Mental Health Monitoring |
| ☐ Community Psychiatric Inpatient | ☐ Occupational Therapy |
| ☐ Community Living Supports | ☐ Outpatient Partial Hospitalization |
| ☐ Crisis Intervention | ☐ Peer-Directed and Operated Support Services |
| ☐ Crisis Observation Care | ☐ Personal Care in Specialized Residential |
| ☐ Crisis Residential Services | ☐ Personal Emergency Response System |
| ☐ Dialectic Behavioral Therapy (Certified Team) | ☐ Physical Therapy |
| ☐ Electroconvulsive Therapy | ☐ Prevention Services |
| ☐ Enhanced Medical Equipment and Supplies | ☐ Respite Care |
| ☐ Enhanced Pharmacy | ☐ Skill Building Assistance |
| ☐ Environmental Modifications | ☐ Speech, Hearing, and Language |
| ☐ Family Therapy | ☐ Supported Employment |
| ☐ Family Training | ☐ Supports Coordination |
| ☐ Fiscal Intermediary | ☐ Targeted Case Management |
| ☐ Health Services | ☐ Transportation |
| ☐ Home Based Services | ☐ Treatment Planning |
| ☐ Housing Assistance | ☐ Wraparound Facilitation |
| ☐ Individual/Group Therapy | ☐ Telemedicine |

**Section III:**

**NETWORK ENROLLMENT INFORMATION – continued**

|  |
| --- |
| **B. Habilitation Supports Waiver Services** |
| ☐ Assistive Technology | ☐ Out of Home Pre-Vocational Services |
| ☐ Community Living Supports | ☐ Personal Emergency Response System |
| ☐ 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 Waiver 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 Waiver 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 |

**Section III:**

**NETWORK ENROLLMENT INFORMATION – continued**

|  |
| --- |
| **E. Substance Use Disorder – State Plan/1915(i)SPA Services** |
| ☐ Women’s Specialty Services  | ☐ Peer Delivered Services (Recovery Coaches)  |
| ☐ Early Intervention Services | ☐ Residential Services |
| ☐ Individual Assessment Services  | ☐ Sub-Acute Detoxification Services |
| ☐ Medication Assessment Services  | ☐ Outpatient Care Services |

By signing below, you attest that your agency has met all the State, Federal and PIHP requirements to be considered the above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Organization Representative Signature Date

**Section IV:**

**REVIEW AND RECOMMENDATION**

*This section is to be reviewed and completed by a Contract Manager or Designee.*

I have reviewed the above statements and submitted documents, including a due diligence review of the organization relative to Section II and find the statements to be true and accurate. ☐ Yes ☐ No

Please list any concerns:

If additional space is needed, please attach a separate document and indicate above.

Please indicate below for the recommendation/non-recommendation for enrollment/re-enrollment and credentialing/re-credentialing of this organization into the Provider Network.

☐ Recommended ☐ Not Recommended

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Contract Manager/Designee Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Contract Manager/Designee Name (Print)

**VERIFICATION SIGNATURE***Completed by designated staff authorized to validate start and end date.*

Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Verifier Signature Date

**Section V:**

**CREDENTIALING COMMITTEE REVIEW AND ATTESTATION**

*This section is to be completed by the Credentialing Committee as applicable.*

**CREDENTIALING COMMITTEE RECOMMENDATION**

**Provider Network Services**

***Upon review of the provider application, the Credentialing Committee recommends:***

☐ Credentialing of the provider organization into the Provider Network for all privileges specified.

Credentialing Term: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Provisionally recommends credentialing of the provider organization into the Provider Network.

Credentialing Term: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Network Credentials Revoked

 Provide Rationale for Recommendation:

 If additional space is needed, please attach a separate document and indicate above.

**Section V:**

**CREDENTIALING COMMITTEE REVIEW AND ATTESTATION - continued**

**CLEAN FILE CHECKLIST FOR ORGANIZATIONS (ALL ARE REQUIRED)**

☐ Completed Disclosure of Control/Ownership/Conflict of Interest Attestation

☐ Verified there are no “Yes” answers on the Attestation

☐ Verification of the organization’s licensing status. Were there any violations or investigations in the last 5 years?

☐ Verified accreditations held by the organization

☐ Verified the applicant is not excluded from participating in the Medicaid/Medicare Program (e.g., OIG, Sanction
 Queries)

☐ Disclosure of any malpractice issues in the last 10 years

☐ Verification of Recipient Rights or Quality of Care process

☐ Children’s CPS checks

Comments:

***I attest that I have completed the Primary Source Verification as indicated above.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
HR Designee Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Reimbursement Designee Signature Date

☐ All Required Trainings Completed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Training Designee Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Committee Chairperson/Designee Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­­­­­­­­­­­­­
Committee Chairperson/Designee Name (Print)