Employee Name: _____

St. Clair County Community Mental Health Authority

PRACTITIONER APPLICATION
Network Enrollment and Credentialing
Complete as a new employee or when re-credentialing.

Section I. Practitioner Profile

(To be completed by applicant)

Name of Practitioner Seeking Privileges: _____

Former Last Name (if applicable): _____ Date of Birth: _____

Title within the Organization you work for: _____Program/Dept. _____

Name of Organization you work for: _____

Address of Organization you work for: _____

Organization Phone Number: _____Supervisor Name: _____

Email Address: _____ Date of Hire: _____

Degree: _____ NPI Number: _____

Licensure: _____License Number:_____ Exp. Date: _____

Certification: _____ Exp. Date: _____

Certification:_____ Exp. Date:_____

Current Credentialing Status: ☐ Provisional ☐ Probationary ☐ Full ☐ N/A Current Term Dates: _____

Applying for: ☐ Provisional ☐ Full ☐ Re-Credentialing *(Term shall be determined by Credentialing Committee)*
☐ Adding Credentials ☐ Changing (Privileges/Credentialing)

Target Populations you are seeking privileges to serve within the Region 10 PIHP Provider Network

☐ Children (0-3 years)
☐ Children with Intellectual/Developmental Disabilities (4-17 years)
☐ Children with Serious Emotional Disturbance (4-17 years)
☐ Children with Substance Use Disorder
☐ ABA

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

Cultural Competencies and Linguistic Capabilities

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):_____

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.

_____

_____

Section II. Privileges Requested

(To be completed by applicant)

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

☐	Psychiatrist	☐ MD ☐ DO
☐	Physician, Non-Psychiatrist	☐ MD ☐ DO
☐	Psychologist	☐ LP
☐	Physician Assistant	☐ PA-C
☐	Nurse Practitioner	☐ APRN-BC ANP ☐ PMHN ☐ PedNP ☐ APRN-BE NHNP ☐ PsychNP ☐ FNP
☐	Therapist/Clinician, Psychologist Limited License	☐ LMSW ☐ LLMSW* ☐ LLP ☐ TLLP* ☐ LPC ☐ LLPC* ☐ LLMFT* ☐ LMFT *May only provide services under the supervision of LMSW, LLP, LPC or LMFT
☐	Supports Coordinator/Case Manager	☐ LBSW ☐ LLBSW* ☐ SST *May only provide services under the supervision of LMSW
☐	Bachelors in Human Services	Write in:
☐	Psychiatric Nurse	☐ MA ☐ MSN in Psych ☐ RN
☐	Registered Nurse, BSN	☐ BSN ☐ RN ☐ LPN
☐	Occupational Therapist	☐ OTR
☐	Occupational Therapy Assistant	☐ COTA
☐	Physical Therapist	☐ PTR
☐	Physical Therapy Assistant	☐ PTA
☐	Speech Pathologist or Audiologist	☐ SLP
☐	Registered Dietician	☐ RD

Other Certifications

☐	Substance Abuse Treatment Specialist	☐ CADC ☐ CADC- M ☐ CAADC ☐ CCS ☐ CCS-M ☐ CCJP ☐ CCDP ☐ CCDP-D ☐ Development Plan
☐	Non-Credentialed Staff	
☐	Qualified Behavioral Health Professional (QBHP)	
☐	Qualified Mental Health Professional (QMHP)	
☐	Qualified Intellectual Disability Professional (QIDP)	
☐	Certified Peer Support Specialist (PSS)	
☐	Children's Mental Health Professional (CMHP)	
☐	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	☐ Successful completion of Certified Training
☐	Communicable Disease Trainer	☐ HAPIS
☐	Parent Management Training – Oregon Model	☐ PMTO, **certification attached**
☐	Infant Mental Health Certification	☐ IMH,
☐	Trauma Focused CBT	☐ TFCBT, **certification attached**
☐	Board Certified Behavioral Analyst	☐ BCBA
☐	Board Certified Aide Behavioral Analyst	☐ BCaBA
☐	Phlebotomist	☐ Certified, **certification attached**

** Must complete Peer Recovery Coach attestation in section III.

Clinical Specialties (master level only)

THIS SECTION SHOULD BE COMPLETED BY APPLICANT AND CONFIRMED/APPROVED BY APPLICANT'S SUPERVISOR

SKILLS REQUIRING CLINICAL TRAINING AND/OR CERTIFICATION:

Applicant: *Refer to information in your training file or list below specialized training (courses, seminars, conferences, clinical experience) which would qualify you to provide clinical treatment in that specific skill area.*

Supervisor: *Approve only those skill areas that indicate expertise to provide clinical treatment in the specialty.*

		Approved by SUPERVISOR	
☐ ADHD		☐ Yes	☐ No
☐ AIDS/HIV/STI		☐ Yes	☐ No
☐ Anger Management		☐ Yes	☐ No
☐ Anxiety Disorders		☐ Yes	☐ No
☐ Autism		☐ Yes	☐ No
☐ Bipolar Disorder		☐ Yes	☐ No
☐ Borderline Personality		☐ Yes	☐ No
☐ CBT Behavioral Therapy		☐ Yes	☐ No
☐ Child/Adolescent Therapy		☐ Yes	☐ No
☐ Child/Adolescent Welfare		☐ Yes	☐ No
☐ Critical Incident Stress Debriefing		☐ Yes	☐ No
☐ Chronic/Terminal Illness		☐ Yes	☐ No
☐ Conduct Disorders		☐ Yes	☐ No
☐ Co-Occurring Disorders (SUD/MH)		☐ Yes	☐ No
☐ Crisis/Lethality		☐ Yes	☐ No
☐ Intellectually Disabled/ Developmentally Disabled		☐ Yes	☐ No
☐ Dialectical Behavior Therapy		☐ Yes	☐ No
☐ Domestic Violence		☐ Yes	☐ No
☐ Eating Disorders		☐ Yes	☐ No
☐ Family Dynamics		☐ Yes	☐ No
☐ Family Psychoeducation		☐ Yes	☐ No
☐ Family Therapy		☐ Yes	☐ No
☐ Gay/Lesbian/Sexual		☐ Yes	☐ No
☐ Geriatric (Dementia) Therapy		☐ Yes	☐ No
☐ Grief/Bereavement		☐ Yes	☐ No
☐ Group Therapy		☐ Yes	☐ No
☐ Hearing Impaired		☐ Yes	☐ No
☐ Integrated Dual Disorder Treatment		☐ Yes	☐ No
☐ Marital/Divorce/Separation		☐ Yes	☐ No
☐ Men's Issues		☐ Yes	☐ No
☐ Mentally Impaired		☐ Yes	☐ No
☐ Multiple Personality Disorder		☐ Yes	☐ No
☐ Neuropsychological Testing		☐ Yes	☐ No
☐ Oppositional/Defiant Disorders		☐ Yes	☐ No
☐ Panic/Phobia		☐ Yes	☐ No
☐ Parenting		☐ Yes	☐ No
☐ Personality Disorder		☐ Yes	☐ No

☐ Physical Abuse		☐ Yes	☐ No
☐ Physical Disability		■ Yes	☐ No
☐ Relationships		☐ Yes	☐ No
☐ Schizophrenia		☐ Yes	☐ No
☐ School Related Problems		☐ Yes	☐ No
☐ Self Esteem		☐ Yes	☐ No
☐ Sexual Abuse		☐ Yes	☐ No
☐ Supports Intensity Scale (SIS)		☐ Yes	☐ No
☐ Stress Management		☐ Yes	☐ No
☐ SUD Prevention		☐ Yes	☐ No
☐ Substance Use Disorder		☐ Yes	☐ No
☐ Traumatic Brain Injury		☐ Yes	☐ No
☐ Trauma/PTSD		☐ Yes	☐ No
☐ Victimization		☐ Yes	☐ No
☐ Women's Issues		☐ Yes	☐ No

**You are expected to keep copies of transcripts, certificates, resumes, supervisory reference letters, etc. or verification of educational experiences in your own personal files. Where certain trainings or certificates are required for credentialing, these records should also be on file in your credentialing file at the provider organization.*

**Some competencies or skills do not require specific training or education but may be acquired through experience. Examples of these skills might be the knowledge of a foreign language or cultural group. Please do your best to describe how you are qualified in the areas identified. The list is meant to be an accurate reflection of your abilities and skills and, thereby, an account of those services and skills that your agency can offer.*

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 group
- ☐ 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 each of 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 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: _____
10. Do you require special accommodations to perform all necessary functions of the position that are requested to be privileged and credentialed? ☐ Yes ☐ No
11. Do you have current illegal drug or un-prescribed, non-over-the-counter, medication use?
    ☐ Yes ☐ No

If you answered "Yes" to question(s) 1 - 11, please attach a signed and dated explanation for confidential review by the privileging entity. This information will not be shared with the Privileging and Credentialing Committee.

12. I attest that I have completed and attached the Region 10 PIHP Conflict of Interest form.
    ☐ Yes ☐ No

    If no, please provide explanation: _____

Section IV. Attestation

(To be completed by all applicants and applicable supervisor)

By signing below, I attest that the afore information is true and I am applying to be privileged to provide specialty services within **PIHP Provider Network** and that my clinical work may be subject to federal, state, PIHP, and/or CMH performance and compliance reviews.

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 to comply with all stated values and guided principles.

By signing below, I attest that the information contained herein is correct and complete.

Signature of Applicant: _____ **Date:** _____

Supervisor Recommendation: ☐ Approve ☐ Disapprove

***Signature of Supervisor:** _____ **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, SATSs other than supervisors and SATPs; and Case Managers or Supports Coordinators who are not QMHPs or QIDPs, 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: _____ Certification: _____
PLEASE PRINT

Section V. Committee Determination

(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 populations:

☐ Children (0-3 years) ☐ Children with Intellectual/Developmental Disabilities (4-17 years) ☐ ABA

☐ Children with Serious Emotional Disturbance (4-17 years) ☐ Children with Substance Use Disorder

☐ Adults with 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**

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

☐	Physical Therapist	☐ PTR
☐	Physical Therapy Assistant	☐ PTA
☐	Speech Pathologist or Audiologist	☐ SLP
☐	Registered Dietician	☐ RD

Employee Name: _____

Other Certifications

☐	Substance Abuse Treatment Specialist	☐ CADC ☐ CADC-M ☐ CAADC ☐ CCS ☐ CCS-M ☐ CCJP ☐ CCDP ☐ CCDP-D ☐ Development Plan
☐	Non-Credentialed Staff	
☐	Qualified Behavioral Health Professional (QBHP)	
☐	Qualified Mental Health Professional (QMHP)	
☐	Qualified Intellectual Disability Professional (QIDP)	
☐	Certified Peer Support Specialist (PSS)	☐ Successful completion of Certified Training
☐	Children's Mental Health Professional (CMHP)	
☐	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	☐ Successful completion of Certified Training
☐	Communicable Disease Trainer	☐ HAPIS
☐	Parent Management Training – Oregon Model	☐ PMTO
☐	Infant Mental Health Certification	☐ IMH
☐	Trauma Focused CBT	☐ TFCBT
☐	Board Certified Behavioral Analyst	☐ BCBA
☐	Board Certified Aide Behavioral Analyst	☐ BCaBA
☐	Phlebotomist	☐ Certified, **certification attached**

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

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

_____ _____

Committee Chairperson/Designee Signature Date

Admin Form: #01-1300
Reviewed Date: 6/1/2022
Policy Ref: # 01-003-0011

Employee Name: _____

(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: Expiration Date:	Verification Source: Verified By: Date:
Certification: Expiration Date:	Verification Source: Verified By: Date:
Certification: Expiration 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: http://w3.lara.state.mi.us/free Verified By: Date:
Free of Medicare/Medicaid Sanctions: ☐ Yes ☐ No **must be done initially and monthly ongoing*	Verification Source: http://exclusions.oig.hhs.gov AND http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-16459--,00.html Verified By: Date:
Satisfactory National Practitioner Databank/Healthcare Integrity and Protection Data Bank (NPDB/HIPDB) query: ☐ Yes ☐ No	Verification Source: www.npdb.hrsa.gov 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 Designee Signature **Date**

☐ **All Required Trainings Completed**

_____ _____

Training Designee Signature **Date**

Reviewed: 05/01/21

Admin Form: #01-1300
Reviewed Date: 6/1/2022
Policy Ref: # 01-003-0011