Clear Form

ORGANIZATION APPLICATION

Network Enrollment and Privileging / Credentialing

SUD Provider ☐ **CMHSP** ☐ **Sub-Contract Provider of CMHSP** ☐

Complete as a new organization or when re-applying

Current Privileging Status: ☐ Provisional ☐ Probationary ☐ Full ☐ N//A

Current Term (if applicable): _____

Applying For: ☐ Provisional ☐ Full ☐ Re-Privileging

(Term shall be determined by Privileging & Credentialing Committee)

Section I. Organizational Profile

Sections I. – V. To be completed by the organization applying for network enrollment both initially and at the time of re-application.

Organization Name: _____

DBA (if applicable):_____

Group Affiliation (if applicable): _____

NPI Number of Primary Location: _____ Organization Web Address:_____

Organization Primary Mailing Address: _____

Organization Primary Phone: _____Fax:_____Hours of Operation:_____

Primary Point of Contact Name: _____ Contact Number: _____

Note: If the organization has multiple locations with which the PIHP contracts, please provide an additional page to this application with all the above information included for each location. An NPI number is required for each location.

Organization Accepting New Beneficiaries: YES ☐ NO ☐

Facility is ADA Compliant: YES ☐ NO ☐

Facility able to accommodate individuals with physical disabilities: YES ☐ NO ☐

Identify specific facility equipment to accommodate individuals: _____

_____

Secondary Languages provided within your organization to assist individuals: YES ☐ NO ☐

Identify languages including ASL: _____

Specialty services the organization is known for: _____

Specific cultural competencies within your agency: _____

Staff have completed Cultural Competency Training: YES ☐ NO ☐

Independent PCP Facilitators (if applicable): _____

Section II. Organizational Licensing and Certification

Accreditation Type: N/A ☐ TJC ☐ CARF ☐ COA ☐ ACHC ☐ NCQA ☐ Other ☐ _____

Note: You must provide the organization accreditation letter, accreditation report as well as accreditation corrective action plan(s) and the status of the action plan(s).

Organization Type: For Profit ☐ Not for Profit ☐ Partnership ☐ Private ☐ Public ☐
Government ☐ Limited Liability Corp. (LLC) ☐ Other ☐ _____

Certification and Licensing – Check all that apply:

☐ MDHHS Certification if the organization is not accredited – Expiration Date: _____

☐ MDHHS Certification Waived if accredited – Expiration Date: _____

☐ MDHHS Certification Pending – Expiration Date: _____

☐ MDHHS Designated Women's Specialty Service Provider

☐ LARA Licensure Obtained

Licensing Type(s): _____ Expiration Date: _____

☐ LARA Licensed Integrated Treatment Provider – Expiration Date: _____

☐ MDHHS ASAM LOC Designation(s) (List all MDHHS LOC Designation(s)

ASAM LOC:_____ Adult ☐ Children ☐ Expiration Date: _____

ASAM LOC: _____ Adult ☐ Children ☐ Expiration Date: _____

ASAM LOC: _____ Adult ☐ Children ☐ Expiration Date: _____

**If the organization has additional certification(s), license(s) and/or ASAM LOC Designation(s), please include this information on an additional page. Copies of license(s) and/or certification(s) are to be submitted with this application.*

Section III. Organizational Key Executive Staff

Chief Executive Officer: _____ Phone: _____ Email: _____
Chief Operating Officer: _____ Phone: _____ Email: _____
Chief Financial Officer: _____ Phone: _____ Email: _____
Medical Director: _____ Phone: _____ Email: _____
Recipient Rights Contact: _____ Phone: _____ Email: _____
Clinical Program Director: _____Phone: _____ Email: _____
Corporate Compliance Contact: _____ Phone: _____Email: _____
Other(Name/Title): _____ Phone: _____Email: _____

Section IV. Organizational State and Federal Regulatory Status Attestation

- This organization is in good standing with all State regulatory bodies: YES ☐ NO ☐
  - If no, provide written explanation on a separate page.
- This organization is in good standing will all Federal Regulatory bodies: YES ☐ NO ☐
  - If no, provide written explanation on a separate page.
- This organization has active Federal or State sanctions: YES ☐ NO ☐
  - If yes, provide written explanation on a separate page.
- This organization has active Federal or State Disbarments: YES ☐ NO ☐
  - If yes, provide written explanation on a separate page.
- This organization has had a malpractice lawsuit and/or judgement within the last ten (10 years)
  - If yes, provide written explanation on a separate page. YES ☐ NO ☐
- This organization has been excluded from Medicare/Medicaid participation: YES ☐ NO ☐
  - If yes, provide written explanation on a separate page.
- This organization maintains liability insurance: YES ☐ NO ☐
  - If yes, provide copy with submission of this application

Attestation:

The signature below indicates that the statement and indications made in Section I, II, III and IV are accurate and true. The below signature is that of an authorized representative within your organization.

Print Name: _____ *Title:* _____

Signature: _____ *Date:* _____

Section V. Provider Services

Indicate the services you are requesting privileges to provide within your organization under subcontract for CMHSP/SUD within the scope of your practice.

***SUD** Contracted Provider: If you are seeking privileges for SUD services only, please only complete table **E**.*

***CMHSP / CMHSP** Contract Provider : Please indicate all items that apply within tables **A-D**.*

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

B. Habilitation Supports Services	
☐ Assistive Technology	☐ Out of Home Pre-Vocational Services
☐ Community Living Supports	☐ Personal Emergency Response System (PERS)
☐ 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 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 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
E. Substance Use Disorder Services	
☐ Recovery Housing	☐ Peer Delivered Services (Recovery Coaching)
☐ Early Intervention Services	☐ Residential Services
☐ Individual Assessment Services	☐ Sub – Acute Detoxification Services
☐ Medication Assisted Treatment Services	☐ Outpatient Care Services
☐ Women's Specialty Services*	☐ Psychiatric Services
☐ Gender Competent Services*	☐ Adolescent Treatment Services

**Substance Use Disorder Women's Specialty and Gender Competent services must meet criteria specified within Region 10 SUD Women's Specialty Services and Gender Competent Programs Policy (05.03.06).*

Section VI. PIHP Review and Recommendation

This section is to be completed by a PIHP / CMHSP Network Manager or Designee.

I have reviewed the application as well as documents submitted by the organization. I, or a designee, have done a due diligence review of all information and find the statements submitted by the organization to be true and accurate.

☐ YES ☐ NO

If NO, note area(s) of concern that have been identified on a separate paper and attach to application.

After review of this information, I Recommend:

☐ Full Privileges
☐ Provisional Privileges
☐ Probationary Privileges
☐ Limitations of Services Requested
☐ Privileges be Revoked/Denied

If privileges are being revoked, denied or the organization is placed on provisional or probationary status, attach a separate document to the application that outlines rationale for decision.

I recommend the following term (If applicable)

Start:_____ Expiration:_____

Network Manager / Designee Signature: _____ *Date:* _____

Network Manager / Designee Name Printed:_____

Section VII. Privileging & Credentialing Committee Review and Recommendation

This section is to be completed by the PIHP / CMH Privileging & Credentialing Committee or Designee

After review of the organization's application, the Privileging & Credentialing Committee recommends:

☐ Full Privileges of the provider organization in the Region 10 PIHP Provider Network for all services as outlined in this application.
☐ Provisional Privileges of the provider organization in the Region 10 Provider Network.
☐ Probationary Privileges
☐ Limitation of Services Requested
☐ Privileges Revoked or Denied

If privileges are being revoked, denied or the organization is placed on provisional or probationary status, attach a separate document to the application that outlines rationale for decision.

Recommended Term: _____ To: _____

Credentialing Committee / Designee Signature: _____ *Date:* _____

Credentialing Committee / Designee Name Printed:_____
