



ORGANIZATION APPLICATION Network Enrollment and Credentialing

Sections I-IV:

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 V:

To be completed by the PIHP contract manager as applicable.

Section VI:

To be completed by the PIHP Credentialing Committee as applicable.

Section I. Agency Information

Agency Name: NPI:

DBA {If applicable}

Locations: NPI:

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:

Key Executive Staff

Administrator/CEO: Phone:

Email:

Chief Operating Officer: Phone:

Email:

Medical Director: Phone:

Email:

Clinical Program Directors: Phone:

Email:

Medical Director: Phone:

Email:

Clinical Program Directors: Phone:

Email:



ORGANIZATION APPLICATION Network Enrollment and Credentialing

Organization Name:

Section II. Organizational Profile

<input type="checkbox"/>	For Profit	<input type="checkbox"/>	Not for Profit	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	Private	<input type="checkbox"/>	Public	<input type="checkbox"/>	Government
<input type="checkbox"/>	Limited Liability Corporation (LLC)	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:

Submission of your organization's Michigan Corporation papers (or equivalent) is required.

	Accreditation (Check all that apply)	Start Date	Expiration Date
<input type="checkbox"/>	TJC		
<input type="checkbox"/>	CARF		
<input type="checkbox"/>	COA		
<input type="checkbox"/>	ACHC:		
<input type="checkbox"/>	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
<input type="checkbox"/>	MDHHS Certification Obtained (Required if not Accredited)		
<input type="checkbox"/>	MDHHS Certification Waived (if Accredited)		
<input type="checkbox"/>	MDHHS Certification Pending		
<input type="checkbox"/>	MDHHS Licensure Obtained (SUD Provider)		
<input type="checkbox"/>	MDHHS Licensed Integrated Treatment Service Provider		
<input type="checkbox"/>	Designated Women's Specialty Services Provider (See Attachment A)		



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Organization Name:

Section II. Organizational Profile Continued

Licensure	Type	Prevention/Treatment	Start Date	Expiration Date
Michigan Substance Use Licensure <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide written explanation.
Good Standing with all Federal Regulatory Bodies	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide written explanation.
Does this Agency currently have any Federal or State Sanctions active?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide a written explanation listing any sanctions.
Does this agency currently have any Federal or State Program Disbarments?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide a written explanation listing any disbarments.
Does this organization have ownership or control interest in the provider organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No If 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 Sections I and II are accurate and true.

Organization Legal Representative Name (Print) _____
Title

Organization Representative Signature _____
Date



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Organizational Name:

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.

<input type="checkbox"/>	Mental Health Services	<input type="checkbox"/>	Intellectual/Developmental Disability Services	<input type="checkbox"/>	Licensed Substance Use Services
<input type="checkbox"/>	Integrated Treatment Services (MH/SUD)	<input type="checkbox"/> 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.

<input type="checkbox"/>	Children Diagnosed with Serious Emotional Disturbance	<input type="checkbox"/>	Children Diagnosed with Substance Use Disorder
<input type="checkbox"/>	Children Diagnosed with Intellectual/Developmental Disability (4 to 17 years)	<input type="checkbox"/>	Adults Diagnosed with Substance Use Disorder
<input type="checkbox"/>	Women with SUD who are pregnant, parenting, or working to regain custody of their children	<input type="checkbox"/>	Infants Diagnosed with Mental Health (0 to 3 years)
<input type="checkbox"/>	Adults Diagnosed with Mental Illness	<input type="checkbox"/>	Adults Diagnosed with Intellectual/Developmental Disability
<input type="checkbox"/>	Other:		



ORGANIZATION APPLICATION Network Enrollment and Credentialing

Organization Name:

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/ B-3 Services	
<input type="checkbox"/> ACT – Assertive community Treatment	<input type="checkbox"/> Integrated Dual Disorders (Fidelity Tested)
<input type="checkbox"/> Assessment and Evaluation	<input type="checkbox"/> Medication Administration
<input type="checkbox"/> Behavioral Management Review	<input type="checkbox"/> Medication Review
<input type="checkbox"/> Child Therapy	<input type="checkbox"/> Nursing Facility Mental Health Monitoring
<input type="checkbox"/> Clubhouse Psychosocial Rehabilitation Program	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Community Psychiatric Inpatient	<input type="checkbox"/> Outpatient Partial Hospitalization
<input type="checkbox"/> Community Living Supports	<input type="checkbox"/> Peer-Directed & Operated Support Services
<input type="checkbox"/> Crisis Interventions	<input type="checkbox"/> Personal Care in Specialized Residential Settings
<input type="checkbox"/> Crisis Observation Care	<input type="checkbox"/> Personal Emergency Response System (PERS)
<input type="checkbox"/> Crisis Residential Services	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Dialectic Behavior Therapy (Certified Team)	<input type="checkbox"/> Prevention Services
<input type="checkbox"/> Electroconvulsive Therapy	<input type="checkbox"/> Respite Care
<input type="checkbox"/> Enhanced Medical Equipment and Supplies	<input type="checkbox"/> Skill Building Assistance
<input type="checkbox"/> Enhanced Pharmacy	<input type="checkbox"/> Speech, Hearing, and Language
<input type="checkbox"/> Environmental Modifications	<input type="checkbox"/> Supported Employment
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Supports Coordination
<input type="checkbox"/> Family Training	<input type="checkbox"/> Targeted Case Management
<input type="checkbox"/> Family Training	<input type="checkbox"/> Transportation
<input type="checkbox"/> Fiscal Intermediary	<input type="checkbox"/> Treatment Planning
<input type="checkbox"/> Health Services	<input type="checkbox"/> Wraparound Facilitation
<input type="checkbox"/> Home Based Services	<input type="checkbox"/> Telemedicine
<input type="checkbox"/> Housing Assistance	<input type="checkbox"/>
<input type="checkbox"/> Individual/Group Therapy	<input type="checkbox"/>
<input type="checkbox"/> Inpatient Psychiatric Hospital – State Facility Admission	<input type="checkbox"/>



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Organization Name:

Section III. Network Enrollment Information Continued

<u>B. Habilitation Supports Waiver Services</u>	
<input type="checkbox"/> Assistive Technology	<input type="checkbox"/> Out of Home Pre-Vocational Services
<input type="checkbox"/> Community Living Supports	<input type="checkbox"/> Personal Emergency Response System (PERS)
<input type="checkbox"/> Enhanced Medical Equipment and Supplies	<input type="checkbox"/> Private Duty Nursing
<input type="checkbox"/> Enhanced Pharmacy	<input type="checkbox"/> Respite Care
<input type="checkbox"/> Environmental Modifications	<input type="checkbox"/> Supported Employment
<input type="checkbox"/> Family Training	<input type="checkbox"/> Supports Coordination
<input type="checkbox"/> Out of Home Non-Vocational Habilitation	
<u>C. Children's Waiver Services</u>	
<input type="checkbox"/> Assessments	<input type="checkbox"/> Home Care Training, Non-Family
<input type="checkbox"/> Behavioral Management Review	<input type="checkbox"/> Individual/Group Therapy
<input type="checkbox"/> Community Living Supports	<input type="checkbox"/> Massage Therapy
<input type="checkbox"/> Environmental Modifications	<input type="checkbox"/> Medication Review
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Family Training	<input type="checkbox"/> Non-Family Training
<input type="checkbox"/> Health Services	<input type="checkbox"/> Respite Care
<input type="checkbox"/> Targeted Case Management	
<u>D. Serious Emotional Disturbance Waiver Services</u>	
<input type="checkbox"/> Community Living Supports	<input type="checkbox"/> Child Therapeutic Foster Care
<input type="checkbox"/> Family Home Care Training	<input type="checkbox"/> Therapeutic Overnight Camp
<input type="checkbox"/> Family Support Training	<input type="checkbox"/> Transitional Services
<input type="checkbox"/> Therapeutic Activities	<input type="checkbox"/> Wraparound Services
<input type="checkbox"/> Respite Care	<input type="checkbox"/> Home Care Training – Non Family
<u>E. Substance Use Disorder – State Plan / B3 Services</u>	
<input type="checkbox"/> Women's Specialty Services (See Page 7)	<input type="checkbox"/> Peer Delivered Services (Recovery Coaches)
<input type="checkbox"/> Early Intervention Services	<input type="checkbox"/> Residential Services
<input type="checkbox"/> Individual Assessment Services	<input type="checkbox"/> Sub – Acute Detoxification Services
<input type="checkbox"/> Medication Assisted Services	<input type="checkbox"/> Outpatient Care Services

Organization Name:



ORGANIZATION APPLICATION Network Enrollment and Credentialing

Section IV. Designated Women's Specialty Services Provider/ Enhanced Women's Services

Women's Specialty Services is a treatment program that meets the requirements specified in 45CFR § 96.124.

Note: A Designated Women's Specialty Services Provider must offer access to all of the following ancillary services as appropriate. Please see the Credentialing and Privileging 01.06.05 Region 10 Policy or the Medicaid Manual for information.

- Primary medical care for women, including referral for prenatal care if pregnant, and while the women are receiving such services, childcare for their dependent children.
- Primary pediatric care, including immunizations for their children.
- Gender specific substance abuse treatment and other therapeutic interventions for women, which may address issues of relationships, sexual and physical abuse, parenting and childcare
- Therapeutic interventions for children in custody of women in treatment, which may, among other things, address their developmental needs, issues of sexual and physical abuse, and neglect.
- Sufficient case management and transportation to ensure that women and their depending children have access to the above mentioned services

Additional Provider Requirements for Women's Specialty Services

- License for either residential or outpatient substance abuse treatment
- Accredited
- Treatment staff must have 12 semester hours of substance abuse training or 2080 hours of supervised gender specific training

Requirements for Enhanced Women's Services

- Provide Intensive Case Management
- Provide long-term case management (up to 12 months)
 - Increase Retention
 - Decrease use
 - Increase Family Planning
 - Decrease unplanned Pregnancies
- Utilize the 3-pronged approach
 - Reduce use of substances
 - Promote use of contraceptive methods
 - Increase use of primary care providers
- Allow Peer Coaches to provide transportation and keep in contact with individuals who are receiving this service.



ORGANIZATION APPLICATION Network Enrollment and Credentialing

Provider Requirements for Gender Competency

A program is considered a Gender Competent Program when an SUD provider organization with gender specific SUD programs and at least one practitioner meeting the state required gender competency qualifications.

Within the SUD Treatment Environment, gender competence is the capacity to identify where difference on basis of gender is significant, and to provide services that appropriately address gender differences and enhance positive outcomes for the population. Gender competence can be a characteristic of anything from individual knowledge and skills, to teaching, learning and practice environments, literature and policy. Those treatment programs engaged in the practice of gender competence will be providing specialized programming, focused not only on substance abuse, but also, on trauma, relationships, self-esteem, and parenting. Staff providing services to this population should have training in women's issues relating to the previously mentioned programming areas, as well as HIV/STI's, family dynamics and potentially child welfare.

Gender Competency Training Requirements: Practitioner

- Must have a minimum of 8 semester hours, or equivalent, of gender specific substance disorder training
- OR**
- 1080 hours of supervised gender specific substance use disorder training (field experience);
 - Those not meeting the requirement must be supervised by another individual working within the program and be working towards meeting the requirements
 - Documentation of trainings is required to be kept in personnel files.

Please indicate below services you are requesting "privileges" to provide within the **Provider Network**, under subcontract for SUD.

Women's Specialty Services Enhanced Women's Services Gender Competency

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

Organization Designee

Date



ORGANIZATION APPLICATION Network Enrollment and Credentialing

Organization Name: _____

Section V. PIHP Review and Recommendation

This section is to be revised and completed by a PIHP 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 a credentialing/re-credentialing of this organization into the Provider Network.

- | | |
|---|--|
| <input type="checkbox"/> Initial / Date: _____ | <input type="checkbox"/> Update / Date: _____ |
| <input type="checkbox"/> Recommended Full | <input type="checkbox"/> Provisional To Full |
| <input type="checkbox"/> Recommended Provisional | <input type="checkbox"/> Full to Probationary |
| <input type="checkbox"/> Recommended Probationary | <input type="checkbox"/> Termination of Privileges |
| <input type="checkbox"/> Not Recommended | |

Initial Recommendation

Contract Manager/Designee Signature

Date

Contract Manager/Designee Name (Print)

Update Recommendations

Contract Manager/Designee Signature

Date

Contract Manager/Designee Name (Print)



ORGANIZATION APPLICATION Network Enrollment and Credentialing

Section VI. Credentialing Committee Review and Attestation

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

PIHP Credentialing Committee Recommendation

Provider Network Services

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

Credentialing of the provider organization into the Region 10 PIHP Provider Network for all privileges specified

Credentialing Term: _____ to _____

Provisionally recommends credentialing of the provider organization into the Region 10 PIHP Provider Network.

Credentialing Term: _____ to _____

Network Credentials Revoked

Provide Rationale for Recommendation:

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

Credentialing Committee Chairman/Designee Signature

Date

Credentialing Committee Chairman/Designee Signature

- cc: PIHP Data Enrollment Staff
- PIHP Contract Manager Contract
- Data Entry Staff
- PIHP Contract Agency: Contract File

PIHP: Upon completion and/or updating of this form please ensure all data is loaded into the designated software/database. Provider enrollment and credentialing or re-credentialing must occur prior to service provision and encounter submission/billing. Additionally, please submit this form to the Provider Network Management Department for entry into the Credentialing Database.