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 Name:

Section II. Organizational Profile

☐	For Profit	☐	Not for Profit	☐	Partnership
☐	Private	☐	Public	☐	Government
☐	Limited Liability Corporation (LLC)	☐	Other:	☐	Other:

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

	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 Certification Waived (if Accredited)		
☐	MDHHS Certification Pending		
☐	MDHHS Licensure Obtained (SUD Provider)		
☐	MDHHS Licensed Integrated Treatment Service Provider		
☐	Designated Women's Specialty Services Provider (See Attachment A)		

Organization Name:

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

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.

☐	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 Health (0 to 3 years)
☐	Adults Diagnosed with Mental Illness	☐	Adults Diagnosed with Intellectual/Developmental Disability
☐	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	
☐ 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	☐

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 (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 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
E. Substance Use Disorder – State Plan / B3 Services	
☐Women's Specialty Services (See Page 7)	☐Peer Delivered Services (Recovery Coaches)
☐Early Intervention Services	☐Residential Services
☐Individual Assessment Services	☐Sub – Acute Detoxification Services
☐Medication Assisted Services	☐Outpatient Care Services

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.

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

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 and credentialing/re-credentialing of this organization into the Provider Network.

☐Recommended ☐ Not Recommended

Attestation:

____ ____________________
Contract Manager/Designee Signature Date

____
Contract Manager/Designee Name (Print)

FOR OFFICIAL USE ONLY

Credentialing Type: ____

□ Genesee Health System □ Lapeer CMH □ Sanilac CMHA

□ St. Clair CMHA □ Substance Use Disorder Provider

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.