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

Clear Form

☐ CMH ☐ SUD ☐ ABA ☐ OTHER

Please type or print all applicable sections.

Section I. Practitioner Profile

Practitioner Name:	**Date of Hire:**
Former Last Name:	**DOB:**
Title:	
Business Name:	**Supervisor:**
Business Phone:	**E-Mail Address**:
Business Address:	

Credentials: Credentials through MCBAP are required for SUD Providers.

Degree(s): **NPI:**
Licensure: **License No.:** **Exp. Date:**
Certification: **Exp. Date:**
Certification: **Exp. Date:**

Privileging Type

☐ Provisional (up to 120 days)	☐ Full	☐ Additional
☐ Probationary	☐ Re-Credentialing *Re-Credentialing must be completed a minimum of every two years*	

Target Populations

*What target populations are you seeking "privileges" to serve within the **PIHP Provider Network**?*

☐ Children (0 through 3 years)	☐ Adults with Intellectual/ Developmental Disabilities
☐ Children with Intellectual/Developmental Disabilities (4 through 17 years)	☐ Adults with Mental Illness
☐ Children with Serious Emotional Disturbance (4 through 17 years)	☐ Adults with Substance Use Disorder
☐ Children with a Substance Use Disorder	☐ Co-occurring Disorder (MH/SUD)

Cultural Ethnic Specialties* **List your qualifications for these skills here**

☐ African American
☐ Single Parent
☐ Teens (13-17)
☐ Other
☐ Other

Foreign and Sign Language Competencies* **List your qualifications for these skills here**

☐ Spanish
☐ Sign Language
☐ Other
☐ Other

*Please see page 9 of this document.

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Employee Name:

Section II. Privileges Requested (Check all that apply)

I am seeking privileges to perform services as:

☐	Psychiatrist	☐ MD ☐ DO
☐	Physician, Non-Psychiatrist	☐ MD ☐ DO
☐	Psychologist	☐ LP
☐	Physician Assistant	☐ PA-C
☐	Nurse Practitioner	☐ APRN-BC ANP ☐ FNP ☐ PedNP ☐ APRN-BE NHNP ☐ PsychNP
☐	Therapist/Clinician, Psychologist Limited License	☐ LMSW ☐ LLMSW* ☐ LLP ☐ TLLP* ☐ LPC ☐ LLPC* *May only provide services under the supervision of LMSW, LLP or LPC
☐	Supports Coordinator/ Case Manager	☐ LBSW ☐ LLBSW* ☐ SST *May only provide services under the supervision of LMSW
☐	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 ☐ Development Plan ☐ CCDP ☐ CCDP-D
☐	Non-Credentialed Staff	
☐	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 **	☐ CPRM ☐ Certified Recovery Coach (CRC)
☐	Certified in SUD Prevention	☐ CPC-R ☐ CPC-M ☐ CPS-R ☐ Development Plan ☐ CHES
☐	Gender Competent	
☐	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)	

**Peer Recovery Coach Practitioner Attestation: This is to be completed when applying for peer recovery coach privileges

☐ 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, equivalent (Provider Certificate of Completion) or a MCBAP Certification for Certified Peer Recovery Mentor.

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Employee Name:

Privileging Questionnaire (all answers will be kept confidential)

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. Do you currently have malpractice coverage either independently or through your agency that you are seeking privileges to provide services through? ☐Yes ☐No
   a. What is the coverage amount?
   b. Dates of coverage:
4. 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 nay of the items below in anticipation of any of these action; 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
5. 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
6. Other than traffic violations, have you had a misdemeanor conviction in the last 5 years? ☐Yes ☐No
7. Have you ever had a felony conviction? ☐Yes ☐No
8. Have you ever been investigated, reprimanded, sanctioned, or fined by any state or local agency? ☐Yes ☐No
9. 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
10. Are you currently able to perform all necessary functions of the position that is requested to be privileged and credentialed? ☐Yes ☐No
11. Do you attest that you have no present/current illegal drug or unprescribed medication use? ☐Yes ☐No

If the answer is "YES" to any of the above questions, please attach a signed and dated written explanation.
☐**YES:** **No. of additional pages** ☐**NO**

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Employee Name:

I understand that I am applying to be appointed 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.

☐YES, I understand ☐NO, I do not understand or consent

I have reviewed the **Mission and Values** statements and **Code of Ethics** as contained in the Corporate Compliance Program and/or Credentialing and Privileging Policy and agree to adhere to these ethical standards of practice and agree to comply with all stated values and guided principles.

☐YES, I agree ☐NO, I do not agree or consent

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

X_____ Date:_____
Staff signature

Supervisor Recommendation: ☐**Approve** ☐**Disapprove**

If disapproved, please provide rationale:

Supervisor Signature: **X**_____ Date:

*A designated supervisor is mandatory for Peer Specialists/Certified Recovery Coaches, TLLPs, Limited LMSWs, Limited LBSWs, LLPCs; Child Mental Health Professionals, SATSs other than supervisors and SATPs; and Case Managers or Supports Coordinators who are not QMHPs or QIDPs.

*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

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

Employee Name:

PROVIDER COMMITTEE/DESIGNEE/DEPARTMENT DETERMINATION
This section of the form is to be completed by the CMHSP/SUD Committee/Designee/Department, as applicable and qualified in the delegation agreement.
The Committee/Designee/Department has reviewed this application enrollment form for credentialing or re-credentialing and recommends:
☐ Provisional (Up to 120 Days) ☐ Full ☐ Additional ☐ Probationary
☐ Re-credentialing (must be completed a minimum of every two years)
☐ Does not recommend privileging of the practitioner into the **Practitioner Network** (provide rationale)
Rationale:

Start Date: **End Date:**

☐	Psychiatrist	☐ MD ☐ DO
☐	Physician, Non-Psychiatrist	☐ MD ☐ DO
☐	Psychologist	☐ LP
☐	Physician Assistant	☐ PA-C
☐	Nurse Practitioner	☐ APRN-BC ANP ☐ FNP ☐ PedNP ☐ APRN-BE NHNP ☐ PsychNP
☐	Therapist/Clinician, Psychologist Limited License	☐ LMSW ☐ LLMSW* ☐ LLP ☐ TLLP* ☐ LPC ☐ LLPC* *May only provide services under the supervision of LMSW, LLP or LPC
☐	Supports Coordinator/ Case Manager	☐ LBSW ☐ LLBSW* ☐ SST *May only provide services under the supervision of LMSW
☐	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 ☐ Development Plan ☐ CCDP ☐ CCDP-D
☐	Non-Credentialed Staff	
☐	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	☐ CPRM ☐ Certified Recovery Coach (CRC)
☐	Certified in SUD Prevention	☐ CPC-R ☐ CPC-M ☐ CPS-R ☐ Development Plan ☐ CHES
☐	Gender Competent	
☐	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)	

PROVIDER COMMITTEE/DESIGNEE/DEPARTMENT DETERMINATION *CONTINUED*

Target Populations Granted:

☐ Children (0 through 3 years)

☐ Children with Developmental Disabilities (4 through 17 years)

☐ Children with Serious Emotional Disturbance (4 through 17 years)

☐ Children with Substance Use Disorder

☐ Adults with Developmental Disabilities

☐ Adults with Mental Illness

☐ Adults with Substance Use Disorder

☐ Co-occurring Disorder (MH/SUD)

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

_____ _____

Committee Chairperson/Designee Signature Date

_____

Chairperson/Designee Print Name

PRACTITIONER APPLICATION
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ATTACHMENT A

PROVIDER HUMAN RESOURCES 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. ☐ 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	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:

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

_____ _____
HR Designee Signature **Date**

☐ **All Required Trainings Completed**

_____ _____
Training Designee Signature **Date**

For Committee Use only:

Received: Initial Approval: Sent to: Review by: Data Entered and Filed:	Date: Date: Date: Date: Date:	Clean File: ☐ Yes ☐ No _____ Medical Director/Designee Approval Date
Type of Credentialing: ☐ Provisional ☐ Full ☐ Recredential		Date Range Approved: Recredential Due: Last date approved:

PRACTITIONER APPLICATION
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Employee Name:

ATTACHMENT B

SPECIALIZED TRAINING/EXPERIENCE – *This section should be completed with staff supervisor.*

SKILLS REQUIRING CERTIFICATION			Approved by Committee	
☐ CBT Behavioral Therapy	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Critical Incident Stress Debriefing	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Dialectical Behavior Therapy	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Family Psychoeducation	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Integrated Dual Disorder Treatment	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Supports Intensity Scale (SIS)	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Women's Issues	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
SKILLS REQUIRING CLINICAL TRAINING: **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 which indicate expertise to provide clinical treatment in the specialty.			Approved by SUPERVISOR	
☐ ADHD	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ AIDS/HIV/STI	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Anger Management	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Anxiety Disorders	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Autism	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Bi-polar Disorder	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Borderline Personality	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Child/Adolescent Therapy	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Child/Adolescent Welfare	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Chronic/Terminal Illness	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Conduct Disorders	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Co-Occurring Disorders (SUD/MH)	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Crisis/Lethality	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Intellectually Disabled Developmentally Disabled	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Domestic Violence	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Eating Disorders	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Family Dynamics	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Family Therapy	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Gay/Lesbian/Sexual	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Geriatric (Dementia) Therapy	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Grief/Bereavement	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Group Therapy	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Hearing Impaired	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Marital/Divorce/Separation	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Men's Issues	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Mentally Impaired	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Multiple Personality Disorder	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Neuropsychological Testing	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Oppositional/Defiant Disorders	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Panic/Phobia	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Parenting	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No

ATTACHMENT B CONTINUED

SKILLS REQUIRING CLINICAL TRAINING CONTINUED:
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 which indicate expertise to provide clinical treatment in the specialty.

☐ Personality Disorder	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Physical Abuse	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Physical Disability	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Relationships	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Schizophrenia	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ School Related Problems	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Self-Esteem	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Sexual Abuse	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Stress Management	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ SUD Prevention	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Substance Use Disorder	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Traumatic Brain Injury	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Trauma/PTSD	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No
☐ Victimization	☐ Certificate Attached	☐Certificate on File	☐Yes	☐No

Supervisor Signature: _____

Supervisor Name: _____
Please print

Date: _____

*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 found on page one. The list is meant to be an accurate reflection of your abilities and skills and, thereby, an account of those services and skills that our agency can offer.