# ORGANIZATION ADDITIONAL CMH LOCATION(S)

**Privileging / Credentialing**

Organization Name: _____

***Note**: If the organization has multiple locations with which the PIHP contracts, an additional location form is needed for **each location***

## Section I. Organizational Profile

Location Address: _____

NPI Number of Location: _____

Location Primary Phone: _____ Fax: _____ Hours of Operation: _____

Location Accepting New Beneficiaries: ☐ YES ☐ NO

Location is ADA Compliant: ☐ YES ☐ NO

If yes, please specify if the office / facility has the following equipment to accommodate individuals with physical disabilities:

☐ Wheelchair(s) ☐ Ramp(s) ☐ Elevator(s) ☐ Accessible Bathroom(s)
☐ Other: _____

Specific linguistic capabilities at your location: ☐ ASL ☐ Language Interpretation Services

☐ Non-English Languages (if your organization maintains non-English languages spoken, please specify those languages): _____

Specific Cultural capabilities at your location: ☐ Sexual Orientation ☐ Gender Competency
☐ Age-Specific Competencies ☐ Race ☐ Religious / Spiritual Beliefs
☐ Ethnic Background(s) (if your organization maintains specific ethnic background(s), please specify those):

_____

☐ Other: _____

Provider has ensured staff have completed Cultural Competency Training: ☐ YES ☐ NO

## Section II. Organizational Licensing and Certification

Certification and Licensing *(check all that apply)*:

☐ LARA Licensure Obtained – License Number: _____

Licensing Type(s): _____

Expiration Date: _____

## Section III. Provider Services

Indicate the services you are requesting privileges to provide within this specific location.

| A. Mental Health Services – CMHSP / CMHSP Contracted Provider | |
|---|---|
| ☐ ACT – Assertive community Treatment | ☐ Inpatient Psychiatric Hospital – State Facility Admission |
| ☐ Assessment and Evaluation | ☐ Integrated Dual Disorders (Fidelity Tested) |

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

| 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 |

**The following item is attached with the additional location(s) form:**

☐ Copy of Michigan Licensure

**The signature below indicates that all appropriate documents listed above are attached and that all information on this additional location(s) form is accurate.**

*Signature:* _____ *Date:* _____

*Printed Name:* _____