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

☐ SUD Provider ☐ PIHP ☐ ACCESS/UM

☐ GHS ☐ Lapeer CMH ☐ Sanilac CMH ☐ St. Clair CMH ☐ Other

Section I. Practitioner Profile

(To be completed by applicant)

Name of Practitioner Seeking Privileges: _____

Former Last Name (if applicable): _____ Date of Birth:_____

Title within the Organization you work for: _____

Name of Organization you work for: _____

Address of Organization you work for: _____

Organization Phone Number: _____ Supervisor Name: _____

Email Address: _____ Date of Hire:_____

Degree**:**_____NPI Number:_____

Licensure:_____License Number:_____Exp. Date:_____

Certification:_____Exp. Date:_____

Certification:_____Exp. Date:_____

Current Credentialing Status: ☐ Provisional ☐ Probationary ☐ Full ☐ N/A - Current Term Dates: _____

Applying for: ☐ Provisional ☐ Full ☐ Re-Credentialing *(Term shall be determined by Credentialing Committee)*

Target Populations you are seeking privileges to serve within the Region 10 PIHP Provider Network

☐ Children (0-3 years) ☐ Children w/Intellectual/Developmental Disabilities (4-17 years)

☐ Children w/ Serious Emotional Disturbance (4-17 years)

☐ Children with Substance Use Disorder

☐ Adults w/ Intellectual / Developmental Disabilities

☐ Adults with Mental Illness

☐ Adults with Substance Use Disorder

☐ Co-occurring Disorders (MH/SUD)

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Cultural Competencies and Linguistic Capabilities

Do you speak a language other than English that can assist non-English speaking individuals within the agency you are providing services? ☐ YES ☐ NO

If you answered 'YES', please identify the language(s): _____

Do you have any cultural or ethnic specialties you would like identified? ☐ YES ☐ NO

If you answered 'YES', please list them here and identify your specialty qualifications.

**Additional specialties may be identified on Attachment B of this application*

Section II. Privileges Requested

(To be completed by applicant)

I am seeking privileges to perform services as (check all that apply):

☐	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* ☐ LLMFT* ☐ LMFT *May only provide services under the supervision of LMSW, LLP, LPC or LLMFT
☐	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 Behavioral Health Professional (QBHP)	
☐	Qualified Mental Health Professional (QMHP)	

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☐	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 (SUD)**	☐ CPRM ☐ Certified Recovery Coach (CRC) ☐ MDHHS Certification ☐ CCAR Completion
☐	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, MDHHS Recovery Coach training, or a MCBAP Certification for Certified Peer Recovery Mentor.

Section III. Privileging Questionnaire

(To be completed by applicant)

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. 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 any of the items below in anticipation of any of these actions; 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

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4. 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
5. Other than traffic violations, have you had a misdemeanor conviction in the last 5 years?
   ☐ Yes ☐ No
6. Have you ever had a felony conviction?
   ☐ Yes ☐ No
7. Have you ever been investigated, reprimanded, sanctioned, or fined by any state or local agency?
   ☐ Yes ☐ No
8. 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
9. 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:
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 you answered "Yes" to any question(s) # 1- # 8, please attach a signed and dated explanation for confidential review by the privileging entity.

Section IV. Attestation

(To be completed by applicant and signed by applicant supervisor)

By signing below I attest that 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.

By signing below I attest that I have reviewed the **Mission and Values** statements and **Code of Conduct** 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.

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

Signature of Applicant:_____ **Date:**_____

Supervisor Recommendation: ☐ Approve ☐ Disapprove

Signature of Supervisor:_____ **Date:**_____

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*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

Section V. Committee Determination

(To be completed by the approving committee or designee only)

The Committee/Designee/Department has reviewed this application enrollment form for credentialing or re-credentialing and recommends a credentialing status of:

☐ Provisional ☐ Probationary ☐ Full ☐ Does Not Recommend *(Provide Rationale)*

For the following target populations:

☐ Children (0-3 years) ☐ Children w/Intellectual/Developmental Disabilities (4-17 years)

☐ Children w/ Serious Emotional Disturbance (4-17 years) ☐ Children with Substance Use Disorder

☐ Adults w/ Intellectual / Developmental Disabilities ☐ Adults with Mental Illness

☐ Adults with Substance Use Disorder ☐ Co-occurring Disorders (MH/SUD)

Start Date of Term: _____

End Date of Term: _____

☐	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

*Employee Name:*_____

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☐	Therapist/Clinician, Psychologist Limited License	☐ LMSW ☐ LLMSW* ☐ LLP ☐ TLLP* ☐ LPC ☐ LLPC* ☐ LLMFT* ☐ LMFT *May only provide services under the supervision of LMSW, LLP, LPC or LLMFT
☐	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
☐	Substance Abuse Treatment Specialist	☐ CADC ☐ CADC- M ☐ CAADC ☐ CCS ☐ CCS-M ☐ CCJP ☐ Development Plan ☐ CCDP ☐ CCDP-D
☐	Non-Credentialed Staff	
☐	Qualified Behavioral Health Professional (QBHP)	
☐	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 (SUD)**	☐ CPRM ☐ Certified Recovery Coach (CRC) ☐ MDHHS Certification ☐ CCAR Completion
☐	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)	

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

_____ _____
Committee Chairperson/Designee Signature Date

_____
Chairperson/Designee Print Name

*Employee Name:*_____

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ATTACHMENT A – Primary Source Verification

(TO BE COMPLETED BY PROVIDER ORGANIZATIONS HUMAN RESOURCE DEPARTMENT OR 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. **must be completed initially and at least every 2-years after* ☐ Yes ☐ No	Verification Source: Verified By: Date:
Satisfactory disciplinary status with regulatory board or agency verified? ☐ Yes ☐ No	Verification Source: https://val.apps.lara.state.mi.us/License/Search Verified By: Date:
Free of Medicare/Medicaid Sanctions: ☐ Yes ☐ No **must be done initially and monthly on-going*	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:
Employee has completed the organizations Cultural Compliance Training as required by the CMHSP/PIHP. ☐ 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**

*Employee Name:*_____

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ATTACHMENT B - SPECIALIZED TRAINING/EXPERIENCE

THIS SECTION SHOULD BE COMPLETED BY APPLICANT AND CONFIRMED/APPROVED BY APPLICANTS' SUPERVISOR

SKILLS REQUIRING CLINICAL TRAINING AND/OR CERTIFICATION:

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 on File	☐ Yes	☐ No
☐ AIDS/HIV/STI	☐ Certificate on File	☐ Yes	☐ No
☐ Anger Management	☐ Certificate on File	☐ Yes	☐ No
☐ Anxiety Disorders	☐ Certificate on File	☐ Yes	☐ No
☐ Autism	☐ Certificate on File	☐ Yes	☐ No
☐ Bi-polar Disorder	☐ Certificate on File	☐ Yes	☐ No
☐ Borderline Personality	☐ Certificate on File	☐ Yes	☐ No
☐ CBT Behavioral Therapy	☐ Certificate on File	☐ Yes	☐ No
☐ Child/Adolescent Therapy	☐ Certificate on File	☐ Yes	☐ No
☐ Child/Adolescent Welfare	☐ Certificate on File	☐ Yes	☐ No
☐ Critical Incident Stress Debriefing	☐ Certificate on File	☐ Yes	☐ No
☐ Chronic/Terminal Illness	☐ Certificate on File	☐ Yes	☐ No
☐ Conduct Disorders	☐ Certificate on File	☐ Yes	☐ No
☐ Co-Occurring Disorders (SUD/MH)	☐ Certificate on File	☐ Yes	☐ No
☐ Crisis/Lethality	☐ Certificate on File	☐ Yes	☐ No
☐ Intellectually Disabled Developmentally Disabled	☐ Certificate on File	☐ Yes	☐ No
☐ Dialectical Behavior Therapy	☐ Certificate on File	☐ Yes	☐ No
☐ Domestic Violence	☐ Certificate on File	☐ Yes	☐ No
☐ Eating Disorders	☐ Certificate on File	☐ Yes	☐ No
☐ Family Dynamics	☐ Certificate on File	☐ Yes	☐ No
☐ Family Psychoeducation	☐ Certificate on File	☐ Yes	☐ No
☐ Family Therapy	☐ Certificate on File	☐ Yes	☐ No
☐ Gay/Lesbian/Sexual	☐ Certificate on File	☐ Yes	☐ No
☐ Geriatric (Dementia) Therapy	☐ Certificate on File	☐ Yes	☐ No
☐ Grief/Bereavement	☐ Certificate on File	☐ Yes	☐ No
☐ Group Therapy	☐ Certificate on File	☐ Yes	☐ No
☐ Hearing Impaired	☐ Certificate on File	☐ Yes	☐ No
☐ Integrated Dual Disorder Treatment	☐ Certificate on File	☐ Yes	☐ No
☐ Marital/Divorce/Separation	☐ Certificate on File	☐ Yes	☐ No
☐ Men's Issues	☐ Certificate on File	☐ Yes	☐ No
☐ Mentally Impaired	☐ Certificate on File	☐ Yes	☐ No
☐ Multiple Personality Disorder	☐ Certificate on File	☐ Yes	☐ No
☐ Neuropsychological Testing	☐ Certificate on File	☐ Yes	☐ No
☐ Oppositional/Defiant Disorders	☐ Certificate on File	☐ Yes	☐ No
☐ Panic/Phobia	☐ Certificate on File	☐ Yes	☐ No
☐ Parenting	☐ Certificate on File	☐ Yes	☐ No
☐ Personality Disorder	☐ Certificate on File	☐ Yes	☐ No
☐ Physical Abuse	☐ Certificate on File	☐ Yes	☐ No
☐ Physical Disability	☐ Certificate on File	☐ Yes	☐ No

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☐ Relationships	☐ Certificate on File	☐Yes	☐No
☐ Schizophrenia	☐ Certificate on File	☐Yes	☐No
☐ School Related Problems	☐ Certificate on File	☐Yes	☐No
☐ Self-Esteem	☐ Certificate on File	☐Yes	☐No
☐ Sexual Abuse	☐ Certificate on File	☐Yes	☐No
☐ Supports Intensity Scale (SIS)	☐ Certificate on File	☐Yes	☐No
☐ Stress Management	☐ Certificate on File	☐Yes	☐No
☐ SUD Prevention	☐ Certificate on File	☐Yes	☐No
☐ Substance Use Disorder	☐ Certificate on File	☐Yes	☐No
☐ Traumatic Brain Injury	☐ Certificate on File	☐Yes	☐No
☐ Trauma/PTSD	☐ Certificate on File	☐Yes	☐No
☐ Victimization	☐ Certificate on File	☐Yes	☐No
☐ Women's Issues	☐ 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 identified. The list is meant to be an accurate reflection of your abilities and skills and, thereby, an account of those services and skills that your agency can offer.*