Section I. Organizational Profile

Sections I. – V. To be completed by the organization applying for network enrollment both initially and at the time of re-application.

Organization Name: ________________________________________________________________

DBA (if applicable): ________________________________

Group Affiliation (if applicable): ______________________________________________________

NPI Number of Primary Location: ________________ Organization Web Address:___________________

Organization Primary Mailing Address: ____________________________________________________

Organization Primary Phone: __________________ Fax:_________________ Hours of Operation:_________________

Primary Point of Contact Name: ___________________________ Contact Number: __________________

Note: If the organization has multiple locations with which the PIHP contracts, please provide an additional page to this application with all the above information included for each location. An NPI number is required for each location.

Organization Accepting New Beneficiaries: YES ☐ NO ☐

Facility is ADA Compliant: YES ☐ NO ☐

Facility able to accommodate individuals with physical disabilities: YES ☐ NO ☐

Identify specific facility equipment to accommodate individuals: ______________________________

Secondary Languages provided within your organization to assist individuals: YES ☐ NO ☐

Identify languages including ASL: ______________________________________________________

Specialty services the organization is known for: __________________________________________

Specific cultural competencies within your agency: _________________________________________

Staff have completed Cultural Competency Training: YES ☐ NO ☐

Independent PCP Facilitators (if applicable): ______________________________________________
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Section II. Organizational Licensing and Certification

**Accreditation Type:**
- [ ] N/A
- [ ] TJC
- [ ] CARF
- [ ] COA
- [ ] ACHC
- [ ] NCQA
- [ ] Other

*Note: You must provide the organization accreditation letter, accreditation report as well as accreditation corrective action plan(s) and the status of the action plan(s).*

**Organization Type:**
- [ ] For Profit
- [ ] Not for Profit
- [ ] Partnership
- [ ] Private
- [ ] Public
- [ ] Government
- [ ] Limited Liability Corp. (LLC)
- [ ] Other

**Certification and Licensing – Check all that apply:**
- [ ] MDHHS Certification if the organization is not accredited – Expiration Date: ________________
- [ ] MDHHS Certification Waived if accredited – Expiration Date: ________________
- [ ] MDHHS Certification Pending – Expiration Date: ________________
- [ ] MDHHS Designated Women’s Specialty Service Provider
- [ ] LARA Licensure Obtained
  - Licensing Type(s): ________________ Expiration Date: ________________
- [ ] LARA Licensed Integrated Treatment Provider – Expiration Date: ________________
- [ ] MDHHS ASAM LOC Designation(s) (List all MDHHS LOC Designation(s))
  - ASAM LOC: ________________ Adult □ Children □ Expiration Date: ________________
  - ASAM LOC: ________________ Adult □ Children □ Expiration Date: ________________
  - ASAM LOC: ________________ Adult □ Children □ Expiration Date: ________________

*If the organization has additional certification(s), license(s) and/or ASAM LOC Designation(s), please include this information on an additional page. Copies of license(s) and/or certification(s) are to be submitted with this application.*

Section III. Organizational Key Executive Staff

**Chief Executive Officer:** _________________________ Phone: _____________ Email: _______________________
**Chief Operating Officer:** _________________________ Phone: _____________ Email: _______________________
**Chief Financial Officer:** __________________________ Phone: _____________ Email: _______________________
**Medical Director:** ______________________________ Phone: _____________ Email: _______________________
**Recipient Rights Contact:** ________________________ Phone: _____________ Email: _______________________
**Clinical Program Director:** ________________________ Phone: _____________ Email: _______________________
**Corporate Compliance Contact:** ____________________ Phone: _____________ Email: _______________________
**Other (Name/Title):** _____________________________ Phone: _____________ Email: _______________________

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Section IV. Organizational State and Federal Regulatory Status Attestation

• This organization is in good standing with all State regulatory bodies: YES ☐ NO ☐
  o If no, provide written explanation on a separate page.
• This organization is in good standing with all Federal Regulatory bodies: YES ☐ NO ☐
  o If no, provide written explanation on a separate page.
• This organization has active Federal or State sanctions: YES ☐ NO ☐
  o If yes, provide written explanation on a separate page.
• This organization has active Federal or State Disbarments: YES ☐ NO ☐
  o If yes, provide written explanation on a separate page.
• This organization has had a malpractice lawsuit and/or judgement within the last ten (10 years)
  o If yes, provide written explanation on a separate page. YES ☐ NO ☐
• This organization has been excluded from Medicare/Medicaid participation: YES ☐ NO ☐
  o If yes, provide written explanation on a separate page.
• This organization maintains liability insurance: YES ☐ NO ☐
  o If yes, provide copy with submission of this application

Attestation:

The signature below indicates that the statement and indications made in Section I, II, III and IV are accurate and true. The below signature is that of an authorized representative within your organization.

Print Name: ____________________________________ Title: _____________________________

Signature: ______________________________________ Date: ___________________
**Section V. Provider Services**

Indicate the services you are requesting privileges to provide within your organization under subcontract for CMHSP/SUD within the scope of your practice.

**SUD Contracted Provider**: If you are seeking privileges for SUD services only, please only complete table E.

**CMHSP / CMHSP Contract Provider**: Please indicate all items that apply within tables A-D.

<table>
<thead>
<tr>
<th>A. Mental Health Services – CMHSP / CMHSP Contracted Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ACT – Assertive community Treatment</td>
</tr>
<tr>
<td>☐ Assessment and Evaluation</td>
</tr>
<tr>
<td>☐ Behavioral Management Review</td>
</tr>
<tr>
<td>☐ Child Therapy</td>
</tr>
<tr>
<td>☐ Clubhouse Psychosocial Rehabilitation Program</td>
</tr>
<tr>
<td>☐ Community Psychiatric Inpatient</td>
</tr>
<tr>
<td>☐ Community Living Supports</td>
</tr>
<tr>
<td>☐ Crisis Interventions</td>
</tr>
<tr>
<td>☐ Crisis Observation Care</td>
</tr>
<tr>
<td>☐ Crisis Residential Services</td>
</tr>
<tr>
<td>☐ Dialectic Behavior Therapy (Certified Team)</td>
</tr>
<tr>
<td>☐ Electroconvulsive Therapy</td>
</tr>
<tr>
<td>☐ Enhanced Medical Equipment and Supplies</td>
</tr>
<tr>
<td>☐ Enhanced Pharmacy</td>
</tr>
<tr>
<td>☐ Environmental Modifications</td>
</tr>
<tr>
<td>☐ Family Therapy</td>
</tr>
<tr>
<td>☐ Family Training</td>
</tr>
<tr>
<td>☐ Family Training</td>
</tr>
<tr>
<td>☐ Fiscal Intermediary</td>
</tr>
<tr>
<td>☐ Health Services</td>
</tr>
<tr>
<td>☐ Home Based Services</td>
</tr>
<tr>
<td>☐ Housing Assistance</td>
</tr>
<tr>
<td>☐ Individual/Group Therapy</td>
</tr>
<tr>
<td>☐ Inpatient Psychiatric Hospital – State Facility Admission</td>
</tr>
</tbody>
</table>
**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 |

**E. Substance Use Disorder Services**

| ☐ Recovery Housing | ☐ Peer Delivered Services (Recovery Coaching) |
| ☐ Early Intervention Services | ☐ Residential Services |
| ☐ Individual Assessment Services | ☐ Sub – Acute Detoxification Services |
| ☐ Medication Assisted Treatment Services | ☐ Outpatient Care Services |
| ☐ Women’s Specialty Services* | ☐ Psychiatric Services |
| ☐ Gender Competent Services* | ☐ Adolescent Treatment Services |

*Substance Use Disorder Women’s Specialty and Gender Competent services must meet criteria specified within Region 10 SUD Women’s Specialty Services and Gender Competent Programs Policy (05.03.06).*
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Section VI. PIHP Review and Recommendation

This section is to be completed by a PIHP / CMHSP Network Manager or Designee.

I have reviewed the application as well as documents submitted by the organization. I, or a designee, have done a due diligence review of all information and find the statements submitted by the organization to be true and accurate.

☐ YES ☐ NO

If NO, note area(s) of concern that have been identified on a separate paper and attach to application.

After review of this information, I recommend:
☐ Full Privileges
☐ Provisional Privileges
☐ Probationary Privileges
☐ Limitations of Services Requested
☐ Privileges be Revoked/Denied

If privileges are being revoked, denied or the organization is placed on provisional or probationary status, attach a separate document to the application that outlines rationale for decision.

I recommend the following term (If applicable)
Start:___________________  Expiration:___________________

Network Manager / Designee Signature: ________________________________ Date: ________________

Network Manager / Designee Name Printed: _______________________________________

Section VII. Privileging & Credentialing Committee Review and Recommendation

This section is to be completed by the PIHP / CMH Privileging & Credentialing Committee or Designee

After review of the organization’s application, the Privileging & Credentialing Committee recommends:
☐ Full Privileges of the provider organization in the Region 10 PIHP Provider Network for all services as outlined in this application.
☐ Provisional Privileges of the provider organization in the Region 10 Provider Network.
☐ Probationary Privileges
☐ Limitation of Services Requested
☐ Privileges Revoked or Denied

If privileges are being revoked, denied or the organization is placed on provisional or probationary status, attach a separate document to the application that outlines rationale for decision.

Recommended Term: ___________________ To: ________________________

Credentialing Committee / Designee Signature: _____________________________ Date: ________________

Credentialing Committee / Designee Name Printed: _______________________________________

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