



ORGANIZATION APPLICATION

Network Enrollment Credentialing

Complete as a new organization or when re-applying



Current Privileging Status: Provisional Probationary Full N/A

Current Term (if applicable): _____

Applying For: Provisional Full Re-Privileging

(Term shall be determined by Privileging & Credentialing Committee)

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 Address Physical Address: _____

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

Primary Point of Contact Name: _____ Contact Number: _____

Note: If the organization has multiple locations 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
 - If no, provide written explanation on a separate page.
- This organization is in good standing will all Federal Regulatory bodies: YES NO
 - If no, provide written explanation on a separate page.
- This organization has active Federal or State sanctions: YES NO
 - If yes, provide written explanation on a separate page.
- This organization has active Federal or State Disbarments: YES NO
 - 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)
 - If yes, provide written explanation on a separate page. YES NO
- This organization has been excluded from Medicare/Medicaid participation: YES NO
 - If yes, provide written explanation on a separate page.
- This organization maintains liability insurance: YES NO
 - If yes, provide copy with submission of this application
- I attest that I have completed and attached the Region 10 PIHP Conflict of Interest form: YES NO

If no, please provide explanation: _____

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: _____



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Section V. Provider Services

Indicate the services you are requesting privileges to provide within your organization under subcontract for St. Clair County Community Mental Health Authority within the scope of your practice.

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

A. Mental Health Services – Contracted Provider	
<input type="checkbox"/> ACT – Assertive community Treatment	<input type="checkbox"/> Integrated Dual Disorders (Fidelity Tested)
<input type="checkbox"/> Applied Behavior Analysis	<input type="checkbox"/> Medication Administration
<input type="checkbox"/> Assessment and Evaluation	<input type="checkbox"/> Medication Review
<input type="checkbox"/> Behavioral Management Review	<input type="checkbox"/> Nursing Facility Mental Health Monitoring
<input type="checkbox"/> Child Therapy	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Clubhouse Psychosocial Rehabilitation Program	<input type="checkbox"/> Outpatient Partial Hospitalization
<input type="checkbox"/> Community Psychiatric Inpatient	<input type="checkbox"/> Peer-Directed & Operated Support Services
<input type="checkbox"/> Community Living Supports	<input type="checkbox"/> Personal Care in Specialized Residential Settings
<input type="checkbox"/> Crisis Interventions	<input type="checkbox"/> Personal Emergency Response System (PERS)
<input type="checkbox"/> Crisis Observation Care	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Crisis Residential Services	<input type="checkbox"/> Prevention Services
<input type="checkbox"/> Dialectic Behavior Therapy (Certified Team)	<input type="checkbox"/> Respite Care
<input type="checkbox"/> Electroconvulsive Therapy	<input type="checkbox"/> Skill Building Assistance
<input type="checkbox"/> Enhanced Medical Equipment and Supplies	<input type="checkbox"/> Speech, Hearing, and Language
<input type="checkbox"/> Enhanced Pharmacy	<input type="checkbox"/> Supported Employment
<input type="checkbox"/> Environmental Modifications	<input type="checkbox"/> Supports Coordination
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Targeted Case Management
<input type="checkbox"/> Family Training	<input type="checkbox"/> Transportation
<input type="checkbox"/> Family Training	<input type="checkbox"/> Treatment Planning
<input type="checkbox"/> Fiscal Intermediary	<input type="checkbox"/> Wraparound Facilitation
<input type="checkbox"/> Health Services	<input type="checkbox"/> Telemedicine
<input type="checkbox"/> Home Based Services	
<input type="checkbox"/> Housing Assistance	
<input type="checkbox"/> Individual/Group Therapy	



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B. Habilitation Supports Services	
<input type="checkbox"/> Assistive Technology	<input type="checkbox"/> Out of Home Pre-Vocational Services
<input type="checkbox"/> Community Living Supports	<input type="checkbox"/> Personal Emergency Response System (PERS)
<input type="checkbox"/> Enhanced Medical Equipment and Supplies	<input type="checkbox"/> Private Duty Nursing
<input type="checkbox"/> Enhanced Pharmacy	<input type="checkbox"/> Respite Care
<input type="checkbox"/> Environmental Modifications	<input type="checkbox"/> Supported Employment
<input type="checkbox"/> Family Training	<input type="checkbox"/> Supports Coordination
<input type="checkbox"/> Out of Home Non-Vocational Habilitation	
C. Children's Services	
<input type="checkbox"/> Assessments	<input type="checkbox"/> Home Care Training, Non-Family
<input type="checkbox"/> Behavioral Management Review	<input type="checkbox"/> Individual/Group Therapy
<input type="checkbox"/> Community Living Supports	<input type="checkbox"/> Massage Therapy
<input type="checkbox"/> Environmental Modifications	<input type="checkbox"/> Medication Review
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Family Training	<input type="checkbox"/> Non-Family Training
<input type="checkbox"/> Health Services	<input type="checkbox"/> Respite Care
<input type="checkbox"/> Targeted Case Management	
D. Serious Emotional Disturbance Services	
<input type="checkbox"/> Community Living Supports	<input type="checkbox"/> Child Therapeutic Foster Care
<input type="checkbox"/> Family Home Care Training	<input type="checkbox"/> Therapeutic Overnight Camp
<input type="checkbox"/> Family Support Training	<input type="checkbox"/> Transitional Services
<input type="checkbox"/> Therapeutic Activities	<input type="checkbox"/> Wraparound Services
<input type="checkbox"/> Respite Care	<input type="checkbox"/> Home Care Training – Non-Family
E. Substance Use Disorder Services	
<input type="checkbox"/> Recovery Housing	<input type="checkbox"/> Peer Delivered Services (Recovery Coaching)
<input type="checkbox"/> Early Intervention Services	<input type="checkbox"/> Residential Services
<input type="checkbox"/> Individual Assessment Services	<input type="checkbox"/> Sub – Acute Detoxification Services
<input type="checkbox"/> Medication Assisted Treatment Services	<input type="checkbox"/> Outpatient Care Services
<input type="checkbox"/> Women's Specialty Services*	<input type="checkbox"/> Psychiatric Services
<input type="checkbox"/> Gender Competent Services*	<input type="checkbox"/> Adolescent Treatment Services



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Section VI. Review and Recommendation

This section is to be completed by a SCCCMHA 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 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: _____