SANILAC COUNTY Community Mental Health
Improving Lives Through Healthy Minds
810-648-0330

Network Enrollment and Credentialing
PRACTITIONER APPLICATION

Complete as a new employee, when changing/adding credentials, or when re-credentialing

PRACTITIONER PROFILE

Practitioner Name: _____ Date of Birth: _____
First Middle Last

Former Last Name(s): _____ Hire Date: _____

Supervisor: _____ Title: _____

Business Name: _____

Business Address: _____

Business Phone: _____ Email Address: _____

PRIVILEGING TYPE

☐ Provisional (up to first 180 days) ☐ Full (after provisional) ☐ Additional ☐ Probationary

☐ Re-credentialing (must be completed a minimum of every two years)

CREDENTIALS

☐ N/A (Non-credentialed staff)

(Only list the license(s)/certification(s) you are seeking credentialing for within the provider network)

Degree(s): _____ NPI: _____

Licensure: _____ License #: _____ Expiration Date: _____

Certification: _____ Expiration Date: _____

Certification: _____ Expiration Date: _____

☐ I have completed an SUD Development Plan (Attach Copy) Expiration Date: _____

CULTURAL & ETHNIC SPECIALTIES

List your qualifications for these skills here:

☐ African American _____
☐ Mexican/Latino _____
☐ Veterans _____
☐ Single Parent _____
☐ LGBTQ+ _____
☐ Teens (13-17) _____
☐ Other _____
☐ Other _____

FOREIGN & SIGN LANGUAGE COMPETENCIES (In addition to English)

List your qualifications for these skills here (e.g., some knowledge, number of years studied, fluent, etc.):

☐ Spanish_____
☐ Sign Language _____
☐ Other _____
☐ Other _____

PRIVILEGES

You are expected to keep copies of transcripts, certificates, resume, 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 employee file.

PRIVILEGES REQUESTED – Check all that apply – *I am seeking privileges to perform services as:*

☐	1	Psychiatrist	☐ MD ☐ DO
☐	2	Physician, Non-Psychiatrist	☐ MD ☐ DO
☐	3	Psychologist	☐ LP
☐	4	Psychologist	☐ LLP ☐ TLLP
☐	5	Physician Assistant	☐ PA-C
☐	6	Mental Health/Psychiatric Nurse Practitioner	☐ APRN-BE NHNP ☐ PsychNP
☐	7	Nurse Practitioner	☐ APRN-BC ANP ☐ FNP ☐ PedNP
☐	8	Medical Assistant/DSP	☐ MA
☐	9	Licensed Master's Social Worker	☐ LMSW ☐ LLMSW* *may only provide services under the supervision of a LMSW*
☐	10	Licensed Bachelor's Social Worker	☐ LBSW ☐ LLBSW* *may only provide services under the supervision of a LMSW*
☐	11	Registered Social Services Technician	☐ RSST
☐	12	Limited Registered Social Services Technician	☐ LRSST
☐	13	Master's Degree in Human Services	☐ M.S. or ☐ M.A.
☐	14	Bachelor's Degree in Human Services	☐ B.S. or ☐ B.A.
☐	15	Mental Health Counselor	☐ LPC ☐ LLPC
☐	16	Psychiatric Nurse	☐ MA or ☐ MSN in Psych ☐ RN
☐	17	Registered Nurse, BSN	☐ BSN ☐ RN
☐	18	Registered Nurse	☐ RN
☐	19	Occupational Therapist	☐ OTR
☐	20	Occupational Therapy Assistant	☐ COTA
☐	21	Physical Therapist	☐ PTR
☐	22	Physical Therapy Assistant	☐ PTA
☐	23	Speech Pathologist or Audiologist	☐ SLP
☐	24	Registered Dietician	☐ RD
☐	25	Substance Abuse Treatment Specialist	☐ CADC ☐ CADC-M ☐ CAADC ☐ CCS ☐ CCS-M ☐ CCJP ☐ Development Plan ☐ CCDP ☐ CCDP-D
☐	26	Qualified Mental Health Professional	☐ QMHP
☐	27	Qualified Intellectual Disability Professional	☐ QIDP
☐	28	Certified Peer Support Specialist	☐ CPSS
☐	29	Children's Mental Health Professional	☐ CMHP ☐ CMHP Supervised
☐	30	Family Psycho Education	☐ FPE - Successful Completion of Certified Training
☐	31	Certified Peer Recovery Coach	☐ CRC
☐	32	Certified in SUD Prevention	☐ CPC-R ☐ CPC-M ☐ CPS-R ☐ CPS-M ☐ Development Plan ☐ CHES
☐	33	Gender Competent	Provider Enrollment & Credentialing Policy 01-003-0011
☐	34	Communicable Disease Trainer	HAPIS
☐	35	Parent Management Training – Oregon Model	PMTO
☐	36	Infant Mental Health Certification	IMH
☐	37	Trauma Focused Cognitive Behavioral Therapy	TFCBT
☐	38	Board Certified Behavioral Analyst	BCBA
☐	39	Board Certified Aide Behavioral Analyst	BCaBA
☐	40	Qualified Behavioral Health Professional	QBHP
☐	41	Qualified Behavioral Technician	QBHT
☐	42	Registered Behavioral Technician	RBT
☐	43	Licensed Practical Nurse	LPN
☐	44	Health Mentor	Health Mentor
☐	45	Care Manager Assistant/DSP	Care Manager Assistant
☐	46	Youth Peer Support Specialist	YPSS
☐	47	Parent Support Partner	Parent Support Partner
☐	48	Non-Credentialed (select if no privileges)	Non-Credentialed
☐	49	Specifically Focused Treatment Staff	Focused Staff

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. 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 action 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

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, FQHC, 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 a provision (medical marijuana) or health services or pharmaceuticals? ☐ Yes ☐ No

If the answer is "YES" to any of the above questions, please attach a signed and dated written explanation.
☐ Yes Number of pages _____ ☐ No

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

SKILLS REQUIRING CERTIFICATION:*

		Supervisor Approval
☐ 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
☐ Eye Movement Desensitization Reprocessing (EMDR)	☐ Certificate Attached ☐ Certificate on File	☐ Yes ☐ No
☐ Family Psychoeducation	☐ Certificate Attached ☐ Certificate on File	☐ Yes ☐ No
☐ Integrated Dual Disorder	☐ Certificate Attached ☐ Certificate on File	☐ Yes ☐ No
☐ Trauma Recovery and Empowerment Model (TREM)	☐ Certificate Attached ☐ Certificate on File	☐ Yes ☐ No
☐ Whole Health Action Management (WHAM)	☐ 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.

Supervisor: Approve only those skill areas which indicate expertise to provide clinical treatment in the specialty.

		Supervisor Approval
☐ 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
☐ Assertive Community Treatment (ACT)	☐ 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	☐ Certificate Attached ☐ Certificate on File	☐ Yes ☐ No
☐ Crisis/Lethality	☐ Certificate Attached ☐ Certificate on File	☐ Yes ☐ No
☐ Crisis Professional	☐ Certificate Attached ☐ Certificate on File	☐ Yes ☐ No
☐ Intellectual/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/Bi-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

SKILLS REQUIRING CLINICAL TRAINING:* - continued			**Supervisor Approval**	
☐ Mentally Impaired	☐ Certificate Attached	☐ Certificate on File	☐ Yes	☐ No
☐ Motivational Enhancement Therapy	☐ Certificate Attached	☐ Certificate on File	☐ Yes	☐ No
☐ Motivational Interviewing (MI)	☐ 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
☐ Opposition/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
☐ 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

*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 employee file.

*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.

*For certifications or trainings in any other evidence based practices or promising practices that are not listed above, attach a list or copy of those certifications.

I understand that I am applying to be appointed to provide specialty services within the **Sanilac County Community Mental Health Authority/Region 10 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 Core 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.

Staff Signature: _____ Date: _____

Staff Name: _____
Please Print

Supervisor Signature: _____ Date: _____

Supervisor Name: _____
Please Print

VERIFICATION OF APPLICATION

This application has been verified as complete as submitted, along with all the other documents required per Agency policy, and authorized to validate start and end date.

Start Date:_____

End Date:_____

_____ _____
Verifier Date

CLEAN FILE CHECKLIST FOR PRACTITIONERS

☐ Completed Disclosure of Control/Ownership/Conflict of Interest Attestation

☐ Verified there are no "Yes" answers on the Attestation

☐ Verification of level of education and current licenses/certifications held

☐ Verified the license has not been revoked or suspended

☐ Verified the applicant is not excluded from participating in the Medicaid/Medicare Program (ex: OIG, Sanction Queries)

☐ Verified background checks are clean

☐ Disclosure of any malpractice issues in the last 10 years

☐ Verification of Recipient Rights or Quality of Care process

☐ Children's CPS checks

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

_____ _____

HR Designee Signature Date

_____ _____

Reimbursement Designee Signature Date

☐ All Required Trainings Completed

_____ _____

Training Designee Signature Date

CHAIR/COMMITTEE DETERMINATION

(Completed by Chair/Committee after initial application is submitted)

The Credentialing Committee has reviewed this application enrollment form for credentialing or re-credentialing and recommends:

☐ Provisional (up to first 180 days) ☐ Full (after provisional) ☐ Additional ☐ Probationary

☐ Re-credentialing (must be completed a minimum of every two years)

☐ Does **not** recommend privileging of the practitioner into the Provider Network

Rationale: _____

Start Date: _____ End Date: _____

TARGET POPULATIONS GRANTED:

☐ Children (0 through 3 years)

☐ Children with Intellectual/Developmental Disabilities (4 through 17 years)

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

☐ Children with Substance Use Disorder

☐ Adults with Intellectual/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

_____

Committee Chairperson/Designee Name (Print)

*A designated supervisor is mandatory for TLLPs, LLMSWs, LLBSWs, LLPCs; CMHPs, SATs 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

SUPERVISORY RECOMMENDATIONS

(To be completed by the Supervisor 180 days after the employee's provisional privileges are in effect)

The Employee: *(Check one in each category; conditional or unsatisfactory ratings require explanation)*

1. Work History: review of at least previous five years (or review of full history for those with less than five years' experience) with satisfactory outcome. ☐ Yes ☐ No

   If No, Rationale: _____

2. Adherence to Agency Policies, Rules and Regulations, and Code of Ethics:
   ☐ Satisfactory ☐ Conditional ☐ Unsatisfactory ☐ N/A

   If Unsatisfactory, Rationale: _____

3. Performance Appraisal:
   - Case Record Review:
     ☐ Satisfactory ☐ Conditional ☐ Unsatisfactory ☐ N/A

     If Unsatisfactory, Rationale: _____

   - Employee Evaluation:
     ☐ Satisfactory ☐ Conditional ☐ Unsatisfactory ☐ N/A

     If Unsatisfactory, Rationale: _____

Supervisor Recommendation: ☐ Approve ☐ Disapprove

If Disapprove, Rationale: _____

_____

Supervisor Signature: _____ Date: _____

Supervisor Name: _____
Please Print

CHAIR/COMMITTEE FULL APPROVAL

(Completed for NEW Staff Only after 180 days of hire)

The Credentialing Committee has reviewed this application enrollment form for credentialing or re-credentialing and recommends:

☐ Provisional (up to first 180 days) ☐ Full (after provisional) ☐ Additional ☐ Probationary

☐ Re-credentialing (must be completed a minimum of every two years)

☐ Does **not** recommend privileging of the practitioner into the Provider Network

Rationale: _____

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☐ Children with Substance Use Disorder

☐ Adults with Intellectual/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

_____

Committee Chairperson/Designee Name (Print)

*A designated supervisor is mandatory for TLLPs, LLMSWs, LLBSWs, LLPCs; CMHPs, SATs 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