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

Network Enrollment and Credentialing
ORGANIZATION APPLICATION

Sections I – III:
To be completed by the organizational provider at the time of initial network application for enrollment and credentialing, or at the time of the biennial re-credentialing.

Section IV:
To be completed by the contract manager as applicable.

Section V:
To be completed by the Credentialing Committee as applicable.

Section I:

ORGANIZATION INFORMATION

Organization Name: _____ NPI: _____

DBA {if applicable}: _____

Locations: _____ NPI: _____

Locations: _____ NPI: _____

Locations: _____ NPI: _____

If additional locations are needed, please attach a separate piece of paper.

Primary Mailing Address: _____

Primary Agency Phone: _____ Primary Agency Fax: _____

Contact Person: _____ Title: _____

Email: _____

KEY EXECUTIVE STAFF

Administrator/CEO: _____ Phone: _____

Email: _____

Chief Operating Officer: _____ Phone: _____

Email: _____

Medical Director: _____ Phone: _____

Email: _____

Clinical Program Director: _____ Phone: _____

Email: _____

Recipient Rights Officer: _____ Phone: _____

Email: _____

Section II:

ORGANIZATIONAL PROFILE

Choose One:

☐	For Profit	☐	Not for Profit
☐	Partnership	☐	Government
☐	Limited Liability Company (LLC)	☐	Designated Collaborating Organization (DCO)
☐	Other:		

	ACCREDITATION (Check all that apply)	Start Date	Expiration Date
☐	TJC		
☐	CARF		
☐	COA		
☐	ACHC		
☐	Other:		

Submission of the following Accreditation material is required:

Accreditation Letter
Accreditation Report
Accreditation Correction Action Plan/Status

	MDHHS CERTIFICATION STATUS (Check all that apply)	Start Date	Expiration Date
☐	MDHHS Certification Obtained (Required if not Accredited)		
☐	MDHHS Certification Waived (if Accredited)		
☐	MDHHS Certification Pending		
☐	MDHHS Licensure Obtained (SUD Provider)		
☐	MDHHS Licensed Integrated Treatment Service Provider		
☐	Designated Women's Specialty Services Provider		

Section II:

ORGANIZATIONAL PROFILE – continued

LICENSURE	Type	Prevention/Treatment	Start Date	Expiration Date
Michigan Substance Use Licensure ☐ Yes ☐ No				

Submission of a copy of the current licensure is required.

STATE AND FEDERAL REGULATORY STATUS – AGENCY ATTESTATION:

Good Standing with all **State** Regulatory Bodies	☐ Yes ☐ No If no, please provide written explanation.
Good Standing with all **Federal** Regulatory Bodies	☐ Yes ☐ No If no, please provide written explanation.
Does this Agency currently have any Federal or State Sanctions active?	☐ Yes ☐ No If yes, please provide a written explanation listing any sanctions.
Does this Agency currently have any Federal or State Program Disbarments?	☐ Yes ☐ No If yes, please provide a written explanation listing any disbarments.
Does this organization have ownership or controlling interest in the provider organization?	☐ Yes ☐ No If yes, please provide a written explanation.

If additional documentation is needed, please attach a separate document and indicate above.

ATTESTATION:

The signature below indicates that the statements and indications made in Section I and II are accurate and true.

_____ _____

Organization Legal Representative Name (Print) Title

_____ _____

Organization Legal Representative Signature Date

Section III:

NETWORK ENROLLMENT INFORMATION

AGENCY SERVICE TYPE:

Indicate the service categories you want your Agency to be enrolled and credentialed in under the subcontract for CMHSP/SUD within the scope of your practice.

Check all that apply:

☐	Mental Health Services	☐	Intellectual/Developmental Disability Services	☐	Licensed Substance Use Services
☐	Integrated Treatment Services (MH/SUD)	☐	Other:		

TARGET POPULATIONS:

Indicate what services you are requesting "privileges" to provide within the **Provider Network**, under subcontract for CMHSP/SUD within the scope of your practice.

Check all that apply:

☐	Children Diagnosed with Serious Emotional Disturbance	☐	Children Diagnosed with Substance Use Disorder
☐	Children Diagnosed with Intellectual/Developmental Disability (4 to 17 years)	☐	Adults Diagnosed with Substance Use Disorder
☐	Women with SUD who are pregnant, parenting, or working to regain custody of their children	☐	Infants Diagnosed with Mental Illness (0 to 3 years)
☐	Adults Diagnosed with Mental Illness	☐	Adults Diagnosed with Intellectual/Developmental Disability
☐	Other:		

Section III:

NETWORK ENROLLMENT INFORMATION – continued

PROVIDER NETWORK SERVICES:

Indicate what services you are requesting "privileges" to provide within the Provider Network, under subcontract for CMHSP/SUD within the scope of your practice.

CMHSP: *Please indicate all items that apply within Boxes A-D only.*

SUD: *Please indicate all items that apply within Box E only.*

A. Mental Health – State Plan/1915(i)SPA Services	
☐ ACT – Assertive Community Treatment	☐ Inpatient Psychiatric Hospital – State Facility
☐ Assessment and Evaluation	☐ Integrated Dual Disorders (Fidelity Tested)
☐ Behavioral Management Review	☐ Medication Administration
☐ Child Therapy	☐ Medication Review
☐ Clubhouse Psychosocial Rehabilitation	☐ Nursing Facility Mental Health Monitoring
☐ Community Psychiatric Inpatient	☐ Occupational Therapy
☐ Community Living Supports	☐ Outpatient Partial Hospitalization
☐ Crisis Intervention	☐ Peer-Directed and Operated Support Services
☐ Crisis Observation Care	☐ Personal Care in Specialized Residential
☐ Crisis Residential Services	☐ Personal Emergency Response System
☐ Dialectic Behavioral 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	☐ Transportation
☐ Home Based Services	☐ Treatment Planning
☐ Housing Assistance	☐ Wraparound Facilitation
☐ Individual/Group Therapy	☐ Telemedicine

Section III:

NETWORK ENROLLMENT INFORMATION – continued

B. Habilitation Supports Waiver Services	
☐ Assistive Technology	☐ Out of Home Pre-Vocational Services
☐ Community Living Supports	☐ Personal Emergency Response System
☐ 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 Waiver 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 Waiver 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

Section III:

NETWORK ENROLLMENT INFORMATION – continued

E. Substance Use Disorder – State Plan/1915(i)SPA Services	
☐ Women's Specialty Services	☐ Peer Delivered Services (Recovery Coaches)
☐ Early Intervention Services	☐ Residential Services
☐ Individual Assessment Services	☐ Sub-Acute Detoxification Services
☐ Medication Assessment Services	☐ Outpatient Care Services

By signing below, you attest that your agency has met all the State, Federal and PIHP requirements to be considered the above.

_____ _____

Organization Representative Signature Date

Section IV:

REVIEW AND RECOMMENDATION

This section is to be reviewed and completed by a Contract Manager or Designee.

I have reviewed the above statements and submitted documents, including a due diligence review of the organization relative to Section II and find the statements to be true and accurate. ☐ Yes ☐ No

Please list any concerns:

If additional space is needed, please attach a separate document and indicate above.

Please indicate below for the recommendation/non-recommendation for enrollment/re-enrollment and credentialing/re-credentialing of this organization into the Provider Network.

☐ Recommended ☐ Not Recommended

_____ _____

Contract Manager/Designee Signature Date

_____

Contract Manager/Designee Name (Print)

VERIFICATION SIGNATURE

Completed by designated staff authorized to validate start and end date.

Start Date: _____

End Date: _____

_____ _____

Verifier Signature Date

Section V:

CREDENTIALING COMMITTEE REVIEW AND ATTESTATION

This section is to be completed by the Credentialing Committee as applicable.

CREDENTIALING COMMITTEE RECOMMENDATION

PROVIDER NETWORK SERVICES

Upon review of the provider application, the Credentialing Committee recommends:

☐ Credentialing of the provider organization into the Provider Network for all privileges specified.

Credentialing Term: _____ to _____

☐ Provisionally recommends credentialing of the provider organization into the Provider Network.

Credentialing Term: _____ to _____

☐ Network Credentials Revoked

Provide Rationale for Recommendation:

If additional space is needed, please attach a separate document and indicate above.

Section V:

CREDENTIALING COMMITTEE REVIEW AND ATTESTATION - continued

CLEAN FILE CHECKLIST FOR ORGANIZATIONS (ALL ARE REQUIRED)

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

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

☐ Verification of the organization's licensing status. Were there any violations or investigations in the last 5 years?

☐ Verified accreditations held by the organization

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

☐ Disclosure of any malpractice issues in the last 10 years

☐ Verification of Recipient Rights or Quality of Care process

☐ Children's CPS checks

Comments:

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

_____ _____

Committee Chairperson/Designee Signature Date

_____

Committee Chairperson/Designee Name (Print)