

Applicant Credentialing Checklist

(This checklist is to assist you in the application process. You do not have to include this checklist in the materials you send for your application.)

- Completed, signed Credentialing Application
- Clinical Responsibilities (privileges) and Populations of Consumers selected. *(located on the credentialing application)*
- Current Resume of Curriculum Vitae
- Degree verification/Transcript *(Sent to WCHO from original source)*
- Professional Liability Insurance
- Names and addresses of (2) professional references, preferably of same discipline as yourself. *(This information may be E-mailed or faxed to the WCHO)*
- Department of Human Services (formerly FIA) – Central Registry Check *(Refer to the instructions that accompany the form)*

All the above items must be received to initiate the credentialing process.

Information should be sent to:

WCHO Provider Relations Unit
555 Towner Boulevard
Ypsilanti, MI 48197
Phone: (734) 544-3000
Fax: (734) 544-6732



CREDENTIALING APPLICATION
for Individual Contractors/Licensed Independent Practitioners
Medical Professionals (doctors, nurses)

1. **Today's Date:** _____

2. **Name:** _____
Last First M.I.

3. **Name as appears on professional license, certification, etc., if different from above:**

Last First M.I.

4. **List any other names used:** _____

5. **Date of Birth:** _____
6. **Social Security Number** _____
National Provider ID Number _____

7. **Office Contact Information:**
Address: _____

Phone: _____ Fax: _____
Email Address: _____ Tax ID #: _____

8. **Home Address and Telephone Number:**

9. **Pager Telephone Number (if applicable):**

- 10. Professional Discipline:**
- M.D.
 - Psychiatry
 - Nurse Practitioner
 - Physician's Assistant
 - Registered Nurse

- 11. Service Location:**
Generally, community mental health services are provided at a CMH site or in a consumer's home. If you will be providing services to community mental health clients at your own office/site, please indicate by checking here:
- I intend to provide services to CMH clients at my office/site

- 12. Service Area:**
The Community Mental Health Partnership of Southeast Michigan (CMHPSM) is an affiliation of mental health service providers who are under contract to the State of Michigan Department of Community Health. The CMHPSM encompasses Washtenaw County, Monroe County, Livingston County, and Lenawee County. You may apply for clinical responsibilities in any or all of these counties. Each local Board will grant clinical responsibilities and issue a contract.

Please indicate in which County(ies) you would be willing to work:

- Washtenaw Monroe Livingston Lenawee

- 13. Professional Work Experience. Complete for the past 5 years; include current position(s) and/or appointment(s)- list most recent first. OR attach current resume / curriculum vitae.**

(1) Employer/Organization name/address/phone: _____

Position/Duties/Privileges granted: _____

Dates to/from: _____

(2) Employer/Organization name/address/phone: _____

Position/Duties/Privileges granted: _____

Dates to/from: _____

(3) Employer/Organization name/address/phone: _____

Position/Duties/Privileges granted: _____

Dates to/from: _____

14. List any internships, residencies, fellowships, or postdoctoral training (as applicable):

Notice: Verification of residency completion will be obtained from the AMA Physician Profile Service.

15. Terminal Degree (for MA and MS degrees, please state what field the degree is in):

- M.D. D.O.
- Ph.D. M.A. _____
- B.S.N. M.S. _____
- Associate Degree in Nursing Nursing Diploma
- Other: _____

16. Education {Terminal Degree(s) Only}:

Institution, City, State	Dates Attended	Degree Awarded

Notice:
M.D.'s, D.O.'s, & PA's – Verification of degree and Board Certification, if applicable, will be obtained from the AMA Physician Profile Service or the Education Commission for Foreign Medical Graduates.

All others – Please make arrangements for written verification of degree to be sent DIRECTLY from awarding institution to:
 Provider Relations Unit, Washtenaw Community Health Organization
 555 Towner Boulevard, Ypsilanti, MI 48197

17. Years of Experience Post Terminal Degree: _____

18. Current Professional Licenses (please indicate state):

- M.D. _____ D.O. _____
- Registered Professional Nurse _____ Nurse Practitioner _____
- Physician's Assistant _____ Certified Nurse Specialist _____

For nurse specialists, indicate specialty: _____

Notice: Verification of the above licensure will be obtained from the State of Michigan

19. For M.D.s & D.O.s only:

DEA Registration No. _____ Effective Dates _____
 Board Eligible in _____
 Board Certified in _____

20. List any memberships in professional organizations/societies and status:

21. Other than English, in which languages are you fluent?

French Spanish German Chinese Japanese ASL
 Other: _____

22. Areas of Special Expertise (based on training, special certificates and/or supervised clinical experience). Check all that apply:

- | | | |
|--|--|---|
| 1 <input type="checkbox"/> ADHD | 17 <input type="checkbox"/> dialectical behavior therapy | 33 <input type="checkbox"/> homelessness |
| 2 <input type="checkbox"/> adolescent beh disorders | 18 <input type="checkbox"/> dissociative identity dis. | 34 <input type="checkbox"/> incarceration |
| 3 <input type="checkbox"/> adolescent sex offenders | 19 <input type="checkbox"/> domestic violence (perp.) | 35 <input type="checkbox"/> marital/divorce/sep. |
| 4 <input type="checkbox"/> adoption/foster care | 20 <input type="checkbox"/> domestic violence (victim) | 36 <input type="checkbox"/> men's issues |
| 5 <input type="checkbox"/> adult sex offenders | 21 <input type="checkbox"/> dual dx (MI/DD) | 37 <input type="checkbox"/> military lifestyle |
| 6 <input type="checkbox"/> alcohol/co-dependency | 22 <input type="checkbox"/> early childhood (<7yrs.) | 38 <input type="checkbox"/> panic/phobias |
| 7 <input type="checkbox"/> biofeedback | 23 <input type="checkbox"/> eating disorders | 39 <input type="checkbox"/> physically disabled |
| 8 <input type="checkbox"/> borderline personality | 24 <input type="checkbox"/> ethnic/cultural issues | 40 <input type="checkbox"/> posttraumatic stress |
| 9 <input type="checkbox"/> brain injuries | 25 <input type="checkbox"/> family therapy | 41 <input type="checkbox"/> psychological testing |
| 10 <input type="checkbox"/> child abuse victims | 26 <input type="checkbox"/> fetal alcohol syndrome | 42 <input type="checkbox"/> religious-based ther. |
| 11 <input type="checkbox"/> chronic/terminal illness | 27 <input type="checkbox"/> forensics | 43 <input type="checkbox"/> schizophrenia |
| 12 <input type="checkbox"/> chronic pain | 28 <input type="checkbox"/> gay/lesbian/bisexual | 44 <input type="checkbox"/> sexual dysfunction |
| 13 <input type="checkbox"/> cognitive behavioral ther. | 29 <input type="checkbox"/> geriatric | 45 <input type="checkbox"/> spirituality |
| 14 <input type="checkbox"/> crisis/trauma | 30 <input type="checkbox"/> grief/bereavement | 46 <input type="checkbox"/> step/blended families |
| 15 <input type="checkbox"/> critical incid. debriefing | 31 <input type="checkbox"/> hearing impaired | 47 <input type="checkbox"/> women's issues |
| 16 <input type="checkbox"/> dementia | 32 <input type="checkbox"/> home based services | |

other: _____

Please provide any supporting information (or attached documentation) for items checked above that would be helpful in considering your application.

23. **Do you have employment experience working with individuals with developmental disabilities?**

Yes No

If yes, describe your experience: _____

Number of years you have worked with this population: _____

24. **Do you have employment experience working with individuals with severe and persistent mental illness?**

Yes No

If yes, describe your experience: _____

Number of years you have worked with this population: _____

25. **Do you have employment experience in the examination, evaluation, and treatment of minors and their families?**

Yes No

If yes, describe your experience: _____

Number of years doing so: _____

26. **Current Malpractice/Professional Liability Coverage:**

Carrier Name: _____

Mailing Address: _____

Policy Number: _____

Coverage Effective Dates: _____

<p>Notice: Please make arrangements for written verification of insurance coverage to be sent or faxed DIRECTLY from carrier to: Provider Relations Unit, Washtenaw Community Health Organization 555 Towner Boulevard, Ypsilanti, MI 48197 Fax (734) 544-6732</p>

27. **Malpractice Carriers for the Past 5 years:**

Carrier Name: _____

Mailing Address: _____

Carrier Name: _____

Mailing Address: _____

28. If any of the following questions are answered yes, please explain fully on a separate page:

Is your health status (physical, mental or emotional) such that it may impair your ability to render professional services? yes no

Do you currently use illegal drugs or abuse drugs or alcohol? yes no

Have you ever had your license/registration/certification revoked, suspended, placed on probation, conditional status or limited? yes no

Is any action currently pending to revoke, suspend or limit any of your licenses/registrations/certifications? yes no

Have you ever voluntarily surrendered any license, certification or registration? yes no

Has your DEA registration ever been revoked, suspended, placed on probation, conditional status or limited? yes no

Have any malpractice claims ever been filed against you or are any currently pending? yes no

Have any malpractice allegations involving your work been settled by you or your carrier prior to the filing of a claim? yes no

Have you ever had malpractice or liability insurance denied, cancelled, or not renewed? yes no

Have you ever been denied privileges/clinical responsibilities by another healthcare organization or facility? yes no

Have your privileges/clinical responsibilities ever been revoked, suspended limited or not renewed by another healthcare organization or facility? yes no

Have you ever been dismissed from the staff of another healthcare organization or facility? yes no

Have you ever had your membership in a professional organization, society or association terminated, cancelled, suspended or denied renewal? yes no

Have you been subject to any disciplinary proceedings by any local, state, or national professional organization? yes no

Have you ever been fined, had an arrangement suspended, been expelled from participation, or had criminal charges brought against you by Medicaid or Medicare? yes no

Have you ever been convicted of a felony or involved in charges relating

to moral or ethical turpitude? yes no

Have you ever been named as a defendant in a criminal proceeding? yes no

Have any Recipient Rights violations related to Abuse or Neglect ever been substantiated against you? yes no

Have you ever been suspended during a Recipient Rights investigation? yes no

29. Adverse Legal Actions and Overpayments (Medicare)

This section is to be completed with information concerning any adverse legal actions and/or overpayments that have been imposed or levied against this supplier (see Attachment B for a list of adverse actions that must be reported).

Have you, under any current or former name or business identity, ever had any of the adverse legal actions listed in Attachment B imposed against you? yes no

IF YES, attach a separate page to report each adverse legal action, when it occurred, the law enforcement authority/court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Do you, under any current or former name or business identity, have any outstanding Medicare overpayments? yes no

IF YES, furnish the name and account number under which the overpayment(s) exists.

30. Clinical Responsibilities Available to Licensed Independent Practitioners:

(Please check the populations for which you are requesting approval. Refer to Attachment A for required competencies.)

Discipline: Psychiatrist (203BP0005X)

Clinical Responsibilities:

- Psychiatric Evaluation
- Medication Review
- Treatment Planning
- Medication Administration
- Crisis Intervention/
Hospital Screening

Population:

- Children w/ developmental disability
- Adults w/ developmental disability
- Children w/ serious emotional disturbance
- Adults w/ serious and persistent mental illness
- Older adults w/ serious, persistent mental illness
- Co-occurring disorders: substance abuse and mental illness
- OBRA—individuals w/ mental illness
- OBRA—individuals w/ developmental disability

Discipline: Physician’s Assistant (363A00000X)

Clinical Responsibilities:

- Psychiatric Evaluation

Population:

- Children w/ developmental disability

- | | |
|--|---|
| Medication Review | <input type="checkbox"/> Adults w/ developmental disability |
| Treatment Planning | <input type="checkbox"/> Children w/ serious emotional disturbance |
| Medication Administration | <input type="checkbox"/> Adults w/ serious and persistent mental illness |
| Crisis Intervention/
Hospital Screening | <input type="checkbox"/> Older adults w/ serious, persistent mental illness |
| | <input type="checkbox"/> Co-occurring disorders: substance abuse and mental illness |
| | <input type="checkbox"/> OBRA–individuals w/ mental illness |
| | <input type="checkbox"/> OBRA–individuals w/ developmental disability |

Discipline: Certified Nurse Practitioner (363L00000X)

Clinical Responsibilities:

- Psychiatric Evaluation
- Medication Review
- Treatment Planning
- Medication Administration
- Crisis Intervention/
Hospital Screening
- Individual Therapy
- Group Therapy
- Family Therapy

Population:

- Children w/ developmental disability
- Adults w/ developmental disability
- Children w/ serious emotional disturbance
- Adults w/ serious and persistent mental illness
- Older adults w/ serious, persistent mental illness
- Co-occurring disorders: substance abuse and mental illness

All responsibilities above, **EXCEPT:** _____

Discipline: Registered Nurse (163W00000X)

Clinical Responsibilities:

- Specialized Nursing Services
- Treatment planning

Population:

- Children w/ developmental disability
- Adults w/ developmental disability
- Children w/ serious emotional disturbance
- Adults w/ serious and persistent mental illness
- Older adults w/ serious, persistent mental illness
- Co-occurring disorders: substance abuse and mental illness
- OBRA–individuals w/ mental illness
- OBRA–individuals w/ developmental disability

Your signature on this application indicates your intent to be granted clinical responsibilities (privileges) in areas in which you are currently competent and able to perform the responsibilities requested and the duties of this position. You are consenting to have any necessary outside primary source verification and relevant records/documents reviewed which are pertinent to this application, and you are consenting to a national background check. In addition, you attest that you understand and accept the terms of Request for Proposal #6193 and that all of the above information you have provided is accurate and complete.

Signature

Date

Attachment A

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN *Population-Specific Competencies*

Below are areas of expected knowledge/competency for each population requested. If you need additional information in any area, please notify the agency issuing a contract at the time the contract is signed.

Children with a developmental disability:

- Childhood and adolescent development
- Conditions/syndromes associated with developmental disabilities
- Resources and supports available to persons with DD and their families
- Special education/school system

Adults with developmental disability:

- Human development across the lifespan
- Conditions/syndromes associated with developmental disabilities
- Resources and supports available to persons with DD and their families
- Special education/school system

Children with serious emotional disturbance:

- Childhood and adolescent development
- Emotional disorders/mental illnesses of childhood and adolescence
- Family dynamics
- Parenting skills/strategies
- Human service system for children (courts, schools, special ed, child welfare, etc)
- Special education/school system

Adults with serious & persistent mental illness:

- Signs and symptoms of major mental illness
- Acute symptoms of mental illness
- Medications used to treat symptoms of mental illness, and their common side effects
- Community supports/resources for persons with serious persistent mental illness (SPMI) and their families
- The recovery model

Older adults with serious & persistent mental illness:

- Basic knowledge of geriatrics/aging
- Mental illness unique to the elderly population
- Intersection of medical and mental illness in older adults
- Medication issues/concerns unique to older adults with SPMI
- Community resources available to older adults with SPMI and their families
- The recovery model

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
Population-Specific Competencies (continued)

Co-occurring diagnosis: mental illness and substance abuse:

- Theories of addiction
- Signs and symptoms of substance abuse
- Signs and symptoms of major mental illness
- Issues unique to co-occurring mental illness and substance abuse
- Medications used to treat symptoms of mental illness, and their common side effects and interaction with street drugs/alcohol
- Community resources and supports available to persons with mental illness and substance abuse and their families

Attachment B

Adverse Legal Actions as Defined by Medicare

- 1) Any felony or misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- 2) Any felony or misdemeanor conviction, under Federal or State law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- 3) Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- 4) Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
- 5) Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
- 6) Any revocation or suspension of accreditation.
- 7) Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
- 8) Any current Medicare payment suspension under any Medicare billing number.

NOTE: All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Community Mental Health Partnership of Southeast Michigan

Professional Reference Request Form

The Washtenaw Community Health Organization must obtain professional references from you as part of the credentialing/recredentialing process for the Community Mental Health Partnership of Southeast Michigan. Please provide the WCHO with the names and addresses of two professional references, preferably individuals in your discipline. The WCHO will send these individuals our reference form, to be completed and returned directly to WCHO.

In order to expedite this step of the credentialing/recredentialing process, you may phone, fax, or email this information to us.

APPLICANT NAME: _____

References:

1. _____
Name

Address

City, State Zip

Email Address

2. _____
Name

Address

City, State Zip

Email Address

Return to: Provider Relations Unit
Washtenaw Community Health Organization
Phone: (734) 544-3000
Fax: (734) 544-6732
Email: wchopru@ewashtenaw.org

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN

Procedure to obtain DHS (formerly FIA) Central Registry Clearance:

1. Complete and sign the attached form:
REQUEST FOR CENTRAL REGISTRY CLEARANCE, DHS-194
2. You must include a stamped, self-addressed envelope so DHS (Department of Human Services) can return your clearance information to you.
3. Photocopy your picture ID (ex: driver's license) onto the request form to facilitate the process at the DHS office.
4. The clearance request must be submitted in person at your local DHS (formerly Family Independence Agency) office. It cannot be mailed.
5. If your local DHS has a "Reception, Mail Only" drop-box, you can staple the stamped, self-addressed envelope to the completed form and simply deposit them in the drop-box. Otherwise, someone at DHS will receive your form and the self-addressed envelope.
6. It may take up to two weeks for you to receive your clearance in the mail from DHS.
7. Once you receive it, please submit the original clearance to:

**Provider Relations Unit
Washtenaw Community Health Organization
555 Towner Boulevard
Ypsilanti, MI 48197**