**Community Mental Health Partnership of Southeast Michigan**

# Applicant Re-Credentialing Checklist

- ☐ Completed, signed Re-Credentialing Application
- ☐ Clinical Responsibilities (privileges) and Populations of Consumers selected. *(located on the re-credentialing application)*
- ☐ Degree verification *(Sent to WCHO from original source– <u>ONLY</u> if new Degree*)
- ☐ Continuing Education transcript(s)
- ☐ DEA Certificate (if applicable)
- ☐ Professional Liability Insurance *(Sent to WCHO from original source)*
- ☐ Family Independence Agency (FIA) – Central Registry Check
  *(Refer to attached instructions)*

## As stated in the attached cover letter, all the above items must be received by the Washtenaw Community Health Organization (WCHO) to initiate the re-credentialing process.

**Return information to**:

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

# RE-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 are providing services to community mental health clients at your own office/site, please indicate by checking here: ☐ I 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. Please update <u>for the past 2 years</u>; 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 in last 2 years:**

___________________________________________________________________________

___________________________________________________________________________

**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:** Have you obtained an additional degree in the last 2 years (since your last application)?
☐ Yes ☐ No If yes, complete below:

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

☐ 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: ______________________________

**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

**27. Malpractice Carriers for the Past 2 Years:**

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:** | **Population:** |
|---|---|
| Psychiatric Evaluation | ☐ Children w/ developmental disability |
| Medication Review | ☐ Adults w/ developmental disability |
| Treatment Planning | ☐ Children w/ serious emotional disturbance |
| Medication Administration | ☐ Adults w/ serious and persistent mental illness |
| Crisis Intervention/ | ☐ Older adults w/ serious, persistent mental illness |
| Hospital Screening | ☐ 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:** | **Population:** |
|---|---|
| Psychiatric Evaluation | ☐ Children w/ developmental disability |
| Medication Review | ☐ Adults w/ developmental disability |
| Treatment Planning | ☐ Children w/ serious emotional disturbance |
| Medication Administration | ☐ Adults w/ serious and persistent mental illness |
| Crisis Intervention/ | ☐ Older adults w/ serious, persistent mental illness |
| Hospital Screening | ☐ Co-occurring disorders: substance abuse and mental illness |
| | ☐ OBRA–individuals w/ mental illness |

☐ 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

**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, <u>regardless</u> of whether any records were expunged or any appeals are pending.**

**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**