EXHIBIT A

CMHPSM Organizational Credentialing/Re-credentialing Application Instructions

Overview

The CMHPSM credentialing/re-credentialing form is to be used for initially applying to become a CMHPSM Mental Health provider, as well as on a semi-annual basis to meet the re-credentialing standards. Providers must retain credentialed status to be eligible to contract with any of the CMHSP's within the CMHPSM region. Providers will receive written documentation related to their application submission acceptance or denial. This application may be updated from time to time, and the most recent version must always be used when applying or re-applying. Providers must remain cognizant of their credentialed term and re-apply prior to that term expiring to remain eligible to contract with the CMHSPs.

Acceptance to the CMHPSM provider network means your organization has been deemed eligible to contract with the CMHSPs during the credentialed term. Acceptance to the CMHPSM network **does not** guarantee a service contract will be issued by any or all of the CMHSPs within the CMHPSM region. **Please review the current CMHPSM Organizational Credentialing Policy for further guidance.**

The following is for CMHPSM/CMHSP use, do not type in this box:

This section for CMHSP or CMHPSM use only:					
Application Reviewer:				Review Date:	
Application Approved:	Yes: ☐ No: ☐	Term Start:		Term End:	
Reviewer Organization:			EHR Upload Date:		

Application will be returned with status information if it is not approved or if more information is needed.
Re-credentialing applications need to be approved prior to the expiration of the previous application term.

Section 1:

- The application is a point in time review of organizational requirements as of the application date identified in this section. Contractually required documentation must be kept current at all times during the contract and will also need to be submitted in between credentialing application submissions (i.e. Accreditation, Insurance, and Debarment Status).
- Select the CMHSP your organization is submitting this application to within the CMHPSM region. The CMHPSM is offering reciprocity across the region related to credentialing applications so the application should be submitted to only one of the regional partners. Providers credentialed in any of the region's CMHSP's will become a part of the regional CMHPSM Provider Network.
- Include contact information for the staff person that the CMHPSM or CMHSP can contact regarding questions related to the application.
- Select the service panel(s) and populations your organization is requesting to be made eligible to serve as a mental health provider. Please list any services your organization provides that aren't on our list of services. Your organization can expand beyond the services or consumer populations initially selected.
    - MI Adult- Adult with Mental Illness
    - Older Adult w/ SPMI- Adult with Serious and Persistent Mental Illness
    - DD Adult- Developmentally Disabled Adult
    - DD Child- Developmentally Disabled Child

- SED Child- Child with Severe Emotional Disturbance
- Co-occuring SUD/MI: Individual with Substance Use Disorder and Mental Illness

Section 2:

- Please complete all organizational information wherever applicable
- Complete all administrative, board of directors and individuals with ownership in the organization as of the application date.
- Provide a detailed explanation on a separate word document related to any and all questions that required a yes related to the last table in section 2.

Section 3:

- Please document your organization's current accreditation status:
  - TJC/JCAHO – The Joint Commission
  - CARF- Commission on Accreditation of Rehabilitation Facilities
  - COA- Council on Accreditation
  - NCQA- National Committee for Quality Assurance
  - Other: Please list your accrediting body, all other accreditations will be reviewed to ensure the standards match CMHPSM requirements.
- Accreditation documentation should be submitted in pdf format.
- Please document your current insurance, and identify the types that are submitted in pdf format.
- No documentation is needed related to expertise, specialized training or certifications.
- Hours of service choose the second row if your organization provides service 24 hours per day/7 days per week, choose the first row if your organization provides services other than 24/7 and identify the days/hours available for service.
- Please list any linguistic capacity your organization currently has, no documentation is required for this informational section.
- Please list any special certifications your organization feels is relevant to this application (The text box expands as you type)
- Provide 3-5 references to agencies your organization contracts with for mental health services.

Section 4

- Backup or more extensive documentation may be requested on a sample of employees during the credentialing period, upon site visits or desk audits.
- Please identify the staff the CMHPSM would contact related to the information entered into this section.
- Contact the local CMHSP you are submitting the application to if you have any questions related to the required trainings. CMHSPs may have additional training requirements or a preferred documentation method.

Section 5

- Please read and attest to the disclaimer and have the designated representative sign the document. According to the ESIGN Act of 2000 the designated representative can sign the

document by typing his or her name into the signature box

Attestation of Organization CEO or Designated Representative			
Signature:			
Enter Title:		Enter Date:	

Completing the application

- The application must be completed using Microsoft Word or equivalent. No handwritten applications will be accepted. An electronic signature is preferred when submitting, the document could also be printed and traditionally signed and scanned to pdf format and submitted.

EXHIBIT A

This section for CMHSP or CMHPSM use only:					
Application Reviewer:				Review Date:	
Application Approved:	Yes: ☐ No: ☐	Term Start:		Term End:	
Reviewer Organization:			EHR Upload Date:		

Application will be returned with status information if it is not approved or if more information is needed.
Re-credentialing applications need to be approved prior to the expiration of the previous application term.

Community Mental Health Partnership of southeast michigan

Community Mental Health Partnership of Southeast Michigan

Mental Health Service Provider Network
Initial Application / Re-Credentialing Application

Application Revised: 5/1/2014

SECTION 1: APPLICATION INFORMATION

Application (Please select one):				Application Date:
Initial Application:	☐	Re-Credentialing Application:	☐	

Application submitted to the following CMHSP within the CMHPSM Region:							
Lenawee	☐	Livingston	☐	Monroe	☐	Washtenaw	☐

Staff Responsible for Completing this Application:		
Name	Email	Phone

Service Panels	MI Adult	Older Adult w/ SPMI	DD Adult	DD Child	SED Child	Co-Occurring: SUD/MI
Agency With Choice Services	☐	☐	☐	☐	☐	☐
Applied Behavioral Analyst Services	☐	☐	☐	☐	☐	☐
Art Therapy	☐	☐	☐	☐	☐	☐
Case Management	☐	☐	☐	☐	☐	☐
Crisis Residential	☐	☐	☐	☐	☐	☐
Fiscal Intermediary Services	☐	☐	☐	☐	☐	☐
Home Based	☐	☐	☐	☐	☐	☐
Licensed Residential Supports	☐	☐	☐	☐	☐	☐
Occupational Therapy	☐	☐	☐	☐	☐	☐
Outpatient Mental Health Services	☐	☐	☐	☐	☐	☐

Peer Delivered or Operated Services	☐	☐	☐	☐	☐	☐
Psychiatrist	☐	☐	☐	☐	☐	☐
Psychologist	☐	☐	☐	☐	☐	☐
Psycho-Social Rehabilitation	☐	☐	☐	☐	☐	☐
Recreation Therapy	☐	☐	☐	☐	☐	☐
Registered Dietician	☐	☐	☐	☐	☐	☐
Registered Nurse	☐	☐	☐	☐	☐	☐
Respite	☐	☐	☐	☐	☐	☐
Respite Camp Services	☐	☐	☐	☐	☐	☐
Skill Building	☐	☐	☐	☐	☐	☐
Speech Language Pathologist	☐	☐	☐	☐	☐	☐
Supported Employment	☐	☐	☐	☐	☐	☐
Unlicensed Comm. Living Supports	☐	☐	☐	☐	☐	☐
Wrap Around Services	☐	☐	☐	☐	☐	☐
Any Other Unlisted Services:	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

SECTION 2: ORGANIZATIONAL INFORMATION

Organization (Complete Billing address only if different than mailing address):			
Legal Name:		**DBA (if different):**	
Address:		**City:**	
State:		**Zip Code (ZIP +4):**	
Main Phone:		**Main Fax:**	
Billing Add.:		**Billing City:**	
Billing State:		**Billing (ZIP + 4)**	

Organization Type:				**Organizational Identification Numbers**	
Governmental Entity:	☐	**Corporation:**	☐	**Tax ID:**	
Private Non-Profit:	☐	**Partnership:**	☐	**Medicaid #:**	
Privately Owned:	☐	**LLC/LLP:**	☐	**Medicare #:**	
Other (Describe):			☐	**NPI #:**	

Administrative Information (Please fill out as applicable to your organization):		
Position	**Name**	**E-Mail or Phone#**
CEO/Executive Director:		
Chief Medical Officer:		
Chief Clinical Manager:		
Recipient Rights Contact:		
Claims Contact:		
Contracts Contact:		

Compliance/HIPAA Officer:		
Primary Contact:		
Secondary Contact:		

Please list your organizations board of directors as of this application date:		
Last Name	**First Name**	**Term Expires**
Notes/Additional Space if more than 12 members:		

If applicable, please list all individuals with an ownership stake in your organization of 5% or greater:		
Last Name	**First Name**	**% Ownership**
Notes/Additional Space if more than five individuals:		

Within the five years preceding the application date, has the organization:	**Yes**	**No**	**N/A**
Had a state license or certification revoked?	☐	☐	☐
Had its accreditation revoked, suspended or limited?	☐	☐	☐
Had any other license, certification or accreditation revoked?	☐	☐	☐
Had any sanctions imposed by Medicaid or Medicare?	☐	☐	
Had professional liability insurance canceled, or denied for renewal?	☐	☐	
Had any malpractice claims related to mental health services?	☐	☐	
Organization has been a defendant in a mental health services lawsuit, where an award or settlement exceeded $50,000.00.	☐	☐	
Has the organization's leadership, board of directors, or owners (if applicable) been listed on any federal or state exclusion or debarment list.	☐	☐	
Does the organization have any pending actions related to any of the above that have yet to be settled or finalized?	☐	☐	☐
For any questions in which a "Yes" was indicated please provide a detailed accounting of the incident or incidents and the current status of any situations.			

SECTION 3. PROVIDER CONTRACTUAL REQUIREMENTS

Provider Accreditation:		
Accreditation Type:	**Select:**	**Expiration Date:**
TJC/JCAHO:	☐	
CARF:	☐	
COA:	☐	
NCQA:	☐	
Other:	☐	
Request accreditation waiver, (may serve no more than six consumers concurrently per CMHPSM policy):	☐	
Please attach your organizations accreditation documentation to this application.		

The following insurances are required for paneled providers:		
Type:	**Notes:**	**Check box if Attached:**
Commercial General	Minimum $1,000,000.00 combined limit per occurrence/claim.	☐
Professional Liability	Minimum $1,000,000.00 combined limit per occurrence/claim.	☐
Workers Disability Compensation	If provider is an employer, if provider is not an employer please attach written assertion of such.	☐
Motor Vehicle Liability	If provider transports consumers, $1,000,000.00 per occurrence combined single limit Bodily Injury and Property Damage.	☐
Please attach documentation of required provider insurances to this application.		

Provider has expertise, specialized training, or certifications in any of the following: (Please check all that apply)			
Adjustment Disorders	☐	Motor Skill Disorders	☐
Anxiety Disorders	☐	P.M.T.O.	☐
Applied Behavioral Analysis	☐	Personality Disorders	☐
Attention & Disruptive Behavior Disorders	☐	Physical/ Sexual Abuse	☐
Communication Disorders	☐	Schizophrenia & other Psychotic Disorders	☐
D.B.T.	☐	Sexual & Gender Identity Disorders	☐
Delirium, Dementia & Other Cognitive Disorders	☐	Sleep Disorders	☐
Developmental Disabilities	☐	Somatoform Disorders	☐
Dissociative Disorders	☐	Speech Impaired Consumers	☐
Eating Disorders	☐	Substance Abuse Related Disorders	☐
Elimination Disorders	☐	Tic Disorders	☐
Factitious Disorders	☐	Visually Impaired Consumers	☐
Hearing Impaired Consumers	☐	Other(s): (Please List below)	
Impulse-Control Disorders	☐		☐
Learning Disorders	☐		☐

Mental Disorders due to General Medical Condition	☐		☐
Mood Disorders	☐		☐
Motivational Interviewing	☐		☐

Hours of Service Availability (Identify availability or indicate 24 hours/7 days per week)								
Choose:		**SUN**	**MON**	**TUE**	**WED**	**THU**	**FRI**	**SAT**
☐	**BEGIN:**							
	END:							
☐	**24 HOUR**	24 HR	24 HR	24 HR	24 HR	24 HR	24 HR	24 HR

Organizational Linguistic Capacity		
Available:		Number of staff fluent or brief explanation of service capacity:
Spanish	☐	
French	☐	
Arabic	☐	
American Sign Language	☐	
Others (Please List)		
	☐	
	☐	
	☐	
	☐	

Special Certifications
Please list all special mental health service certifications the organization and/or its staff members have obtained (Text Box Expands) :

Organizational References-Please provide contact information for individuals for at least three, but no more than five separate agencies your organization contracts with to provide mental health services:				
#	Agency Name:	Individual Name:	Email Address:	Phone Number:
1				
2				
3				
4				
5				

Section 4. Staff Information Sheets

New panel providers will have the opportunity to complete staff trainings after application is approved and contract is executed. Providers with staff trained under other CMHSP training programs or other training sources may be deemed permissible upon review of training materials or reciprocity standards.

	Attached:	**# of Pages**
Staff Credential Review	☐	
Staff Background Review	☐	

Staff Training	☐	

Current Staff Responsible for Staff Credential Review:		
Name	Email	Phone
Current Staff Responsible for Criminal Background Checks		
Name	Email	Phone
Current Staff Responsible for Staff Training Documentation		
Name	Email	Phone

SECTION 5. PROVIDER CERTIFICATION, RELEASE & SIGNATURE

I hereby certify that all information contained in this application is accurate, complete, and true:
I understand that in making this application to CMHPSM, the organization agrees to the following:

1. Any information contained in this application which subsequently is found to be false could result in denial of my application or termination of participation in the CMHPSM Provider Network;
2. It is the organization's responsibility to promptly advise the CMHPSM Provider Network of any changes or additions to the information contained in this application;
3. All the information contained in this application is subject to CMH investigation and review; only complete applications will be reviewed, a complete application shall include the following:
    a. Application Sections 1-5 completely and accurately filled out.
    b. Staff Credential Review; completed on all staff that will serve CMHPSM consumers, as many copies as needed.
    c. Staff Background Review; completed on all staff that will serve CMHPSM consumers, as many copies as needed.
    d. Staff Training Review; completed on all staff that will serve CMHPSM consumers, as many copies as needed.
    e. Any documentation requested within the application (i.e. accreditation documentation, financial audits, proof of insurances) is attached to the application package.
    f. Any documentation requested by CMHPSM staff during the application process.
4. This is an application only and that submission of this application does not automatically result in participation in the CMHPSM Provider Network; and
5. Acceptance in to the provider network does not guarantee any specific level of utilization or guarantee utilization at all.
6. The information contained in this document provides an initial baseline for monitoring of the contractual requirements between this agency and CMHPSM Provider Network. Information provided could result in adverse contract action including sanction, suspension or termination.
7. The credentialing application will not be the sole resource for obtaining information for contractual requirements. The CMHPSM may also conduct administrative desk and site audits, service site audits, financial reviews, recipient rights visits, and/or any other reviews outlined in the service contract.

We hereby authorize the CMHPSM to consult with administrators and members of the organization and/or institutions which the agency has been or is currently associated with, and others, including past and present malpractice carriers, who may have information bearing on professional competence, character, and ethical qualifications. We further consent to the inspection by representatives of the CMHPSM Provider Network of all documents that may be material to an evaluation of the organization's professional competence, character, and ethical qualifications.

WE HEREBY RELEASE FROM LIABILITY ALL REPRESENTATIVES OF CMHPSM FOR THEIR ACTS PERFORMED IN GOOD FAITH AND WITHOUT MALICE IN CONNECTION WITH EVALUATING THIS APPLICATION, CREDENTIALS, AND QUALIFICATIONS, AND WE RELEASE FROM ANY LIABILITY ANY AND ALL INDIVIDUALS AND ORGANIZATIONS WHO PROVIDE INFORMATION TO CMHPSM IN GOOD FAITH AND WITHOUT MALICE CONCERNING PROFESSIONAL

COMPETENCE, CHARACTER, AND ETHICS. WE HEREBY CONSENT TO THE RELEASE AND EXCHANGE OF INFORMATION RELATING TO ANY DISCIPLINARY ACTION, SUSPENSION, OR CURTAILMENT OF PROFESSIONAL PRIVILEGES AND/OR CLINICAL SERVICES TO THE CMHPSM PROVIDER NETWORK.

1. All applications for participation in the CMHPSM Provider Network shall be reviewed by the CMHPSM. Recommendations for CMHPSM Provider Network participation will be forwarded to the appropriate CMHSP Board, or designee for approval. By signing this, the organization gives consent for verification of the information provided in this application.
2. In the event that the agency, organization, or institution is accepted for participation in the CMH Provider Network, we consent to CMH inspection of our patient records relating to consumers as necessary for its peer and utilization review process.

We understand that if this application is rejected for reasons relating to professional conduct or competence, CMH may report the rejection to the appropriate State licensing board and/or the National Practitioner Data Bank.
To abide by applicable bylaws, rules and regulations, policies and procedures of the CMH Provider Network as in force at the time of this application, and agree to be bound by the terms thereof in all matters related to the consideration of this application.
Acknowledge the organization's obligation to provide continuous care and supervision to all for whom we have responsibility, and that the organization will seek clinical consultation as necessary to insure the highest quality of consumer care.
That the organization, or designee will be willing to appear before any appropriate committee of CMH with regard to this application.
It is understood that failure to comply with the agreements specified above or providing inaccurate, incorrect, or withholding information on this application will automatically terminate appointment as a provider of behavioral health service in the CMHPSM Provider Network.

Attestation of Organization CEO or Designated Representative			
Signature:			
Enter Title:		Enter Date:	

EXHIBIT A

CMHPSM Provider Network Application & Re-Credentialing Application **Staff Credential Review**

Provider Name:		**Application Date:**		**Initial App:☐ Renewal App:☐**			
Please include as many copies as necessary to cover all applicable staff members indicate page number(s):				**Page #:**		**of:**	

	Staff		**Education** (Can Leave blank if not required for service)		**Clinical License Information** (Can Leave blank if not required for service/position)				**Other**	
#	**Last Name**	**First Name**	**Degree**	**Grad Date**	**License Type(s)**	**License #**	**Expiration Date:**	**Licensor:**	**NPI #:**	**Special Certifications:**
1								Select:		
2								Select:		
3								Select:		
4								Select:		
5								Select:		
6								Select:		
7								Select:		
8								Select:		
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12								Select:		
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15								Select:		
16								Select:		
17								Select:		
18								Select:		
19								Select:		
20								Select:		

EXHIBIT A

CMHPSM Provider Network Application & Re-Credentialing Application

Provider Name:		**Application Date:**		**Initial App:** ☐ **Renewal App:** ☐			
Please include as many copies as necessary to cover all applicable staff members indicate page number(s):				**Page #:**		**of:**	

	Staff Information			**Most Recent Criminal Background Review**			**Motor Vehicle Record**		**E-Verify**	
	Last Name	**First Name**	**Position**	**Date**	**Data Source(s)**	**Outcome**	**Date**	**Outcome**	**Date**	**Outcome**
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EXHIBIT A

CMHPSM Provider Network Application & Re-Credentialing Application

Provider Name:		Application Date:		Initial App: ☐ Renewal App: ☐			
Please include as many copies necessary to cover all applicable staff members indicate page number(s):				Page #:		of:	

Staff Information					Staff Trainings (Please enter date of last verified training in MM/DD/YY format.)									
#	Last Name	First Name	Position	Hire Date	Recipient Rights	Due Process, Grievance & Appeals	Medicaid Integrity	Blood-borne Infectious Disease	First Aid and CPR	Limited English Proficiency	Cultural Competence	Person Centered Planning	Medication Administration	Behavior Management
1														
2														
3														
4														
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