8/14/2015

Thank you for your interest in joining Mid-State Health Network. Enclosed is an application for credentialing and privileges, along with related attachments.

The following qualifications must be demonstrated in your application materials in order for us to accept your application:

* License: A current unrestricted, unconditional license to practice mental health and/or substance use disorder services in the State of Michigan;
* Certification (if applicable): Current certifications to provide specialized services as required by the State of Michigan;
* Board Certification (applies to physicians);
* Insurance: Current malpractice insurance and professional liability insurance in the amount required by MSHN (minimum $1,000,000 per occurrence and $3,000,000 aggregate).

The application and attachments may be filled out electronically, however, you must print, date, and sign the application and required attachments. The application and attachments must be dated within 30 days of receipt by the MSHN Provider Credentialing Specialist.

If you have any questions related to the criteria identified above, or questions about completing the application and/or attachments, please feel free to contact me at 517.657.3000.

For your convenience, a checklist has been included on page 7 of the application.

Thank you,



Carolyn T. Watters, MA

Provider Credentialing Specialist

Mid-State Health Network

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| **Demographic Information** (and directory information) | | | | | | | | |
| Name (Last, First, Middle): | | | | Today’s Date: | | | | |
| Other Names Used: | | | | Email: | | | | |
| Organization Name/DBA (if applicable): | | | | | | | | |
| Check Appropriate Status:  Sole Proprietorship  Partnership  Corporation  LLC  Other | | | | | | | | |
| Address: | | | | Billing Address: | | | | |
| City: | State: | | Zip: | City: | | State: | | Zip: |
| Phone: | Fax: | | | Phone: | | | Fax: | |
| Response time (days) from first point of contact: | | | | # of new referrals you will accept per week: | | | | |
| Same Day Service?  Yes  No | | 24 hr on-call?  Yes  No | | | ADA Accessible?  Yes  No | | | |
| Please specify all fluent communicable languages, including sign language: | | | | | | | | |

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| **National Databank Identifying Information** (required for data bank queries) | | |
| Gender:  Male  Female | Date of Birth: | SSN or ITIN: |

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| **Billing Information** | |
| EIN: | NPI#: |
| Medicaid: | Medicare #: |
| Other Insurer(s): | |
| Indicate all insurance companies and/or managed care plans you currently participate with or have provider agreements with:  None | |
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| **Current Malpractice and Professional Liability Insurance Information** (attach copy of cover sheet) | | | |
| Insurance Carrier: | | | Policy #: |
| Address: | | | Coverage Amount: |
| City: | State: | Zip: | Expiration Date: |

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| **Valid Certifications/Licenses** (attach current copies) | | | | | | | | | | |
| License/Certification: | | | MD | | DO | RPH | | LP | LPC | LMSW |
| RPT | OTR | CCC-SLP | NP | | PA | SATS | | SATP | CPS-M | CPC-M |
| CPS | CPC-R | CHES | DP-P | | DP-C | CADC-M | | CADC | CAADC | CCJP |
| DP-S | CCDP-D | CCDP | CCS | | CCS-M | Other | |  | | |
| *Indicate all past and current licenses and certifications. Physicians – include Board Certifications* | | | | | | | | | | |
| Certification/License Type | | | | State/Province | | | Number | | Expiration Date | |
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| **Education** | | | |
| You must provide an original transcript for your **highest degree –** this must be sent directly to MSHN from the conferring institution and not delivered by the applicant. | | | |
|  | Degree | Name and Location of Institution | Dates Attended |
| Undergrad |  |  |  |
| Graduate |  |  |  |
|  | Specialty | Name and Location | Dates Attended |
| Internship |  |  |  |
| Residency |  |  |  |
| Fellowship |  |  |  |

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| **Professional Experience -** at minimum, the previous 5 years OR attach a current CV/resume with full details | | | | |
| ***Employer (most recent)*** | ***Dates*** | ***Emp. Type*** | ***Populations Served*** | |
| Name: | Start: | Contract | Child/Adoles. | Older Adult w/MI |
| Address: | End: | Employee | Adult w/MI | Dev. Disabled |
| Title: | Supervisor: | | Contact #: | |
| Privileges Granted: | | | | |
| Reason for Leaving: | | | | |
| ***Employer*** | ***Dates*** | ***Emp. Type*** | ***Populations Served*** | |
| Name: | Start: | Contract | Child/Adoles. | Older Adult w/MI |
| Address: | End: | Employee | Adult w/MI | Dev. Disabled |
| Title: | Supervisor: | | Contact #: | |
| Privileges Granted: | | | | |
| Reason for Leaving: | | | | |
| ***Employer*** | ***Dates*** | ***Emp. Type*** | ***Populations Served*** | |
| Name: | Start: | Contract | Child/Adoles. | Older Adult w/MI |
| Address: | End: | Employee | Adult w/MI | Dev. Disabled |
| Title: | Supervisor: | | Contact #: | |
| Privileges Granted: | | | | |
| Reason for Leaving: | | | | |
| ***Employer*** | ***Dates*** | ***Emp. Type*** | ***Populations Served*** | |
| Name: | Start: | Contract | Child/Adoles. | Older Adult w/MI |
| Address: | End: | Employee | Adult w/MI | Dev. Disabled |
| Title: | Supervisor: | | Contact #: | |
| Privileges Granted: | | | | |
| Reason for Leaving: | | | | |
| ***Employer*** | ***Dates*** | ***Emp. Type*** | ***Populations Served*** | |
| Name: | Start: | Contract | Child/Adoles. | Older Adult w/MI |
| Address: | End: | Employee | Adult w/MI | Dev. Disabled |
| Title: | Supervisor: | | Contact #: | |
| Privileges Granted: | | | | |
| Reason for Leaving: | | | | |
| *Attach additional sheets if necessary* | | | | |
| Please explain any gaps in employment of six (6) months or more (or enter N/A if not applicable): | | | | |

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| **Professional References** | | | |
| Please provide the names and addresses of three (3) individuals and/or organizations who can verify your employment over the last five (5) years and can comment on your scope/level of performance, clinical performance, satisfactory professional obligations, ethical performance, clinical judgement, and technical skills in performing procedures and in treating and managing client’s needs.  *The first reference must be your most recent employer/organization.* | | | |
|  | Reference #1 | Reference #2 | Reference #3 |
| Supervisor/Manager Name |  |  |  |
| Title/Occupation |  |  |  |
| Company Name |  |  |  |
| Email Address |  |  |  |
| Phone |  |  |  |

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| **Privileges, Licensure, and Malpractice History** - *if you answer yes to any of the following, attach full explanation* |
| 1. Have you ever had any privileges revoked, suspended, or restricted?  Yes  No |
| 1. Have you ever been dismissed from a hospital or behavioral healthcare organization staff?  Yes  No |
| 1. Have you ever had a hospital initiate suspension, restriction, dismissal or been refused or  Yes  No   denied privileges? |
| 1. Have you ever voluntarily surrendered any privileges?  Yes  No |
| 1. Have you ever surrendered privileges upon threat of censure, restriction, suspension, or revocation of privileges?  Yes  No |
| 1. Have any of your licenses or certifications been suspended, revoked, placed on probation or conditional status, restricted, or voluntarily surrendered?  Yes  No |
| 1. Is any action currently pending to suspend, revoke, or restrict any of your licenses or certifications?   Yes  No |
| 1. Have you been subject to any disciplinary proceedings by any local, state, or national professional organization?   Yes  No |
| 1. Have any malpractice claims ever been filed against you, or to the best of your knowledge, are there any claims currently pending in regard to the practice of mental health or substance use treatment?  Yes  No |
| 1. Have any malpractice allegations involving your work been settled by you or your carrier prior to the filing of a claim?  Yes  No |
| 1. Have you ever been denied professional liability insurance, had your insurance cancelled, or your renewal denied?  Yes  No |
| 1. Have you ever been a defendant in any lawsuit in regard to the practice of health or substance use treatment?   Yes  No |
| 1. You must provide, at minimum, the prior 5 year’s history of any professional liability claims resulting in a judgement or settlement. ***Complete Attachment D - Professional Liability Action Detail***  Attached  N/A |

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| **Statement of Ability to Perform** |
| 1. Do you now, or have you had any physical condition, mental condition, or substance abuse condition (alcohol, illegal or prescription drugs) that has interfered with your ability to practice or perform clinical duties, or led to suspension, termination, or any other disciplinary action?  Yes  No |
| 1. Are you currently engaged in the illegal use of controlled substances?  Yes  No |

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| **Policy & Practices** (attach copies of policies and procedures) | | Pg. # |
| 1. Do you have a policy/practice for access to services? (Including timeliness of response to referral, availability of services, access to services, emergency services, etc.) | Yes  No |  |
| 1. Does your policy on treatment planning describe person-centered planning? | Yes  No |  |
| 1. Does your policy on treatment planning include consumer involvement in the development of the plan of service? | Yes  No |  |
| 1. Do you have a policy/practice regarding serving persons with Limited English Proficiency? | Yes  No |  |
| 1. Do you have a continuous quality improvement (CQI) policy/practice? | Yes  No |  |
| 1. Do you have a process to assess customer satisfaction? | Yes  No |  |
| 1. Do you have policies and procedures for clinical standards of care? | Yes  No |  |
| 1. Do your standards of care include defined treatment philosophies and orientations? | Yes  No |  |
| 1. Do you have a policy/procedure describing case records, record review, security, and case record access? | Yes  No |  |
| 1. Do you have a corporate compliance policy? | Yes  No |  |
| 1. Do you have a safety management plan that includes: | | |
| a. General Safety | Yes  No |  |
| b. Security | Yes  No |  |
| c. Hazardous materials and wastes | Yes  No |  |
| d. Emergency preparedness | Yes  No |  |
| e. Fire | Yes  No |  |
| f. Medical equipment | Yes  No |  |
| g. Utility systems | Yes  No |  |
| h. Physical environment | Yes  No |  |
| i. Infection control | Yes  No |  |

Consent and Release of Liability

Upon the signing of this application, I represent that all of the information now or hereafter given by me in support of my application is true, correct and complete to the best of my knowledge and belief. I agree to promptly notify MSHN if there are any material changes in the information provided, whether prior to or after acceptance as a MSHN participating provider. I hereby authorize the release of any information from any source including but not limited to information from individuals, peers, customers, companies, institutions, agencies, data banks or references who may have information bearing on my moral and ethical qualifications and competence to carry out the privileges I have requested, and I authorize them to release such information as you require, including my prior disciplinary records, for purposes of verifying information obtained in the attached application or any re-application information without any obligation to give me written notice of such disclosure. I agree to hold MSHN and the informant harmless from any liability to me and/or my organization for providing such information.

I hereby further authorize MSHN to release any and all information related in any way to my professional practice to any person, entity or governmental agency which: (a) provides MSHN with an authorization signed by me; or (b) has a legal right to know under any state or Federal law. I agree to hold MSHN harmless from any liability for providing any such information as specified herein.

I release all parties from all liability from any damages, causes of action, including, but not limited to, slander and libel, that may result from furnishing any information to you. I agree that any false information in support of my application may result in action up to and including cancellation of any or all contracts subject to contract provisions regardless of when discovered by MSHN. I release MSHN, the MSHN Credentialing Committee, individually and collectively, from any and all liability from any damages and/or causes of action associated with the MSHN credentialing and privileging process.

I hereby signify my willingness to appear for interviews with MSHN. I fully consent to the inspection of any and all records and documents pertinent to my application for appointment and/or privileges. If there is a doubt as to my competence, morals, or ethics, the burden shall be on me to resolve the same. I understand and agree that if MSHN determines that this application contains any significant misstatements, misrepresentations, or omissions, MSHN’s acceptance of this application for participation and any subsequent participating provider agreement which MSHN enters into with me will be voidable at MSHN’s sole discretion.

I understand and agree that: (a) I have the burden of producing all information required or requested by MSHN in connection with this application; (b) MSHN is under no obligation to complete the processing of this application until all information requested is provided; (c) MSHN has the sole discretion to determine whether or not I or my organization will be accepted as a participating provider; and (d) in the event that MSHN decides not to accept me or my organization as a participating provider, I may initiate administrative appeal procedures as defined in the instructions for completing the application.

I understand and agree that the certifications, authorizations and other provisions contained herein shall remain in force for so long as this application is pending and, if accepted for participation, for so long as my and/or my organizations’ provider agreement with MSHN remains in force.

I understand that MSHN is not obligated to grant any or all requested privileges and that application for such is not a guarantee of a contract with MSHN.

**Applicant Signature:** **Date:**

**Print Name:**

Application Checklist

The following items are required:

All applicable items on the application are complete and legible

Copy of valid picture identification issued by a state or federal agency (e.g. driver’s license or passport)

Official transcript for your highest degree sent directly to the MSHN Credentialing Specialist from the conferring institution (student issued copies are not accepted)

Signed and dated Consent and Release of Liability

Copy of current CV/Resume

Copy of current Malpractice and Professional Liability Policy

Copy of all current licenses/certificates/approvals necessary to support requested privileges

Attachment A - Substance Abuse Treatment Service/Privilege Request Form

Attachment B - Consent to Conduct Criminal Background Investigations

Attachment C – Disclosure of Ownership & Controlling Interest Statement

If applicable:

Written explanations for any gaps in employment history greater than six (6) months

Written explanations attached for any privilege, licensure, or malpractice history questions answered “Yes”

Attachment D – Professional Liability Action Detail

Attachment E – Electronic Funds Transfer

Copy of current DEA certificate

Proof of Board Certification

Education Council for Foreign Medical Graduates (ECFMG) certificate

Proof of American Society of Addiction Medicine (ASAM) certificate

Copy of Current Fidelity Bonding Certificate