8/14/2015

Thank you for your interest in joining Mid-State Health Network. Enclosed is an application for credentialing, service request, and 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;
* Accreditation (treatment programs only): Current accreditation from a national body approved by the State of Michigan;
* 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 6 of the application.

Thank you,



Carolyn T. Watters, MA

Provider Credentialing Specialist

Mid-State Health Network

|  |  |  |
| --- | --- | --- |
| **Organizational Information** | | |
| Name of Organization: | | Website: |
| Names of Chief Administrator/Title: | | |
| Phone #: | Fax #: | email: |
| Check Appropriate Status: Sole Proprietorship Partnership Corporation LLC S-Corp  Other: | | |

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| **Provider Directory Information -** *attach additional sheets if necessary for multiple sites* | | | | | | | | | | | |
| Office Address #1: | | | | | | Office Address #2: | | | | | |
| City: | | State: | | | Zip: | City: | | | St: | | Zip: |
| Primary Contact/Title: | | | | | | Primary Contact/Title: | | | | | |
| email: | | | | | | email: | | | | | |
| Phone: | | Fax: | | | | Phone: | | | Fax: | | |
| Hours of Operation: | | M: | | | | Hours of Operation: | | | M: | | |
| T: | W: | | | R: | | T: | | W: | | R: | |
| F: | Sa: | | | Su: | | F: | | Sa: | | Su: | |
| 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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| **Billing Information** | |
| EIN: | NPI#: |
| Medicaid #: | Medicare #: |
| Indicate all insurance companies and/or managed care plans you currently participate with or have provider agreements with:  None | |
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| **Organizational Certifications/Licenses***- attach current copies of all license; attach additional sheets if necessary* | | | | | |
| CAIT | Case Management | | Early Intervention | Inpatient | |
| Integrated Treatment | Outpatient | | Outpatient Methadone | Peer Recovery/Support | |
| Residential | Residential Detox | | SARF |  | |
| Certification/License Type | | License # | | | Expiration Date |
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| **Current Professional Liability Insurance Information** - *attach copy of cover sheet* | | | |
| Insurance Carrier: | | | Policy #: |
| Address: | | | Coverage Amount: |
| City: | State: | Zip: | Expiration Date: |

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| **Professional References** | | | |
| Please provide the names and addresses of three (3) individuals who have personal knowledge of your organization over the last five (5) years and can comment on the 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. *Professional references only.* | | | |
|  | Reference #1 | Reference #2 | Reference #3 |
| Full Name |  |  |  |
| Title/Occupation |  |  |  |
| Organization |  |  |  |
| Email Address |  |  |  |
| Phone |  |  |  |

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| **Privileges, Licensure, and Malpractice History** | |
| Has your organization had any of the following denied, revoked, suspended, reduced, limited, or placed on probation or have voluntarily relinquished any of the following in anticipation of these actions, or are any of these actions now pending? I*f you answer yes to any of the following, attach full explanation.* | |
| 1. License/Certificate to Operate in the State of Michigan | Yes  No |
| 1. Accreditation (*treatment providers only*) | Yes  No |
| 1. Professional Liability Insurance | Yes  No |
| 1. Malpractice suits settled resulting in a judgment against you in the past five (5) year, or currently pending? | Yes  No |
| 1. Are any malpractice judgements pending? | Yes  No |
| 1. Within the past ten (10) years, has your organization ever been convicted of, or plead guilty to, a criminal offense? | Yes  No |
| 1. Are there any medical incidents for which you have been contacted by an attorney regarding potential malpractice liability (settlement request, writ of summons, etc.)? | Yes  No |
| 1. Have your organization had any Medicaid, Medicare, or other governmental or third-party payor sanctions? | Yes  No |
| 1. Have your organization ever been excluded from the Medicaid or Medicare program?   If yes, specify date:       Date of Reinstatement: | Yes  No |
| 1. Have civil and monetary penalties been levied against your organization by Medicare or Medicaid programs? | 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. Does the organization have 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 the organization have a credentialing and re-credentialing policy/practice? | Yes  No |  |
| 1. Does the organization conduct primary verification of credentials? | Yes  No |  |
| 1. Does the organization conduct criminal background checks at time of hire and periodically during employment? | Yes  No |  |
| 1. Does the organization assess staff competency on an ongoing basis through performance evaluation? | Yes  No |  |
| 1. Does the organization have a policy/practice regarding ongoing professional development? (Including orientation and ongoing training) | Yes  No |  |
| 1. Does the organization assess the cultural backgrounds of persons served and provide training to staff on any identified cultural issues? | Yes  No |  |
| 1. Does the organization's policy on treatment planning describe person-centered planning? | Yes  No |  |
| 1. Does the organization’s policy on treatment planning include consumer involvement in the development of the plan of service? | Yes  No |  |
| 1. Does the organization have a policy/practice regarding serving persons with Limited English Proficiency? | Yes  No |  |
| 1. Does the organization have a continuous quality improvement (CQI) policy/practice? | Yes  No |  |
| 1. Does the organization have a process to assess customer satisfaction? | Yes  No |  |
| 1. Does the organization have policies and procedures for clinical standards of care? | Yes  No |  |
| 1. Do the clinical standards of care include defined treatment philosophies and orientations? | Yes  No |  |
| 1. Does the organization have policy/procedure describing case records, record review, security, and case record access? | Yes  No |  |
| 1. Does the organization have a corporate compliance policy? | Yes  No |  |
| 1. Does the organization 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:**

**Organization:**

Application Checklist

The following items are required:

All applicable items on the application are complete and legible

Signed and dated Consent and Release of Liability

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

Copy of organization’s Licensure/Certification necessary to support requested services/privileges

Copy of the organization’s Accreditation Certificate and most recent survey report

Copy of the organization’s Credentialing and Privileging Policy

Copy of current Malpractice and Professional Liability Policy

Copy of current Fidelity Bonding Certificate

Copy of the organization’s most recent Compliance Plan

Copies of all professional licenses/certifications for all staff

Federal W-9 Form - Request for Taxpayer Identification Number and Certification

Attachment A – Substance Abuse Treatment Service/Privilege Request Form

Attachment C – Disclosure of Ownership & Controlling Interest Statement

Attachment D – Professional Liability Action Detail (if applicable)

Attachment E – Electronic Funds Transfer Request (if applicable)

Attachment F – Credentialing Information – Licensed Professionals

Attachment G – Credentialing Information – Paraprofessionals

Attachment H – Provider Training Log