Southwest Michigan Behavioral Health

Southwest Michigan Behavioral Health is an affiliation of Barry County Community Mental Health Authority, Kalamazoo Community Mental Health & Substance Abuse Services, Woodlands Behavioral Healthcare (Cass County Community Mental Health), Riverwood Center (Berrien Mental Health Authority), Pines Behavioral Health (Branch County Community Mental Health Authority), Community Mental Health & Substance Abuse Services of St. Joseph County, Summit Pointe (Community Mental Health of Calhoun County) and Van Buren Community Mental Health Authority.

INSTRUCTIONS

- Applications should be typed or legibly printed in black or dark blue ink. If more space is needed, attach additional sheets and reference the question being answered. ALL fields are required to be completed unless otherwise directed.
- Modification to the wording or format of the application will invalidate the application.
- See shaded areas of each section for further instructions.
- Current copies of all applicable documentation requested on page 7 *Attachments*, must accompany this application.
- Failure to legibly complete all sections of this Application and submit current copies of required documentation may result in the Application being returned to the provider without processing. And for returning Providers it may result in the termination of Provider Status while awaiting re-credentialing.
- If you have credentialing questions, please send an email message to moira.kean@swmbh.org or jarrett.cupp@swmbh.org. You may also contact us by phone at 1-800-676-0423.

>> NOTICE <<

ACCEPTANCE OF THIS APPLICATION DOES NOT CONSTITUTE APPROVAL, ACCEPTANCE OR PARTICIPATING PROVIDER STATUS WITHIN THE SWMBH PROVIDER NETWORK, AND GRANTS THIS APPLICANT NO RIGHTS OR PARTICIPATION PRIVILEGES UNTIL SUCH TIME A CONTRACT IS CONSUMMATED AND WRITTEN NOTICE OF PARTICIPATION STATUS IS ISSUED BY THE CREDENTIALING COMMITTEE.

Southwest Michigan Behavioral Health and CMHSP Participants will not discriminate against a provider solely on the basis of license or certification. SWMBH and CMHSP Participants will not discriminate against a health care professional who services high-risk populations or who specializes in the treatment of costly conditions.

ORGANIZATIONAL CREDENTIALING APPLICATION

☐ **INITIAL CREDENTIALING** ☐ **RECREDENTIALING**

IDENTIFICATION

CORPORATE INFORMATION

Legal Business Name: (As reported to the IRS)	Federal Tax Identification Number (TIN):
Doing Business As (DBA) Name: (If applicable)	National Provider Identifier (NPI) for organization being credentialed: ☐ **N/A (if N/A please specify reason)**
Corporate Address: --- ---	Type and ownership: (please check one) ☐ **Federal** ☐ **Corporation** ☐ **City** ☐ **Privately Owned** ☐ **LLC/LLP** ☐ **State** ☐ **Partnership** ☐ **County** ☐ **Private Non-Profit**

Phone:	Fax:	Website: www.
Credentialing Contact:		Email:
Contract Administrator:		Email:
Billing Manager:		Email:
Medicaid #: (if applicable)		Medicare #: (if applicable)

SITE INFORMATION (if you are contracting for more than one site that will be providing contracted services)
Address must be a street address, not a Post Office box. Please attach list of any other locations using below format.

Name:			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	County:

BILLING ADDRESS
PAYMENTS WILL BE MAILED TO THIS ADDRESS.

☐ Check here if payments can be directed to the Corporate address above.
If not, complete the section below.

Name:

Mailing Address Line 1:			
Mailing Address Line 2:			
City:	State:	Zip:	Phone:

PROVIDER TYPE
Check ONE box only

☐ Psychiatric Hospital
☐ General Hospital with Psychiatric Unit
☐ Partial Hospitalization – free standing
☐ Partial Hospitalization – hospital based
☐ Specialized Residential
☐ SUD Residential Treatment Center
☐ SUD Outpatient Service Facility / Clinic
☐ SUD Detoxification Treatment Center
☐ Opioid/Methadone Treatment Program
☐ Autism Service Provider
☐ Behavioral Healthcare Group / Private Practice
☐ Other (please specify)

LICENSURE

Is this organization state licensed? ☐ YES ☐ NO (if yes complete the following license information)
Attach a copy of each license for this organization.
All licenses must be current and unrestricted
Do not submit practitioner licenses

License Number	State or City	Licensing Agency	Initial Issue Date	Renewal Date	Expiration Date

SPECIALIZED RESIDENTIAL PROVIDER LICENSING AUDIT

Complete this section and attach copy of most recent onsite DHHS survey along with your Corrective Action Plan (CAP), if deficiencies were cited, and letter from DHHS stating organization is in substantial compliance with most recent survey standards.

Has this organization had an onsite licensing survey by the DHHS within the past 48 months?

☐ YES – Date of most recent onsite survey: mm/dd/yyyy ***See instructions above.***

☐ NO – Please explain:

Please complete this section for all locations if multiple surveys were completed by DHHS

ACCREDITATION

Complete this section and attach copy of current Accreditation certificate or letter. Certificate/letter should list location as being included in the accreditation.

☐ **JCAHO** – The Joint Commission
☐ **CARF** - Commission on Accreditation of Rehabilitation Facilities
☐ **COA** – Council on Accreditation
☐ **AOA -** American Osteopathic Association
☐ **CHAMPS**

☐ **Other (please specify)**

1. Date of last full survey: mm/dd/yyyy
2. Effective dates of accreditation: mm/dd/yyyy through mm/dd/yyyy

☐ **Non-Accredited Organization**

STAFFING

Does this organization validate, for each licensed practitioner employed or contracted at the organization, the credentials necessary to perform health care services?

- If YES, indicate how the organization conducts the credentialing process for each practitioner:
  ☐ Credentialing procedures are performed internally.
  ☐ Credentialing procedures are outsourced/delegated to _____
  ☐ Other, specify: _____
- If NO, explain: _____

- If N/A, explain: _____

INSURANCE

Complete this section and attach a copy of the organization's insurance certificate(s)
****The CMH or PIHP may contractually require a specific amount of insurance coverage and listing the CMH or PIHP as a named insured. Proof will be required at the time of contract between the Provider and the CMH or PIHP if pursued. Please note: credentialing is not a guarantee that an offer to contract with the CMH or PIHP will be extended.***

1. Is this organization covered by commercial General liability insurance per contract requirements?
   ☐ Yes
   ☐ No - ***Please provide explanation.***

2. Is this organization covered by Professional liability insurance per contract requirements? Must be a organizational policy, not Individual-only, policy.
   ☐ Yes
   ☐ No - ***Please provide explanation.***

3. Is this organization covered by Workers Compensation insurance? If no, is there an exemption?
   ☐ Yes
   ☐ No – ***Please attach copy of exemption.***

4. Is the CMHSP or PIHP listed as an additional insured?
   ☐ Yes
   ☐ No

ATTESTATION

Answer every question YES, NO or N/A
Responses need to cover the past five (5) years to present.

☐**YES** ☐**NO** ☐**N/A**	1. Has the organization's state license/certificate ever been revoked, suspended or limited?
☐**YES** ☐**NO** ☐**N/A**	2. Is there action pending to suspend, revoke, or limit the organization's license/certification?
☐**YES** ☐**NO** ☐**N/A**	3. Has the organization ever had its JCAHO, CARF, COA, AOA or any other accreditation revoked, suspended or limited?
☐**YES** ☐**NO** ☐**N/A**	4. Is there action pending to revoke, suspend, or limit the organization's current accreditation?
☐**YES** ☐**NO** ☐**N/A**	5. Has the organization ever had sanctions imposed by Medicaid?
☐**YES** ☐**NO** ☐**N/A**	6. Has the organization ever had sanctions imposed by Medicare?

☐YES ☐NO ☐N/A	7. Has the organization commercial general or professional liability insurance ever, for any reason, been denied, cancelled, non-renewed or initially refused upon application?
☐YES ☐NO ☐N/A	8. Has the organization ever been a defendant in any lawsuit in regard to the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000 or more?
☐YES ☐NO ☐N/A	9. Has the organization had any malpractice claims in regard to the practice of mental health or substance abuse treatment?

If you have answered "YES" to any of the above questions, please provide the current status and details on a separate sheet of paper. Include the following: description of incident, correspondence with state licensing boards, and/or a detailed description of any litigation, including settlements, court awards, etc. Please feel free to include a personal summary of the events; however, your application cannot be processed without the necessary official documentation.

Language Competence

In addition to English, please list the languages in which services are provided:

Special Populations

Please indicate if you have any training and experience with the following. Check all that apply.

☐ Hearing Impaired ☐ Visually Impaired ☐ Speech Impaired ☐ Other (Specify):

Facility/Office Accessibility

Does your facility/office have accommodations for people with physical disabilities, including offices, exam rooms and equipment? ☐**YES** ☐**NO**

Hours of Operation

If not a 24 hour residential setting please complete the Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Specialized Residential Services

Community Living Supports (CLS)/Personal Care in Licensed Setting: Provide staffing patterns per home (staffing ratio). Please complete this section per home if staffing varies per location.

Day of week	1st Shift	2nd Shift	3rd Shift

Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			
Total FTE Staffing:			

ATTACHMENTS

Have you attached <u>all</u> required documents? If not, the processing of your application will be delayed.
Check all documents included with this application.

- ☐ Copy of all State and/or local licenses required to operate.
- ☐ Copy of Commercial General liability insurance certificate.
- ☐ Copy of Professional liability insurance certificate covering <u>all</u> agency employees.
- ☐ Copy of Workers Compensation Insurance
- ☐ Copy of Accreditation certificate or letter.
- ☐ For Specialized Residential provider a copy of most recent onsite governmental licensing agency survey including corrective action plan if deficiencies were cited, and letter from licensing agency stating organization is in substantial compliance with licensing standards from most recent survey.
- ☐ Completed W9 Form
- ☐ Other (specify): _____

_____

By signing and affixing your signature below, the Applicant agrees to be bound by the following:

1. **Certification of Truth, Accuracy and Completion:** By submitting this Application and signing below, it is agreed and understood that all information contained in this Application, and all of the attachments provided are accurate, complete and true. If information provided by Applicant is discovered to be inaccurate, incorrect or information is withheld, SWMBH and participant CMHPs reserve the right to automatically terminate the Applicant as a provider of service(s) in this Provider Network.

2. **Continuing Duties of the Applicant**:
   a) The Applicant is under a continuing duty to promptly advise this organization and participants of any changes, additions or deletions to the information contained in the Application or that would be relevant to its provision of services.
   b) The applicant agrees to abide by all applicable laws, rules, regulations, policies, by-laws and procedures in effect at the time of this Application, and during the term of the credentialing cycle.

3. **Release of Information:** By submitting this Application and placing an authorized signature below, the applicant hereby authorizes and consents to the following:
   a) All information contained in the Application and any attachments is subject to verification and review by CMHP and/or SWMBH employees or their agents.
   b) Authorize SWMBH and/or CMHP employees or agents to discuss matters directly related to this Application and any attachments provided with third parties, including but not limited to past/ present malpractice carriers and Community Mental Health Programs outside of SWMBH for the purposes of evaluating the Applicant's professional competence, character and ethical qualifications.
   c) The Release of Information is valid for two years.

4. **Release of Liability**: By submitting this Application and signing below, the applicant releases for liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with the investigating and evaluation provider's application, and waive all legal claims against any and all individuals and organizations who provide information in good faith and without malice concerning professional competence, character and ethics.

5. **Reservation of Rights:** SWMBH and Participant CMHPs have the right to suspend and/or terminate providers credentials and status within the Provider Network when the provider's behavior and/or practice appears to pose a significant risk to the health, welfare or safety of our customers.

I hereby agree and consent to be bound by the requirements stated above:

_____ _____

Signature of Applicant Date

_____

Title

A PHOTOCOPY OF THIS DOCUMENT SHALL BE EFFECTIVE AS THE ORIGINAL