Southwest Michigan
BEHAVIORAL HEALTH

Section: **Provider Network Management**	Policy Name: **Credentialing & Re-Credentialing: Organizational Providers**	Policy Number: **02.03**
Owner: **Director of Provider Network Management**	Reviewed By: **Mila Todd**	Total Pages: **8**
Required By: ☒ **BBA** ☒ **MDHHS** ☐ **Other (please specify):** _____	Final Approval By: Mila C. Todd Mila Todd (Mar 31, 2023 05:59 EDT) **Approved by SWMBH Board**	Date Approved: Mar 31, 2023
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☒ **MI Health Link** ☐ **Other (please specify):** _____	Effective Date: **1/1/14**

Policy: Southwest Michigan Behavioral Health (SWMBH) and its participant Community Mental Health Service Providers (CMHSPs) will credential and re-credential behavioral health organizational providers with whom they contract and that fall within their scope of authority and action. Neither SWMBH nor its participant CMHSPs will discriminate against any provider solely on the basis of licensure, registration or certification. Neither SWMBH nor its participant CMHSPs will discriminate against health care professionals or organizations who serve high-risk populations or those that specialize in the treatment of conditions that require costly treatment.

Purpose: To ensure that all customers served receive care from organizational providers that are properly credentialed, licensed and/or qualified.

Scope: SWMBH Provider Network ManagementParticipant CMHSPs Network Providers

Responsibilities: SWMBH Provider Network Management, participant CMHSPs, and network providers will follow the requirements listed herein as it relates to credentialing.

Definitions: Organizational provider: An entity that directly employs and/or contracts with individuals to provide health care services. Examples of organizational providers include, but are not limited to, community mental health services programs (CMHSPs); hospitals; nursing homes; homes for the aged; psychiatric hospitals, units, and partial hospitalization programs; substance use disorder programs; and home health agencies

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Standards and Guidelines:

A. **Process for Credentialing and Re-Credentialing Organizational Providers**

1. Initial credentialing of all organizational providers applying for inclusion in the SWMBH network must be completed within 90 calendar days.
    a. The 90-day time frame starts when SWMBH or the participant CMHSP has received a completed, signed and dated credentialing application from the organizational provider.
    b. The completion time is the date when written communication is sent to the organizational provider notifying them of SWMBH or the participant CMHSP's decision.
    c. Primary source verification must be completed within the 180 days preceding the credentialing decision date.
2. During initial credentialing and at re-credentialing, SWMBH or participant CMHSPs will submit credentialing packets along with primary source verifications and other supporting documentation to its Credentialing Committee for a decision regarding the inclusion on the SWMBH Provider Network. Packets will be reviewed for completeness prior to committee meeting. If files meet clean file criteria in every category listed, the medical director or designee may sign off to approve the provider, in lieu of taking to Credentialing Committee.
3. During initial credentialing and at re-credentialing, SWMBH and its participant CMHSPs will ensure that organizational providers are notified of the credentialing decision in writing within 10 business days following a decision. In the event of an adverse credentialing decision, the organizational provider will be notified of the reason(s) in writing and of their right to and process for appealing/disputing the decision in accordance with SWMBH Policy 2.14.

B. **Organizational Provider Assignments**

1. SWMBH is responsible for credentialing/recredentialing the following organizational provider types, on behalf of the Region:
    a. Substance Use Disorder
    b. Psychiatric Inpatient
    c. Crisis Residential
    d. Autism Services
    e. Financial Management Services
    f. Specific Specialized Residential service providers as determined by the Regional Provider Network Management Committee
2. Participant CMHSPs are responsible for credentialing/recredentialing all other organizational provider types for inclusion in each participant CMHSP subcontracted network of providers.
3. SWMBH retains the right to approve, suspend, or revoke/terminate from participation in the provision of Medicaid funded services, any provider (organizational or practitioner) in the Region 4 network (including participant CMHSP network providers), regardless of whether SWMBH or a participant CMHSP performed the credentialing activities.

C. **Requirements for Credentialing and Re-Credentialing Organizational Providers**

1. Before executing an initial contract and at least every 2 years thereafter, SWMBH and its participant CMHSPs will require organizational providers wishing to provide contracted services in the SWMBH network to submit a fully completed application, using the current approved SWMBH Organizational Credentialing Application.
2. The application will contain the following:

a. A signed and dated statement from an authorized representative.
b. Documentation collected and verified for organizational providers will include (as applicable), but are not limited to, the following information:

Documentation Requirement	Clean File Criteria
Complete application with a signed and dated statement from an authorized representative of the organizational provider attesting that the information submitted with the application is complete and accurate to the facilities' knowledge, and authorization for SWMBH or CMHSP to collect any information necessary to verify the information in the credentialing application.	Complete application with no positively answered attestation questions.
State licensure or certification information. License/certification status and any violations or special investigations thereof incurred during the past five years or during the current credentialing cycle will be included in the credentialing packet for committee consideration.	No license/certification violations and no special state investigations in timeframe (in past five years for initial credentialing and past two years for re-credentialing).
Accreditation by a national accrediting body (if such accreditation has been obtained). Substance abuse treatment providers are required to be accredited. If an organization is not accredited, an on-site quality review will occur by SWMBH or CMHSP provider network staff prior to contracting.	Full accreditation status during the last accreditation review or no plan of correction for an on-site pre-credentialing site review. SWMBH recognizes the following accrediting bodies: CARF, Joint Commission, DNV Healthcare, NCQA, CHAPS, COA, and AOA.
Primary-source verification of the past five years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query.	No malpractice lawsuits and/or judgments from within the last five (5) years.
Verification that the organization and any individuals listed as a "Screened Person" under SWMBH Policy 10.13 have not been excluded from participation in Medicare, Medicaid, or other Federal contracts, and are not excluded from participation through the MDHHS Sanctioned Provider list.	Organization and its "Screened Persons" are not listed as sanctioned and/or excluded by the OIG, the System for Award Management (SAM), or the Michigan Sanctioned Provider list (for initial credentialing). Queries will be made monthly thereafter as part of on-going

	monitoring and for re-credentialing. Provider and its Screened Persons must not have been listed as excluded during any month since the prior credentialing activity (re-credentialing).
A copy of the organization's liability insurance policy declaration sheet.	Current insurance coverage meeting contractual expectations.
Any other information necessary to determine if the organization meets the network-based health benefits plan participation criteria that the network-based health benefits plan has established for that type of organization.	Information provided as requested by SWMBH or CMHSP.
Quality information will be considered at re-credentialing.	Grievance and appeals, recipient rights, and customer services complaints are within the expected threshold given the provider size; there are no substantiated fraud; MMBPIS and other performance indicators substantially meet set standards (if applicable).

D. **Temporary/Provisional Credentialing Process**

a. Temporary or provisional status can be granted one time to organizations until formal credentialing is completed. Temporary or provisional credentialing should be used when it is in the best interest of Medicaid members to have providers available to provide care prior to formal completion of the entire credentialing process.

b. **Timeframes.**

i. A decision regarding temporary/provisional credentialing shall be made within 31 days of receipt of a complete application and the minimum documents listed below.

ii. Temporary/provisional credentialing status shall not exceed 150 days, after which time the credentialing process shall move forward according to this credentialing policy.

iii. Primary source verification must be completed within the 180 days preceding the provisional credentialing decision date.

c. **Requirements.**

i. Providers seeking temporary or provisional status must complete the current approved SWMBH Organizational Credentialing Application, signed and dated by an authorized representative.

ii. SWMBH and/or Participant CMHSPs shall perform verification from primary sources of:

1. Current valid license or certification and in good standing as necessary to operate in the State of

Michigan.

2. National Practitioner Databank (NPDB)/Healthcare Integrity and Protection Databank (HIPDB) query or, in lieu of the NPDB/HIPDB query, all of the following:
   a. Minimum five (5) year history of professional liability claims resulting in a judgment or settlement; and
   b. Disciplinary status with regulatory board or agency.
3. Medicare/Medicaid sanctions (OIG, SAM, and Michigan Sanctioned Provider lists)

iii. SWMBH and/or Participant CMHSPs shall evaluate the organizational provider's continuing operation as a provider for the prior five (5) years. Gaps in operation of six (6) months or more in the prior five (5) years must be addressed in writing during the application process.

d. SWMBH/Participant CMHSPs shall follow the same process for presenting provisional credentialing files to the Credentialing Committee as it does for its regular credentialing process. Temporary/Provisional credentialing decisions shall be made by the applicable entity's Credentialing Committee and not through the clean file process.

E. **Credentialing Reciprocity (Deemed Status).**

a. **Out of Region.** SWMBH and its participant CMHSPs may accept credentialing activities conducted by any other Region in lieu of completing its own credentialing activities. If SWMBH chooses to accept the credentialing activities of another Region, copies of the credentialing Region's decision shall be maintained in the SWMBH/Participant CMHSP credentialing file.

b. **In Region.** SWMBH and its participant CMHSPs shall work collaboratively to reduce the burden on shared network providers (providers that contract with two are more participant CMHSPs) by coordinating credentialing/recredentialing activities to ensure, to the extent practicable, that shared providers in the SWMBH network only complete credentialing/recredentialing through a single participant CMHSP or SWMBH, and that those credentialing/recredentialing results are shared with the Region.

c. **Reciprocity Procedure.** When accepting credentialing activities performed by another Region or another in-Region entity, SWMBH and its participant CMHSPs shall follow the SWMBH Procedure 02.03.01 – Credentialing Reciprocity.

F. **Site Reviews and Quality Assessments**

a. Initial Credentialing.

i. On-site reviews must be performed prior to initial credentialing/contracting for the following:
   1. Non-accredited organizational providers that are not solely community-based; and
   2. Specialized Residential sites (homes).
      a. The Specialized Residential parent organization's accreditation does not eliminate the requirement for an on-site review of each specialized residential site (home).

ii. For solely community-based providers (e.g. ABA or CLS in private residences), an on-site review is not required. An alternative quality assessment shall be performed in lieu of an on-site review. The alternative quality assessment shall be performed prior to initial credentialing/contracting.

iii. SWMBH and its participant CMHSPs may accept on-site reviews performed by another Region as part of Credentialing Reciprocity.

b. Re-credentialing

i. The most recent annual site review/monitoring results shall be reviewed during the re-credentialing process.

ii. The following information will be reviewed as part of the Quality checks during recredentialing:

1. Grievances and appeals;
2. Recipient Rights complaints;
3. Customer Services complaints;
4. Compliance-related issues including fraud/waste/abuse;
5. If applicable, status of MMBPIS and other performance indicators.

iii. SWMBH and its participant CMHSPs will perform on-going monitoring of network providers in accordance with SWMBH Policy 2.18 – Ongoing Monitoring of Network Practitioners and Organizations.

G. **Organizational Provider credentialing of its direct employees and contractors.**

a. Organizational providers may be held responsible for credentialing and re-credentialing their direct employees and subcontracted professional service providers per SWMBH or SWMBH participant CMHSP contractual requirements.
b. Organizational providers shall maintain written credentialing/re-credentialing policies and procedures consistent with SWMBH and MDHHS credentialing policies and any other applicable requirements.
c. Organizational providers shall perform credentialing/re-credentialing activities in accordance with applicable contractual requirements, SWMBH policies and procedures, MDHHS policies and procedures, and any other applicable requirements.
d. SWMBH or a participant CMHSP shall verify through annual on-site reviews and other means as necessary that the organizational provider's credentialing practices meet applicable policies and requirements.

H. **Reporting Requirements.**

a. **Routine.**
   i. Participant CMHSPs shall submit a monthly credentialing report to SWMBH, utilizing the MDHHS credentialing report template.
   ii. SWMBH shall submit quarterly reports to MDHHS at the timeframes referenced in the MDHHS-PIHP Master Contract Schedule E, utilizing the MDHHS credentialing report template.
b. **Ad hoc.**
   i. Participant CMHSPs shall promptly report to SWMBH's Director of Provider Network information about an organizational provider which could result in suspension or termination from the SWMBH network, including but not limited to:
      1. known improper conduct (e.g. fraud, threats to member health and safety, etc.);
      2. Positive sanctions/exclusions screening results, in accordance with SWMBH Procedure 10.13;
      3. Any other information that may affect the organizational provider's status as a SWMBH network provider.
   ii. SWMBH shall report any known improper conduct of an organizational provider which could

result in suspension or termination from the SWMBH network in accordance with applicable SWMBH policies and to the applicable regulatory authority (MDHHS, MI OIG, MI AG, provider's governing board, etc.).

Procedures: SWMBH Operating Procedure 2.03.01 Credentialing Reciprocity

Effectiveness Criteria: N/A

References:

MDHHS-PIHP Contract Schedule A, Section 1(N)(1)
MDHHS BPHASA Credentialing and Re-Credentialing Processes
BBA § 438.214
SWMBH Policy 2.18

Attachments:

2.03A SWMBH Organizational Credentialing Application
2.03B SWMBH Organizational Credentialing Checklist

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BEHAVIORAL HEALTH

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
1	5/18/15	N/A: before new template	N/A: before new template	N/A: before new template
2	12/1/16	N/A: before new template	N/A: before new template	N/A: before new template
3	12/1/17	N/A: before new template	N/A: before new template	N/A: before new template
4	12/14/18	N/A	Annual Board approval as required by MDHHS contract	Mila Todd & SWMBH Board
5	01/10/20	N/A	Annual Board approval as required by MDHHS contract	Mila Todd & SWMBH Board
6	09/28/21	Paragraph E	Added Reporting Requirements	Mila Todd
7	11/12/21	N/A	Annual Board approval as required by MDHHS contract	Mila Todd & SWMBH Board
8	02/10/23	Multiple	Revised entire policy to ensure alignment with revised MDHHS Credentialing Policy, and to add specificity around Quality checks and Reciprocity process.	Mila Todd
9	03/17/23	N/A	Reviewed by Regional PNM Committee	Mila Todd

02.03 Credentialing & Re-Credentialing - Organizational Providers

Final Audit Report 2023-03-31

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Southwest Michigan Behavioral Health

Southwest Michigan Behavioral Health is an affiliation of Barry County Community Mental Health Authority, Integrated Services of Kalamazoo (Kalamazoo Community Mental Health Authority), 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 **kelly.norris@swmbh.org** or **ryan.king@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 – can be owner's name if not incorporated)	Federal Tax Identification Number (TIN) OR SSN:
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. Copies of paper licenses and printouts of electronic licenses are both acceptable. 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 for all locations if multiple onsite licensing surveys were completed by MDHHS. Attach copies of:

- All onsite licensing surveys completed by MDHHS during the past 48 months.
- All Corrective Action Plans (CAPs) submitted in response to MDHHS onsite licensing surveys during the past 48 months.
- All letters received from MDHHS stating organization is in substantial compliance with most recent survey standards during the past 48 months.

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

☐ YES – ***See instructions above.*** Date of most recent onsite survey:

☐ NO – Please explain:

Has this organization received provisional HCBS approval from any other CMH: Yes No

▹ Indicate name of CMH that provisionally approved you:

ACCREDITATION

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

☐ **TJC** – The Joint Commission
☐ **CARF** – Commission on Accreditation of Rehabilitation Facilities
☐ **COA** – Council on Accreditation
☐ **AOA** – American Osteopathic Association
☐ **MARR** – Michigan Association of Recovery Residences
☐ **NCQA** – National Committee of Quality Assurance
☐ **BHCOE** – Behavioral Health Center of Excellence

☐ **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**

Is this organization enrolled into The Community Health Automated Medicaid Processing System (CHAMPS)?
CHAMPS Enrollment ☐ Yes ☐ No

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 an 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. If the organization has multiple homes/sites, have any of these homes/sites had licenses revoked, suspended, limited etc. or is there an action pending to do so?
☐YES ☐NO ☐N/A	3. Is there action pending to suspend, revoke, or limit the organization's license/certification?
☐YES ☐NO ☐N/A	4. Has the organization ever had its JCAHO, CARF, COA, AOA or any other accreditation revoked, suspended or limited?
☐YES ☐NO ☐N/A	5. Is there action pending to revoke, suspend, or limit the organization's current accreditation?
☐YES ☐NO ☐N/A	6. Has the organization ever had sanctions imposed by Medicaid?

☐YES ☐NO ☐N/A	7. Has the organization ever had sanctions imposed by Medicare?
☐YES ☐NO ☐N/A	8. 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	9. 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	10. 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 select the language(s) in which services are or can be provided:

☐ Spanish ☐ French ☐ German ☐ Italian ☐ Chinese ☐ Arabic ☐ Russian ☐ Portuguese ☐ Hindi
☐ American Sign Language ☐ Burmese ☐ Other (Specify): _____

Provider / Organization offers interpretation services: ☐ Yes ☐ No

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 ☐**YES** ☐**NO**

If "YES", please select all the accessible features your site(s) include ☐ handicap parking ☐ wide entries ☐ wheelchair access ☐ accessible waiting area and rooms ☐ lifts ☐ accessible bathrooms ☐ grab bars ☐ other equipment (Specify): _____

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

Southwest Michigan
BEHAVIORAL HEALTH

Principal Office: 5250 Lover's Lane,
Suite 200, Portage, MI, 49002
P: 800-676-0423
F: 269-883-6670

APPLICANT RIGHTS FOR CREDENTIALING AND RECREDENTIALING

1. The Applicants Rights for Credentialing and Re-credentialing will be included in the credentialing packet sent to Applicants applying to be providers in the SWMBH provider network.

2. Applicants have the right, upon request, to be informed of the status of their application. Applicants may contact the credentialing staff via telephone, in writing or email as to the status of their application.

3. Applicants have the right to review the information submitted in support of their credentialing application. This review is at the applicant's request. The following information is excluded from a request to review information:
    a. Southwest Michigan Behavioral Health is not required to provide the applicant with information that is peer-review protected.
    b. Information reported to the National Practitioner Data Bank (NPDB).
    c. Criminal background check data.

4. Should the information provided by the applicant on their application vary substantially from the information obtained and/or provided to Southwest Michigan Behavioral Health by other individuals or organizations contact as part of the credentialing and/or re-credentialing process, credentialing staff will contact the applicant within 180 days from the date of the signed attestation and authorization statement to advise the applicant of the variance and provide the applicant with the opportunity to correct the information if it is erroneous.

5. The applicant will submit any corrections in writing within fourteen (14) calendar days to the credentialing staff. Any additional documentation will be date stamped and kept as part of the applicant's credentialing file.

6. The applicant shall be notified in writing of a denial, restriction or reduction of their credentialing privileges with SWMBH. The applicant has the right to file a grievance and appeal by contacting the SWMBH customer service department at 1-800-890-3712.

Southwest Michigan Behavioral Health Credentialing Staff Contact Information

Kelly Norris, Provider Network Specialist
Phone: 269-488-6966
Email: Kelly.Norris@swmbh.org

Ryan King, Provider Network Specialist
Phone: 269-488-6443
Email: Ryan.King@swmbh.org

Serving Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren Counties

For Administrative Use ONLY

Recredentialing Due Date:	**Prior Recredentialing Date:**
Initial Credentialing Date:	**Credentialing Start Date:**
Credentialing Completion Date:	**Credentialing Decision Date:**

Organizational Provider File:

Initial ☐

Recredentialing ☐

PROVIDER NAME, ADDRESS and PHONE:

Is application obtained from another participant CMHSP: ☐

	Date Received	Date Reviewed	Date of 2nd Review
Organizational application and attestation			
Date of provider signature			
Copy of state license/certification (List with expiration date)			
Primary Source verification of license			
Quality Data check/ PI information (site review info/score) Plan of Correction?			
Copy of insurance w/exp. Date - Is CMH an additional insured?			
OIG sanctions list verification			
Michigan OIG sanction list verification			
SAM verification			
Copy of TJC, CARF, COA, AOA, MARR, NCQA, BHCOE DNV report. Date of expiration:			
NPI Verification			
Tax ID # / W-9			
G&A data base information			
QI Data Check (Required for Recredentialing Only)			
1. Compliance F/W/A or other billing issues: ☐ No issues reported. ☐ Issues reported [insert summary]			

2. Customer Services Issues (Other than formal Grievances / Appeals): ☐ No issues reported. ☐ Issues reported [insert summary]			
3. Utilization Management ☐ No issues reported. ☐ Issues reported [insert summary]			
Date file complete			
Application was signed/dated no more than 180 days prior to credentialing committee review?	Y☐ N☐		
Primary/secondary source verification occurred no more than 6 months prior to credentialing committee review?	Y☐ N☐		
Clean file reviewed by Medical Director **Date:**	Y☐ N☐		
Date of Credentialing committee decision: (N/A if clean file reviewed and approved by Medical Director)			
Provider notified of credentialing status			
Re-credentialing required by:			
HCBS Provisional Approval Date: CMHSP:			

Initial file review completed by: _____ Date: _____

Second file review completed by: _____ Date: _____

Approved by Medical Director: _____ Date: _____