MENTAL AND PHYSICAL HEALTH

Please answer every question

☐YES ☐NO	1. Do you presently have a physical or mental health condition, including alcohol/drug dependence, which would affect your ability to provide professional or medical staff duties as requested/required, with or without reasonable accommodations?
☐YES ☐NO	2. Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify that the use of drugs may have an ongoing impact and that it has occurred recently enough to indicate the individual is actively engaged in such conduct.)
☐YES ☐NO	3. Do you have any reason to believe that you would pose a risk to the safety or the well-being of your patients?
☐YES ☐NO	4. Are you ever unable to perform the essential functions of a practitioner in your area of practice, even with reasonable accommodations? We will not discriminate if reasonable accommodations are requested.

If you have answered "YES" to any of the above questions, you must include an explanation (attach an additional sheet if necessary):

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 practice
- ☐ Copy of Commercial General liability insurance certificate
- ☐ Copy of Professional liability insurance certificate
- ☐ Copy of Certificate(s) required to practice
- ☐ Current Resume
- ☐ Copy of W9 Form if private practice practitioner
- ☐ Completed malpractice explanation form if applicable
- ☐ Release to obtain transcripts and Consent for Criminal Background Check
- ☐ Other (specify): _____

_____

Clinician Name:
Agency/Business Name (if different than above):

Please fill this out as it applies to you and/or your practice. These answers help our organization understand our network better to ensure we are meeting all the needs of our members. Please provide evidence of formal certification or training.

LANGUAGES, CULTURAL COMPETENCIES AND/OR EXPERTISE

Language (Select all that apply)					
☐	Spanish	☐	French	☐	German
☐	Italian	☐	Chinese	☐	Arabic
☐	Russian	☐	American Sign Language	☐	Burmese
☐	Portuguese	☐	Hindi	☐	Other (Please Specify):
Cultural Expertise (Select all that apply)					
☐	African American	☐	Arabic/Middle Eastern	☐	Hispanic/Latino
☐	LGBTQA	☐	Native American Indian	☐	Poverty
☐	Racism	☐	Religion	☐	Gender Identity or Expression
☐	Spirituality	☐	Other (Please Specify):		

SPECIALTY PRACTICES and EVIDENCE BASED PRACITICES

Specialty Practices (Select all that apply)					
☐	Sex Offender Treatment	☐	Aging	☐	Eating Disorder Treatment
☐	Substance Use Disorder	☐	Obsessive Compulsive Disorder	☐	Sexual Identity
☐	Developmental disabilities	☐	PTSD/Trauma	☐	Other (Please Specify):
Evidence Based Practices (Select all that apply)					
☐	Parent Management Training – Oregon Model	☐	Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	☐	Eye Movement Desensitization and Reprocessing (EMDR)
☐	Trauma Recovery & Empowerment Model	☐	Seeking Safety	☐	Family Psycho-Education (FPE)
☐	Cognitive Behavior Therapy – General	☐	Cognitive Enhancement Therapy	☐	Moral Reconation Therapy
☐	Motivational Interviewing	☐	Contingency Management	☐	Assertive Community Treatment
☐	Evidence Based Supported Employment	☐	Multisystemic Therapy (MST)	☐	Motivational Enhanced Therapy (CBT)
☐	Dialectical Behavioral Treatment (DBT)	☐	Integrated Dual Diagnosis Treatment (IDDT)	☐	Other (Please Specify):

Race/Ethnicity

Clinician's Individual Race/Ethnic Category					
☐	American Indian	☐	Asian	☐	African American
☐	Hispanic or Latino	☐	Native Hawaiian/Other Pacific Islander	☐	White/Caucasian
☐	Other (Please Specify):	☐	Prefer not to answer		

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

1. **Certification of Truth, Accuracy and Completion:** By signing this, I attest that the information provided within the application is complete and accurate to my knowledge. All information submitted by me in this application is warranted to be true, correct and complete. I fully understand that if any matter stated in this application is or becomes false, Southwest Michigan Behavioral Health and participant CMHSPs will be entitled to terminate my provider agreement for breach.

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 his/her provision of services.
   b) Acknowledge an obligation to provide continuous care and supervision to all customers for whom I have responsibility and that I will seek clinical consultation whenever necessary and as directed by Southwest Michigan Behavioral Health and participant CMHSPs policies and procedures.
   c) 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 from 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 realize that certification of my credentials and/or license does not necessarily qualify me to perform certain clinical or medical procedures/treatment modalities without the written consent of the governing board.

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

_____ _____

Signature of Applicant Date

PROVIDER STATEMENT TO RELEASE INFORMATION

I consent to the release of all information that may be relevant to an evaluation of my professional competency, character, moral and ethical qualifications, including information about disciplinary action, suspension or other confidential or privileged information, to Southwest Michigan Behavioral Health or participant CMHSPs **(see list below)**. I understand and agree this consent is irrevocable for any period for which I am a credentialed provider. I release Southwest Michigan Behavioral Health, participant CMHSPs and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials.

PRINT NAME:_____

SIGNATURE:_____

DATE:_____

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.

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

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

Provider Network Fax #: 269-222-1708

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