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.
- To submit a completed credentialing application, please send an email with the completed application attached to **kelly.gabriel@swmbh.org** or **ryan.king@swmbh.org**. Alternatively, you may submit completed applications via the **Provider Network Fax #: 269-222-1708**. Please contact us by phone with any questions **- Kelly: 269-488-6966 and Ryan: 269-488-6443**.

>> 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. Most recent Program Certification or ASAM LOC must be attached, as noted below.

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

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): _____
☐ No additional languages spoken

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 Accreditation certificate or letter.
- ☐ Copy of Commercial General liability insurance certificate.
- ☐ Copy of Professional liability insurance certificate covering <u>all</u> agency employees.
- ☐ Copy of Workers Compensation Insurance.
- ☐ Completed W9 Form.
- ☐ For Clubhouse and Crisis Residential Providers, a copy of most recent Program Certification.
- ☐ For all SUD Providers, a copy of most recent ASAM LOC letter(s).
- ☐ For Specialized Residential provider, a copy of most recent on-site governmental licensing agenc 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.
- ☐ Cultural Competencies and/or Expertise – Specialty Practices & EBP – Race/Ethnicity Form

☐ Other (specify):

Agency Name:

Please check off boxes in the three below sections of any or all items that apply to the clinicians within your agency that are serving the Medicaid population. These answers help our organization understand our provider network better to ensure we are meeting all the needs of our members. We appreciate your commitment to the people we serve!

CULTURAL COMPETENCIES AND/OR EXPERTISE

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	☐ Sexual Identity	☐ Obsessive Compulsive Disorder
☐ 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 (ACT)
☐ Evidence Based Supported Employment	☐ Multisystemic Therapy (MST)	☐ Motivational Enhanced Therapy (CBT)
☐ Dialectical Behavioral Treatment (DBT)	☐ Integrated Dual Diagnosis Treatment (IDDT)	☐ Other (Please Specify):
☐ Other (Please Specify):	☐ Other (Please Specify):	☐ Other (Please Specify):

Race/Ethnicity

Race/Ethnic Category		
☐ American Indian	☐ Asian	☐ African American
☐ Hispanic or Latino	☐ White/Caucasian	☐ Other (Please 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

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