Southwest Michigan Behavioral Health

Southwest Michigan Behavioral Health is an affiliation of Barry County Community Mental Health Authority, Integrated Services of Kalamazoo (Kalamazoo County 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. For returning Providers it may result in the termination of Provider Status while awaiting re-credentialing.
- Keep a copy of this for your records and to provide to another participant CMHSP
- 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.

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

INDEPENDENT PRACTITIONER CREDENTIALING APPLICATION

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

IDENTIFICATION

First Name:	Middle Name:	Last Name:	Maiden or Former Name:
Agency/Business Name:		Email Address:	
Address:	City:	State:	Zip:
Business Telephone:		National Provider Identifier (NPI): (Application **cannot** be processed without a valid 10-digit NPI)	
Date of Birth:		Tax ID **OR** SSN: (Applicable for clinicians that are Private Practice)	

LICENSURE / CERTIFICATION

List all current professional licenses / certifications. Please attach valid copies of all licenses and/or certifications with application. (Copies of paper licenses and printouts of electronic licenses are both acceptable).

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

BOARD CERTIFICATION

List all current Board certifications. Please attach copy of Board Certificate, including copy of original letter of verification from the conferring body.

Name of Board	Date Certified	Date(s) Re-certified

Have you ever taken and failed a certification examination? Yes ☐ No ☐ If yes, please provide an explanation on separate sheet.

MEDICARE

Medicare Certification: Yes ☐ No ☐	Date Obtained:	Medicare ID Number:

INSURANCE

Complete this section and attach a copy of insurance certificate(s).

☐ I am employed or applying to be employed by Southwest Michigan Behavioral Health or participant CMHSP and would be covered under their organizational liability insurance coverage. (please move onto educational background if this box is checked)

Insurance Carrier	
Address	
Duration Period	
Amount of Coverage	
Insurance Carrier	
Address	
Duration Period	
Amount of Coverage	

Facility/Office Accessibility

Does your facility and/or office have accommodations for people with physical disabilities ☐**YES** ☐**NO**

If "YES", please list the accessible features your facility and/or office include (i.e., *wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment):* _____

_____

_____

EDUCATIONAL BACKGROUND

By signing this application, primary verification of education in the form of an official transcript or letter issued by the institution conferring your most advanced degree will be obtained by the credentialing department or designee.

Undergraduate Education	
Address	
Dates Attended	
Degree Received	

Clinical Graduate Education	
Address	
Dates Attended	
Degree Received	
Medical Education / Advanced Education	
Address	
Dates Attended	
Degree Received	
ECFMG # (if foreign Graduate) Please attach copy	
Internship / Residency / Fellowship	
Placement Setting	
Address	
Dates Attended	
Internship / Residency / Fellowship	
Placement Setting	
Address	
Dates Attended	

PROFESSIONAL WORK EXPERIENCE

Have you been practicing continuously within last 5 years or since obtaining your license (if less than 5 years) without a gap in employment 6 months or greater? ***Yes*** ☐ ***No*** ☐ ***If No, attach details***

If you are submitting a CV or Resume that documents professional experience including dates since obtaining licensure you do not need to complete below work experience section.

Employer ***(please list current or most recent first)***	
Address	
Phone Number	
Position	
Dates of Employment	

Supervisor	
Employer	
Address	
Phone Number	
Position	
Dates of Employment	
Supervisor	
Employer	
Address	
Phone Number	
Position	
Dates of Employment	
Supervisor	

HOSPITAL AFFILIATIONS

Physicians only

Hospital Name	
Address	
Dates of Affiliation	
Category of Membership	
Hospital Name	
Address	
Dates of Affiliation	
Category of Membership	

DISCLOSURE QUESTIONS

Please answer every question.

☐YES ☐NO	1. Has your professional license or certification to practice in your profession ever been denied, suspended, restricted, or revoked?

☐YES ☐NO	2. Have you ever been subjected to a fine, reprimand or limitations by any state of professional licensing, registration, or certification board?
☐YES ☐NO ☐N/A	3. Have your Federal DEA and/or your State Controlled Dangerous Substance certificates or authorizations ever been challenged, denied, suspended, restricted, revoked or denied renewal?
☐YES ☐NO	4. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, or otherwise restricted in regard to participation in the Medicare or Medicaid programs, or in regard to other federal or state governmental health plans or programs?
☐YES ☐NO	5. Have you ever had professional liability insurance denied, canceled, issued on special terms or renewal refused?
☐YES ☐NO	6. Have there been, or are there currently pending, any malpractice claims, suits, settlements, or arbitration proceedings involving your professional practice within the past 10 years? If yes, please provide information for each case.
☐YES ☐NO ☐N/A	7. Have your clinical privileges or medical staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital, healthcare institution or medical staff committee or governing board?
☐YES ☐NO	8. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action by any managed care organizations including HMOs, PPOs, or provider organizations such as IPAs and PHOs?

If you have answered "YES" to any of the above questions, you must include an explanation (attach an additional sheet if necessary. A malpractice explanation template form has been included for question 6):

CRIMINAL HISTORY

Please answer every question

☐YES ☐NO	1. In the last ten (10) years, or since obtaining licensure, whichever is longer, have you been convicted of a felony criminal offense?
☐YES ☐NO	2. In the last ten (10) years, or since obtaining licensure, whichever is longer, have you pled guilty or no contest to any felony criminal charges?
☐YES ☐NO	3. Are there any felony criminal charges currently pending against you?
☐YES ☐NO	4. In the last ten (10) years, or since obtaining licensure, whichever is longer, have you been charged with offenses of a sexual nature?

If you have answered "YES" to any of the above questions, please explain the nature of the charges, relevant dates, and how the matter was disposed (attach an additional sheet if necessary):

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	☐	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	☐	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
☐	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 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:_____

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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