

ORGANIZATIONAL PROVIDER CREDENTIALING APPLICATION

Please complete and return this application as soon as possible. Print or type the following information and complete each section in its entirety. Respond N/A for any questions that are not applicable. Sign and date the application/release and include copies of all requested documents listed on the last page.

Corporate Name _____

Facility/Program Name (DBA.) _____

Tax Identification Number _____

Administrative Address _____

City _____ State _____ Zip _____

CEO/President _____ Medical Director _____

Senior Staff Person at site _____ Clinical Director _____

Contact Person for Credentialing Inquiries _____

Telephone () _____ Fax () _____

E-mail Address _____

Hours of Operation (including evening and weekend): _____

Type of Facility *Please check appropriate box*

- Community Mental Health Center
- Community Mental Health Clinic
- Residential Treatment Center (RTC)
- Alcohol and Drug Treatment Center
- Child Placement Agency
- 24-hour Behavioral Health Unit in a General Hospital
- Psychiatric Hospital
- Other (specify) _____

Check any languages in addition to English spoken at this facility:

- | | | |
|------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Armenian | <input type="checkbox"/> French | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> German | <input type="checkbox"/> Laotian |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Greek | <input type="checkbox"/> Mandarin |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Hebrew | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Hindi | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Farsi | <input type="checkbox"/> Italian | <input type="checkbox"/> Sign Language |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Japanese | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Other: | | |

Do you prefer that referrals be made:

- directly to your staff, or through your central intake or administration?

LICENSURE

Please list all state and federal licenses for the facility. If there is a license for each service location, please indicate. Attach a copy of each license.

State	Type	Number	Date First Issued	Expiration Date	Status

Has any license ever been revoked, suspended, placed on probation or conditional status, limited, or voluntarily surrendered? Yes No If "yes" is checked, please explain fully on a separate sheet.

MEDICAID AND MEDICARE CERTIFICATION

Attach a copy of the last certification survey report for each site. Include the plan of correction to address any identified deficiencies.

Is your facility certified for Medicaid Participation? Yes <input type="checkbox"/> No <input type="checkbox"/>	Medicaid No:
Is your facility certified for Medicare Participation? Yes <input type="checkbox"/> No <input type="checkbox"/>	Medicare No.:

Has your organization ever been fined, suspended or excluded from participation, or had criminal charges brought by Medicaid or Medicare? Yes No If "yes" is checked, please explain fully on a separate sheet.

ACCREDITATION—JCAHO, NCQA, CARF, COA, CHAP

Attach a copy of the accreditation certificate

Is your facility accredited? Yes <input type="checkbox"/> No <input type="checkbox"/> *see below	Name of Accrediting Body:
Date of last survey:	Survey results valid through:
Outcome of survey:	

Staff Qualifications - *If your organization is currently not accredited, attach a copy of the Policy & Procedure or documented process used to ensure that direct care providers are legally and professionally qualified for the position to which they are appointed and for the performance of the privileges granted.

To your knowledge, has any member of your organization's medical/clinical staff ever been the subject of disciplinary proceedings by any state licensing board? Yes No If "yes" is checked, please explain fully on a separate sheet.

STATE AGENCY SURVEY OR INSPECTION REPORT

Attach a copy of:

- (1) the most recent State of Colorado annual survey or inspection report for each site. Include the plan of correction to address any identified deficiencies;**
- (2) current MHS designation for the delivery of Mental Health Services**

Agency Performing Survey or Inspection:
Date of Survey or Inspection:

Designation Certificate Expiration Date: _____

BACKGROUND INVESTIGATIONS

The organization's Executive Director, Medical Director, or Clinical Director must sign the following:

I attest that this organization conducts background investigations on all employees, interns, volunteers, and contract agents having contact with clients, consisting of at least the following, prior to hire:

1. A name search through the Colorado Bureau of Investigation;
2. A reference from the licensing board for licensed persons;
3. A check of the Central Registry of Child Abuse for persons having unsupervised contact with clients under age 18; and
4. A check of references of former employees for clinical staff.

The organization has written criteria for evaluating which convictions or complaints make an applicant unacceptable for hire, or a person unacceptable for retention.

Signature Title Date

PROFESSIONAL & GENERAL LIABILITY INSURANCE COVERAGE

Attach a copy of the declaration sheet of your current policy showing policy limits, coverage limitations and policy period.

Professional

Carrier _____

Address _____

City State Zip

Telephone () Fax ()

Effective Date:	Expiration Date:	Retroactive Date:
Policy No:		
Limit per Occurrence:	Aggregate Limit:	

Has your professional liability insurance coverage ever been denied, cancelled, non-renewed, or initially refused upon application? Yes No If "yes" is checked, please explain fully on a separate sheet.

General

Carrier _____

Address _____

City State Zip

Telephone () Fax ()

Effective Date:	Expiration Date:	Retroactive Date:
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Policy No:	
Limit per Occurrence:	Aggregate Limit:

PRACTICE INFORMATION

Identify the approximate percentage of practice time dedicated to the following client population:

Population	Young Child (0 - 5)	Child (6 - 12)	Adolescent (13 - 17)	Adult (18 - 64)	Older Adult (65+)
Percentage					

Are there any specific populations that your organization does not serve? Yes No
 If yes, please list: _____

Specialized Training/Experience

Check all that apply

Specialized Training in Treatment Modalities:

- | | | |
|--|--|--|
| Individual Therapy <input type="checkbox"/> | Brief/ Solution Focused Therapy <input type="checkbox"/> | Rehab/ Vocational Therapy <input type="checkbox"/> |
| Couples Therapy <input type="checkbox"/> | Cognitive-Behavioral Therapy <input type="checkbox"/> | Art/ Music/ Dance Therapy <input type="checkbox"/> |
| Family Therapy <input type="checkbox"/> | Dialectical Behavior Training <input type="checkbox"/> | Recreation Therapy <input type="checkbox"/> |
| Group Therapy <input type="checkbox"/> | EMDR: Level _____ <input type="checkbox"/> | Experiential Therapy <input type="checkbox"/> |
| Child Play Therapy <input type="checkbox"/> | Biofeedback <input type="checkbox"/> | Psychodrama <input type="checkbox"/> |
| Medication Management <input type="checkbox"/> | ECT <input type="checkbox"/> | |
- Faith-Based Therapy: *specify:* _____
- Other: *specify:* _____

Clinical Specialties with Training and Experience of at least 1 year:

- | | | |
|---|---|---|
| Initial Assessment/ Evaluation <input type="checkbox"/> | Personality/Character Disorders <input type="checkbox"/> | Grief/Loss <input type="checkbox"/> |
| Psychological Testing <input type="checkbox"/> | Post Traumatic Stress Disorder <input type="checkbox"/> | Gay/Lesbian Issues <input type="checkbox"/> |
| Neuropsychological Testing <input type="checkbox"/> | Schizophrenia/ Psychotic Disorders <input type="checkbox"/> | Adjustment Issues <input type="checkbox"/> |
| Crisis Intervention <input type="checkbox"/> | Severe & Persistent Mental Illness <input type="checkbox"/> | Anger Management <input type="checkbox"/> |
| Critical Incident Debriefing <input type="checkbox"/> | Sexual Dysfunctions <input type="checkbox"/> | Stress Management <input type="checkbox"/> |
| Psychopharmacology <input type="checkbox"/> | Sleep Disorders <input type="checkbox"/> | Developmental Disabilities <input type="checkbox"/> |
| Chemical Dependency/ Abuse <input type="checkbox"/> | Somatoform Disorders <input type="checkbox"/> | Physical Disabilities <input type="checkbox"/> |
| Anxiety/Panic/Phobia Disorders <input type="checkbox"/> | Marriage <input type="checkbox"/> | Medical Stress <input type="checkbox"/> |
| Attention Deficit Disorders <input type="checkbox"/> | Divorce <input type="checkbox"/> | Head Trauma/ OBS <input type="checkbox"/> |
| Bipolar Disorders <input type="checkbox"/> | Domestic Violence <input type="checkbox"/> | Chronic Pain <input type="checkbox"/> |
| Depressive Disorders <input type="checkbox"/> | Parent/Child Problems <input type="checkbox"/> | Chronic/ Terminal Illness <input type="checkbox"/> |
| Dissociative Identity Disorder <input type="checkbox"/> | Adoption Issues <input type="checkbox"/> | Physical Abuse <input type="checkbox"/> |
| Eating Disorders <input type="checkbox"/> | Blended Families <input type="checkbox"/> | Sexual Abuse <input type="checkbox"/> |
| Gender Identity Issues <input type="checkbox"/> | Foster Family Issues <input type="checkbox"/> | Other Trauma <input type="checkbox"/> |
| Impulse Control Disorders <input type="checkbox"/> | Caregiver Support <input type="checkbox"/> | Victims Issues <input type="checkbox"/> |
| Obsessive/Compulsive Disorders <input type="checkbox"/> | School Problems <input type="checkbox"/> | Forensics <input type="checkbox"/> |
- Specific cultural/ethnic specialties:

Please list any other category: _____

Clinical Staffing: specify the number of full-time (FT) and part-time (PT) staff in each category

ORGANIZATIONAL PROVIDER CREDENTIALING APPLICATION

	MD/ DO	Licensed PhD/ PsyD/ EdD	LCSW	LPC	LMFT	RN/ BSN/ LPN	CNS/ NP	Nurses w/ Prescriptive Authority	CAC I, II, or III	Unlicensed Doctoral or Master	Bachelor degree	Para-professionals
FT												
PT												

ATTESTATION/RELEASE

The following statement must be signed by the organization’s Executive Director, Medical Director, or Clinical Director

I, the undersigned, an authorized representative of the named health care facility, hereby attest and certify that the information given in, or attached to, this application is true to the best of my knowledge. I understand that any misinformation entered on this application which is subsequently found to be knowingly incomplete or false may lead to termination, denial, or disqualification from participation from any or all networks.

I attest and certify that the medical and/or clinical staff (direct service providers) are provided licensed clinical supervision and are legally and professionally qualified for the positions to which they are appointed and for the performance of the privileges granted.

I hereby release from any liability all individuals who submit information at the request of the organizations indicated on page one from whom credentialing is being requested, or their designee(s), to facilitate the assessment of the qualifications for the facility for affiliation. I release from liability and hold harmless Northeast Behavioral Health, LLC, as applicable, its designee(s), their directors, employees, or agents for acts in good faith and without malice in connection with the evaluation of this facility.

I understand, as an authorized agent of the applicant, that I and the organization have the burden of producing adequate information for proper evaluation of the organization’s competence, character, ethics and for resolving doubts about such qualifications.

I agree that a photocopy of this document will serve as a duplicate original.

Executive/Medical/Clinical Director Signature

Date

Printed Name

Checklist

Have you included the following?

- Copy of all facility licenses
- Copy of JCAHO, NCQA, CARF, COA, or CHAP accreditation certificate
- Policy & procedure ensuring staff is qualified for their position (if not accredited)
- Copy of declaration page proving current Professional & General liability coverage
- Malpractice history report from your insurance carrier covering the last 5 years
- Copy of last HCFA, Health Facilities Division survey report (Hospitals only)
- Copy of State of Colorado survey or inspection report
- Copy of Mental Health Services Designation Certificate
- Attestation/Release is signed by a Director

Please return this form with copies of applicable documents to:

Libby Goode-Grasmick
Northeast Behavioral Health, LLC
1306 11th Avenue
Greeley, CO 80631

Telephone: 970-347-2360
Fax: 970-392-1354
E-mail: libby.goode@northeastbho.org