

CMHPSM Organizational Credentialing/Re-credentialing Application Instructions

Overview

The CMHPSM credentialing/re-credentialing form is to be used for initial application and semi-annual renewal of an organization's credentialing standards to become or remain a Mental Health provider in the Community Mental Health Partnership of Southeast Michigan (CMHPSM) (Region 6). Providers must retain credentialed status to be eligible to contract with any of the Community Mental Health Service Program's within the CMHPSM region. Providers will receive written documentation related to their application submission acceptance or denial. This application may be updated from time to time, and the most recent version must always be used when applying or re-applying. Providers must remain cognizant of their credentialed term and re-apply prior to that term expiring to remain eligible to contract with the CMHSPs.

The application is a point in time review of organizational requirements as of the application date identified in Section 1. Contractually required documentation must be kept current at all times during the contract and will also need to be submitted between credentialing application submissions as they are updated or renewed (i.e. Accreditation, Insurance, and Debarment Status).

Approval of organizational credentialing means your organization has been deemed eligible to contract with the CMHSPs within the CMHPSM during the credentialed term.

Full Credentialing is granted for two years to organizations that have completed the application, attachments and debarment information in full.

Provisional Credentialing is granted to organizations that have completed the application and debarment information but need to resubmit attachments with missing information. Provisional Credentialing is typically awarded for a 90 day period of time.

Acceptance to the CMHPSM network **does not** guarantee a service contract will be issued by any or all of the CMHSPs in the CMHPSM region. **Please review the current CMHPSM Organizational Credentialing Policy for further guidance.** www.cmhpsm.org

Submission Requirements

The main application and attachments must be completed using Microsoft Word or equivalent.

No handwritten applications or attachments will be accepted. An electronic signature is preferred when submitting the document but could also be printed and traditionally signed and scanned to pdf format and submitted.

All required applications, attachments and documentation should be submitted by email to your local CMHSP contract or network management contact. Any incomplete applications will delay finalization of credentialing and potential contract opportunities.

A complete application includes:

Application - submit as a Microsoft Word Document or Adobe PDF Document

Attachments A-G - submit as a Microsoft Word Document or Adobe PDF Document

All other documentation (Proof of Accreditation and Certificate of Insurance) - submit as an Adobe PDF Document

The following box (below) is for CMHPSM/CMHSP use. Providers do not need to type in this box.

This section for CMHSP or CMHPSM use only:					
Application Reviewer:				Review Date:	
Application Approved:	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	Term Start:		Term End:	
Reviewer Organization:				EHR Upload Date:	

Application will be returned with status information if it is not approved or if more information is needed.
Re-credentialing applications need to be approved prior to the expiration of the previous application term.

Section 1 - Application Information

Select the CMHSP your organization is submitting this application to within the CMHPSM region. The CMHPSM is offering reciprocity across the region related to credentialing applications so the application should be submitted to only one of the regional partners. Providers credentialed in any of the region's CMHSP's will become a part of the regional CMHPSM Provider Network.

Include contact information for the staff person that the CMHPSM or CMHSP can contact regarding questions related to the application.

Select the service panel(s) and populations your organization is requesting to be made eligible to serve as a mental health provider. Please list any services your organization provides that aren't on our list of services. Your organization can expand beyond the services or consumer populations initially selected.

- ☐ MI Adult- Adult with Mental Illness
- ☐ Older Adult w/ SPMI- Adult with Serious and Persistent Mental Illness
- ☐ DD Adult- Developmentally Disabled Adult
- ☐ DD Child- Developmentally Disabled Child
- ☐ SED Child- Child with Severe Emotional Disturbance
- ☐ Co-Occurring SUD/MI: Individual with Substance Use Disorder and Mental Illness

Section 2 – Organizational Information

Complete all organizational information boxes, including;

*Organization (addresses)

*Organization Type

*Administrative Information (**add training**)

*Answer the series of questions related to licenses, certifications, sanctions, cancellations, malpractice, lawsuits, exclusion and debarments, etc. as listed. Provide a detailed explanation on a separate word document related to any and all questions that required a "yes" related to this table in section 2.

*Provider Delivered Service - Select the service panel(s) and populations that your organization is requesting as eligible to serve as a mental health provider. Please list any additional services that your organization provides that are not listed. Your organization can expand beyond the services or consumer populations initially selected.

MI Adult- Adult with Mental Illness

Older Adult w/ SPMI (Serious & Persistent Mental Illness)

I/DD Adult – Intellectual/Developmentally Disabled Adult

I/DD Child- Intellectual/Developmentally Disabled Child

Section 3 – Provider Contractual Requirements

Accreditation: Document your organization’s current accreditation status with any or all of the accreditation bodies listed below:

A copy of your current organization’s accreditation certificate or letter needs to be included with this application.

- TJC/JCAHO – The Joint Commission
 - CARF- Commission on Accreditation of Rehabilitation Facilities
 - COA- Council on Accreditation
 - NCQA- National Committee for Quality Assurance
 - BHCOE – Behavioral Health Center of Excellence (typically for ABA providers)
- Other: Please list your accrediting body, all other accreditations will be reviewed to ensure the standards match CMHPSM requirements.

Note: Medicaid and Medicare are not accreditation bodies. Do not list them here.

Insurance:

Document your current insurance by type. A copy of your current Certificate(s) of Insurance need(s) to be included with this application.

ADA Compliant Accommodations:

Indicate “Yes”, “No” or “N/A”

Hours of Service Availability:

Choose the first row, if your organization provides services other than 24/7 and identify the days/hours available for service.

Choose the second row, if your organization provides service 24 hours per day/7 days per week.

Organizational Staff Linguistic Capacity:

List the current linguistic capacity your organization. No documentation is required for this section.

Provider has expertise, specialized training or certifications in any of the following:

Check any special certifications your organization feels is relevant to this application. If you are adding to the list, the text box will expand as you type.

Sub-Contracting:

Check the appropriate boxes.

Organizations that contract for services under a CMHSP contract will require a waiver to do so. Explain any current or potential arrangements.

Special Certifications:

List as applicable. No documentation is needed related to expertise, specialized training or certifications.

Organizational References:

Provide 3 references to agencies that your organization contracts with for mental health services.

Section 4 – Staff Information:

This section is intended to be a point in time look at your organization’s staff credentialing and training. The items requested are contractual obligations. If your organization is large and you are able to provide the information in an Excel spreadsheet generated by your system, we will accept that in lieu of our attachment(s). Please label your version as it relates to our version (A-F).

Out of State Providers: If your corporate headquarters are in another state, complete the forms with all staff associated with your Michigan operations.

New Providers to the CMH System: As a new provider to the CMH system in Michigan, you will need to update this section of the credentialing to be awarded full credentialing.

Application Type:

Indicate how you will be submitting your staff credentialing and training information.

Re-Credentialing Application-Staff Information Type:

Document the number of pages attached for each of the Attachments A - F.

These attachments can be in pdf or word format and all the information should reflect the makeup of the organization as of the application date.

Backup or more extensive documentation may be requested on a sample of employees during the credentialing period, upon site visits or desk audits.

Please identify the staff the CMHPSM would contact related to the information entered into these attachments.

Contact the local CMHSP you are submitting the application to if you have any questions related to the required trainings. CMHSPs may have additional training requirements or a preferred documentation method.

Attachment A –Administrative Staff Requirements:

This section is designed to capture your organization’s administrative staff’s background and training information. These staff include, but are not limited to, CEO, CFO, etc. Complete all boxes related to each listed staff, as applicable. If any of the items listed have not occurred, leave the box blank. These will be expected to be completed in the event that a contract is being considered by one of our CMHSPs.

Attachment B – Aide level Staff Background:

This section is designed to capture your organization’s aide-level staff’s background information (including, but not limited to criminal background checks, motor vehicle checks, e-verify verification, etc.). Complete all boxes related to each listed staff, as applicable. If any of the items listed have not occurred, leave the box blank. These will be expected to be completed in the event that a contract is being considered by one of our CMHSPs.

Attachment C – Aide Level Staff Training:

This section is designed to capture your organization's aide-level staff. Complete all boxes related to each listed staff, as applicable. If any of the items listed have not occurred, leave the box blank. These will be expected to be completed in the event that a contract is being considered by one of our CMHSPs.

Attachment D – Licensed Clinical Practitioners Background:

This section is designed to capture your organization's Licensed Clinical Practitioner's background information (including, but not limited to criminal background checks, motor vehicle checks, e-verify verification, etc.). Complete all boxes related to each listed staff, as applicable. If any of the items listed have not occurred, leave the box blank. These will be expected to be completed in the event that a contract is being considered by one of our CMHSPs.

Attachment E – Licensed Clinical Practitioner Training:

This section is designed to capture your organization's Licensed Clinical Practitioner's training information. Complete all boxes related to each listed staff, as applicable. If any of the items listed have not occurred, leave the box blank. These will be expected to be completed in the event that a contract is being considered by one of our CMHSPs.

Attachment F – Licensed Clinical Practitioner Credentialing:

This section is designed to capture your organization's Licensed Clinical Practitioner's education and license information. Complete all boxes related to each listed staff, as applicable. If any of the items listed have not occurred, leave the box blank. These will be expected to be completed in the event that a contract is being considered by one of our CMHSPs.

Re-Credentialing Application - Debarment, Suspension and Exclusion Form:

Attachment G - Debarment, Suspension and Exclusion Form

Complete all pages as it pertains to your organization at application date.

Section 5 – Provider Certification, Release and Signature

Review the attestation and have the designated representative sign the document.

According to the ESIGN Act of 2000 the designated representative can sign the document by typing his or her name into the signature box.

Attestation of Organization CEO or Designated Representative			
Signature:	<input type="text"/>		
Enter Title:	<input type="text"/>	Enter Date:	<input type="text"/>