1333 Brewery Park Blvd., Suite140
Detroit, MI 48207-2635
313-576-2500

Credentialing/Re-Credentialing Application

This Credentialing/Re-Credentialing application was developed in accordance with Detroit Wayne Mental Health Authority certification/credentialing criteria.

DWMHA has designated Wellplace Michigan to act as a limited Credentialing Verification Organization (CVO). In this capacity Wellplace obtains information, including from primary sources, for the purpose of verifying an individual's credentials.

This application applies to **all** MD/DO/PhD/PsyD/EdD and Residents, Fellows and Interns, Nurse Practitioners (NP) and Physician Assistant (PA) professionals that provide direct services.

Submit this application with the required documentations to:

Wellplace Michigan
Attention: Credentialing Dept.
1333 Brewery Park Blvd., Suite 140
Detroit, MI 48207-2635

PLEASE TYPE OR PRINT CLEARLY

Please type or print clearly

Section 1: DEMOGRAPHICS

_____

Last First Middle

DOB: _____

_____ _____

S.S# Degree

Please list additional office locations on a separate sheet and attach to this page

Primary Office Location	**Secondary Office Location**
_____	_____
Street	Street
_____	_____
City State Zip County	City State Zip County
_____	_____
Area Code Number Extension	Area Code Number Extension
_____	_____
Fax Area Code Fax Number	Fax Area Code Fax Number
_____	_____
E-Mail Address	E-Mail Address
Correspondence To:	Correspondence To:
_____	_____
_____	_____
_____	_____
_____	_____
Tax Identification Number	**National Provider Identification Number (NPI)**

Preceptor means teacher or instructor.

Preceptor National Provider Identification Number (NPI) (For Residents only) _____

_____	_____	_____	_____
Medicare Provider #	Medicaid Provider #	DEA Number (**MD/DO/NP/PA)** 2/ 2N/ 3/ 3N/ 4/ 5 (Circle applicable schedule(s)	State Controlled Substance Certification **(MD/DO)**

Primary State of Licensure/Certification and Number _____

Secondary State of Licensure/Certification and Number _____

Preceptor Primary State of Licensure/Certification and Number **(For Residents only)** _____

For QBHP, if you are not yet a BCBA, please provide the name and license/certification number of the BCBA who is providing your supervision:

_____

Section 2: AFFILIATION AND PRIVILEGES

Primary Hospital Affiliation _____City _____

Address _____

Staff Privileges: _____ Active _____ Provisional _____ Consulting _____ Courtesy _____ Other

Other Hospital Affiliation _____ City _____

Address _____

Staff Privileges: _____ Active _____ Provisional _____ Consulting _____ Courtesy _____ Other

Other Hospital Affiliation _____ City _____

Section 3: PRACTICE ORIENTATION

Please indicate your Primary (1) and Secondary (2) therapeutic orientation:

_____ Biological/Psychopharmacological
_____ Psychodynamic/Insight oriented
_____ Psychoanalytical
_____ Behavioral
_____ Cognitive
_____ Other, please specify _____
_____

Specify your professional discipline:

_____ MD., AMA approved medical school, completed psychiatric residency
_____ DO., AOA approved medical school, completed psychiatric residency
_____ MD., Other _____
_____ PhD, APA approved clinical /counseling psychology program
_____ Psy.D, APA approved clinical /counseling psychology program
_____ Ed.D, APA approved clinical /counseling psychology program
_____ Resident
_____ Intern
_____ Fellow
_____ Nurse Practitioner (NP)
_____ Physician Assistant (PA)
_____ Other, (please specify) _____

_____

SECTION 4: CERTIFICATIONS

Are you Board eligible? __ Yes __ No – Specialty: _____

Are you Board certified? __ Yes __ No – Specialty: _____

Do you provide services for the hearing impaired? __Yes __ No

Are your offices accessible for physically challenged persons? __Yes __ No

Is English your primary language? __Yes __ No

Specify other language(s):

Language(s) Spoken	Degree of Fluency (Circle all that apply)	(Circle all that apply)
English	Little/ Moderate/ Full	Write/ Read
Spanish	Little/ Moderate/ Full	Write/ Read
Arabic	Little/ Moderate/ Full	Write/ Read
French	Little/ Moderate/ Full	Write/ Read
Italian	Little/ Moderate/ Full	Write/ Read
Polish	Little/ Moderate/ Full	Write/ Read
Other_____	Little/ Moderate/ Full	Write/ Read

Please identify the services you provide:

Mental Health Child_____ Adolescent _____ Geriatric _____ Other_____

Substance Abuse Child_____ Adolescent _____ Geriatric _____ Other _____

Please identify the treatment modality (ies) in which you practice and are requesting to be credentialed:

_____ Individual
_____ Peer Group
_____ Couples
_____ Family
_____ Multiple Family Group
_____ Multiple Couples Group
_____ Other – specify:
_____

SECTION 5: CREDENTIALING

Check the credentialing status (es) you are requesting:

□ Child Mental Health Professional (CMHP)
Minimum of 24 hours of continuing education specific to child/adolescent training for CMHP certification. The 24 hours is required by MDCH and must be accrued and documented between January 1 and December 31, each calendar year.

□ Qualified Mental Health Professional (QMHP)
Minimum 5 hours of SMI required specific training and/or continued education per year.

□ Qualified Intellectual Disabilities Professional (QIDP)
Minimum 5 hours of DD required training and/or continued education per year.

□ Substance Abuse Treatment Specialist (SATS)
Minimum 20 hours of population-specific training and CADC

□ Qualified Behavioral Health Professional (QBHP)
Minimum of 24 hours of Autism or ABA specific training every 2 years (4 of which are in Ethics)
Minimum of a Master's Degree in mental health field, or field approved through the BACB, minimum of 3 of the 6 BACB courses completed, and a minimum of one year of experience with ASD.

**** For QBHP – please submit supporting documentation/transcripts indicating completion of 3 of the 6 BACB courses.**

SECTION 6: EDUCATION

Institution	Location	Graduation Date
Institution	Location	Graduation Date

RESIDENCY/FELLOWSHIP (MD/DO):

Facility	Location	Date
Facility	Location	Date

If applicable, foreign medical graduate number _____

Internships/Fellowships **(PhD/ PsyD/ EdD):**

Facility	Location	Date
Facility	Location	Date

Post-Graduate Supervised Educational Experience (PA and NP):

Facility	Location	Date
Facility	Location	Date

One (1) year of Supervisory experience (PA):

Facility	Location	Date
Facility	Location	Date

SECTION 7: LIABILITY COVERAGE

Professional Liability Carrier _____ Policy Number _____

_____

Address City State Zip

Do you have worker's compensation coverage? ____Yes ____ No
Do you have general liability coverage? ___ Yes ___ No Amount $ _____ Date of Expiration _____
Are you covered by general liability insurance of your employer? Yes ___ No ___
Do you have claims made policy or occurrence policy? Yes _____ No _____
Amount of coverage per occurrence $_____ (If none, please write none) Date of Expiration _____
Number of prior judgments or prior settlements in the past **10** years: _____ (If none, please write none)
(For each malpractice action, please attach, to this application, an explanation of the claim associated.)

SECTION 8: QUESTIONNAIRE

Do any of the following apply now or have they ever applied to you? (Check Yes, No, or N/A)

	YES	NO	N/A
Received a Suspension or limitations of hospital practice privileges?			
Received a Suspension or sanction from Medicare/ Medical provider?			
Professional liability insurance cancellation in the past 5 years?			
Do you currently have Professional liability insurance? **If yes, please attach copy of Insurance certificate.** Amount of coverage per occurrence $ _____ Date of Expiration _____			
Are you covered by general liability of your employer?			
Have been the subject of a DEA licensing investigation(s) or action(s)?			
Have been the subject of a State Licensing investigation(s) or action(s)?			
Convicted of a felony, moral or ethical crime?			
Have a chronic physical illness, psychological impairment or Disorder that would affect your ability to practice your specialty?			
Have a chronic physical illness, psychological impairment or Disorder that would affect your ability to practice your specialty?			
Own more than 5% ownership in any facility to which you might refer patients?			
Have you ever received any suspensions, dismissals or disciplinary action?			
Dismissed or received disciplinary actions(s) for sexual misconduct?			
If yes, did the disciplinary action involve children?			
Are you currently engaged in the illegal use of controlled substances which would impair or limit your ability in any way to practice medicine with reasonable skill and safety?			
Are you currently engaged in the illegal use of controlled substances?			

If you have answered YES to any of the questions listed above, please attach on a separate sheet of paper an explanation and the date of reinstatement, if applicable.

Please submit copies of the following with your application:

☐ Current CV/Resume
☐ Copy of degree/official transcript
☐ MI- LARA Professional License
☐ Proof of Liability insurance (copy of current insurance certificate or Affiliation Agreement (**Residents**))
☐ MI- LARA Certification
☐ Photocopy of highest degree earned
☐ Copy of your DEA/State Certificate **(MD/DO only)**
☐ Current Copy of CV/Resume with employment date ranges
☐ MCBAP Certification
☐ MCBAP MAFE w/Development Plan
☐ CAFAS Child Adolescent Functional Assessment Scale Reliability Training (if applicable)
☐ PECFAS: Preschool and **E**arly Childhood Functional Assessment Scale Reliability Training (if applicable)
☐ **Continued Education 24 hrs. of specified training for CMHP**
☐ **Continued Education 5 hrs. of specific training for QMHP**
☐ **Continued Education 5 hrs. of specific training for QIDP**
☐ **Continued Education 20 hrs. of specific training for SATS**
☐ **Continued Education 24 hrs. of specific training for QBHP (Required every 2 years with 4 of those hours in Ethics)**
☐ **ASAM Certification (if applicable)**

Note: Please read, sign, and date pages 8 and 9 of this application.

CONSENT FOR RELEASE OF INFORMATION

I certify that all information provided is true and correct to the best of my knowledge and belief and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current liability insurance and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

I will notify Wellplace Michigan, the accredited organization that Detroit Wayne Mental Health Authority has designated to act as a limited Credentialing Verification Organization (CVO), within ten (10) calendar days of any material changes to the information that I have provided in my application or authorized to be released pursuant to the credentialing process.

I authorize Wellplace Michigan to consult with and inspect all documents from individuals and organizations having information bearing on my qualifications. I agree that Wellplace Michigan, acting in good faith pursuant to the release, shall not be liable for any act or omission related to evaluation or verification of information contained in this application.

I fully understand my rights as a practitioner include the following:

- The right to review information in my file that has been used to evaluate my credentialing application.
- The right to correct erroneous information obtained from other sources that is used to review my credentialing application.
- The right to be informed of my credentialing status upon request.

A photocopy of this release shall be as effective as an original when presented.

Signature of Applicant _____

Print Name _____Date_____

Credentialing/Re-Credentialing Application
Practitioner Rights

Practitioners have a right to be informed (upon request to the Credentialing Department) of the status of their application, a right to review non-protected information obtained during the credentialing or re-credentialing process and the right to correct erroneous information. In the event that information is obtained that varies substantially from that submitted by the applicant, including actions on license, professional liability claims history, sanctions by Medicare and Medicaid, pending or past actions involving hospital staff privileges, board certification decisions or information about professional training participation, the applicant is notified and has the right to correct the discrepancy.

I fully understand my rights as a practitioner include the following:

- The right to review information in my file that has been used to evaluate my credentialing application
- The right to correct erroneous information obtained from other sources that is used to review my credentialing application
- The right to be informed of my credentialing status upon request

Procedures for requesting status of credentialing/re-credentialing applications:

- Practitioner must submit in writing via email, letter of fax a request to Wellplace Michigan
- Responses to request must be made by Wellplace Michigan within 5 business days of the request.
- Type of information shared will include: type of documentation received, additional documentation needed, type of clearances completed correspondence sent or being sent to Practitioner

Procedures to correct erroneous information:

- Practitioner must complete a request in writing within 7 days of notification that information is incorrect.
- Practitioner has a total of 30 days to correct any erroneous information.
- Written documentation of corrections must be submitted to the Credentialing Committee at the Detroit Wayne Mental Health Authority (Authority)
- Within 10 days of receipt of corrected information, the Authority will verify corrections and notify Practitioner of the status of their application.

A photocopy of this consent shall be as effective as an original when presented.

Signature_____ Date_____

Print Name_____

FOR WELLPLACE USE ONLY

Date received: _____

Date Credentialing/Re-credentialing completed: _____

Action Taken:

_____ Additional information required
Reason(s): _____

Letter Sent _____
Date

_____ Additional information received _____
Date

_____ Application Deferred
Reason(s): _____

Letter Sent _____
Date

_____ Application Approved
Letter Sent _____
Date

NOTES/COMMENTS: _____

_____

_____

_____

_____

CREDENTIALING STAFF NAME **(Signature)** _____

Print name_____

Revised 9/2016