1333 Brewery Park Blvd., Suite 140
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 (DWMHA) 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** Substance Abuse Professionals, Peer Recovery Coaches, Associate, Bachelor and Master level 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

Name
Mr./Mrs./Ms.____
(Circle one) First Name Middle Initial Last Name

Date of Birth __________________________

Clinical Discipline: ____

Credentialing Expiration Date (**Wellplace Only**): _______________________________________

Section 2: Credentialing

What credentialing status (es) are you requesting? *Please check all that apply*

☐ 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/or continued education per year.
Health Professional License, or MCBAP/ IC&RC Certification.

☐ Substance Abuse Treatment Practitioner (SATP)

Minimum 20 hours of population-specific training and/or continued education per year.
State approved Development Plan.

☐ Qualified Behavioral Health Professional (QBHP)

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

POPULATION BEING SERVICED: (*check all that apply)*

- ☐ SEVERE MENTALLY ILL (SMI)
- ☐ SEVERE EMOTIONAL DISTURBANCE (SED)
- ☐ I/DD ADULT
- ☐ I/DD CHILD
- ☐ HABILITATION WAIVER
- ☐ CO-OCCURRING
- ☐ SUBSTANCE ABUSE
- ☐ AUTISM

Section 3: Language(s): Primary Language ____

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

Section 4: EDUCATION

Attach your Degree and if a*pplicable*, indicate if your Education/Degree status changed since the time you were credentialed? If so please update the information below.

(Required supporting documents: copy of diploma/degree or letter verifying degree earned on school's letterhead and copy of CV/Resume; For QBHP – please submit supporting documentation/transcripts indicating 3 of 6 BACB courses complete.))

Institution: ____

City/State: ____

Degree achieved in clinical specialty: ____

Section 5: LICENSURE/CERTIFICATION/LIABILITY COVERAGE

License/Registration/Certification(s):____

License No.:____________________________ Expiration Date: ___________________

Clinicians with a Temporary and/or Limited License, provide your Supervisor's name, license type, license number and date of expiration (For QBHP, if you are not a BCBA, please provide the information for the BCBA providing your supervision):

____

____

NPI # (if applicable) ___________________________________

MCBAP Certification # _________________________________

MCBAP Development Plan Approval Date: _______________ **Expiration Date:** _______________

SECTION 6: 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 or Medicaid?			
Do you **currently have or have you ever had** Professional liability insurance? Amount: $ _____________ Expiration date: ___________ **If yes, please attach copy of Certificate.**			
Are you covered by general liability insurance of your employer?			
Have been the subject of a State Licensing investigation or actions?			
Have you ever been convicted of a felony, moral or ethical crime?			
Have been the subject of a DEA licensing investigation(s) or action(s)?			
Have a chronic physical illness, psychological impairment or Substance Use 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 action(s) for sexual misconduct?			
If yes, did the disciplinary action involve children?			
Are you currently engaged in the illegal use of controlled substances?			

Section 7: WORK EXPERIENCE (*Current*)

Organization Name: ____

____

(Street Address)

____

City State Zip

____

Office Phone Office Fax Email Address Cell Phone

Date(s) of Employment: Start___________ End______________

Work Status: ❑Full-Time Employee ❑Part-Time Employee

❑Contractual Employee _________________ (Please provide Liability insurance)

Population serviced: ____

Description of duties performed: ____
____
____
____

Please attach copies of the following required documents to this application:

- ☐ **Current CV/Resume**
- ☐ **Copy of Degree/Official Transcript**
- ☐ **MI - LARA Professional License**
- ☐ **MI - LARA Certification**
- ☐ **MCBAP Certification**
- ☐ **MCBAP - MAFE w/Development Plan**
- ☐ **CAFAS: Child Adolescent Functional Assessment Scale Reliability Training (if applicable)**
- ☐ **PECFAS: Preschool and Early 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 20 hrs. of specific training for SADP**
- ☐ **Continued Education 24 hrs. of specific training for QBHP (Required every 2 years with 4 of those hours in Ethics)**

Note: Please read, sign and date pages 5 and 6 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 MICHIGAN 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:

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CREDENTIALING Staff Name (Signature) ____

Print name____

Revised 9/2016