MSHN
Mid-State Health Network

Application for Credentialing
Organizational Providers

Agency Contact Information	
Agency Name:	Website:
Chief Administrator Contact/Title: Phone #:	email:
Finance Contact: Phone #:	email:
Site Review/Quality Contact: Phone #:	email:
Check Appropriate Status: ☐ Sole Prop. ☐ Partnership ☐ Corp. ☐ LLC ☐ Non-Profit ☐ Other: ☐ Governmental entity (i.e., government, governmental subdivision or agency, or public corporation)	
Federally Qualified Health Center: ☐ Yes ☐ No	

Program Information - *attach additional sheets if necessary for multiple sites*			
Facility/Program #1 Name:		SA License #: *Gov. Entities: provide previously issued SA#, if not previously issued use 'NA'*	
Address #1:	City:	Zip:	County:
Primary Contact/Title: Phone:		email: Fax:	
Same Day Service? ☐ Yes ☐ No		Accepting new enrollees? ☐ Yes ☐ No	
24 hr on-call? ☐ Yes ☐ No		ADA Accessible? ☐ Yes ☐ No	
Please specify all fluent communicable languages, including sign language:			
Women's Specialty Designation, if applicable: ☐ Designated ☐ Enhanced			
MARR Certification (Recovery Housing Providers): ☐ Level III ☐ Level IV			
ASAM LOC Designation(s) – SUD Providers			
Early Intervention ☐ 0.5		Outpatient ☐ 1.0 ☐ 2.1 ☐ 2.5	
Withdrawal Management ☐ 3.2 ☐ 3.7		Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7	
Opioid Treatment Program ☐ Level 1		Hours of Operation:	

Facility #2 Name:		SA License #: *Gov. Entities: provide previously issued SA#, if not previously issued use 'NA'*	
Address #2:	City:	Zip:	County:
Primary Contact/Title: Phone:		email: Fax:	
Same Day Service? ☐ Yes ☐ No		Accepting new enrollees? ☐ Yes ☐ No	
24 hr on-call? ☐ Yes ☐ No		ADA Accessible? ☐ Yes ☐ No	
Please specify all fluent communicable languages, including sign language:			
Women's Specialty Designation, if applicable: ☐ Designated ☐ Enhanced			
MARR Certification (Recovery Housing Providers): ☐ Level I ☐ Level II ☐ Level III ☐ Level IV			
ASAM LOC Designation(s) – SUD Providers			
Early Intervention ☐ 0.5		Outpatient ☐ 1.0 ☐ 2.1 ☐ 2.5	
Withdrawal Management ☐ 3.2 ☐ 3.7		Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7	
Opioid Treatment Program ☐ Level 1		Hours of Operation:	

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Facility #3 Name:	SA License #: *Gov. Entities: provide previously issued SA#, if not previously issued use 'NA'*
Address #3: City:	Zip: County:
Primary Contact/Title: Phone:	email: Fax:
Same Day Service? ☐ Yes ☐ No	Accepting new enrollees? ☐ Yes ☐ No
24 hr on-call? ☐ Yes ☐ No	ADA Accessible? ☐ Yes ☐ No
Please specify all fluent communicable languages, including sign language:	
Women's Specialty Designation, if applicable: ☐ Designated ☐ Enhanced	
MARR Certification (Recovery Housing Providers): ☐ Level I ☐ Level II ☐ Level III ☐ Level IV	
ASAM LOC Designation(s) – SUD Providers	
Early Intervention ☐ 0.5	Outpatient ☐ 1.0 ☐ 2.1 ☐ 2.5
Withdrawal Management ☐ 3.2 ☐ 3.7	Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7
Opioid Treatment Program ☐ Level 1	Hours of Operation:

Accreditation - *attach a copy of the most recent accreditation certificate*	
Accrediting Body: ☐ CARF ☐ COA ☐ TJC ☐ AAAHC ☐ AOA ☐ NCQA ☐ N/A	Expiration Date:

Billing Information	
EIN:	NPI#:
Medicaid #:	Medicare #:
Indicate all insurance companies and/or managed care plans you currently have provider agreements with:	

Current Professional Liability Insurance Information - *attach copy of cover sheet (1 million/3 million minimum)*	
Insurance Carrier:	Policy #:
Address:	Coverage Amount:
City: State: Zip:	Expiration Date:

Privileges, Licensure, and Malpractice History	
Has the agency had any of the following **denied, revoked, suspended, reduced, limited, or placed on probation or have voluntarily relinquished** any of the following in anticipation of these actions, or are any of these actions now pending? I*f you answer yes to any of the following, attach full explanation.*	
1. License/Certificate to Operate in the State of Michigan	☐ Yes ☐ No
2. Accreditation (*treatment providers only*)	☐ Yes ☐ No
3. Professional Liability Insurance	☐ Yes ☐ No
4. Malpractice suits settled resulting in a judgment against you in the past five (5) year, or currently pending?	☐ Yes ☐ No
5. Are any malpractice judgements pending?	☐ Yes ☐ No
6. Within the past ten (10) years, has your organization ever been convicted of, or plead guilty to, a criminal offense?	☐ Yes ☐ No
7. Are there any medical incidents for which you have been contacted by an attorney regarding potential malpractice liability (settlement request, writ of summons, etc.)?	☐ Yes ☐ No
8. Have your organization had any Medicaid, Medicare, or other governmental or third-party payor sanctions?	☐ Yes ☐ No

9. Have your organization ever been excluded from the Medicaid or Medicare program? If yes, specify date: Date of Reinstatement:	☐ Yes ☐ No
10. Have civil and monetary penalties been levied against your organization by Medicare or Medicaid programs?	☐ Yes ☐ No
11. You must provide, at minimum, the prior 5 year's history of any professional liability claims resulting in a judgement or settlement. ***Complete Attachment B -Professional Liability Action Detail***	☐ Attached ☐ N/A

Non-Discrimination/Diversity Assurances
MSHN is committed to identifying and encouraging the participation of minority-owned, women-owned, and handipcapper-owned businesses within its provider network. Please check all that apply (optional): ☐ Minority-owned ☐ Women-owned ☐ Handicapper-owned

Policy & Practices *attach copies of policies and procedures*		Pg. #
1. Does the organization have policy/practice for access to services? (Including timeliness of response to referral, availability of services, access to services, emergency services, etc.)	☐ Yes ☐ No	
2. Does the organization have a credentialing and re-credentialing policy/practice, including primary source verification?	☐ Yes ☐ No	
3. Does the organization conduct criminal background checks at time of hire and periodically during employment?	☐ Yes ☐ No	
4. Does the organization assess staff competency on an ongoing basis through performance evaluation?	☐ Yes ☐ No	
5. Does the organization have a policy/practice regarding ongoing professional development? (Including orientation and ongoing training)	☐ Yes ☐ No	
6. Does the organization assess the cultural backgrounds of persons served and provide training to staff on any identified cultural issues?	☐ Yes ☐ No	
7. Does the organization's policy on treatment planning describe individualized treatment?	☐ Yes ☐ No	
8. Does the organization's policy on treatment planning include consumer involvement in the development of the plan of service?	☐ Yes ☐ No	
9. Does the organization have a policy/practice regarding serving persons with Limited English Proficiency?	☐ Yes ☐ No	
10. Does the organization have a continuous quality improvement (CQI) policy/practice?	☐ Yes ☐ No	
11. Does the organization have a process to assess customer satisfaction?	☐ Yes ☐ No	
12. Does the organization have policy/procedure describing case records, record review, security, and case record access?	☐ Yes ☐ No	
13. Does the organization have a corporate compliance policy?	☐ Yes ☐ No	
14. Does the organization have a safety management plan that includes: General Safety, Security, Hazardous Materials, Emergency Preparedness, Fire, Infection Control, etc.	☐ Yes ☐ No	

Consent and Release of Liability

Upon the signing of this application, I represent that all of the information now or hereafter given by me in support of this application is true, correct and complete to the best of my knowledge and belief. I agree to promptly notify MSHN if there are any material changes in the information provided, whether prior to or after acceptance as a MSHN participating provider. I hereby authorize the release of any information from any source including but not limited to information from individuals, peers, customers, companies, institutions, agencies, data banks or references who may have information bearing on my moral and ethical qualifications and competence to carry out the privileges I have requested, and I authorize them to release such information as you require, including my prior disciplinary records, for purposes of verifying information obtained in the attached application or any re-application information without any obligation to give me written notice of such disclosure. I agree to hold MSHN and the informant harmless from any liability to me and/or my organization for providing such information.

I hereby further authorize MSHN to release any and all information related in any way to agency professional practice to any person, entity or governmental agency which: (a) provides MSHN with an authorization signed by an agency designee; or (b) has a legal right to know under any state or Federal law. I agree to hold MSHN harmless from any liability for providing any such information as specified herein.

I release all parties from all liability from any damages, causes of action, including, but not limited to, slander and libel, that may result from furnishing any information to you. I agree that any false information in support of this application may result in action up to and including cancellation of any or all contracts subject to contract provisions regardless of when discovered by MSHN. I release MSHN, the MSHN Credentialing Committee, individually and collectively, from any and all liability from any damages and/or causes of action associated with the MSHN credentialing and privileging process.

I hereby signify my willingness to appear for interviews with MSHN. I fully consent to the inspection of any and all records and documents pertinent to agency application for appointment and/or privileges. I understand and agree that if MSHN determines that this application contains any significant misstatements, misrepresentations, or omissions, MSHN's acceptance of this application for participation and any subsequent participating provider agreement which MSHN enters into with me will be voidable at MSHN's sole discretion.

I understand and agree that: (a) I have the burden of producing all information required or requested by MSHN in connection with this application; (b) MSHN is under no obligation to complete the processing of this application until all information requested is provided; (c) MSHN has the sole discretion to determine whether or not my organization will be accepted as a participating provider; and (d) in the event that MSHN decides not to accept my organization as a participating provider, I may initiate administrative appeal procedures as defined in the MSHN provider appeal policy.

I understand and agree that the certifications, authorizations and other provisions contained herein shall remain in force for so long as this application is pending and, if accepted for participation, for so long as my organizations' provider agreement with MSHN remains in force.

Applicant Signature:_____ Date:_____

Print Name:_____

Organization:_____

Application Checklist

The following items are required to be completed and/or submitted:

Yes	NA	
☐	☐	All applicable items on the application are complete and legible
☐	☐	Signed and dated Consent and Release of Liability (pg. 4)
☐	☐	Written explanations attached for any privilege, licensure, or malpractice history questions answered "Yes"
☐	☒	Copy of Physicians DEA/Controlled Substances License (MAT providers only)
☐	☒	Copy of SAMHSA Certification for Opioid Treatment Program (MAT Providers only)
☐	☒	Copy of Accreditation Certificate and most recent survey report (SUD treatment only)
☐	☒	Copy of ASAM LOC Designation Application(s) or letter from MDHHS (SUD treatment only)
☐	☐	Copy of current Malpractice and Professional Liability Policy
☐	☐	Completed and Signed Federal W-9 Form
☐	☐	Attachment A – Staff Credentialing & Training Information
☐	☐	Attachment B – Professional Liability Action Detail (if applicable)
☐	☐	Attachment C – Disclosure of Ownership & Controlling Interest Statement
☐	☐	Attachment D – Electronic Funds Transfer Form
☐	☐	REMI Multiple User Request Form
☐	☐	Copy of most recent program audit conducted by home PIHP (if applicable)
☐	☒	Copy of MDHHS/OROSC SUD Women's Specialty designation letter (if applicable)
☐	☒	Copy of MARR Certification Letter (Recovery Residences only)

Application can be emailed to Carolyn.Tiffany@MidstateHealthNetwork.Org
Or mailed to 530 W. Ionia, Suite C | Lansing, MI 48933