**HealthWest**

**DCO Provider Credentialing Packet Checklist**

Please complete this credentialing application packet and submit via email, along with the required documents listed in the checklist following the instructions below.

* Save this packet to your computer
* Fill out forms and sign by typing your name in the signature boxes and then resave to your computer
* Obtain copies of the documents needed listed below and scan them and save on your computer
* Attach the completed packet and required documents to an email and return to the requester; please include “contracted provider credentialing” in the subject line
* Order transcripts per the instructions at the end of this packet (they are sent directly to HealthWest Human Resources)

Applicant Information:

Formal (legal) Name of Applicant:

Phone number of Applicant:

Email address of Applicant:

Address of Applicant:

Position/Job Title:

Provider type (SUD, MI, IDD, ABA etc.):

Population Served: [ ]  Adult [ ]  Child

Service Codes to be Provided:

Type of Provider: [ ]  Employee [ ]  Intern [ ]  Volunteer

**DCO/Employer Information**

Name of Employer/DCO:

Employer DCO/Contact Name:

Employer Contact Telephone #:

Employer contact E-Mail:

Start Date for HealthWest work:

**Please provide the following documentation with this checklist. Electronic documents are preferred, but copies or scanned documents are acceptable.**

|  |  |
| --- | --- |
| [ ]  | Copy of Employment Application, Resume and/or Intern application packet |
| [ ]  | Copy of Signed Job Description or Intern Agreement |
| [ ]  | Copy of Offer of Employment or Contract – Must include start date |
| [ ]  | Copy of Driver’s License (front and back) |
| [ ]  | Copy of Official Transcript(s) (see attached instructions) – **Not Needed for volunteers or interns** |
| [ ]  | Copy of Clinical License(s), Certification(s), and Registration(s)Please note, if you are applying to provide SUD services, you must include a copy of your CAADC, CADC or MCBAP Development plan proofs including your ASAM Certificate. |
| [ ]  | Copy of Central Registry Clearance Request **Results** - Use form [DHS-1929](https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Adult-and-Childrens-Services/Abuse-and-Neglect/Central-Registry/1929.pdf?rev=6f882751166b44759091b4b14c93c108&hash=03D2F5CA55BF4E9F6C48EC114E78B6DC) to request – **ONLY FOR YOUTH SERVING STAFF** |

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**HEALTHWEST**

**TRANSCRIPT AND LICENSE REQUIREMENTS**

HealthWest is required to have your official transcripts and a copy of your license(s) included in your human resources file. If your employer has your official transcript on file, you may submit a copy with your packet. If not, please follow the instructions below.

* **TRANSCRIPTS:** The transcript must be delivered to HealthWest Human Resources directly from your school (please do not have it sent to yourself).

Many schools have an electronic transcript system and allow you to order transcripts via their website. Check into that option first, as it is much faster and less burdensome.

Make sure you also send payment if a fee is required for the transcript.

The official transcript must be sent directly to HealthWest Human Resources in a sealed envelope or via email directly from the college or university transcript service.

**Please have transcripts emailed to:**

**Human.Resources@healthWest.net**

**OR mailed to:**

**Human Resources**

**376 E. Apple Avenue**

**Muskegon, MI 49442**

* **LICENSES:** Please include a copy of your license with your credentialing application. It can be scanned and emailed with your credentialing packet.

**Please continue to next page**

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**HealthWest**

**BACKGROUND CHECK INFORMATION AND AUTHORIZATION FORM**

It is this Agency’s policy to secure criminal conviction history information from ICHAT, the Michigan State Police and/or the Federal Bureau of Investigation (FBI). In addition, HealthWest requires a Secretary of State Driver Record check, Recipient Rights check, Michigan Sanction Provider check (MSP), Office of Inspector General (OIG) check, System for Awards Management (SAM) check, National Practitioner Data Bank (NPDB) check, Michigan and National Sex Offender Registry checks, and the MDHHS Central Registry check as part of the pre-employment screen process. The information listed below is required in order to process these checks.

**Note: Failure to accurately complete this form may result in rescinding the offer.**

**Name:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **First** | **Full Middle Name** | **Last** |

**Maiden Name or Other Name(s) Used (if none, please document N/A):**

**Birth Date (Month/Day/Year):**

**Race (Select One Race You Identify with Most):**

*[ ]* White/Hispanic *[ ]*  Black *[ ]*  Asian/Pacific Islander *[ ]* American Indian/Alaskan Native *[ ]*  Other/Unknown

**Gender**: *[ ]*  Male *[ ]* Female*[ ]*  Unknown

|  |  |
| --- | --- |
| **Driver’s License Number** | **State Issued** |
| **Last 4 Digits of Social Security Number** |

1. **Have you lived in the State of Michigan for the past 5 years?** ***[ ]* Yes** ***[ ]* No**
2. **Do you have any misdemeanor or felony convictions?** ***[ ]* Yes** ***[ ]* No**
3. **Have you ever had a substantiated Recipient Rights claim against you? *[ ]* Yes *[ ]* No**

**If you answered yes to 2. and/or 3. above, give a brief explanation and include the date and location of each occurrence:**

By signing below, I attest that this information was collected after an offer was accepted and I give my authorization for human resources staff to conduct all necessary background checks*,* both pre-employment, as well as ongoing*,* throughout my tenure with HealthWest.

|  |  |  |
| --- | --- | --- |
|  |  |  |
|       |  |       |

Signature Date

**If the applicant is under the age of 18, a parent or guardian must sign below:**

|  |  |  |
| --- | --- | --- |
|       |  |       |

Signature of Parent or Guardian Date

**HealthWest**

**Initial Credentialing and Insurance Paneling Application**

Please complete this application in full. Information requested will be used only for credentialing and insurance paneling purposes and will be treated as HIPAA protected information. Only those who need this information for billing, credentialing and/or audit purposes will have access.

|  |  |
| --- | --- |
| Name:  | Date: |
| Home Street Address:  |
| City:  | State:  | ZIP Code:  |
| Telephone Number:  | Email Address:  |
|  |  |

Please answer the following questions by checking appropriately beside each question being asked. If the answer to any of the questions is “Yes”, please attach a brief explanation on a separate sheet of paper. All questions must be answered, or this application will be sent back to you for completion.

|  |  |
| --- | --- |
| **All Questions Must Be Answered** | **Place an “x” in the box for one answer below** |
| 1. As it relates to sanctions, complaints and/or quality issues: has your license, registration, or certification ever been limited, suspended, or revoked?
 | Yes No N/A  |
| 1. (Practitioners) Have your privileges ever been suspended, diminished, or revoked or not renewed?
 | Yes No N/A  |
| 1. (Practitioners) Have you ever voluntarily withdrawn your privileges?
 | Yes No N/A  |
| 1. Are you currently using any illegal drugs?
 | Yes No  |
| 1. Have you ever been convicted of a felony?
 | Yes No  |
| 1. Have you ever been disciplined by any State Board, or by any Professional Conduct Board, or have you ever been reprimanded or fired by any state or federal agency that disciplines physicians or healthcare professionals?
 | Yes No  |
| 1. Are you able to perform the essential functions of the position you are being credentialed for with or without accommodation? Please explain if you answered no or need an accommodation.

 | Yes No  |

**Please continue to the next page.**

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**EDUCATION AND DEGREE(S)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Degree Type** | **Degree Major** | **School/College/University** | **Start/End** |
| High School Diploma/GED | N/A |  | Start: Month End: Month  | Year: Year:  |
| Technical School |  |  | Start: Month End: Month  | Year: Year:  |
| Undergraduate/Associates |  |  | Start: Month End: Month  | Year: Year:  |
| Undergraduate/Bachelor’s |  |  | Start: Month End: Month  | Year: Year:  |
| Graduate/Master’s |  |  | Start: Month End: Month  | Year: Year:  |
| Graduate/Doctorate |  |  | Start: Month End: Month  | Year: Year:  |
| Other: |  |  | Start: Month End: Month  | Year: Year:  |

**Please continue onto the next page**

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**LICENSES AND CERTIFICATIONS**

Please list all licenses and certifications and attached copies of them with this application. Examples of certifications include, but is not limited to, BCBA, RBT, CADC, CAADC, Parent Support Partner, Peer Support Specialist, TF-CBT, EMDR, etc. If you will be providing SUD Services, you must supply a CADC, CAADC or proof of a MCBAP Development Plan.

Type/Name of License/Certification:

License/Certification number:

Initial issue date: Expiration Date:

Type/Name of License/Certification:

License/Certification number:

Initial issue date: Expiration Date:

Type/Name of License/Certification:

License/Certification number:

Initial issue date: Expiration Date:

Type/Name of License/Certification:

License/Certification number:

Initial issue date: Expiration Date:

Type/Name of License/Certification:

License/Certification number:

Initial issue date: Expiration Date:

Type/Name of License/Certification:

License/Certification number:

Initial issue date: Expiration Date:

**Please continue onto the next page**

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**WORK HISTORY/MILITARY EXPERIENCE/INTERNSHIPS**

Please include your work history for the past 5 years, including your HealthWest experience if you are a current employee or have been an intern at HealthWest. Any gap in employment of 6 months or more in the previous 5 years must be explained in the last section on this page.

|  |  |
| --- | --- |
| Employer Name & Address |  |
| Dates of Employment | **From:**    | **To:**  |
| Position Title |  |
| Populations Served: Place and “x” in the box(es) next to the population(s) served while working in this job. | Mental Illness Intellectual Developmental DisabilitySubstance Use Disorder Seriously Emotionally Disturbed None |
| Age group(s) served. |  Adult Youth  |
| Job Duties: explain how you examined, evaluated, treated and/or provided supports to the above selected populations. |  |
| Reason for Leaving |  |

|  |  |
| --- | --- |
| Employer Name & Address |  |
| Dates of Employment | **From:**    | **To:**  |
| Position Title |  |
| Populations Served: Place and “x” in the box(es) next to the population(s) served while working in this job. | Mental Illness Intellectual Developmental DisabilitySubstance Use Disorder Seriously Emotionally Disturbed None |
| Age group(s) served. | Adult Youth  |
| Job Duties: explain how you examined, evaluated, treated and/or provided supports to the above selected populations. |  |
| Reason for Leaving |  |

**Please continue onto the next page**

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|  |  |
| --- | --- |
| Employer Name & Address |  |
| Dates of Employment | **From:**    | **To:**  |
| Position Title |  |
| Populations Served: Place and “x” in the box(es) next to the population(s) served while working in this job. | Mental Illness Intellectual Developmental DisabilitySubstance Use Disorder Seriously Emotionally Disturbed None |
| Age group(s) served. | Adult Youth  |
| Job Duties: explain how you examined, evaluated, treated and/or provided supports to the above selected populations. |  |
| Reason for Leaving |  |

|  |  |
| --- | --- |
| Employer Name & Address |  |
| Dates of Employment | **From:**    | **To:**  |
| Position Title |  |
| Populations Served: Place and “x” in the box(es) next to the population(s) served while working in this job. | Mental Illness Intellectual Developmental DisabilitySubstance Use Disorder Seriously Emotionally Disturbed None |
| Age group(s) served. |  Adult Youth  |
| Job Duties: explain how you examined, evaluated, treated and/or provided supports to the above selected populations. |  |
| Reason for Leaving |  |

**Please continue onto the next page**

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**WORK HISTORY/MILITARY EXPERIENCE/INTERNSHIPS**

|  |  |
| --- | --- |
| Employment Gap of Six (6) Months or More. Please Explain: |  |

**Please continue onto the next page**

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**INSURANCE PANELING INFORMATION**

|  |  |
| --- | --- |
| Date of Birth: State of Birth:  | Soc Sec #:  |

Do you have a CAQH (Council for Affordable Quality Healthcare) Proview Account? Place an “x” in the correct response: Yes No

Are you enrolled in CHAMPS (Michigan Medicaid)? Place an “x” in the correct response: Yes No

Are you enrolled/Credentialed with Medicare? Place an “x” in the correct response: Yes No

Do you have an NPI number? If so, please provide:

Do you fluently speak any language other than English?

If yes, which language(s):

**Practitioners/Prescribers**

DEA #:

Please submit a copy of your DEA Registration Card with this application.

Primary Specialty:

Secondary Specialty:

Are you Board Certified? Place an “x” in the correct response: Yes No

If yes, please list name of certifying Board:

Initial Certification date: Expiration Date:

**I attest that these questions and any supplemental information regarding them are answered truthfully, completely, and to the best of my knowledge. I also consent to inspection of any and all records and documents pertinent to this application.**

Signature Date

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