Southwest Michigan Behavioral Health
5250 Lovers Lane, Suite 200
Portage, MI 49002
(800) 676-0423

Barry County • Berrien County • Branch County • Calhoun County • Cass County • St. Joseph County • Kalamazoo County • Van Buren County

BECOMING A PROVIDER FOR SOUTHWEST MICHIGAN BEHAVIORAL HEALTH

APPLICATION

Individual and Organizational Providers seeking network participation must submit a completed Credentialing application to the Southwest Michigan Behavioral Health Provider Network Manager or Participant CMHSP designee through the SWMBH website. There are two application forms: One for individual providers and the other for organizational providers.

FOR INDIVIDUAL PROVIDERS, a completed application contains and attests to the completeness and accuracy of the following:

• A professional resume or Curriculum Vitae which provides the Provider's work history;

• A copy of all valid licenses, certificates, and/or registrations required for the practice of the profession for which the Provider is seeking approval;

• A practice history which contains a statement by the Provider in reference to professional liability claims history, any history loss of licensure or certification, any history of loss or limitations of clinical appointments or any disciplinary action by the state or a regulatory professional association, Medicare/Medicaid sanctions, felony convictions;

• All required attestations, including a release to perform primary source verification of all required information.

• Evidence of current and adequate malpractice insurance in the amount required by contract (date of coverage and the amount);

• For *physicians only,* as applicable, a primary source verification is required from a credible source as proof of the following:

1) Medical school graduation,

2) Completion of residency (ies) or board status (eligibility, application, status or certification date) as applicable,

3) Valid Medical license to practice (last date of issue or renewal),

4) Valid CDS and/or DEA certificate,

5) Documentation of good standing with any hospital designated by the physician

as a primary admitting facility including date of appointment, clinical appointments, and any restrictions placed or recommendations given by the hospital.

6) Confirmation of professional liability claims history.

• Southwest Michigan Behavioral Health Provider Network Staff or designee reserves the right to question Individual Providers. Applications must be complete and indicate that the applicant is mentally, physically, and emotionally capable of fulfilling clinical responsibilities. In addition, signature on the attestation indicates that the applicant is free from illegal drug use, chemical dependency and is able to perform the essential functions needed of the professional position.

• Evidence of acceptability as an Individual Provider may be documented through a site visit to complete a structured review of the site, practitioner records and the record keeping practices as well as other areas of compliance.

FOR ORGANIZATIONAL PROVIDERS, a completed application contains and attests to the completeness and accuracy of the following:

• A copy of any licenses, certificates and/or registrations required for the type of facility for which the Organizational Provider is seeking approval;

• A signed application containing, at minimum:

1) The specific programs/services requested for approval;

2) Any history of loss of licensure or certification, any history of loss or limitations or any disciplinary actions against the facility or its service providers by the State or any other regulatory body as well as an Medicare/Medicaid sanctions;

3) Staffing pattern;

4) Evidence of accreditation or evidence that the accreditation is in process;

5) Other documentation as required relative to requested services/programs. Southwest Michigan Behavioral Health Provider Network reserves the right to review all policies and procedures. It is a requirement that the facility be clean, safe, and accessible, capable to delivering sound clinical programs and in compliance with standards for Facility Providers. A structured review of the site, the practitioner files and record keeping practices as well as other areas may be initiated by the SWMBH Provider Network Manager or designee.

APPLICATION PROCESSING: Southwest Michigan Behavioral Health: Acute Care Providers, Substance Abuse Treatment Providers and Shared providers

1) Upon receipt of the application, the Provider Network Manager or designee reviews the application for completeness. If the application is incomplete a request for any missing documentation will be sent to the provider.

2) If the application is complete, the Provider Network Manager will contact references, review all materials, primary source verify as required and may

interview the applicant (as indicated).

3) The SWMBH Credentialing Committee will review the provider application and supporting documentation.

4) The Provider Network Manager will notify the applicant in writing of the Credentialing decision. The SWMBH provider manual can be located at www.swmbh.org

5) The Provider Network Manager or designee will notify the Operations Manager and the Utilization Management Systems of the new Provider, the services approved and the contractual provisions. Finance is notified to allow Provider payment mechanisms to be initiated.

Re-Credentialing (occurs every 2 years): At least sixty (60) days prior to the expiration of current credentialing, the Provider must complete and submit a reapplication form. A completed re-application form consists of the following: a signed reapplication form, documentation of additional licenses, certifications, or registration not previously documented, evidence of continued malpractice insurance, and any other documentation reasonably required for the types of appointment requested. The reapplication includes an attestation of continuing ability to function as a Behavioral Health practitioner and requests identification of any legal actions initiated against the Practitioner since previous approval was obtained.

As part of the re-credentialing process, the Provider Network Manager will review information about the Provider from the following internal sources:

- Site Review reports
- Member complaints
- Performance Indicator data
- Clinical Documentation review audits

This data will be combined with the Provider's re-application materials and presented to the Credentialing committee. The committee will review the package and make a determination regarding the providers' status.

The Provider Network Manager will notify the Provider of the renewal decision.

A decision to suspend, reduce, or revoke credentialing of programs, facilities or services can be made by the Venture Credentialing Committee. Reasons to do so are:

- Consumer complaints and service inquiries;

- Consistently poor Consumer outcome as determined from quality assurance and utilization review activities;

- Violations of contractual provisions;

- Other reasons include but are not limited to:

1) Loss of licensure or certification,

2) Loss of accreditation,

3) Loss of malpractice coverage,

4) Evidence of malpractice,

5) Ethics violations,

6) Billing fraud,

7) A felony conviction,

8) Inability to cooperate with case manager.

If such a decision is made, the Provider Network Manager of Southwest Michigan Behavioral Health will be responsible for notifying the Provider in writing. This action is also documented in the Provider's file and in the minutes of the meeting at which the action was taken.

The Provider Network Manager formally cancels the contractual relationship with the Provider with written notification detailing the reasons for termination. At the time of notification, the Provider will be informed of the right to appeal the decision and the specific process to utilize will be provided and is outlined in SWMBH policy 2.14 Provider Grievance and Appeals Process.

All contracted / participating providers in the Southwest Michigan Behavioral Health network have the right to appeal actions taken by SWMBH relating to a participating provider's status within the provider network and actions related to a provider's professional competency or conduct. These actions may include decisions made in the network credentialing or re-credentialing process, or instances when SWMBH has chosen to discontinue a provider's participating status with the network based on issues of quality of care/service. It also includes action taken as a result of any other breaches highlighted in the contract as a "material breach" and a potential cause for termination such as nondiscrimination, non-compliance with applicable laws, non-compliance with consumers' recipient rights and consumer grievance procedures, etc. The process for appeal is outlined in SWMBH's Policy number 2.14 and can be found on the SWMBH website located at www.swmbh.org.

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INSTRUCTIONS

- Applications should be typed or legibly printed in black or dark blue ink. If more space is needed, attach additional sheets and reference the question being answered. ALL fields are required to be completed unless otherwise directed.
- Modification to the wording or format of the application will invalidate the application.
- See shaded areas of each section for further instructions.
- Current copies of all applicable documentation requested on page 7 *Attachments*, must accompany this application.
- Failure to legibly complete all sections of this Application and submit current copies of required documentation may result in the Application being returned to the provider without processing. For returning Providers it may result in the termination of Provider Status while awaiting re-credentialing.
- If you have credentialing questions, please send an email message to moira.kean@swmbh.org or scott.vankirk@swmbh.org. You may also contact us by phone at 1-800-676-0423.

>> NOTICE <<

ACCEPTANCE OF THIS APPLICATION DOES NOT CONSTITUTE APPROVAL, ACCEPTANCE OR PARTICIPATING PROVIDER STATUS WITHIN THE SWMBH PROVIDER NETWORK, AND GRANTS THIS APPLICANT NO RIGHTS OR PARTICIPATION PRIVILEGES UNTIL SUCH TIME A CONTRACT IS CONSUMMATED AND WRITTEN NOTICE OF PARTICIPATION STATUS IS ISSUED BY THE CREDENTIALING COMMITTEE.

Southwest Michigan Behavioral Health and CMHSP Participants will not discriminate against a provider solely on the basis of license or certification. SWMBH and CMHSP Participants will not discriminate against a health care professional who services high-risk populations or who specializes in the treatment of costly conditions.

INDEPENDENT PRACTITIONER CREDENTIALING APPLICATION

☐ **INITIAL CREDENTIALING** ☐ **RECREDENTIALING**

IDENTIFICATION

First Name:	Middle Name:	Last Name:	Maiden or Former Name:
Business Name:		Email Address:	
Address:	City:	State:	Zip:
Business Telephone		National Provider Identifier (NPI): (Application **cannot** be processed without a valid 10-digit NPI)	
Date of Birth:		Tax ID: (Applicable for clinicians that are Private Practice)	

LICENSURE / CERTIFICATION

List all current professional licenses / certifications. Please attach valid copies of all licenses and/or certifications with application.

License / Certification Number	State or City	Licensing / Certification Agency	Initial Issue Date	Renewal Date	Expiration Date

BOARD CERTIFICATION

List all current Board certifications. Please attach copy of Board Certificate, including copy of original letter of verification from the conferring body.

Name of Board	Date Certified	Date(s) Re-certified

Have you ever taken and failed a certification examination? Yes ☐ No ☐ If yes, please provide an explanation on separate sheet.

MEDICARE

Medicare Certification: Yes ☐ No ☐	Date Obtained:	Medicare ID Number:

INSURANCE

Complete this section and attach a copy of insurance certificate(s).

☐ I am employed or applying to be employed by Southwest Michigan Behavioral Health or participant CMHSP and would be covered under their organizational liability insurance coverage. (please move onto educational background if this box is checked)

Insurance Carrier	
Address	
Duration Period	
Amount of Coverage	
Insurance Carrier	
Address	
Duration Period	
Amount of Coverage	

EDUCATIONAL BACKGROUND

By signing this application, primary verification of education in the form of an official transcript or letter issued by the institution conferring your most advanced degree will be obtained by the credentialing department or designee.

Undergraduate Education	
Address	
Dates Attended	
Degree Received	
Clinical Graduate Education	
Address	
Dates Attended	
Degree Received	
Medical Education / Advanced Education	

Address	
Dates Attended	
Degree Received	
ECFMG # (if foreign Graduate) Please attach copy	
Internship / Residency / Fellowship	
Placement Setting	
Address	
Dates Attended	
Internship / Residency / Fellowship	
Placement Setting	
Address	
Dates Attended	

PROFESSIONAL WORK EXPERIENCE

Have you been practicing continuously within last 5 years or since obtaining your license (if less than 5 years) without a gap in employment 6 months or greater? ***Yes*** ☐ ***No*** ☐ ***If No, attach details***

If you are submitting a CV or Resume that documents professional experience including dates since obtaining licensure you do not need to complete below work experience section.

Employer ***(please list current or most recent first)***	
Address	
Phone Number	
Position	
Dates of Employment	
Supervisor	
Employer	
Address	
Phone Number	
Position	

Dates of Employment	
Supervisor	
Employer	
Address	
Phone Number	
Position	
Dates of Employment	
Supervisor	

HOSPITAL AFFILIATIONS

Physicians only

Hospital Name	
Address	
Dates of Affiliation	
Category of Membership	
Hospital Name	
Address	
Dates of Affiliation	
Category of Membership	

DISCLOSURE QUESTIONS

Please answer every question.

☐YES ☐NO	1. Has your professional license or certification to practice in your profession ever been denied, suspended, restricted or revoked?
☐YES ☐NO	2. Have you ever been subjected to a fine, reprimand or limitations by any state of professional licensing, registration or certification board?
☐YES ☐NO ☐N/A	3. Have your Federal DEA and/or your State Controlled Dangerous Substance certificates or authorizations ever been challenged, denied, suspended, restricted, revoked or denied renewal?
☐YES ☐NO	4. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid programs, or in regard to other federal or state governmental health plans or programs?

☐YES ☐NO	5. Have you ever had professional liability insurance denied, canceled, issued on special terms or renewal refused?
☐YES ☐NO	6. Have there been, or are there currently pending, any malpractice claims, suits, settlements, or arbitration proceedings involving your professional practice within the past 10 years? If yes please provide information for each case.
☐YES ☐NO ☐N/A	7. Have your clinical privileges or medical staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital, healthcare institution or medical staff committee or governing board?
☐YES ☐NO	8. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action by any managed care organizations including HMOs, PPOs or provider organizations such as IPAs and PHOs?

If you have answered "YES" to any of the above questions, you must include an explanation (attach an additional sheet if necessary. A malpractice explanation template form has been included for question 6):

CRIMINAL HISTORY

Please answer every question

☐YES ☐NO	1. In the last ten (10) years, or since obtaining licensure, whichever is longer, have you been convicted of a felony criminal offense?
☐YES ☐NO	2. In the last ten (10) years, or since obtaining licensure, whichever is longer, have you pled guilty or no contest to any felony criminal charges?
☐YES ☐NO	3. Are there any felony criminal charges currently pending against you?
☐YES ☐NO	4. In the last ten (10) years, or since obtaining licensure, whichever is longer, have you been charged with offenses of a sexual nature?

If you have answered "YES" to any of the above questions, please explain the nature of the charges, relevant dates, and how the matter was disposed (attach an additional sheet if necessary):

MENTAL AND PHYSICAL HEALTH

Please answer every question

☐YES ☐NO	1. Do you presently have a physical or mental health condition, including alcohol/drug dependence, which would affect your ability to provide professional or medical staff duties as requested/required, with or without reasonable accommodations?
☐YES ☐NO	2. Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify that the use of drugs may have an ongoing impact and that it has occurred recently enough to indicate the individual is actively engaged in such conduct.)
☐YES ☐NO	3. Do you have any reason to believe that you would pose a risk to the safety or the well-being of your patients?
☐YES ☐NO	4. Are you ever unable to perform the essential functions of a practitioner in your area of practice, even with reasonable accommodations? We will not discriminate if reasonable accommodations are requested.

If you have answered "YES" to any of the above questions, you must include an explanation (attach an additional sheet if necessary):

ATTACHMENTS

Have you attached <u>all</u> required documents? If not, the processing of your application will be delayed.
Check all documents included with this application.

- ☐ Copy of all State and/or local licenses required to practice
- ☐ Copy of Commercial General liability insurance certificate
- ☐ Copy of Professional liability insurance certificate
- ☐ Copy of Certificate(s) required to practice
- ☐ Current Resume
- ☐ Copy of W9 Form if private practice practitioner
- ☐ Completed malpractice explanation form if applicable
- ☐ Other (specify): _____

_____

SPECIALTY PRACTICES and EVIDENCE BASED PRACITICES (OPTIONAL ATTACHMENT)

- ***Please enter an "X" for Specialty Practices and EBPs in gray box to left of Practices that are Applicable***

Specialty Practices Please provide evidence of formal certification or training					
	Sex Offender Treatment		Spanish Speaking		Eating Disorder Treatment
	Culturally Diverse Population		Obsessive Compulsive Disorder		Sexual Identity
	Other (Please Specify)				
Evidence Based Practices Please provide evidence of formal certification or training					
	Parent Management Training – Oregon Model		Trauma Focused Cognitive Behavioral Therapy (TF-CBT)		Eye Movement Desensitization and Reprocessing (EMDR)
	Trauma Recovery & Empowerment Model		Seeking Safety		Family Psycho-Education (FPE)
	Cognitive Behavior Therapy – General		Cognitive Enhancement Therapy		Moral Reconation Therapy
	Motivational Interviewing		Contingency Management		Assertive Community Treatment
	Evidence Based Supported Employment		Multisystemic Therapy (MST)		Motivational Enhanced Therapy (CBT)
	Dialectical Behavioral Treatment (DBT)		Integrated Dual Diagnosis Treatment (IDDT)		Other (Please Specify)

By signing and affixing your signature below, the Applicant agrees to be bound by the following:

1. **Certification of Truth, Accuracy and Completion:** By signing this, I attest that the information provided within the application is complete and accurate to my knowledge. All information submitted by me in this application is warranted to be true, correct and complete. I fully understand that if any matter stated in this application is or becomes false, Southwest Michigan Behavioral Health and participant CMHSPs will be entitled to terminate my provider agreement for breach.

2. **Continuing Duties of the Applicant**:
   a) The Applicant is under a continuing duty to promptly advise this organization and participants of any changes, additions or deletions to the information contained in the Application or that would be relevant to his/her provision of services.
   b) Acknowledge an obligation to provide continuous care and supervision to all customers for whom I have responsibility and that I will seek clinical consultation whenever necessary and as directed by Southwest Michigan Behavioral Health and participant CMHSPs policies and procedures.
   c) The Applicant agrees to abide by all applicable laws, rules, regulations, policies, by-laws and procedures in effect at the time of this Application, and during the term of the credentialing cycle.

3. **Release of Information:** By submitting this Application and placing an authorized signature below, the Applicant hereby authorizes and consents to the following:
   a) All information contained in the Application and any attachments is subject to verification and review by CMHP and/or SWMBH employees or their agents.
   b) Authorize SWMBH and/or CMHP employees or agents to discuss matters directly related to this Application and any attachments provided with third parties, including but not limited to past/ present malpractice carriers and Community Mental Health Programs outside of SWMBH for the purposes of evaluating the Applicant's professional competence, character and ethical qualifications.
   c) The Release of Information is valid for two years.

4. **Release of Liability**: By submitting this Application and signing below, the Applicant releases from liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with the investigating and evaluation provider's application, and waive all legal claims against any and all individuals and organizations who provide information in good faith and without malice concerning professional competence, character and ethics.

5. **Reservation of Rights:** SWMBH and Participant CMHPs have the right to suspend and/or terminate providers credentials and status within the Provider Network when the provider's behavior and/or practice appears to pose a significant risk to the health, welfare or safety of our customers. I realize that certification of my credentials and/or license does not necessarily qualify me to perform certain clinical or medical procedures/treatment modalities without the written consent of the governing board.

I hereby agree and consent to be bound by the requirements stated above:

_____ _____

Signature of Applicant Date

PROVIDER STATEMENT TO RELEASE INFORMATION

I consent to the release of all information that may be relevant to an evaluation of my professional competency, character, moral and ethical qualifications, including information about disciplinary action, suspension or other confidential or privileged information, to Southwest Michigan Behavioral Health or participant CMHSPs. I understand and agree this consent is irrevocable for any period for which I am a credentialed provider. I release Southwest Michigan Behavioral Health, participant CMHSPs and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

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ORGANIZATIONAL CREDENTIALING APPLICATION

☐ **INITIAL CREDENTIALING** ☐ **RECREDENTIALING**

IDENTIFICATION

CORPORATE INFORMATION

Legal Business Name: (As reported to the IRS)	Federal Tax Identification Number (TIN):
Doing Business As (DBA) Name: (If applicable)	National Provider Identifier (NPI) for organization being credentialed: ☐ **N/A (if N/A please specify reason)**
Corporate Address: --- ---	Type and ownership: (please check one) ☐ **Federal** ☐ **State** ☐ **County** ☐ **City** ☐ **Private Non-Profit** ☐ **Privately Owned** ☐ **Corporation** ☐ **Partnership** ☐ **LLC/LLP**
Medicaid #: (if applicable)	Medicare #: (if applicable)

PROVIDER INFORMATION

Address must be a street address, not a Post Office box. **Please attach list of any other locations.**

Name:			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	County:
Phone:	Fax:	Website: www.	
Credentialing Contact Name:		Contact Title:	
Phone:	Fax:	Email:	
Contract Administrator:		Email:	
Billing Manager:		Email:	

MAILING/CORRESPONDENCE ADDRESS

Must be an address where provider can be contacted directly. ***PAYMENTS WILL BE MAILED TO THIS ADDRESS.***

☐ Check here if all correspondence can be directed to the location above.
If not, complete the section below.

Name:			
Mailing Address Line 1:			
Mailing Address Line 2:			
City:	State:	Zip:	Phone:

PROVIDER TYPE
Check ONE box only

☐ Psychiatric Hospital
☐ General Hospital with Psychiatric Unit
☐ Partial Hospitalization – free standing
☐ Partial Hospitalization – hospital based
☐ Specialized Residential
☐ SUD Residential Treatment Center
☐ SUD Outpatient Service Facility / Clinic
☐ SUD Detoxification Treatment Center
☐ Opioid/Methadone Treatment Program
☐ Behavioral Healthcare Group / Private Practice
☐ Other (please specify)

LICENSURE

Is this organization state licensed? ☐ YES ☐ NO (if yes complete the following license information)
Attach a copy of each license for this organization.
All licenses must be current and unrestricted
Do not submit practitioner licenses

License Number	State or City	Licensing Agency	Initial Issue Date	Renewal Date	Expiration Date

SPECIALIZED RESIDENTIAL PROVIDER LICENSING AUDIT

Complete this section and attach copy of most recent onsite DHS survey along with your Corrective Action Plan (CAP), if deficiencies were cited, and letter from DHS stating organization is in substantial compliance with most recent survey standards.

Has this organization had an onsite licensing survey by the DHS within the past 48 months?

☐ YES – Date of most recent onsite survey: mm/dd/yyyy ***See instructions above.***

☐ NO – Please explain:

Please complete this section for all locations if multiple surveys were completed by DHS

ACCREDITATION

Complete this section and attach copy of current Accreditation certificate or letter. Certificate/letter should list location as being included in the accreditation.

☐ **JCAHO** – The Joint Commission
☐ **CARF** - Commission on Accreditation of Rehabilitation Facilities
☐ **COA** – Council on Accreditation
☐ **AOA -** American Osteopathic Association
☐ **CHAMPS**

☐ **Other (please specify)**

1. Date of last full survey: mm/dd/yyyy
2. Effective dates of accreditation: mm/dd/yyyy through mm/dd/yyyy

☐ **Non-Accredited Organization**

STAFFING

Does this organization validate, for each licensed practitioner employed or contracted at the organization, the credentials necessary to perform health care services? ☐ YES ☐NO ☐N/A

- If YES, indicate how the organization conducts the credentialing process for each practitioner:
  ☐ Credentialing procedures are performed internally.
  ☐ Credentialing procedures are outsourced/delegated to _____
  ☐ Other, specify: _____
- If NO, explain: _____
  _____

INSURANCE

Complete this section and attach a copy of the organization's insurance certificate(s)

1. Is this organization covered by Commercial General liability insurance in the amount of $1 million per occurrence and $3 million aggregate?
   ☐ Yes
   ☐ No - *Please obtain the above amount of required coverage before submitting application.*

2. Is this organization covered by Professional liability insurance in the amount of $1 million per occurrence and $3 million aggregate? Must be a organizational policy, not Individual-only, policy.
   ☐ Yes
   ☐ No - *Please obtain the above amount of required coverage before submitting application.*

3. Is this organization covered by Workers Compensation insurance? If no, is there an exemption?
   ☐ Yes
   ☐ No – *Please attach copy of exemption.*

4. Is the CMHSP listed as an additional insured?
   ☐ Yes
   ☐ No

ATTESTATION

Answer every question YES, NO or N/A
Responses need to cover the past five (5) years to present.

☐**YES** ☐**NO** ☐**N/A**	1. Has the organization's state license/certificate ever been revoked, suspended or limited?
☐**YES** ☐**NO** ☐**N/A**	2. Is there action pending to suspend, revoke, or limit the organization's license/certification?
☐**YES** ☐**NO** ☐**N/A**	3. Has the organization ever had its JCAHO, CARF, COA, AOA or any other accreditation revoked, suspended or limited?
☐**YES** ☐**NO** ☐**N/A**	4. Is there action pending to revoke, suspend, or limit the organization's current accreditation?
☐**YES** ☐**NO** ☐**N/A**	5. Has the organization ever had sanctions imposed by Medicaid?
☐**YES** ☐**NO** ☐**N/A**	6. Has the organization ever had sanctions imposed by Medicare?
☐**YES** ☐**NO** ☐**N/A**	7. Has the organization commercial general or professional liability insurance ever, for any reason, been denied, cancelled, non-renewed or initially refused upon application?
☐**YES** ☐**NO** ☐**N/A**	8. Has the organization ever been a defendant in any lawsuit in regard to the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000 or more?
☐**YES** ☐**NO** ☐**N/A**	9. Has the organization had any malpractice claims in regard to the practice of mental health or substance abuse treatment?

If you have answered "YES" to any of the above questions, please provide the current status and details on a separate sheet of paper. Include the following: description of incident, correspondence with state licensing boards, and/or a detailed description of any litigation, including settlements, court awards, etc. Please feel free to include a personal summary of the events; however, your application cannot be processed without the necessary official documentation.

Language Competence

In addition to English, please list the languages in which services are provided:

Special Populations

Please indicate if you have any training and experience with the following. Check all that apply.

☐ Hearing Impaired ☐ Visually Impaired ☐ Speech Impaired ☐ Other (Specify):

Hours of Operation

If not a 24 hour residential setting please complete the Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Specialized Residential Services

Community Living Supports (CLS)/Personal Care in Licensed Setting: Provide staffing patterns per home (staffing ratio). Please complete this section per home if staffing varies per location.

Day of week	1st Shift	2nd Shift	3rd Shift
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			
Total FTE Staffing:			

ATTACHMENTS

Have you attached all required documents? If not, the processing of your application will be delayed.
Check all documents included with this application.

- ☐ Copy of all State and/or local licenses required to operate.
- ☐ Copy of Commercial General liability insurance certificate.
- ☐ Copy of Professional liability insurance certificate covering all agency employees.
- ☐ Copy of Workers Compensation Insurance
- ☐ Copy of Accreditation certificate or letter.
- ☐ For Specialized Residential provider a copy of most recent onsite governmental licensing agency survey including corrective action plan if deficiencies were cited, and letter from licensing agency stating organization is in substantial compliance with licensing standards from most recent survey.
- ☐ Completed W9 Form
- ☐ Other (specify): _____

_____

SERVICE PROFILE and EVIDENCE BASED PRACITICES

- ***Please enter an "X" for services contracted or contracting for in gray box to left of service***
- ***For Behavioral Health Services checked please include populations served under service (SPMI, DD, SED)***
- ***Refer to Medicaid Provider Manual for service definitions***
- ***For EBPs checked please provide evidence of formal certification or training***

Behavioral Health Services					
	ACT		Autism Services / Applied Behavioral Analysis		Case Management
	Peer Directed / Consumer Run		Community Employment Services		Community Living Support
	Crisis Residential (must be approved by MDCH)		Home-Based Services (must be approved by MDCH)		Inpatient Mental Health
	Intensive Crisis Stabilization (Must be approved by MDCH)		Mental Health Individual and Group Therapy		Nursing / Private Duty Nursing
	Occupational Therapy		Physical Therapy		Clubhouse / Psychosocial Rehabilitation (Must be approved by MDCH)
	Respite Care Services		Skill Building		Speech / Language Therapy
	Supports Coordination		Support / Integrated Employment Services		Supported Independent Living
	Wraparound Services		Specialized Residential		

Substance Abuse					
	Family Therapy		Sub-Acute Detox		Residential Treatment
	Medication Assisted Treatment		Peer Recovery Support Services		Prevention Services
	Early Intervention		Care Coordination		
Evidence Based Practices					
	Parent Management Training – Oregon Model		Trauma Focused Cognitive Behavioral Therapy (TF-CBT)		Eye Movement Desensitization and Reprocessing (EMDR)
	Trauma Recovery & Empowerment Model		Seeking Safety		Family Psycho-Education (FPE)
	Cognitive Behavior Therapy - General		Cognitive Enhancement Therapy		Moral Recognition Therapy
	Motivational Interviewing		Contingency Management		Assertive Community Treatment
	Evidence Based Supported Employment		Multisystemic Therapy (MST)		Motivational Enhanced Therapy (CBT)
	Dialectical Behavioral Treatment (DBT)		Integrated Dual Diagnosis Treatment (IDDT)		

Southwest Michigan Behavioral Health and CMHSP Participants will not discriminate against a provider solely on the basis of license or certification. SWMBH and CMHSP Participants will not discriminate against a health care professional who services high-risk populations or who specializes in the treatment of costly conditions.

By signing and affixing your signature below, the Applicant agrees to be bound by the following:

1. **Certification of Truth, Accuracy and Completion:** By submitting this Application and signing below, it is agreed and understood that all information contained in this Application, and all of the attachments provided are accurate, complete and true. If information provided by Applicant is discovered to be inaccurate, incorrect or information is withheld, SWMBH and participant CMHPs reserve the right to automatically terminate the Applicant as a provider of service(s) in this Provider Network.

2. **Continuing Duties of the Applicant**:
   a) The Applicant is under a continuing duty to promptly advise this organization and participants of any changes, additions or deletions to the information contained in the Application or that would be relevant to its provision of services.
   b) The applicant agrees to abide by all applicable laws, rules, regulations, policies, by-laws and procedures in effect at the time of this Application, and during the term of the credentialing cycle.

3. **Release of Information:** By submitting this Application and placing an authorized signature below, the applicant hereby authorizes and consents to the following:
   a) All information contained in the Application and any attachments is subject to verification and review by CMHP and/or SWMBH employees or their agents.
   b) Authorize SWMBH and/or CMHP employees or agents to discuss matters directly related to this Application and any attachments provided with third parties, including but not limited to past/ present malpractice carriers and Community Mental Health Programs outside of SWMBH for the purposes of evaluating the Applicant's professional competence, character and ethical qualifications.
   c) The Release of Information is valid for two years.

4. **Release of Liability**: By submitting this Application and signing below, the applicant releases for liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with the investigating and evaluation provider's application, and waive all legal claims against any and all individuals and organizations who provide information in good faith and without malice concerning professional competence, character and ethics.

5. **Reservation of Rights:** SWMBH and Participant CMHPs have the right to suspend and/or terminate providers credentials and status within the Provider Network when the provider's behavior and/or practice appears to pose a significant risk to the health, welfare or safety of our customers.

I hereby agree and consent to be bound by the requirements stated above:

_____ _____

Signature of Applicant Date

_____

Title

A PHOTOCOPY OF THIS DOCUMENT SHALL BE EFFECTIVE AS THE ORIGINAL

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Exempt payee

☐ Other (see instructions) ▶

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,
- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

Note. Check the appropriate box for the federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/ disregarded entity name" line.

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/ disregarded entity name," sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt payees 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements. Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity [4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Southwest Michigan Behavioral Health
5250 Lovers Lane, Suite 200
Portage, MI 49002
(800) 676-0423

APPLICANT RIGHTS FOR CREDENTIALING AND RECREDENTIALING

- Practitioners may be informed of the status of the application upon written, email, or telephone request.

- Practitioners may review all information obtained by SWMBH during the credentialing process, including the source of that information, unless it is prohibited or protected by law. This review is at the applicant's request.

- SWMBH will notify an applicant within 180 days from the signed attestation date of the application if any information obtained during the credentialing verification process varies substantially from the information provided by the applicant. SWMBH will advise the applicant of the variance and provide the applicant with the opportunity to correct the information if it is erroneous.

- The applicant will submit any corrections in writing within fourteen (14) calendar days of notification of discrepant information to the credentialing staff. Any additional documentation will be kept as part of the applicant's credentialing file.

- Practitioners may correct any erroneous information. Practitioners need to submit corrections to the SWMBH Provider Network Department in writing within fourteen (14) calendar days. Corrected information will be shared with the SWMBH Credentials Committee for consideration. Supplemental information is subject to verifications by SWMBH.

- Practitioners will be informed of the credentialing decision within ten (10) days of the decision date.

- Copies of all application and credentialing verification policies and procedures are available on SWMBH's website.

Southwest Michigan Behavioral Health Credentialing Staff Contact Information

Moira Kean, Manager Provider Network Development
Phone: 269-202-8378
Email: moira.kean@swmbh.org

Scott VanKirk, Provider Network Specialist
Phone: 269-202-8375
Email: scott.vankirk@swmbh.org

Woodlands Behavioral Healthcare Network
960 M60 E
Cassopolis, MI 49031
269-445-2451

Provider Disputes and Appeals Process

All contracted / participating providers in the Woodlands Behavioral Healthcare Network (WBHN) network have the right to appeal actions taken by WBHN relating to a participating provider's status within the provider network and actions related to a provider's professional competency or conduct.

This appeals process does not apply to medical necessity appeals or conditions dictated in the provider contract that result in immediate termination such as provider loss of required certification/licensure; listing of the provider by a department or agency the State of Michigan as being suspended from service participation in the Michigan Medicaid and/or Medicare programs; and/or the provider being listed by a department or agency of the State of Michigan in its registry for Unfair Labor Practices.

If an organizational provider, facility provider, group/individually licensed practitioner disagrees with a determination by WBHN in the application process or during review of a provider's status, and wishes to have the matter reviewed at a higher level, the provider may do so by submitting a written request to the payor's representative within (30) calendar days of disposition. The request must include the following (see attached Appeals Request Form):

1. Reason for dispute;
2. Documentation to support the appeal

The Appeals Request Form and supporting documentation must be sent to WBHN Manager - Provider Network Development who will begin the process to review the appeal.

Providers can mail the Appeal Request Form to:

Woodlands Behavioral Healthcare Network
Attn: Manager - Provider Network Development
960 M60 E
Cassopolis, MI 49031

Or the appeal request can be emailed to Chaka Darden at chakad@woodlandsbhn.org or Yvonne Roebeck at yvonner@woodlandsbhn.org.

Woodlands Behavioral Healthcare Network
960 M60 E
Cassopolis, MI 49031
269-445-2451

APPEAL REQUEST FORM

Provider Name: _____

Today's Date: _____

Date notified of WBHN's network participation decision: _____

Reason for dispute:

Additional information:

Please attach any relevant supporting documentation.

Provider Signature:_____

For Office Use Only
Date appeal received: _____
Date appeal reviewed by first level panel: _____
Determination and findings: _____
Date request reviewed by second level panel (if applicable): _____
Determination and findings: _____

WOODLANDS BEHAVIORAL HEALTHCARE NETWORK

PROVIDER NETWORK POLICIES

Subject: Provider Grievance and Appeal: non-clinical

I. Purpose

To outline the mechanism for provider complaints (grievances) and requests for reconsideration of decisions (appeal) related to non-clinical issues. This policy does not apply to medical necessity appeals which are addressed in a separate WBHN policy.

II. Policy

The intent of WBHN is to foster a positive and mutually supportive relationship with its provider network. When non-clinical problems and disagreements arise, the following policy should be used for provider grievances and appeals.

III. Standards and Guidelines:

Application

The provider grievance and appeals process applies to non-clinical issues including, but not limited to:

a. Suspension or termination of a provider with cause (issues of quality of care/service).
b. Credentialing or re-credentialing decisions
c. Contract compliance issues resulting in a sanction or decision to place the provider on a provisional status
d. Material breaches highlighted in the contract.
e. Claims payment and authorizations
f. Reduction, suspension or adjustments to provider payments
g. Results reported through provider monitoring reviews.
h. Other non-clinical issues

An appeal of contract termination shall have no effect on the immediate termination of the contract and services under contract. The termination will remain in effect until the appeal process is completed, and will be rescinded only if the termination in not upheld on appeal.

Notification of the Right to Appeal

The right to appeal will be included in each provider agreement and/or referenced by policy. Providers will be informed of a progressive appeal process as part of the notification of a negative appeal result.

Filing an Appeal or Grievance

Providers are asked to communicate concerns and grievances with the appropriate WBHN staff before making a formal appeal. If providers are still unable to reach resolution or a satisfactory agreement, they may file an appeal in writing (see required information below). All appeals should be sent directly to the WBHN Provider Network Manager.

Appeals for credentialing decisions and any services (other than claims or authorization) must be filed within 30 calendar days after receiving an adverse notification from WBHN.

Any/all claims are permanently denied after one year (365 days) from the date of service. Appeals involving claims or authorizations must be filed within 180 calendar days after receiving an adverse notification.

First Level Appeal Review:

The WBHN Compliance Committee will review all first level appeals and a decision will be issued within 30 calendar days of receiving the Appeal Request. All appeals involving more than $5,000 will automatically be moved to a second level appeal.

Appeals resulting in the potential use of General Fund dollars will also automatically be considered a Second Level Appeal.

The Provider must complete a written Appeal Request including the following information:

1. Reason for the appeal (i.e., service was in Person-Centered Plan, but not matching authorization; covered dates of service within the Person-Centered Plan)
2. Service activity code
3. Total number of units
4. Date range involved in the appeal
5. Claim line not paid

WBHN will render a decision to dismiss or substantiate the appeal within 30 days of receipt of the Appeal Request.

Second Level Review:

If the provider is dissatisfied with the First Level decision, a second appeal can be filed within 15 calendar days of the First Level review decision notification. This review will be conducted by WBHN's Executive Leadership Team with a decision rendered within 15 days of receipt of the Appeal Request.

The Provider must complete a written Provider Appeal Request to include, the following information:

1. Information contained in the First Level.
2. Additional supporting information for the Second Level Appeal that includes additional information that is outlined in the decision criteria.

Providers within the Southwest Michigan Behavioral Health (SWMBH) region may, as a final step, appeal Medicaid claims dispute decisions to the SWMBH Director of Operations within 14 calendar days of the Second level Appeal decision.

At any level of appeal, if there are unforeseen circumstances which cause a delay in response, adequate notification will be sent to the provider including timeframes for determination.

If the appeal is not filled out in its entirety upon receipt, it will be sent back to the provider for completion.

Definitions:

1. Adverse Notification
   A notice, by any means, that documents a denial of authorization or claim, a reduction, suspension or adjustment to a claim, or the denial of participation as a panel provider.

2. Appeal
   A formal process which is established so that providers may request reconsideration of an action or decision that has been made by the PIHP or contracting CMHSP.

3. Grievance
   An expression of dissatisfaction by a provider or customer regarding a perceived inequitable issue, aspects of interpersonal relation or other related issues.

Originated: 10/05
Reviewed: 10/06, 10/07, 10/08, 6/10, 11/11, 4/15, 3/16
Revised: 9/09, 11/12, 4/13, 3/14, 12/17

Southwest Michigan Behavioral Health
5250 Lovers Lane, Suite 200
Portage, MI 49002
(800) 676-0423

Barry County • Berrien County • Branch County • Calhoun County • Cass County • St. Joseph County • Kalamazoo County • Van Buren County

Reporting Material Changes

Southwest Michigan Behavioral Health Providers are required to report material changes to information that was submitted as part of the credentialing or re-credentialing process to our Provider Network Manager at (800) 676-0423. **All information must be reported within five (5) business days of the provider becoming aware of the information.**

These changes include, but are not limited to:

A. Any action against any of its licenses and/or accreditation by JCAHO, CARF, AOA, or COA

B. Any changes in ownership or business address.

C. Any legal or government action initiated that could materially affect the rendering of services in connection with this agreement.

D. Any legal action commenced by or on behalf of a SWMBH member against provider.

E. Any initiation of bankruptcy or insolvency proceedings with regard to Provider.

F. Discovery that a claim, suit or criminal or administrative proceeding is being brought against the provider relating to the provider's malpractice, compliance with applicable laws, including any action by licensing or accreditation authorities and exclusions from government programs (i.e. Medicare/Medicaid).

G. Expiration of required professional liability insurance coverage (must be reported within 30 days prior to the expiration of such coverage).

H. Any changes in demographic information such as change of address, name change, coverage arrangements, tax identification number, hours of operation, and etc.

I. Expiration of professional license/certification, DEA certificate, CDS Certificate, board certification and malpractice insurance. Current copies must be submitted within five (5) days of expiration. Failure to comply may result in sanctions.

Malpractice Claims Explanation Form

Date of Occurrence:

Location (State occurred):

Open, Pending or Closed:

Date Claim Was Settled:

Amount of Award:

Method of Resolution:

Description of Allegation:

Description of Alleged Injury to Patient:

Did the Alleged Injury Result in Death: