Salish Behavioral Health Organization

Serving Clallam, Jefferson and Kitsap Counties

Click to enter Contractor name
2017-18 Contractor Credentialing Application Instructions and Checklist

One complete Credentialing Application Package should be submitted for your organization. Until all information is received, the Credentialing Application Package is incomplete. If applications are incomplete or not fully responsive, the Contractor will be requested to submit additional supporting information prior to acceptance.

Please complete all documents checked below:

☐ **Credentialing Application** *(signed, in PDF format)*

☐ **Contractor Profile Table** *(in Excel format)*

☐ **Staff Roster** *(in Excel format)*

☐ **Debarment Certification Form** *(signed PDF)*

☐ **Practitioner Attestation Questions and Professional Liability Action Detail**
(do not submit, but retain on file if completed by staff)

☐ **All required attachments or explanations**
(each attachment as separate document, format may vary)

Please submit all required documents via the medium checked below:

☐ **Email to: mcrownov@co.kitsap.wa.us**

Please do not change the name of the documents when submitted.

Please submit hard copies/signed PDF copies of signature pages only via regular mail/email.

614 Division Street, MS-23 Port Orchard, WA 98366-4676 (360) 337-7050
FAX (360) 337-5721

Salish Behavioral Health Organization

Serving Clallam, Jefferson and Kitsap Counties

2017-18 Credentialing Application

I. CONTRACTOR PROFILE

A. Contractor Information

- Contractor Name: _____
- Contractor Federal Tax Identification #: _____

B. Contractor Status (Please check the status that applies to your organization. If Other is checked, add additional information.)

The Contractor is a: ☐ Public Entity

☐ Non-Profit 501(c)(3) Organization

☐ Other (describe): _____

C. Governing Board/Board of Trustees/Ownership

Provide a list of Governing Board/Board of Trustees members that includes all of the following:

1. Identification of the Chair and function of other Board members (e.g., President/Chair, Vice President/Vice Chair and Treasurer);

2. Full names of Board members, as well as their city of residence, a direct phone number, and at least one of the following: an email address, a mailing address, or a fax number; and

3. If the Contractor is neither a public entity nor a non-profit 501(c)(3) organization, provide the same contact information as requested in I.C.1 and I.C.2 for all individuals who have direct or indirect ownership of 5% or more.

4. If substance use disorder (SUD) services are part of a larger organization (e.g., hospital, university, healthcare organization), identify by title and provide the same contact information as requested in I.C.1 and I.C.2 for the staff who actually manage the SUD services, including the Administrator, Director, General Manager, and Business Manager, as applicable, as well as any individuals occupying substantively similar roles.

D. Complete the attached Contractor Profile Table and submit it electronically in Excel format.

II. DISCIPLINARY INFORMATION AND DEBARMENT

If any item in section II Disciplinary Information and Debarment is NOT **initialed by the signer**, please attach an explanation.

A. _____ I confirm that within the past five years, the Contractor has not been subject to any State licensing investigations or actions.

B. _____ I confirm that within the past five years, the Contractor has not been named as a party in any malpractice suits which are pending, have gone to trial, and/or resulted in payment made to any plaintiffs.

C. _____ I confirm that within the past five years, the Contractor has not had a debarment or suspension by Medicaid or Medicare.

D. _____ I confirm that within the past five years, no staff member (including Subcontractor staff) has had a debarment or suspension by Medicaid or Medicare.

E. _____ I confirm that within the past five years, no member of the Contractor's Board of Directors has had a debarment or suspension by Medicaid or Medicare.

F. _____ I confirm that the Contractor consults a SBHO-approved database at least annually, to confirm that none of the following entities and individuals have been debarred or suspended:

1. The Contractor,
2. Members of the Governing Board/Board of Directors

SBHO-approved databases include:

1. Federal System for Award Management (SAM), formerly EPLS
2. Office of Inspector General (OIG)

G. Debarment Certification
Please attach the SBHO Debarment Certification Form for your organization. Signature by the Contractor's Executive Director/Chief Executive Officer on the Debarment Certification Form indicates that the Contractor, staff, Board of Directors, and Subcontractors are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract.

H. Criminal History Background Checks

1. _____ I confirm that the Contractor has Policies and Procedures for conducting criminal background checks, and conducts such criminal background checks, as a routine condition of hire for new employees, consistent with WAC 388-805-200(2) and RCW 43.43.830.

2. I confirm that the Contractor either:

   _____ Conducts annual criminal background checks on employees of the Contractor after the initial criminal background check, OR

   _____ Requires completion of the *Practitioner Attestation Questions* annually of each employee of the Contractor after the initial criminal background check.

III. TOBACCO-FREE BUILDINGS AND GROUNDS

If the item below is NOT **initialed by the signer**, please attach an explanation.

_____ I confirm that the Contractor provides and promotes tobacco-free buildings and grounds. Tobacco-free grounds are defined as tobacco-free private property or, if the agency is located in a public space, enforcement of the law requiring no smoking within 25 feet (RCW 70.160.075).

IV. LICENSING AND REGULATORY REVIEW

If any item in section IV Licensing and Regulatory Review is NOT **initialed by the signer**, please attach an explanation.

A. _____ I confirm that the Contractor solicits primary verification for all licensed or certified staff, including contracted staff.

B. _____ I confirm that the Contractor checks with the Washington Department of Health at least annually to assure that Contractor staff possess and have maintained a license or certification in good standing.

C. Please complete the Staff Roster in the attached Excel format, including all Contractor clinical staff as well as any individual subcontractors/consultants who provide direct services. Special population consultants do not need to be included.

D. Please provide the additional documentation noted below.

   1. For each M.D., whether consulting or employed, provide a current copy of the DEA Certificate and Board Certificate or documentation of board eligibility. The current status of each M.D.'s state license will also be verified, although documentation need not be submitted.

   2. For each Advanced Registered Nurse Practitioner (ARNP), whether consulting or employed, provide a current copy of the DEA Certificate. The current status of each ARNP's state license will also be verified, although documentation need not be submitted.

E. Please respond to the items below by initialing, or noting "N/A" if your organization does not have any individual subcontractors/consultants who provide direct services.

If the item is applicable but not initialed, please attach an explanation.

1. _____ I confirm that each individual subcontractor/consultant holds a relevant current license or certificate with the Washington Department of Health, commensurate with his or her scope of practice.

2. _____ I confirm that the Contractor performs verification of licenses for individual subcontractors/consultants according to the same frequency as it does for other direct service staff, in accordance with the guidelines in sections IV.A. and IV.B. above.

3. _____ I confirm that for each individual subcontractor/consultant who provides direct service, the Contractor provides clinical supervision and other monitoring that is equivalent to the level of supervision provided to clinical providers who are staff of the organization, in accordance with all applicable laws and guidelines for clinical supervision.

V. REQUIREMENTS FOR INFORMING CLIENTS OF CONTRACTOR'S MORAL OR RELIGIOUS OBJECTIONS/RESTRICTIONS

Contractors are required to inform clients at orientation of any moral or religious objections or restrictions regarding care provided (e.g. abortions, end of life counseling). The Contractor is additionally required to provide SBHO with copies of pertinent language and materials used at orientation to communicate these objections.

If the item below is NOT **initialed by the signer**, please attach relevant orientation materials.

_____ I confirm that the Contractor does not have any moral or religious objections or restrictions regarding care. Documentation about objections is not applicable to this organization.

VI. NOTICE OF FUTURE REQUIREMENT

At the time of the SBHO implementation on April 1, 2016, all organizations of the provider network will be required to hold dual certification and/or licensing for both SUD and MH, or be actively working toward obtaining it.

Has your organization begun the process? Yes No

Please briefly describe the steps that have been taken or the plan to obtain MH licensing:

_____

VII. CERTIFICATE OF INSURANCE AND ENDORSEMENT

All Contractors that contract with SBHO must submit an annual certificate of insurance and an endorsement on a separate page. The endorsement language must list as additional parties covered "The policy shall be endorsed and certificate shall reflect that the SBHO and Clallam, Jefferson, and Kitsap Counties are named as an additional insureds on the Contractor's General Liability Policy with respect to the activities under this Contract."

Insurance levels must meet the levels specified in the Standard Contract (Boilerplate). Insurance agencies utilized by providers must have a minimum Bests' rating of no less than A. Insurance certificates and endorsements may carry over from one contract period to another. If the certificate of insurance indicates that the policies expire during the contract period, the Contractor shall provide an up to date certificate of insurance and endorsement for the contract at the time of the expiration of the policies.

Public Entities (municipal corporations, school districts, universities, hospital districts, educational services districts, or other public entities) may self-insure.

Initial the statement that describes the status of the Contractor's insurance documentation.

_____ A current certificate of insurance, with an endorsement naming "The policy shall be endorsed and certificate shall reflect that the SBHO and Clallam, Jefferson, and Kitsap Counties are named as an additional insureds on the Contractor's General Liability Policy with respect to the activities under this Contract."

_____ I confirm that the Contractor is a public entity and self-insures, and a current self-insurance letter is attached.

Please complete and return the Certification and Signature on the following page.

VIII. CREDENTIALING APPLICATION CERTIFICATION AND SIGNATURE

Note: The signature of an authorized representative, such as the Chief Executive Officer or equivalent, is required to complete this Credentialing Application Form. Stamped signatures are not acceptable.

Signature: _____

(Authorized Representative)

Print name: _____

Title: _____

Contractor: _____

Date: _____

Submission Instructions: Submit the signed signature page electronically as part of a PDF version of this document.

Provider Profile Table

Agency Name:

	Name	Address	Email	Telephone Number
Executive Director/CEO :				
Chief Financial Officer:				
Chief Operations Officer:				
HIPAA Privacy Officer:				
Compliance Officer:				
Disaster Response Lead:				
Data Security Officer:				

Main Site Name and Branch Site Name

Main Site Name						
Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website

On-Site Management (Please include names & titles)

Main Contact:	Phone #:	Email Address:
Back-Up:	Phone #:	Email Address:
Back-Up:	Phone #:	Email Address:

Branch Site Name						
#1 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website

On-Site Management (Please include names & titles)

Main Contact: Phone #: Email Address:
Back-Up: Phone #: Email Address:
Back-Up: Phone #: Email Address:

Branch Site Name						
#2 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website

On-Site Management (Please include names & titles)

Main Contact: Phone #: Email Address:
Back-Up: Phone #: Email Address:
Back-Up: Phone #: Email Address:

Branch Site Name						
#3 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website

On-Site Management (Please include names & titles)

Main Contact: Phone #: Email Address:
Back-Up: Phone #: Email Address:
Back-Up: Phone #: Email Address:

Branch Site Name						
#4 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website

On-Site Management (Please include names & titles)

Main Contact: Phone #: Email Address:
Back-Up: Phone #: Email Address:
Back-Up: Phone #: Email Address:

Branch Site Name						
#5 - Street Address (enter below)	Zip Code	Main Phone #	Main Fax #	TDY	Hours of Operation	Website

On-Site Management (Please include names & titles)

Main Contact:	Phone #:	Email Address:
Back-Up:	Phone #:	Email Address:
Back-Up:	Phone #:	Email Address:

License/Certification

Enclose a current copy of the Contractor's DBHR Certification for each site, and DOH License, if applicable.

Agency Name:

Please list the Division of Behavioral Health and Recovery (DBHR) Certification # for each site:

Main Facility: _____
DBHR Certification #: _____ Expiration Date: _____
Certified for: _____ NPI # _____

Branch: _____
DBHR Certification #: _____ Expiration Date: _____
Certified for: _____ NPI # _____

Branch: _____
DBHR Certification #: _____ Expiration Date: _____
Certified for: _____ NPI # _____

Department of Health (DOH) License (if applicable):
License # _____
Expiration Date: _____

Drug Enforcement Administration (DEA)/Federal Drug Administration (FDA) (if applicable)
Methadone License #: _____
Expiration Date: _____

Closure Dates

Agency:

Common Contractor Holiday Closure Dates		
Holiday	**2017 Observed**	**Closed yes/no**
New Year's Day	January 1	
MLK Jr Birthday	January 16	
President's Day	February 20	
Memorial Day	May 29	
Independence Day	July 4	
Labor Day	September 4	
Veterans Day	November 11	
Thanksgiving Day	November 23	
Day After Thanksgiving	November 24	
Christmas Eve	December 24	
Christmas Day	December 25	
New Year's Eve	December 31	

Other Contractor Closure Dates (if any)	
Event	**2017 Date**

2017 Staff Roster

This document is intended to serve as a complete, current roster of Contractor clinical staff as well as any individual subcontractors/consultants who provide direct services. Please include any consulting prescribers (psychiatrists or advanced registered nurse practitioners (ARNPs)), and any other subcontracted individual practitioners (therapists, case managers) who provide direct services. Please note that certain additional information is needed only for individuals who have prescription authority.

** CDP = Chemical Dependency Professional. CDPT = Chemical Dependency Professional Trainee. MHP = Mental Health Professional. CPP = Certified Prevention Professional.*
*** Note that either the DEA (Drug Enforcement Administration) or NPI (National Provider Identifier) number is required. It is not necessary to provide both.*

REQUIRED FOR ALL DIRECT SERVICE PROVIDERS										REQUIRED ONLY FOR INDIVIDUALS WITH PRESCRIPTION AUTHORITY			
Staff Name		**Status** *(Staff, Subcontractor, Consultant)*	**Title/Function**	**Assigned Site/Branch**	**Washington State Professional License Number**	**Washington State License Expiration Date**	**Degree**	**Specialization(s)** *(CDP, CDPT, MHP, Board Certifications, CPP) **	**Language(s) Spoken by the Person**	**Contact Information Shown on Prescriptions Written by this Person**		**Drug Enforcement Administration (DEA) Number ****	**National Provider Identifier (NPI) Number ****
Last	**First**									**Address**	**Phone Number** *111-222-3333 format*		

2017 Staff Roster

This document is intended to serve as a complete, current roster of Contractor clinical staff as well as any individual subcontractors/consultants who provide direct services. Please include any consulting prescribers (psychiatrists or advanced registered nurse practitioners (ARNPs)), and any other subcontracted individual practitioners (therapists, case managers) who provide direct services. Please note that certain additional information is needed only for individuals who have prescription authority.

** CDP = Chemical Dependency Professional. CDPT = Chemical Dependency Professional Trainee. MHP = Mental Health Professional. CPP = Certified Prevention Professional.*
*** Note that either the DEA (Drug Enforcement Administration) or NPI (National Provider Identifier) number is required. It is not necessary to provide both.*

REQUIRED FOR ALL DIRECT SERVICE PROVIDERS										REQUIRED ONLY FOR INDIVIDUALS WITH PRESCRIPTION AUTHORITY			
Staff Name		**Status** *(Staff, Subcontractor, Consultant)*	**Title/Function**	**Assigned Site/Branch**	**Washington State Professional License Number**	**Washington State License Expiration Date**	**Degree**	**Specialization(s)** *(CDP, CDPT, MHP, Board Certifications, CPP) **	**Language(s) Spoken by the Person**	**Contact Information Shown on Prescriptions Written by this Person**		**Drug Enforcement Administration (DEA) Number ****	**National Provider Identifier (NPI) Number ****
Last	**First**									**Address**	**Phone Number** *111-222-3333 format*		

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DEBARMENT CERTIFICATION

Contractor is prohibited from paying with funds received under this Contract for goods and services furnished, ordered, or prescribed by excluded individuals and entities (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 CFR 455.104, 455.106, and 1001.1901(b)). Contractor shall:

a. Monitor for excluded individuals and entities as outlined in the Credentialing Application and by:
b. Screening Contractor and subcontractor's employees and individuals and entities with an ownership or control interest for excluded individuals and entities prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Contract.
c. Screening monthly newly added Contractor and subcontractor's employees and individuals and entities with an ownership or control interest for excluded individuals and entities that would benefit directly or indirectly from funds received under this Contract.
d. Screening monthly Contractor and subcontractor's employees and individuals and entities with an ownership or control interest that would benefit from funds received under this Contract for newly added excluded individuals and entities.

Report to SALISH BHO:

a. Any excluded individuals and entities discovered in the screening within 10 business days.
b. Any payments made by Contractor that directly or indirectly benefit excluded individuals and entities and the recovery of such payments.
c. Any actions taken by Contractor to terminate relationships with Contractor and subcontractor's employees and individuals with an ownership or control interest discovered in the screening.
d. Any Contractor and subcontractor's employees and individuals with an ownership or control interest convicted of any criminal or civil offense described in SSA section 1128 within 10 business days of Contractor becoming aware of the conviction.
e. Any subcontractor terminated for cause within 10 business days of the effective date of termination to include full details of the reason for termination.
f. Any Contractor and subcontractor's individuals and entities with an ownership or control interest.

Contractor must provide a list with details of ownership and control interest with credential submission in comport with Attachment I herein incorporated by reference. Contractor shall keep the list up-to-date thereafter.

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Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity. Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.

Contractor will immediately terminate any employment, contractual and control relationships with an excluded individual and entity that it discovers.

Civil monetary penalties may be imposed against Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to enrollees (SSA section 1128A(a)(6) and 42 CFR 1003.102(a)(2)).

An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of five (5) percent or more, or are a managing employee (i.e., a general manager, business manager, administrator, or director) who exercises operational or managerial control or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 CFR 455.104(a), and 1001.1001(a)(1)).

In addition, if SALISH BHO and /or DSHS notifies Contractor that an individual or entity is excluded from participation by DSHS in RSN's, Contractor shall terminate all beneficial, employment, contractual and control relationships with the excluded individual or entity immediately (WAC 388-502-0030 and 388-877-0500).

The list of excluded individuals will be found at: http://exclusions.oig.hhs.gov

SSA section 1128 will be found at: http://www.ssa.gov/OP_Home/ssact/title11/1128.htm

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions

(1) The prospective participant certifies, by submission of this packet, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

(2) Where the prospective participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

(3)

_____

Signature **Date**

_____

Print Name and Title

Salish Behavioral Health Organization

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(For information only, this form does not need to be completed and submitted)

WASHINGTON PRACTITIONER ATTESTATION QUESTIONS – *To be completed by the practitioner*

Please answer all of the following questions. If your answer to any of the following questions is 'Yes', provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*				
A.	**PROFESSIONAL SANCTIONS**			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?			
	a.	License to practice any profession in any jurisdiction	YES ☐	NO ☐
	b.	Other professional registration or certification in any jurisdiction	YES ☐	NO ☐
	c.	Specialty or subspecialty board certification	YES ☐	NO ☐
	d.	Membership on any hospital medical staff	YES ☐	NO ☐
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES ☐	NO ☐
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES ☐	NO ☐
	g.	Professional society membership or fellowship	YES ☐	NO ☐
	h.	Participation/membership in an HMO, PPO, IPS, PHO or other entity	YES ☐	NO ☐
	i.	Academic Appointment	YES ☐	NO ☐
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES ☐	NO ☐
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES ☐	NO ☐
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES ☐	NO ☐
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES ☐	NO ☐
B.	**CRIMINAL HISTORY**			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES ☐	NO ☐
	a.	Do you have notice of any such anticipated charges?	YES ☐	NO ☐
	b.	Are you currently under governmental investigation?	YES ☐	NO ☐

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C.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section,** please document in the PROFESSIONAL LIABILITY ACTION DETAIL form.)		
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?	YES ☐	NO ☐
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?	YES ☐	NO ☐
3.	Are there any such claims being asserted against you now?	YES ☐	NO ☐
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?	YES ☐	NO ☐
5.	Are any of the privileges that you are requesting not covered by your current malpractice coverage?	YES ☐	NO ☐

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature: _____ Date: _____

Type or Print name here: _____

614 Division Street, MS-23 Port Orchard, WA 98366-4676 (360) 337-7050

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