MCCMH-SUBSTANCE USE SERVICES DIRECTOR'S VERIFICATION OF STAFF CREDENTIALS

Staff Name:_____ Title/Position:_____
Agency Name:_____ Site:_____
Requested Effective Date:_____

TYPE OF CREDENTIALING (check all that apply):

- ❑ **Substance Use Disorder Treatment Specialist - *Master's Licensed, Limited Licensed, Temporary Licensed* Individual**
  - ❑ Social Worker, Psychologist, Marriage & Family Therapist, Professional Counselor, ***and***
    - ❑ MCBAP Certified or,
    - ❑ MCBAP Development Plan

- ❑ **Substance Use Disorder Treatment Practitioner - *Non-Master's licensed* Individual (not eligible for reimbursement of psychotherapy services)**
  - ❑ Non-Licensed Individual, or
  - ❑ License or Limited Licensed Bachelor's Social Worker, ***and***
    - ❑ MCBAP Certified or,
    - ❑ MCBAP Development Plan

- ❑ **Clinical Supervisor - *Licensed, Limited Licensed, Temporary Licensed* Individual**
  - ❑ Social Worker, Psychologist, Marriage and Family Therapist, ***and***
    - ❑ MCBAP Certified Clinical Supervisor or,
    - ❑ MCBAP Development Plan Certified Clinical Supervisor

- ❑ **Substance Use Disorder Prevention Specialist/Consultant**
  - ❑ Certified Prevention Specialist, or
  - ❑ Certified Prevention Consultant, or
  - ❑ MCBAP Development Plan

- ❑ **Substance Use Disorder Prevention Specialty Focused Staff**
  - ❑ Providing one specific service under a certified supervisor

- ❑ **Peer Recovery Coach**
  - ❑ MDHHS Certified Peer Recovery Coach
  - ❑ CCAR Trained Peer Recovery Coach
  - ❑ MCBAP Certified, or
  - ❑ MCBAP Development Plan

- ❑ **Medical Staff**
  - ❑ Physician, Psychiatrist, Physician Assistant, Nurse Practitioner, Registered Nurse, Licensed Practical Nurse
  - ❑ EMT

- ❑ **SUDHH Only**
  - ❑ Community Health Worker
  - ❑ Peer Recovery Coach
    - ❑ MDHHS Certified
    - ❑ CCAR Trained
    - ❑ MCBAP Development Plan and/or Credential
  - ❑ Behavioral Health Specialist (Licensed or Limited Licensed Bachelor's or Master's Level Social Worker, Licensed Marriage & Family Therapist, Licensed Professional Counselor, or Licensed Psychologist)

Application must be submitted and approved prior to the provision of direct service, or services may not be reimbursed. Documentation must be submitted for all items checked above (attach copy of License and/or Certification).

- ❑ Requesting FOCUS Login ID and password (attach FOCUS Access Request Form)
- ❑ Requesting ASAM permission (attach training Certificate)
- ❑ Requesting GAIN permission (attach training Certificate)

I attest that Communicable Disease, Substance Use Recipient Rights, Confidentiality, and other required training has/will be completed within 30 days of hire.

The undersigned attests to the personal possession of, and the authenticity and validity of the above-described license, credential or equivalent and training, and are in good standing.

_____ _____

Staff Member's Signature Date

The undersigned attests that the above-described license, credential or equivalent, and training, has been verified as being possessed and in good standing by the staff person named above. The program has/will complete all staff qualification requirements, including criminal background check, completed credentialing/recredentialing, and/or privileging requirements, obtained direct source verification, and has this information available at the SUD Department's request.

_____ _____

Program Director's Signature Date

_____

PRINT Program Director's Name

SUD Department Use Only

Packet received on:_____

Information Complete? ☐ Yes ☐ No If no, list missing information requested:_____

Additional information received on date:_____

OIG/MDHHS Sanctioned provider check ☐ Yes ☐ n/a

Information provided supports Credentialing: ☐ Yes, for:

☐ Substance Abuse Treatment Specialist ☐ Substance Abuse Treatment Practitioner

☐ Clinical Supervisor ☐ Substance Abuse Prevention Specialist/Consultant

☐ Substance Abuse Prevention Specialty Focused Staff ☐ Peer Recovery Coach

☐ Medical Staff ☐ SUDHH Only Staff

☐ No/Denied, due to _____

Authorization Effective Date:_____

SUD Department Signature: _____ Signature Date:_____

Response sent to provider on: _____