CAMHD

Paraprofessional & Mental Health Professional Provider Credentialing Application Form

RESET FORM

This is an application for providers undergoing the CAMHD Credentialing process. If more space is needed than provided on this original, please attach additional sheets and reference the questions being asked. If a question is not applicable to you please mark **N/A** in the space. All fields marked with an * are required.

IDENTIFYING INFORMATION:

Current Legal **First** Name

Current Legal **Last** Name

Social Security Number

NPI #

Date of Birth

Phone # Including Area Code

Email Address

Are there any other names with which you have been known? ie. Maiden name or any aliases.
Please list all alias names and Identify whether it is a first, last, nickname or maiden name.

EDUCATIONAL INFORMATION:

Highest Degree/Diploma Obtained & Field of Study

Date of Graduation (month/year)

Name of School Degree / Diploma was Obtained

School City and State

LICENSURE:

Please list all active and inactive professional licenses you now hold or previously held - attach a clear photocopy of all current license(s). Attach a separate sheet as needed to identify all licensure.

State:	License Type & Number:	Expiration Date:
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HEALTH STATUS: *(Must Be Completed By ALL Applicants)*

Health status is defined as including the physical and mental condition of the applicant as it relates to the individuals ability to exercise those clinical privileges requested.

Do you have any physical and/or mental condition which would interfere with the performance of those privileges which you are requesting and/or the essential functions of the contractual arrangement for which you are applying, with our without accommodation?

Check One: ◯ No ◯ Yes (explanation required)

RESTRICTIVE ACTION QUESTIONS: *(Must Be Completed By ALL Applicants)*

If you answer **yes** to any of the questions below, please **attach an explanation of each occurrence** to include the date, parties involved, circumstances surrounding the situation, and outcome.

1. Have you ever been denied, for possible incompetence or improper professional conduct, clinical privileges, membership, contractual participation or employment by any medical organization (i.e. hospital medical staff, health plan, health maintenance organization (HMO), professional association, medical school faculty position, or other health delivery entity or system). Or have your clinical privileges, membership, participation, or employment at any such organization ever been suspended, restricted, revoked, or not renewed – or is any such action pending?

   Check One: ◯ No ◯ Yes (explanation required)

2. Have you ever voluntarily relinquished privileges or a license anywhere at any time?

   Check One: ◯ No ◯ Yes (explanation required)

3. Have you ever been denied certification/recertification, or has your eligibility status changed with respect to certification/recertification by a specialty board?

   Check One: ◯ No ◯ Yes (explanation required)

4. Have there been, or are there currently pending, any malpractice claims, suits, settlements, or arbitration proceedings involving your professional practice?

   Check One: ◯ No ◯ Yes (explanation required)

5. Have you been denied professional liability insurance or has your coverage ever been cancelled?

Check One: ◯ No ◯ Yes (explanation required)

6. Have you ever been convicted of a crime, pled guilty or "no contest" to a crime, or are currently serving a sentence for a crime? Or are you currently under indictment for an alleged crime?

Check One: ◯ No ◯ Yes (explanation required)

7. Do you presently or have you used any illegal drugs in the past two years?

Check One: ◯ No ◯ Yes (explanation required)

AFFIRMATION:

I represent that information provided in or attached to this credentialing application form is accurate. I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and may result in the denial of appointment and clinical privileges. In the event of my termination for this reason, I will not be entitled to any hearing, appeal, or other due process rights. Upon subsequent discovery of such misrepresentation, misstatement, or omission, the CAMHD or Provider Agency may immediately terminate my appointment.

Signature of Applicant

Date

Printed Name of Applicant

RELEASE AND IMMUNITY:

By applying for a position with CAMHD or a CAMHD Contracted Provider Agency, I accept the following conditions regardless of whether or not I am granted the position, and intend to be legally bound thereby. These conditions shall remain in effect for the duration of my employment.

1. I authorize the release of all information necessary for an evaluation of my qualifications for initial appointment and or privileges;
2. I authorize CAMHD, the Provider Agency, its staff and their representative to consult with any prior associate and others who may have information bearing on my professional competence, character, health status, ethical qualification, and ability to work cooperatively with others;

3. I agree to release from liability CAMHD, the Provider Agency, the staff, or anyone acting by and/or for this agency, and its staff, who act without malice for any matter relating to this application for inclusion and referral, the evaluation of my qualifications or any matter related to appointment or clinical privileges.

Signature of Applicant

Date

Printed Name of Applicant

AUTHORIZATION FOR RELEASE OF INFORMATION:

I, hereby authorize the Child and Adolescent Mental Health Division (hereafter referred to as CAMHD) or the Provider Agency and its representatives to consult with representatives of other hospitals, institutions, government agencies, previous employers, and other persons or entities (hereafter collectively referred to as "persons" or "entities") to obtain and verify information concerning my professional qualifications, competence, moral character, ethical qualifications, and physical and mental condition and to conduct criminal background checks and Child Abuse and Neglect checks.

I consent to release by any and all hospitals, institutions, government agencies, previous employers, and other persons or entities to CAMHD and/or the Provider Agency all information and documents that may be relevant to an evaluation of my professional qualifications, competence, moral character, ethical qualifications and physical and mental condition.

I hereby release all representatives of CAMHD, the Provider Agency, and all such persons or entities from any and all liability for their acts performed in good faith and without malice in giving, obtaining, and verifying such information in connection with evaluating my applications, my credentials, and my qualifications

I understand and agree that I, as an applicant, have the burden of producing adequate information to demonstrate to the satisfaction of CAMHD and/or the Provider Agency, my professional qualifications, clinical competence, moral character, ethical qualifications and physical and mental condition and for resolving doubts thereto. I further understand and agree that it is my responsibility to inform CAMHD of any changes in the information provided through the application during the application period or at any subsequent time.

Signature of Applicant

Date

Printed Name of Applicant

PRINT FORM SAVE FORM

CAMHD PROVIDER RIGHTS

1. **Process used to making credentialing and re-credentialing decisions:**

   The credentials of applicants are evaluated against pre-determined criteria in conjunction with NCQA and state licensing requirements. This policy outlines the criteria used to approve applicants. The CAMHD Provider Checklists were created to facilitate auditing of primary source verifications in the clinician's chart. In addition, committee members are also required to use their professional and personal knowledge of the applicant's business practices, ethics, and ability to provide quality services to CAMHD clients in a safe treatment environment in the decision making process. All of these elements are taken into consideration during the credential approval decision- making process.

2. **The process used to ensure that credentialing and re-credentialing are conducted in a non-discriminatory manner:**

   The CAMHD Credentialing Section and SARM Committee does not make credentialing decisions based on the applicant's race, ethnic / national identity, religion, gender, age, sexual orientation, or the types of procedures or types of patients the practitioner (e.g., Medicaid) specializes in.

3. **The process of notification to Provider Agencies of any information obtained during the credentialing process that varies substantially from the information provided to CAMHD and/or the CAMHD Contracted Provider Agency by the provider:**

   CAMHD and/or the CAMHD Contracted Provider Agency must notify the applicant of any information obtained during the credentialing process, which varies substantially from the information provided to them in writing. The applicant must respond within 15 business days from the date of the notification with a letter of explanation for the varying information. Additional documents may be submitted to CAMHD and/or the CAMHD Contracted Provider Agency to substantiate or explain the variations. CAMHD has 15 business days from the date of receipt of the letter of explanation to review documents and render a decision. The decision letter includes the reconsideration and appeal process stated below.

4. **The Request for Reconsideration & Appeal Process:**

   If the Provider Agency does not agree with the CAMHD Credentialing decision, they have the right to request for reconsideration. Reconsideration requests must be submitted with additional documentation to support the request. These must be received at CAMHD within 15 business days from the decision notification, unless otherwise stated. The CAMHD SARM Committee will review the submitted documents and issue a reconsideration decision to the CAMHD Contracted Provider agency within 15 business days from the date of receipt of the reconsideration request. The CAMHD Contracted Provider Agency has the option to file a formal complaint with CAMHD's Grievance and Appeal Office at 733-9333 in the event the CAMHD SARM Committee holds to the Credentialing Section's original decision.

5. **The process to ensure that Provider Agencies are notified of the credentialing or re-credentialing decision within 15 business days of the Credentialing Section's decision:**

   A CAMHD Credentialing Section notification is sent to the CAMHD Contracted Provider Agency within 15 business days of the decision. If the Provider Agency does not agree with the decision they are entitled to request for reconsideration through the "Request for Reconsideration & Appeal Process" outlined above.

6. **The process used to ensure confidentiality of all information obtained in the credentialing process, except if otherwise provided by law:**

The CAMHD Credentialing Section, SARM Committee, CAMHD Contracted Provider Agencies' Credentialing Specialists and other personnel that have access to credential information must hold all practitioner data and information obtained through the credentialing/re-credentialing process in strict confidence. Any discussions held during the CAMHD SARM Committee must remain confidential except when otherwise provided by law.

7. **The Practitioner's right to review submitted information in support of their credentialing applications:**

The applicant has the right to request and review primary source verifications obtained on their behalf. A written request must be sent to the CAMHD Credentialing Specialist, CAMHD Credentialing Section, 3627 Kilauea Avenue, Room 101, Honolulu, HI 96816. The CAMHD Credentialing Section has 30 days to forward copies of primary source documents to the applicant. In the event that the primary source verification function has been delegated to the CAMHD Contracted Provider Agency, the written request must be sent to the attention of the CAMHD Contracted Provider Agency Credentialing Specialist. The CAMHD Contracted Provider Agency Credentialing Specialist has 30 days to forward the copies of the primary source documents to the applicant.

8. **The Practitioner's right to correct erroneous information:**

In the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner, CAMHD must notify the Provider Agency in writing within 15 business days from date of discovery. Notification may be sent directly to the applicant or through the CAMHD Contracted Provider Agency Credentialing Specialist.

The applicant has the right to correct erroneous information by sending a letter directly to the CAMHD Credentialing Section at the following address: CAMHD Credentialing Specialist, CAMHD Credentialing Section, 3627 Kilauea Avenue, Room 101, Honolulu, HI 96816 or through the CAMHD Contracted Provider Agency in writing within 15 business days from date of receipt of the notification from CAMHD. Additional documents may be submitted to CAMHD and/or the CAMHD Contracted Provider agency to substantiate or explain the erroneous information. CAMHD has 30 days from the date of receipt of the letter of explanation to review documents and render a decision. The decision letter includes the reconsideration and appeal process stated in the "Request for Reconsideration & Appeal Process" section of the CAMHD Credentialing policy.

9. **The right of practitioners, upon request, to be informed of the status of their credentialing or re-credentialing application:**

The applicant has the right to request, in writing or through telephone, the status of their credentialing or re-credentialing application. CAMHD must respond to such inquiry within 10 business days either in writing or through telephone.

Peer-review protected information, references, and letters or recommendations may not be reviewed by applicants.

CAMHD CHILD ABUSE/NEGLECT
DISCLOSURE STATEMENT

Please complete the following sections completely and legibly.

Current, Legal First and Last Name:			
Any Alias(es), Former Name(s), Including Maiden & Married Name(s):			
Date of Birth (DOB):		**Social Security Number (SSN):**	
Agency Name:			

*Sign below to the statement A **or** B that you are declaring to be true.*

A. FOR APPLICANTS WITH A POSSIBLE CHILD ABUSE/NEGLECT RECORD: I am aware, or suspect that there may be a Child Abuse and/or Neglect record concerning me and/or my family because of an investigation conducted by the Department of Human Services' Child Protective Services. I am disclosing the detailed circumstances in a written, dated, and signed statement attached to this document.

_____ _____
SIGNATURE DATE

OR

B. FOR APPLICANTS ATTESTING THEY DO NOT HAVE A CHILD ABUSE/NEGLECT RECORD: This is to certify that I have not been an involved party to any investigation conducted by the Department of Human Services' Child Protective Services. Discovery to the contrary, of my involvement in an investigation may result in denial or revocation of my active CAMHD credential status.

_____ _____
SIGNATURE DATE

State of Hawaii
DEPARTMENT OF HUMAN SERVICES

Social Services Division
Child Welfare Services Branch

CONSENT TO RELEASE INFORMATION FROM THE
Child Protective Services System Central Registry

I, _____ hereby give my consent to have the Department of Human Services (DHS) conduct a child welfare services Child Protective Services System Central Registry check on me and to release the information to:

Name of Individual or Organization: _____

Relationship: **EMPLOYER**

Address: _____

Phone Number: _____

This consent shall terminate a year from the date of my signature below. I understand that the information I provide about myself shall be used solely for the purpose of conducting the Child Protective Services System Central Registry check.

My Date of Birth: _____ **My Social Security Number:** _____

Any Alias, Former Name, Including Maiden Name: _____

The information to be released shall be limited to the history of abuse or neglect in which I was identified as a Perpetrator and as specified below:

Child Protective Services System Central Registry:

- Date of CONFIRMED incident(s) only
- Type of abuse for each incident

I understand that the release of this information may be used as part of a background check for employment Purposed and to comply with the requirements for various social services programs within the Department of Human Services, which may result in employment suspension or termination.

Signature	Date

Mail the original form to: Department of Human Services, Child Welfare Services Branch, Statewide Child Welfare Services Section, 420 Waiakamilo Road, Suite 300A, Honolulu, Hawaii 96817. Faxes will not be accepted.