



***Community Healthlink, Inc.
CREDENTIALING PROFILE FORM***

CHL is responsible for credentialing all providers. Please complete the attached profile and return it to Human Resources along with all of the following that are applicable:

- A copy of all valid licenses
- A copy of your highest degree
- A copy of any applications or letters of acceptance from the Managed Care panels
- A copy of your resume or curriculum vitae
- Medicare Number
- National Provider Identification (NPI) number.
- Child and Adolescent Needs and Strengths Assessment (CANS) certificate number

If you are a licensed social worker (LCSW, LICSW), a licensed psychologist, or an advanced practice nurse (RNCS) and anticipate seeing Medicare clients, please ask Human Resources for a Medicare Application. If you already have a Medicare ID number, please ask for an assignment form.

If you will be working with children, you must be certified to administer The Child and Adolescent Needs and Strengths tool (CANS). If you are not certified, please talk to your supervisor about becoming certified. If you are certified, please attach a copy of your certification.

If you do not currently have a National Provider Identifier number (NPI), please ask Human Resources for the information sheet on applying.

Thank you in advance, and welcome to CHL!



CREDENTIALING PROFILE FORM

Section 1: PERSONAL INFORMATION

Name: _____
Last First Middle

Home Address: _____

Home Telephone: _____ SS# _____

Birth Date: _____ Place of Birth: _____ Citizenship: _____

If not an American citizen, status and visa number: _____

Program(s)/Site(s) that you have been hired for: _____

Job Title: _____

Section 2: EDUCATION INFORMATION

Include Undergraduate, Graduate, and Postgraduate Education (attach copy of highest degree)

School Name and Mailing Address	Degree Awarded	Dates Attended	Graduation Date

Section 3: LICENSURE

Please list all current professional licenses and attach a copy

State	License Type	Number	Originally Issued	Expiration Date

Please list any past professional licenses that are no longer active.

State	License Type	Number	Originally Issued	Expiration Date

Years of full time experience since obtaining highest degree:

Years of supervisory experience since obtaining highest license:

Number of people you have formally supervised:

Section 4: ADMITTING PRIVILEGES (Physicians and Psychologists only)

Physicians/psychologists list hospitals/health care facilities for which you have admitting privileges.

Facility Name	Mailing Address	City and State	Telephone

Section 5: REGISTRATIONS AND CERTIFICATIONS

Please indicate any registrations and certification that you possess and attach copies.

Type of Registration/Certification	Registration/Certificate #	Date Issued	Expiration Date
CANS			
Federal DEA #			
State Controlled Substance #			
Universal Personal Identification # (PIN)			
Medicare #			
NPI #			NA
Others			

Section 6: PANELING/CREDENTIALING

Please list Managed Care panels on which you have served. Submit any copies of applications or letters of acceptance from the Managed Care panels that you have.

Managed Care Company	Date of Paneling	Practice Name/Location	Current/Expired?

Section 7: LANGUAGES SPOKEN

Please indicate languages spoken and degree of proficiency.

Language Spoken	Degree of Proficiency	Have you provided treatment in this language?

Section 8: Questionnaire

If you answer “yes” to any of the questions in section 8, you must provide an explanation of each occurrence. Additional information may be required as indicated in certain questions.

1. Have there ever been any actions against or investigations relating to your professional license(s) in any jurisdiction?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
2. Have you ever voluntarily or involuntarily surrendered your license?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
3. Have there ever been any actions against or investigations relating to your hospital, HMO and/or health/managed care plan privileges?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
4. Have you ever voluntarily or involuntarily surrendered hospital, HMO and/or health/managed care plan privileges?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
5. Have you ever been named in any malpractice action?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
6. Does your current liability malpractice insurance coverage exclude any specific procedures?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
7. Has your professional liability insurance coverage ever been denied, suspended, restricted, limited, modified, cancelled or not renewed by the action of any insurance company?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

8. Have there ever been any actions against or investigations relating to your DEA registration and/or CDS certification or have you ever voluntarily or involuntarily surrendered your DEA registration and/or CDS certification?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
9. Have you ever been convicted of a felony, including, but not limited to, fraud, narcotics, or crimes involving children? (Misdemeanors do not need to be reported). This statement is answered under the penalty of perjury, subject to applicable Federal punishment for perjury. If yes, please include the disposition of the arrest or charge and explain all such occurrences in an attachment.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
10. Have you ever been sanctioned or otherwise disciplined by a professional organization/association?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
11. Have you ever voluntarily or involuntarily surrendered membership in a professional organization/association?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
12. Has there ever been any disciplinary action, suspension, probation, formal reprimand or request to voluntarily or involuntarily resign during your education, internship, residency, fellowship, preceptorship, or additional applicable training?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
13. Has there been any action against or investigation relating to your board certification (e.g. medical professional board/society) or have you voluntarily or involuntarily surrendered any board certification?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
14. Has an adverse action been filed against you or have you received any disciplinary procedures regarding your participation in any private, state, or federal insurance program including Office of Personnel, Medicare, Medicaid or TRICARE?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
15. Is there anything that would prevent you from being able to competently perform essential job-related functions without risk to client safety or health, with or without reasonable accommodation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
16. Are you currently using any illegal substances or are you chemically dependent on alcohol, drugs, or illegal substances?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Section IX: PROFESSIONAL TRAINING ATTENDANCE

CPR Certification

Expiration Date:

First Aid

Expiration Date:

Training Attended in the last year (include subject, presenter, organization or individual, and month/year)	

Section X: SPECIALTIES

From the list below, identify any specialty area where you have training or expertise:

- | | | |
|--|--|---|
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Personality Disorder |
| <input type="checkbox"/> Adjustment Disorders | <input type="checkbox"/> ECT | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Adolescent Behavior disorders | <input type="checkbox"/> Ethnic/Cultural Issues | <input type="checkbox"/> Physically disabled |
| <input type="checkbox"/> Affective Disorders | <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Post Traumatic Stress disorder |
| <input type="checkbox"/> Alcohol/Drug Counseling | <input type="checkbox"/> Family Violence | <input type="checkbox"/> Psychiatric Evaluations |
| <input type="checkbox"/> Anxiety Disorders | <input type="checkbox"/> Forensics | <input type="checkbox"/> Psychological testing |
| <input type="checkbox"/> ADD-ADHD | <input type="checkbox"/> Gay/Lesbian/Bisexual/Trans. | <input type="checkbox"/> Psychopharmacology |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Genetic Therapy | <input type="checkbox"/> Relapse Prevention: SA |
| <input type="checkbox"/> Borderline Personality Traits | <input type="checkbox"/> Geriatric Services | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Brief Therapy | <input type="checkbox"/> Grief Bereavement | <input type="checkbox"/> School Related Problems |
| <input type="checkbox"/> Child Therapy | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Severe/Persistent Mental Illness |
| <input type="checkbox"/> Chronic Terminal Illness | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Court Ordered Evaluations | <input type="checkbox"/> Homeless Services | <input type="checkbox"/> Sexual Offenders |
| <input type="checkbox"/> Crisis Intervention | <input type="checkbox"/> Martial Issues | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> DBT Treatment | <input type="checkbox"/> Men's Issues | <input type="checkbox"/> Step Blended Families |
| <input type="checkbox"/> Dual Diagnosis: MH/MR | <input type="checkbox"/> Multiple Personality Disorder | <input type="checkbox"/> Stress Management |
| <input type="checkbox"/> Dual Diagnosis: w/ SA | <input type="checkbox"/> Neuropsychological Testing | <input type="checkbox"/> Women's Issues |
| <input type="checkbox"/> Employee Assistance Work Issues | <input type="checkbox"/> Obsessive Compulsive Disorder | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Early Intervention | <input type="checkbox"/> Panic Phobia | <input type="checkbox"/> Other: |

Section XI: VERIFICATION

My signature below indicates that all of the information provided above is accurate and complete. My signature also indicates my consent for Community Healthlink to obtain my academic records, state licensure records, and Medicare/Medicaid records to ensure that the information provided is accurate, my licensure is in good standing, and that I have not been excluded to participate in any public or private insurance program.

Signature

Date