Community Healthlink
A Member of UMass Memorial Health Care

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 for 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 certified, please attach a copy of your certification. If you are not certified, please talk to your supervisor about becoming certified.

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

Thank you in advance, and welcome to CHL!

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CREDENTIALING PROFILE FORM

Section I: PERSONAL INFORMATION

Name: _____
Last First Middle

Home Address: _____

Home Telephone: ( ) - SS#: - -

Driver's License #: _____ Exp Date: _____ State Issued: _____

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: _____

Clinical Supervisor: _____ NPI #: _____

Section II: 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 III: LICENSURE

Please list all current professional licenses and attach a copy

State	License Type	Number	Date 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 IV: 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 V: PROFESSIONAL TRAINING ATTENDANCE

☐ CPR Certification Expiration Date: _____

☐ First Aid Expiration Date: _____

☐ Other: _____ Expiration Date: _____

Section VIII: 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.

My typed name below shall have the same force and effect as my written signature.

_____ _____

Signature Date