MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE
DIRECTOR'S VERIFICATION OF STAFF CREDENTIALS

Staff Name:_____ Title:_____
Program Name:_____ Site:_____
Requested Effective Date:_____

I. Substance Abuse Treatment Specialist - Check *all that apply*

Has licensure in good standing in one of the following areas, is working within their licensure-specified scope of practice **AND** has SUD Certification or a Registered Development Plan and is timely in its implementation:

Licensure

- ❑ Physician (MD/DO)
- ❑ Physician Assistant (PA)
- ❑ Nurse Practitioner (NP)
- ❑ Registered Nurse (RN)
- ❑ Licensed Practical Nurse (LPN)
- ❑ Licensed Psychologist (LP)
- ❑ Limited Licensed Psychologist (LLP)
- ❑ Temporary Limited Licensed Psychologist (TLLP)
- ❑ Licensed Professional Counselor (LPC)
- ❑ Limited Licensed Professional Counselor (LLPC)
- ❑ Licensed Marriage and Family Therapist (LMFT)
- ❑ Limited Licensed Marriage and Family Therapist (LLMFT)
- ❑ Licensed Masters Social Worker (LMSW)
- ❑ Limited Licensed Masters Social Worker (LLMSW)
- ❑ Licensed Bachelor's Social Worker (LBSW)
- ❑ Limited Licensed Bachelor's Social Worker (LLBSW)
- ❑ EMT

Certification

- ❑ Certified Alcohol and Drug Counselor – Michigan (CADC-M)
- ❑ Certified Alcohol and Drug Counselor – IC&RC (CADC-R)
- ❑ Certified Advanced Alcohol and Drug Counselor – ICRC (CAADC)
- ❑ Certified Co-Occurring Disorders Professional (CCDP)
- ❑ Certified Co-Occurring Disorders Professional-Diplomat (CCDP-D)
- ❑ Certified Criminal Justice Professional – IC&RC (CCJP-R)
- ❑ State approved alternative credential (ASAM, CHES, APA Specialty in Addition, UMICAD)
- ❑ Registered Development Plan - Expiration date:_____

II. Substance Abuse Treatment Practitioner (not eligible for reimbursement of psychotherapy services)

□ Has a Registered Development plan and is timely in its implementation
Plan expiration date: _____

III. Clinical Supervisor

□ Certified Clinical Supervisor – IC&RC (CCS-R)
□ Certified Clinical Supervisor – Michigan (CCS-M)
□ Clinical Supervisor Registered Development Plan – Plan expiration date:_____

Communicable Disease Training (*Must be completed within 30 days of hire)*

- ❑ Level I Communicable Disease Training Requirements Completed on _____(attach verification), OR, Will be completed by _____

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. ALSO INCLUDE A CURRENT RESUME.

Required Documentation Attached:

☐ Resume

☐ License

☐ Certification

☐ Development Plan

Application Includes:

☐ Communicable Disease Training/Plan

☐ Required Signatures

☐ FOCUS Access Form

The undersigned attests to the personal possession of, and the authenticity and validity of the above described license, credential or equivalence and training.

_____ _____

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 MCOSA Staff Qualification and Credentialing requirements and has this information available at MCOSA's request.

_____

PRINT Program Director's Name

_____ _____

Program Director's Signature Date

MCOSA Use Only

Packet received on:_____

Information Complete? ☐Yes ☐No

If no, list missing information requested:_____

Date additional information received:_____

Additional follow up required:_____

_____

Directors Verification: ☐ Approved ☐ Denied

Authorization Effective Date:_____

_____ _____

MCOSA Authorization Signature Date

☐ Response sent to provider on: _____