

**MACOMB COUNTY OFFICE OF 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 Abuse Treatment Specialist**
 - Licensed, Limited Licensed or Temporary Licensed: Social Worker, Psychologist, Marriage and Family Therapist, Professional Counselor
 - *MCBAP Certified or,
 - MCBAP Development Plan

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

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

- Substance Abuse Prevention Specialist/Consultant**
 - Certified Prevention Specialist
 - Certified Prevention Consultant
 - *MCBAP Certified or,
 - MCBAP Development Plan

- Substance Abuse Prevention Specialty Focused Staff**
 - Providing one specific service under certified supervisor

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

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

*State approved alternative certification will be accepted.

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: _____

Date additional information received: _____

Information provided supports Credentialing: No/Denied 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

Authorization Effective Date: _____

SUD Department Signature: _____

Signature Date: _____

Response sent to provider on: _____