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| 1. | Date:  Agency Name: |
| 2 | Name and Credentials:  National Provider Identification (NPI) Number:  Both Qualified Addiction Professional (QAP) and Peer Support Specialist (PSS)(Complete items 1-14)  and/or  Qualified Addiction Professional (QAP) only (Fill out items 1-10 and 13-14)  Peer Support Specialist (PSS) only (Fill out items 1- 6, and 11-14) |
| 3 | Physical location i.e. street address for **EACH** agency location the QBHP will be working at [7AAC 70.030(b)(3)] |
| 4 | Mailing address for the agency: |
| 5 | Medical Professional:  Licensed Medical Doctor  Doctors of Osteopathic Medicine  Physicians Assistants  Accredited Nurse Practitioners  The professional in this section attest to the following as proof of their qualifications: The professional in this section will work as a QBHP only within their education, scope of practice, experience, ethical guidelines and area of specialty.  **Yes**   **No  (skip to signature)** |
| 5 | Who will be the point of contact (Clinical Supervisor) supervising the Qualified Behavioral Health Professional or Professional In Training:  Name:  Phone: E-mail:  Credentials:  Agency/ Clinical Supervisor attests that the he/she has the education necessary to provide clinical supervision to the Qualified Behavioral Health Professional or Professional in Training (QAP/PSS) for the provision of SUD services:  **Yes**   **No** |
| 6 | Do you understand and attest to the understanding that the start date to bill services is not until A) full individual enrollment and affiliation is completed by Medicaid Enrollment and B) the provider receives a letter from Conduent providing the billable start date: and C) **THERE IS NO BACK DATING of enrollment dates?**  **Yes**   **No** |
| 7 | **Agency/Clinical Supervisor attests that the QAP applicant is WORKING TOWARD one of the following certifications (Choose any applicable):**  Alaska Behavioral Health Certification:  CDC II  CDCS  CDC Admin  ANTHC Behavioral Health Aide Certification**:**  BHA I  BHA II  BHA III  BHA / P  National Certification Commission for Addiction Professionals:  NCAC I  NCAC II  MAC |
| 8 | **Applicants who are ALREADY CREDENTIALED and have one or more of the below (check all that apply):**  Alaska Behavioral Health Certification:  CDC II  CDCS  CDC Admin  ANTHC Behavioral Health Aide Certification Level:  BHA II  BHA III  BHA/P  National Certification Commission for Addiction Professionals:  NCAC I  NCAC II  MAC  \*If you meet one of the above credentials, you will be automatically approved as a QAP and will not need to go through the 3 year provisional process. You will still need to fill out this application and attach your credential to this application.  \*Your approval expiration date will match your credential expiration date. |
| 9 | **Mental Health Professional Clinician - (Licensed or Unlicensed), Registered Nurse and/or Licensed Practical Nurse who are applying for a QAP:**  Agency/ Clinical Supervisor attests that the applicant has or is working toward obtaining additional education that is necessary for the provision of SUD services:  The following licensed types are required to have a minimum the following education and be able to show proof that they have these. These education topics and number of units are required for the individual every license renewal period.  Addiction 4 units  ASAM 2units  Cultural Competency 2 units  **\***These CEU requirements differ from the licensing boards for these professionals. This requirement is specific to the provision of 1115 services.  \*Please attach a copy of your CEU’s for above additional requirements if completed to this application  \*Please attach a copy of your diploma and/or license to this application |
| 10 | Do you understand that if the QAP with provisional approval achieves certification, the QAP and Clinical Supervisor will provide the Division with proof of certification, the certified QAP’s enrollment in Medicaid will change from Provisional to fully-certified QAP enrollment?  **Yes**   **No** |
| 11 | **Peer Support Specialist:** **Agency/Supervising Clinician acknowledges and attests the understanding of the following:**  A peer support specialist is someone with similar experience to the individuals he/she are supporting  Family members are most appropriate to provide Peer Support Services to family members and individuals with lived experience of recovery from mental illness and/or addiction are most appropriate to provide peer support services to other individuals with recovery from mental illness and/or addiction. |
| 12 | **Agency/Supervising Clinician attests that this individual is qualified to provide Peer Support Services by meeting all of the following criteria:**  Able to self-identify as someone who has lived experience of recovery from mental illness and/or addiction and/or is a family member of someone with lived experience of recovery from mental illness and/or addiction.  Has skills learned in formal training and/or supervised work experience, to deliver services in behavioral health settings to promote mind-body recovery and resiliency.  Has training and/or experience in providing direct services reflective of, and consistent with the Alaska Core Competencies for Direct Service Providers.  Has training and/or experience in providing direct services that is consistent with qualifications of a behavioral health clinical associate. |
| 13 | Do you understand that the Qualified Behavioral Health Professional (QAP/PSS) must be enrolled under an 1115 Waiver  **Yes**   **No** |
| 14 | **Agency/Supervising Qualified Mental Health Clinician understanding that** once a certification process for Peer Support Specialists has been developed, all Peer Support Specialists with an approved provisional status will be required to obtain full certification and to comply with educational requirements within the provisional timeframe.  **Yes**   **No** |
| 15 | Do you understand that any QAP-in-training who has not obtained full certification **in Three (3) years of date of approval letter** will automatically lose their Medicaid enrollment status and any claims submitted will be denied:  **Yes**   **No** |

**Certification Statement:**

I certify that the responses in this request and the information in the attached documents are accurate, complete, and current. I understand the information may be verified by Division of Behavioral Health staff upon on-site evaluations.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Applicant) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Clinical Supervisor) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **\*DIVISION OF BEHAVIORAL HEALTH USE ONLY\*** |
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| Follow-up Required: |