

State of Alaska Department of Health and Social Services
Division of Behavioral Health

**Qualified Behavioral Health Professional
PROVISIONAL PROVIDER APPLICATION**

Please send applications to:

MPASS Unit

Mailing address: 3601 C Street, Suite 878, Anchorage, AK 99503

Fax 907-269-3623 or mpassunit@alaska.gov

1.	Date: Agency Name:
2.	Name and Credentials: National Provider Identification (NPI) Number: <input type="checkbox"/> Both Qualified Addiction Professional (QAP) and Peer Support Specialist (PSS)(Complete items 1-14) and/or <input type="checkbox"/> Qualified Addiction Professional (QAP) only (Fill out items 1-10 and 13-14) <input type="checkbox"/> 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 <input type="checkbox"/> Doctors of Osteopathic Medicine <input type="checkbox"/> Physicians Assistants <input type="checkbox"/> Accredited Nurse Practitioners <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> (skip to signature)
6.	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 <input type="checkbox"/> No <input type="checkbox"/>
7.	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 <input type="checkbox"/> No <input type="checkbox"/>

8.	<p>Agency/Clinical Supervisor attests that the applicant is <u>WORKING TOWARDS</u> obtaining QAP certification within three years (Choose any applicable):</p> <p>Alaska Behavioral Health Certification: CDC II <input type="checkbox"/> CDCS <input type="checkbox"/> CDC Admin <input type="checkbox"/></p> <p>Behavioral Health Aide Certification: BHA I <input type="checkbox"/> BHA II <input type="checkbox"/> BHA III <input type="checkbox"/> BHA/P <input type="checkbox"/></p> <p>National Certification Commission for Addiction Professionals: NCAC I <input type="checkbox"/> NCAC II <input type="checkbox"/> MAC <input type="checkbox"/></p>
9.	<p>Applicants who are <u>ALREADY CREDENTIALLED</u> and have one or more of the below (check all that apply):</p> <p>Alaska Behavioral Health Certification: CDC II <input type="checkbox"/> CDCS <input type="checkbox"/> CDC Admin <input type="checkbox"/></p> <p>Behavioral Health Aide Certification Level: BHA II <input type="checkbox"/> BHA III <input type="checkbox"/> BHA/P <input type="checkbox"/></p> <p>National Certification Commission for Addiction Professionals: NCAC I <input type="checkbox"/> NCAC II <input type="checkbox"/> MAC <input type="checkbox"/></p> <p>*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. <input type="checkbox"/> A copy of applicant's credentials has been attached to this application.</p> <p>*Your approval expiration date will match your credential expiration date.</p>
10	<p><u>Mental Health Professional Clinician - (Licensed or Unlicensed), Registered Nurse and/or Licensed Practical Nurse who are applying for a QAP:</u></p> <p>Agency/ Clinical Supervisor attests that the applicant has or is working toward obtaining additional education that is necessary for the provision of SUD services. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>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. If applicant is an unlicensed master level clinician, please submit the proof the required education topics and number of units have been completed every two years.</p> <p>Addiction 4 units <input type="checkbox"/> ASAM 2 units <input type="checkbox"/> Cultural Competency 2 units <input type="checkbox"/> Ethics 3 units <input type="checkbox"/></p> <p>*These CEU requirements differ from the licensing boards for these professionals. This requirement is specific to the provision of 1115 services.</p> <p>*Please attach a copy of your CEU's for above additional requirements if completed to this application.</p> <p>*Please attach a copy of your diploma and/or license to this application.</p>
11	<p>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 <input type="checkbox"/> No <input type="checkbox"/></p>

12	<p>Peer Support Specialist: Agency/Supervising Clinician acknowledges and attests the understanding of the following:</p> <p><input type="checkbox"/> A peer support specialist is someone with similar experience to the individuals he/she are supporting.</p> <p><input type="checkbox"/> 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.</p>
13	<p>Agency/Supervising Clinician attests that this individual is qualified to provide <u>Peer Support Services</u> by meeting all of the following criteria:</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> Has training and/or experience in providing direct services reflective of, and consistent with the Alaska Core Competencies for Direct Service Providers.</p> <p><input type="checkbox"/> Has training and/or experience in providing direct services that is consistent with qualifications of a behavioral health clinical associate.</p>
14	<p>Do you understand that the Qualified Behavioral Health Professional (QAP/PSS) must be enrolled under an 1115 Waiver</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
15	<p>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.</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
16	<p>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:</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
17	<p>Applicant attests that they have completed a background check application in accordance with 7 AAC 10.910 (a)(b) and AS.48.05.310(d).</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

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: _____
(Applicant)

Printed Name: _____
Date: _____

Signature: _____
(Clinical Supervisor)

Print Name: _____
Date: _____

DIVISION OF BEHAVIORAL HEALTH USE ONLY
Follow-up Required: