STATE OF NEW HAMPSHIRE
Department of Health and Human Services
Division for Children, Youth and Families

Form 2617
October 2016

APPLICATION FOR CERTIFICATION AND ENROLLMENT OF PRIVATE BEHAVIORAL HEALTH PROVIDERS

Provider Type	
☐ **Alcohol/Drug Abuse Counseling - Individual**	☐ **Family Counseling**
☐ **Alcohol/Drug Abuse Counseling - Group**	☐ **Outpatient Counseling - Individual**
☐ **Diagnostic Evaluations**	☐ **Outpatient Counseling - Group**

PART A: IDENTIFYING INFORMATION

Name of Applicant: _____ Federal Taxpayer ID Number (TIN): _____

or

Telephone: _____

Fax Number: _____ Social Security Number (SSN): _____

Physical Address: Street: _____ Email: _____

City / Town: _____ State: _____ Zip Code: _____

Mailing Address *(if different)*: _____

Languages in which you are proficient: _____

NH Medicaid Number: _____ National Provider Identification Number (NPI): _____

If you work for an agency Please complete this section:

Name of Agency: _____ Federal Taxpayer Id Number (TIN): _____

Physical Address: _____

Billing Address: _____ Telephone: _____

City/Town: _____ State: _____ Zip Code: _____ Fax Number: _____

Name of Billing Contact Person: _____ Telephone # of Billing Contact: _____

Agency Website Address: _____

NH Medicaid Number: _____ National Provider Identification Number (NPI): _____

PART B: PROVIDERS SERVICE SPECIALTIES

Please indicate whether you offer any service specialties within the services for which you are certified, or are requesting certification.

Alcohol/Drug Abuse Individual Outpatient Counseling

- ☐ Substance Abuse Evaluation (LADAC)
- ☐ Other: (specify) _____

Diagnostic Evaluation

- ☐ Behavioral Consultation
- ☐ Child Psychiatric Evaluation
- ☐ Competency Evaluation
- ☐ Developmental Evaluation
- ☐ Domestic Violence Evaluation
- ☐ Dual Diagnosis Evaluation
- ☐ Family Functional Assessment
- ☐ Fire-setting Evaluation
- ☐ Neuropsychiatric Evaluation
- ☐ Parenting Assessment
- ☐ Psycho-educational Evaluation
- ☐ Psycho-sexual Risk Evaluation
- ☐ Sexual Abuse Victim Evaluation
- ☐ Other: (specify) _____

Family Counseling

- ☐ Sibling Counseling
- ☐ Blended Families
- ☐ Divorce/Custody Issues
- ☐ Other: (specify)

Group Outpatient Counseling

- ☐ Adolescents
- ☐ Anger Management
- ☐ Batterers
- ☐ Children
- ☐ DBT
- ☐ Domestic Violence Survivors
- ☐ Gay/Lesbian/Bisexual/Transgender issues
- ☐ Loss/Bereavement
- ☐ Parenting Group - Therapeutic
- ☐ Sexual Abuse Victims
- ☐ Sexual Offenders - Adults
- ☐ Sexual Offenders - Youth
- ☐ Trauma
- ☐ Other: (specify) _____

Individual Outpatient Counseling

- ☐ Adolescents
- ☐ Adults
- ☐ Art Therapy
- ☐ Attachment Disorder
- ☐ Behavioral Interventions
- ☐ Biofeedback
- ☐ Children
- ☐ EMDR
- ☐ Gay/Lesbian/Bisexual/Transgender issues
- ☐ Loss/Bereavement
- ☐ Medication Monitoring
- ☐ Motion Therapy
- ☐ Music Therapy
- ☐ Neuro feedback
- ☐ Play therapy
- ☐ Other: (specify) _____

PART C: EVIDENCE BASED PRACTICES

Please indicate Evidence Based Practices that you are proficient in.

☐	Adolescent Trauma Focused CBT	Trained by:
☐	Latency Aged Trauma Focused CBT	Trained by:
☐	The Joy Osofsky Child-Parent Psychotherapy Model 0-06	Trained by:
☐	Other EBP:	Trained by:
☐	Other EBP:	Trained by:

PART D: INSURANCE INFORMATION

Please complete the following items. Use the space below for answers or attach sheets as needed.

Does the agency or individual have General and Professional Liability Insurance? Yes ☐ No ☐

Has the agency or individual ever had any General or Professional Liability Insurance policy revoked? Yes ☐ No ☐

If "yes" please state the reason why it was revoked.

PART E: APPLICANT INFORMATION

Name of Applicant: _____ **List Current Licenses:** _____

License Expiration Date: _____

All applicants must answer the following questions. If any questions are answered "yes" identify the individual involved and provide information including dates, details, and results on a separate sheet and submit it with the application.

HAVE YOU EVER:		**YES**	**NO**
1.	Had membership on any hospital, medical or allied health provider staff revoked? If yes, describe by whom, reason(s) , dates and results	☐	☐
2.	Had provider status with any group or health maintenance organization revoked? If yes, describe by whom, reason(s) , dates and results	☐	☐
3.	Had clinical privileges revoked? If yes, describe by whom, reason(s) , dates and results	☐	☐
4.	Had academic appointment terminated? If yes, describe by whom, reason(s) , dates and results	☐	☐
5.	Had professional or general liability insurance cancelled for disciplinary purposes? If yes, describe by whom, reason(s) , dates and results	☐	☐
6.	Been subject to disciplinary action by a licensing body or professional society? If yes, describe by whom, reason(s) , dates and results	☐	☐
7.	Been found civilly liable for professional misconduct, if so by whom, the reasons, dates, and results.	☐	☐
8.	Been found to have committed an ethical violation by a state or national professional association or any state's regulatory board? If yes, describe by whom, reason(s) , dates and results	☐	☐
9.	Had any judgments or settlements made against you in a professional liability case or are there any pending law suits?	☐	☐
10.	Been convicted of a felony or any crimes against a person, if yes, provide the court name, details of the offense, date of the conviction, and the sentence.	☐	☐
11.	Have been or currently are listed in any state registry of founded child or elder abuse and neglect?	☐	☐

I declare that all the information contained above is true, correct and complete to the best of my knowledge and belief. I acknowledge that the provision of false information in the application is a basis for denial of the application.

_____ _____

Signature of Applicant Date

PART F STATEMENT OF AFFIRMATION

I have reviewed Administrative Rule He-C 6344 and will adhere to the rules as an enrolled provider. I understand that DCYF has the right to verify information contained in this application.

I will notify DCYF in writing within ten business days of any change to the information contained in this application.

I authorize the NH Division for Children, Youth and Families (DCYF) to conduct a certification for payment review to determine the program's compliance with the Administrative Rule.

I understand and agree that any individual whom provides services or agency that I subcontract with will have a current and valid license for the service being provided.

The information contained in this application is correct to the best of my knowledge.

Signature of Applicant _____ Date _____

Printed Name of Applicant _____

Return Completed Application to:

NH Department of Health and Human Services or
Division for Children, Youth and Families
Provider Relations
129 Pleasant St
Concord, NH 03301-3857

*Below mentioned items **MUST** be submitted with the application in order for enrollment to occur.*

☐ License to Practice or Operate
☐ Alternate W-9

FOR DCYF OFFICE USE ONLY

Enrollment Valid: From: _____ *To:* _____ *NH Bridges Provider Number:* _____

Approved for Initial Enrollment ☐ _____

Approved for Enrollment Renewal: ☐ _____ Provider relations: _____
Signature