



Instructions – Individual/Staff Provider Enrollment

Include credential information for each individual who will provide services. A copy of each individual's license, certification, or registration must be provided with the application (only if applicable: many recovery support providers do not have formal credentials). Each individual providing clinical treatment and/or recovery support must fill out this form (pages 17-22).

RECOVERY SUPPORT and CLINICAL TREATMENT

Name of Provider
Organization:

Physical Location/Site Where Person is
Housed:

Name of Tribe and/or Tribal Program if
under a "Tribal Umbrella:"

Individual Provider Enrollment Information

Make copies of these pages for Each Individual person who will provide service(s).

1. Name _____
2. Position/Title _____
3. Education & Specialty Area _____
4. Email _____
5. License/Certification Board Name: _____
6. License/Certification Number: _____
7. License/Certification Dates (Effective) _____ (mm/dd/yy) (Expiration) _____ (mm/dd/yy)

This person is seeking approval as an ATR

Clinical Treatment Provider Recovery Support Provider Both

Services the staff member is qualified and/or licensed to provide:

Clinical Treatment Services

- Intake Interview
- Individual Service Coordination (Case Management)
- Individual Counseling
- Group Counseling (per person)
- Family/Marriage Counseling
- Family Therapy w/o Client
- Family Therapy w/ Client
- Substance Abuse Education Group (per person)
- Crisis Intervention
- Residential Treatment
- Discharge Plan
- Traditional Healing
- Sweat Lodge
- Talking Circle
- Other Clinical Services _____

Co-occurring Treatment Services

- Psychological Testing
- Psychiatric Evaluation
- Interpretation of results to family or other responsible person
- Other Co-occurring _____

Medical Services

- Medical Examination
- Alcohol/Drug Testing
- Pharmacological Interventions
- HIV/AIDS Counseling
- Other Medical Services _____
- Acupuncture
- Auricular Acupuncture
- Alternative Therapies: (list) _____

Please Describe Any Specialty Services that your program provides:

Recovery Support Services

- Family Services (Marriage Education, parenting and child development services.)
- Child Care Services
- Employment Services
- Pre-Employment Services/ Job Readiness
- Employment Coaching
- Individual Services Coordination (Case Management)
- Recovery Support Planning
- Transportation Services
- HIV/AIDS Services
- Transitional Drug Free Housing Services (Limits Apply)
- Other Case Management
- Continuing Care
- Relapse Prevention
- Recovery Coaching
- Pastoral Guidance
- Traditional Healing Services
- Spiritual Support Services
- Group/Peer Support Services/Self Help Support Groups
- Individual/Peer Support Service
- Traditional Healing
- Sweat Lodge

- Substance Abuse Education
- HIV/AIDS Education
- Daily Living Skills/Group
- Indigenous Language Recovery/Expression
- Storytelling/Cultural Teaching
- Talking Circle
- Tribal Song and Dance
- Tribal Arts and Crafts
- GED Preparation
- Educational Tutoring
- Other Education Services
- Peer Coaching/Mentoring
- Alcohol- and Drug-Free Social Activities
- Physical Fitness and Well-Being Activities
- Stress Management
- Nutritional Management
- Information and Referral
- Other Peer to Peer Recovery Support Services
- Other _____
- Other _____

Individual Attestation Questions

Must be completed, signed, and dated by each individual or staff person providing RECOVERY SUPPORT SERVICES.

Each individual staff person/provider is required to complete, sign, and date this form. An application will not be considered complete unless a completed attestation question form is submitted for each person who is identified to provide services in the provider application.

Please answer "YES" or "NO" to the questions below. If you answer "YES" to questions A through C, please provide a full explanation on a separate sheet of paper referencing the section number.

A. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes No If yes, give particulars on a separate sheet of paper.

B. Do you presently use any drugs illegally?

Yes No

C. Have you had a criminal background check within the last 12 months? Yes No

Is it on file with your organization or agency and/or available for audit? Yes No

I hereby affirm that the information submitted in this Section (Individual Provider Attestation Questions) and any attached addendums is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that omissions and misrepresentations may result in denial of my application or termination of my privileges as a provider under ATR.

Print Name

Signature

Date

Provide a copy of credential information or license for each person, if applicable.

Individual Attestation Questions

**Must be completed, signed, and dated by each individual providing
CLINICAL TREATMENT SERVICES.**

Each staff member (individual provider) is required to complete, sign, and date this form. For programs that have more than one person providing services, please make a copy of this form for each staff person. An application will not be considered complete unless a completed attestation question form is submitted for each person who is identified to provide clinical treatment services in the provider application.

Please answer "YES" or "NO" to the questions below. If you answer "YES" to questions A through K, or if you answer "NO" to question L, please provide a full explanation on a separate sheet of paper referencing the section number.

A. Has your license, registration, or certification to practice in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license, registration, or certification or voluntarily or involuntarily accepted any such actions or conditions, or have been fined or received a letter of reprimand or is such action pending?

Yes No

B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subject to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any other public program, or is any such action pending?

Yes No

C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association [IPA], health plan, health maintenance organization [HMO], preferred provider organization [PPO], medical society, professional association, medical school faculty possession, or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct, or breach of contract, or is any such action pending?

Yes No

D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association [IPA], health plan, health maintenance organization [HMO], preferred provider organization [PPO], medical society, professional association, medical school faculty position, or other health delivery entity or system) while under investigation for possible incompetence, improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

Yes No

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, or other clinical education program?

Yes No

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?

Yes No

G. Have you ever been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?

Yes No

H. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes No If yes, give particulars on a separate sheet of paper.

I. Do you presently use any drugs illegally?

Yes No

J. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?

Yes No

K. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with a written notice of any intent to deny, cancel, renew, or limit your professional liability insurance or its coverage of any procedures?

Yes No

L. Are you able to perform all of the services required by your agreement with, or the professional staff bylaws of the health organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance standards and without posing a direct threat to the safety of clients?
 Yes No

M. Have you had a criminal background check within the last 12 months? Yes No
Is it on file with your organization or agency? Yes No

I hereby affirm that the information submitted in this Part 3 – Provider Attestation Questions, and any attached addendums is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that omissions and misrepresentations may result in denial of my application or termination of my privileges as a provider under ATR.

Staff Member (Individual Provider) Name (Print)

Staff Member (Individual Provider) Name (Signature)

Date

Provide a copy of credential information or license for each person, if applicable.