AAIR *Access to American Indian Recovery*

Provider Enrollment Application

Outpatient/Residential/Recovery Support/Transitional Housing or Sober Living

Welcome to the Access to American Indian Recovery program (AAIR). To participate as an AAIR provider, each provider organization must complete a provider application. The application has six (6) parts; you are required to complete only the parts that correspond to the types of services your organization will provide. The application must be complete for it to be processed by AAIR.

General Application Instructions and Provider Qualification Standards follow Part 6 of this application.

Residential Treatment Facilities- complete the following,

Part 1 – General applicant information
Attach copy of State Licensure
Attach copy of W-9
Attach proof of malpractice insurance coverage (except PL 93-638 facilities)

Organized Outpatient Clinics- complete the following,

Part 1 – General applicant information
Part 6 – Clinic based provider application
Attach copy of State Licensure, if applicable
Attach copy of W-9
Attach proof of malpractice insurance coverage (except PL 93-638 facilities)

Sole Providers- complete the following,

Part 1 – General applicant information
Part 2 – Individual provider information
Part 3 – Provider attestation questions
Part 4 – Provider information release & acknowledgements
Attach copy of W-9
Attach proof of malpractice insurance

Traditional Healers/Spiritual Advisors- complete the following,

Part 2 – Individual provider information – Complete items 1, 2 (indicate TH/SA), 3, 5, signature and date.
AAIR Traditional Healer/Spiritual Advisor form

Must be an employee of or work under contract to an AAIR credentialed Residential Treatment Facility, Outpatient Clinic, or Sole Provider. The AAIR provider is fully responsible for the oversight of the referral for TH/SA's activities, and all billings and payments. The AAIR provider is responsible for maintaining the documentation of TH/SA services in the client record.

Transitional/Sober Living Facilities- complete the following,

There are two (2) ways a Transitional/Sober Living Facility may provide AAIR services.

1) The Transitional/Sober Living Facility applies to become an AAIR provider by completing and submitting:

Part 1 – General applicant information
Part 3 – Provider attestation questions
Part 4 – Provider information release & acknowledgements
Attach copy of current business license
Attach copy of W-9
Attach proof of general liability insurance
Attach copy of fee schedule

2) An existing AAIR approved provider (non-sober living) can request a sober living voucher and send their AAIR client to a sober living facility of their choice if that facility is not an AAIR provider. The AAIR approved provider must pay the sober living facility prior to billing AAIR for services (This is a reimbursable expense and proof of payment to the sober living facility must be maintained for each AAIR client. The AAIR provider is responsible for assuring, and documenting, the sober living facility owner(s) are eligible to receive federal healthcare dollars, as evidenced by the owner(s) not being on the OIG Excluded Provider List, http://exclusions.oig.hhs.gov, or the GSA Excluded Parties List, https://www.epls.gov. The AAIR provider is responsible for assuring the Transitional/Sober Living facility maintains documentation to support each day of the client's residence at the facility.

Application Sections

General Application Instructions and Provider Qualification Standards follow Part 6 of this application.

Part 1 – Provider Organization Information (SECTIONS A – H)

❑ All applicable questions are answered. If your organization has multiple locations please list them in Part 1, Section D. If an item is not applicable, write N/A.

❑ Cooperate fully with SAMHSA's data collection and evaluation requirements. Ensure that all GPRAs (Intake, Discharge, and the five-month post intake follow-up) are completed accurately and on time. Failure to complete GPRAs accurately and on time will result in the Provider Organization's suspension from the AAIR Program.

❑ The organization participation agreement is signed and dated by an authorized individual (i.e., executive director) on behalf of the organization.

Part 2 – Individual Provider Information

❑ Provide credential information for each individual who will provide service(s). Please refer to the Provider Qualification Standards located in the instructions section.

❑ Signed and dated by an authorized individual (i.e., executive director) on behalf of the Provider Organization.

Part 3 – Provider Attestation Questions

❑ Each provider has completed, signed, and dated the attestation statement.

Part 4 – Provider Information Release and Acknowledgments

❑ Each provider has signed and dated the release and acknowledgments.

Part 5 – Supporting Documentation (Attach copies of the following documents if applicable)

❑ License and/or certification for the provider organization or program (if applicable).

❑ W-9 – Request for Taxpayer Identification Number and Certification for the provider organization or sole provider.

❑ Current resume for each individual provider.

❑ Current license, certification, and/or registration for each individual provider.

❑ Provide appropriate business license and liability insurance.

Part 6 - Clinic Based provider Application

❑ List all licensed or certified employees who will be providing clinical services to AAIR clients.

Once the application is complete, the application and supporting documentation must be mailed to:

AAIR Administration - Provider Enrollment
California Rural Indian Health Board, Inc.
4400 Auburn Boulevard, 2nd Floor, Sacramento, CA 95841
Phone: (916) 929-9761, Facsimile: (916) 263-0207

Part 1 - Provider Organization Information

Your Organization Will Provide – (check all that apply)

❑ Outpatient/Clinical ❑ Residential ❑ Recovery Support ❑ Transitional/Sober Living Facilities ❑ Traditional Healer/Spiritual Advisor

A - Organization Information

1. Organization Name and Type ❑ Corporation ❑ Partnership ❑ Sole Proprietor

2. Physical Address (Street, City, State, ZIP Code)

3. Mailing Address (Street/P.O. Box, City, State, ZIP Code)

4. Contact Name and Title (Executive Director)

5. Telephone Number 6. Facsimile Number 7. Email

B – Fiscal/Payment Information

Provide Payment Information for Payment of Service(s)

1. Organization Name

2. Mailing Address – (Street/P.O. Box, City, State, ZIP Code)

3. Tax ID #/ SSN

❑ Profit

4. Fiscal Contact Name and Title

❑ Non-Profit

5. Telephone Number 6. Facsimile Number Email

C – Business License, Liability Insurance

Provide current appropriate business license and liability insurance information for the provider organization. Liability insurance must be a minimum of $1,000,000.

1. Insurance Company and Policy Number

____

2. Insurance Liability Amount 3. Insurance Policy Dates (Effective) (Expiration)

____

D – Locations of Operation

If your organization has multiple locations of operation please list them here. (Attach additional pages if necessary) This location will provide (check all that apply)

❑ Outpatient/Clinical ❑ Residential ❑ Recovery Support ❑ Transitional/Sober Living Facilities

____

1. Name of Facility

____

2. Physical Address (Street, City, State, ZIP Code)

____

3. Telephone Number

E – Program/Department Information (If Applicable)

Provide information for the program/department that will provide service(s).

____

1. Program/DepartmentName

____

2. Program Contact Name and Title

____

3. Physical Address (Street/P.O. Box, City, State, ZIP Code)

____

4. Mailing Address (Street/P.O. Box, City, State, ZIP Code)

____

5. Telephone Number 6. Facsimile Number Email

____

F – Program/Department License and/or Certification (Clinical and Residential)

Provide licensing and/or certification information for each program/department that will provide service(s). Must be licensed and certified by the applicant's State Department of Licensing and Certification or the Department of Alcohol and Drug Programs if required by state.

____

1. State Licensing/Certifying Agency Name

____

2. State Licensing/Certification Classification

____

3. State Licensing/Certification Number

____

4. State Licensing/Certification Dates

(Effective) ______________________ (Expiration) ______________________

G – Program/Department Services (If Applicable)

1. Type of organization

Primary health care facility (Tribal health program)
Primary health care facility (Urban Indian Health Program)
Other primary health care facility
Specialized outpatient or residential substance abuse treatment facility
(not housed at a primary health care clinic)
Social service organization (e.g., food banks, family service organizations, legal assistance, employment and training organizations)
Faith-based institution (e.g., church, synagogue, mosque)
Traditional healing interventionist or Native American cultural organization
Other ______________________

2. Culturally-based services

Do the services offered by your organization incorporate traditional American Indian/Alaskan Native (AI/AN) customs and cultural beliefs?

Yes No

3. Sources of Payment

Which of the following sources of payment are usually used to cover the cost of direct services to your clients?"

Private health insurance
MediCal/MediCare
Tribal funds
IHS funds
Government or foundation grants
Private donations
Fee-based services (out-of-pocket)
Fee-based services with sliding scale
Other sources ______________________

4. Identify the Gender and Age of Clients that Your Program/Department Serves

Adults (Specify gender and age range): ________________ ________________

Youth (Specify gender and age range): ________________ ________________

5. Service(s) that your Program/Department provides (Check all that apply)

Screening, Assessment, and Diagnosis Services

Client eligibility and substance abuse screening
Substance abuse assessment and diagnosis
Substance abuse treatment planning
Clinical case management
Pharmacological assessment
Alcohol and drug testing

Substance Abuse Services

Individual substance abuse counseling
Group substance abuse counseling
Single family/marriage substance abuse counseling
Multiple family/marriage substance abuse counseling
Substance abuse education
HIV/AIDS/STD/HEPC education
HIV/AIDS/STD/HEPC counseling

Mental Health Services (for co-occurring mental health disorders)

Mental health assessment and diagnosis
Mental health treatment planning
Individual psychotherapy
Group psychotherapy
Single family/marriage counseling
Multiple family/marriage counseling
Pharmacological management

Recovery Support Services

Relapse prevention/Recovery coaching
Supportive transitional drug-free housing services
Nutritional Counseling
Exercise Activity Support
Single-family services
Multiple family services
Employment services
Traditional activities
Spiritual support
Peer coaching or mentoring
Self-help and support groups
Childcare
Transportation

6. Substances that your program is qualified to treat (check all that apply)

Methamphetamine	Heroin	Crack	Cocaine
Marijuana/Hashish	Alcohol	Stimulants	Nicotine
Depressants	Hallucinogens	Other (Specify) _____________________	

H – Organization Participation Agreement

Must be signed and dated by an authorized individual on behalf of the provider organization. To participate as a provider under AAIR, our organization, as the provider of services agrees to:

1. Not charge a client for the following:
   a. Services for which the provider is entitled to payment from AAIR;
   b. Services for which the provider could have been entitled to payment from AAIR had the provider complied with certain procedural requirements;
   c. Services not necessary and appropriate for the clinical management of the presenting problem(s);
   d. Services for which the provider could have been entitled to payment from AAIR had the provider not been charged with a reduction or denial in payment as a result of quality review; and
   e. Services rendered during a period in which the provider was not authorized to provide services.

2. Not charge AAIR for services paid for by other funding sources.

3. Comply with the applicable provisions related to AAIR policy.

4. Accept the AAIR allowable payment combined with any cost share or other health insurance amounts payable by, or on behalf of, the client, as full payment for authorized services.
5. Collect from the client those amounts that the client has a liability to pay for.
6. Allow AAIR to review the clinical records of AAIR clients, the financial and organizational records of the provider, and the reports of evaluations and inspections conducted by state, private agencies, or organizations.
7. Cooperate fully with utilization and clinical quality management reviews conducted by AAIR.
8. Cooperate fully with SAMHSA's data collection and evaluation requirements. Ensure that all GPRAs (Intake, Discharge, and the Six-Month post intake follow-up) are completed accurately and on time. Failure to complete GPRAs accurately and on time will result in the Provider Organization's suspension from the AAIR Program.
9. Obtain authorized Assessment or Treatment Voucher from AAIR before rendering services.
10. Maintain clinical and other records related to clients for whom payment was made for services rendered by the provider or otherwise under arrangement, for a period of 7 years from the date of service.
11. Maintain clinical records that substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment.
12. Notify AAIR within five (5) business days when a client's eligibility status has changed.
13. Notify AAIR immediately of suspected fraud and abuse and notify AAIR immediately if either the provider or one of the provider's employees becomes excluded from participation in federal programs.
14. Notify AAIR when an employee who serves as a provider is no longer employed by the organization or their eligibility status changes.
15. Not use AAIR program funds for clinical research involving human subjects, and not enroll clients in clinical research involving human subjects.
16. Maintain malpractice insurance in the amounts specified by AAIR; notify AAIR if the malpractice insurance falls below the required limit.
17. Provide quality services within the appropriate standards of care for each provider's profession.
18. Meet all AAIR reporting requirements.
19. Meet future requirements established by AAIR.

The AAIR program agrees to make this agreement effective until terminated by either party. The effective date shall be the date the agreement is signed below:

____

Print, Organization Name (corporation, partnership, or sole-proprietor name)

____

Print, Authorized Signer's Name Print, Authorized Signer's Title

____

Signature, Authorized Signer's Name (Stamped signature is not acceptable) Date

Part 2 – Individual Provider Information

Provide Credential Information for Each Individual who will Provide Service(s)
Please refer to the Provider Qualification Standards located in the instructions section.

1. Provider Name 2. Education/Credentials & Specialty

3. Date of Birth 4. TIN/SSN 5. Email

6. License/Certification/Registration Board Name

7. License/Certification/Registration Number

8. License/Certification/Registration Dates

Effective ______________________ Expiration ___________________

1. I understand that I/we have a right to appeal any decision regarding the disposition of this application.
2. I declare under the penalty of perjury that the statements on this application are correct to the best of my knowledge.
3. I am authorized to sign this application on behalf of the named applicant.

Signature ________________________________Title _________________________Date _____________
Authorized Organization Representative

Part 3 - Provider Attestation Questions

Must be completed, signed, and dated by each individual provider.

Each provider is required to complete, sign, and date this form. For programs that have more than one provider, please make a copy of this form for each provider. An application will not be considered complete unless a completed attestation question form is submitted for each provider 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 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 charge, 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 possession, 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

Part 3 - Provider Attestation Questions, Continued

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

❑ Yes ❑ No

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, or 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

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 AAIR.

Print, Provider Name

Signature, Provider Name Date

(Stamped signature is not acceptable)

Part 4 - Provider Information Release and Acknowledgments

Must be completed, signed, and dated by each provider. **Each provider is required to sign and date this form. For programs that have more than one provider, please make a copy of this form for each provider. An application will not be considered complete unless a completed information release and acknowledgment form is submitted for each provider who is identified to provide services in the provider application.**

1. I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between CRIHB or its agent and other healthcare organizations (e.g., hospital medical staff, medical groups, independent practice associations [IPA], health plans, health maintenance organizations [HMO], preferred provider organizations [PPO], and other health delivery systems or entities, medical societies, professional associations, schools, training programs, professional liability insurance companies [with respect to certification of coverage and claims history], licensing, registration, and certification authorities, and businesses and individuals acting as their agents, for the purpose of evaluating this application and any re-application regarding my professional training, experience, character, conduct, and judgment, ethics, and ability to work with others.

2. I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for acts and/or communications in connection with evaluating qualifications of healthcare providers. I hereby release all persons and entities, including CRIHB, engaged in quality assessment, peer review and credentialing on behalf of AAIR, and all persons and entities providing credentialing information to such representatives of CRIHB or AAIR, from any liability incurred for acts and/or communications in connection with the evaluation of my qualifications for participation in AAIR, to the extent that those acts and/or communications are protected by state and federal law.

3. I understand that I shall afford such fair procedures with respect to my participation in AAIR as may be required by state and federal law and regulation. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. During such time as this application is being processed, I agree to update the application should there be any changes in the information provided.

4. In addition to any notice required by AAIR, I agree to notify CRIHB immediately in writing of the occurrence of any of the following: (i) the suspension, revocation or non-renewal of my license, registration, and/or certification to practice; or (ii) any cancellation or non-renewal of my professional liability insurance coverage.

5. I further agree to notify CRIHB in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the licensing, registration, and/or certification board taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license, registration, and/or certification; or (ii) the denial, revocation, suspension, reduction, limitation, non-renewal or voluntary relinquishment by resignation of my privileges; or (iii) any material reduction in my professional liability insurance coverage; or (iv) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (v) my conviction of any crime (excluding minor traffic violations); (vi) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

6. This release of information pertains to records directly related to my professional qualifications and conduct, and specifically excludes personal medical and mental health records.

I hereby affirm that the information submitted in this application and any attached addendums (including my curriculum vitae, resume, etc.) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions and misrepresentations may result in denial of my application or termination of my privileges as provider under AAIR. A photocopy of this document shall be as effective as the original.

Print, Provider Name ____

Signature, Provider Name ____ Date ______________

Part 5 – Supporting Documentation

Attach copies of the following documents if applicable

❑ License and/or certification for the provider organization or program (if applicable)

❑ W-9 – Request for taxpayer identification number and certification for the provider organization

❑ Current resume for each individual provider

❑ Current license, certification, and/or registration for each individual provider

❑ Current business license and liability insurance for each provider organization

Part 6 – Clinic Based Provider Application

Health Program Name:

List all licensed or certified employees who will be providing clinical services to AAIR clients.

(**Do not include Traditional Healers/Spiritual Advisors; there is a separate application form.**)

Provider Name/Credential	D.O.B.	M/F	License/Certification Number	Social Security # for Licensed Providers Only	State of Licensure/ Certification

Clinical services billed to AAIR must be provided at your AAIR approved clinic site(s) by an employee of, or an individual functioning under a signed Professional Services Agreement to, your health program. AAIR will individually credential providers. AAIR reserves the right to deny credentialing to any individual named on this list. No clinical services provided by non-credentialed providers are billable to AAIR.

Signed:____ Date: ____________

Executive Director

General Instructions and Provider Qualification Standards

Part 1 - Provider Organization Information

Section A – Organization Information

1. Organization Name and Type – Provide the name of the corporation, partnership, or sole-proprietorship.
2. Physical Address – Provide the street, city, state, and ZIP code of the administrative office for the corporation, partnership, or sole-proprietorship.
3. Mailing Address – Provide the street or post office box, city, state, and ZIP code where mail is received by the corporation, partnership, or sole-proprietorship administration.
4. Contact Name and Title – Provide the name and title of the individual who is authorized to represent the corporation, partnership, or sole-proprietorship administratively.
5. Telephone Number – Provide the area code and telephone number for the corporation, partnership, or sole-proprietorship where the administrative representative can be reached.
6. Facsimile Number and Email – Provide the area code, facsimile number and Email for the corporation, partnership, or sole proprietorship where the administrative representative can be reached.

Section B – Fiscal/Payment Information

1. Organization Name – Provide the name of the corporation, partnership, or sole-proprietorship.
2. Mailing Address – Provide the street or post office box, city, state, and ZIP code where mail is received by the fiscal office.
3. TIN/SSN – Provide the tax identification number (TIN) or social security number (SSN) for the corporation, partnership, or sole-proprietorship. Identify if your organization is profit or non-profit.
4. Fiscal Contact Name and Title – Provide the name of the individual who is authorized to provide and receive fiscal information (billing, payment, records, etc.).
5. Telephone Number – Provide the area code and telephone number for the fiscal office.
6. Facsimile Number and Email – Provide the area code, facsimile number and email for the fiscal office.

Section C – Business License, Liability Insurance

1. Provide current appropriate business license and liability insurance information for the provider organization.

Section D – Hours of Operation

1. Provide the hours that services may be delivered to clients.

Section E – Program/Department Information

1. Program/Department Name – Provide the name of the program/department that may provide service(s).
2. Contact Name and Title – Provide the name of the individual who is authorized to provide and receive information on behalf of the program/department.
3. Physical Address – Provide the street, city, state, and ZIP code where service(s) will be delivered.
4. Mailing Address – Provide the street or post office box, city, state, and ZIP code where mail is received by the program/department.
5. Telephone Number – Provide the area code and telephone number for the program/department.
6. Facsimile Number and Email Address – Provide the facsimile number and email address for the program/department.

Section F – Program/Department License and/or Certification

If the program/department is a licensed and/or certified program/department in the state of jurisdiction, provide the information requested in section F. A copy of the license and/or certification must be provided with the application. If a program/department has more than one license and/or certification, make a copy of section F and provide the additional information.

Section G – Program/Department Services

Check boxes of all that apply (1) types of service, (2) service populations, (3) services, (4) substances qualified to treat, (5) language options that each program/department will offer to AAIR clients.

Section H – Organization Participation Agreement

The individual who is authorized to sign the application (i.e., executive director) on behalf of the corporation, partnership, or sole-proprietorship must sign section G to certify that the information provided in the application is correct.

Part 2 – Individual Provider Information

Provide credential Information for each individual within the organization that will provide clinical service(s)

Please refer to the Provider Qualification Standards located in the instructions section.

Part 3 - Provider Attestation Questions

Must be completed, signed, and dated by each individual provider.

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

Part 4 - Provider Information Release and Acknowledgments

Must be completed, signed, and dated by each provider.

Each provider is required to sign and date this form. For programs that have more than one provider, please make a copy of this form for each provider. An application will not be considered complete unless a completed information release and acknowledgment form is submitted for each provider who is identified to provide services in the provider application.

Part 5 – Supporting Documentation

Provider Qualification Standards (Attach copies of required documents.)

- State License, Certification, and Registration
- Psychiatrist
- Psychologist
- Clinical Social Worker
- Marriage and Family Therapist
- Chemical Dependency Counselor
- Pastoral Counselor
- Clinical Interns
- Traditional Medicine/Spirituality
- Recovery Support Service Coordination

All licenses, certificates, and registrations must be located at the providing organization's place of business and available for inspection.

State License, Certification, and Registration

Each clinical provider must hold a current and valid license, certification, or registration to practice in the state where the service(s) will be rendered. The provider must also be in good standing with the licensing, certifying, or registering board. The license, certification, or registration must be at the full and unrestricted clinical level of practice.

License, Certification, or Registration: Each provider shall possess and maintain, as applicable, the appropriate license, certification, or registration as required by AAIR even if it is not required by the state where the service is rendered. If the site of service is on Tribal land, the provider must be licensed in a state.

Excluded Parties: No individual providing AAIR services or having oversight of AAIR services or providers may be excluded from participation by the OIG, GSA, Medicare or Medicaid.

Psychiatrist

A psychiatrist is a medical doctor who specializes in the diagnosis and treatment of behavioral abnormalities and mental diseases. A psychiatrist may be reimbursed for providing services when practicing within the scope of his or her license. The psychiatrist must meet all of the following criteria:

1. License Required: Is licensed as a physician in his/her jurisdiction.
2. Education and Experience: Graduation from an approved medical school and possession of an M.D. or D.O. degree, supplemented by completion of a recognized internship.
3. Is in good standing with the licensing board in his/her jurisdiction.

Psychologist

A psychologist may provide covered services when practicing within the scope of his or her license or registration. The psychologist must meet all of the following criteria:

1. Is licensed or registered as a psychologist at the independent practice level in his/her jurisdiction.
2. Is in good standing with the licensing or registering board in his/her jurisdiction.
3. Has a doctoral degree in psychology from a regionally accredited university.
4. Has two (2) years or 3,000 hours of supervised clinical experience in psychological health services of which at least one (1) year is post-doctoral and one (1) year (may be the post-doctoral year) is in an organized psychological health service training program, and 100 hours of face-to-face supervision.
5. If required, provides services under the supervision qualified in the jurisdiction.

Clinical Social Worker

A clinical social worker may provide covered services independent of physician referral and supervision when practicing within the scope of his or her license or certification. The clinical social worker must meet all of the following criteria:

1. Is licensed as a clinical social worker at the independent practice level in his/her jurisdiction; or, if the jurisdiction does not provide for licensure of clinical social workers, is certified by the National Association of Social Workers (NASW). If a provider is eligible for full clinical membership in the NASW but is not a member, he/she must submit documentation obtained from the NASW of such eligibility.
2. Is in good standing with the licensing board in his/her jurisdiction.
3. Has at least a master’s degree in social work from an accredited graduate school.
4. Has a minimum of two (2) years or 3,000 hours of supervised clinical social work practice under the supervision of a master’s level social worker in an appropriate clinical setting and 100 hours of face-to-face supervision.
5. If required, provides services under the supervision qualified in the jurisdiction.

Marriage and Family Therapist

A marriage and family therapist may provide covered services independent of physician referral and supervision when practicing within the scope of his or her license or certification. The marriage and family therapist must meet all of the following criteria:

1. Is licensed or certified as a marriage and family therapist by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure of marriage and family therapists, is certified by the American Association for Marriage and Family Therapy (AAMFT). If a provider is eligible for full clinical membership in the AAMFT but is not a member, he/she must submit documentation obtained from the AAMFT of such eligibility.
2. Is in good standing with the licensing or certification board in his/her jurisdiction.
3. Has at least a master's degree in marriage and family therapy from an accredited graduate school.
4. Has a minimum of two (2) years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate clinical setting and 100 hours of face-to-face supervision.
5. If required, provides services under the supervision qualified in the jurisdiction.

Chemical Dependency Counselor

A chemical dependency counselor may provide covered services independent of physician referral and supervision when practicing within the scope of his or her certification. The chemical dependency counselor must meet all of the following criteria:

1. **Is certified as a chemical dependency counselor by a certification board authorized by the state where services will be rendered.**
2. **Is in good standing with the certification board in his/her jurisdiction.**
3. **If required, provides services under the supervision qualified in the jurisdiction.**

Pastoral Counselor

A pastoral counselor may provide covered services upon request of the client. The pastoral counselor must meet all of the following criteria:

1. **Is licensed or certified as a pastoral counselor by the jurisdiction where practicing; or, if the jurisdiction does not provide for licensure of pastoral counselors, is certified by the American Association of Pastoral Counselors (AAPC). If a provider is eligible for full clinical membership in the AAPC but is not a member, he/she must submit documentation obtained from the AAPC of such eligibility.**
2. **Is in good standing with the licensing or certification board in his/her jurisdiction.**
3. **Has at least a master's degree in an appropriate behavioral science field or mental health discipline from an accredited graduate school.**
4. **Has a minimum of two (2) years or 3,000 hours of supervised clinical practice of pastoral counseling under master's level supervision in an appropriate clinical setting and 100 hours of face-to-face supervision.**
5. **If required, provides services under the supervision qualified in the jurisdiction.**

Clinical Interns

Clinical interns may provide covered services when practicing within the scope of his or her intern registration or license. Clinical interns must meet all of the following criteria:

1. Is licensed or registered as an intern in the field of medicine, psychology, marriage and family therapy or clinical social work.
2. Is in good standing with the licensing or registering board in his/her jurisdiction.
3. Has at least a master's degree from a regionally accredited university.

   Clinical interns may only provide services under the direct supervision of a licensed psychologist, board-certified psychiatrist, or other licensed clinician qualified in the jurisdiction.

Providers of Traditional Medicine/Spirituality

Providers of traditional medicine/spirituality must be in good standing with the community and recognized as a traditional healer/spiritual advisor in the community where services are to be provided.

Providers of traditional medicine/spirituality must have a minimum of two (2) years of experience as a recognized traditional healer/spiritual advisor in the community where services are to be provided.

To demonstrate a provider's qualifications, a written letter of good standing and recognition must be signed and submitted to the provider organization and AAIR by a tribal chairperson or by the board of directors of an Indian health organization in the community where services will be provided (see c5.a1 – Letter Verifying Community Recognition and Good Standing to Serve as a Traditional Healer/Spiritual Advisor).

Recovery Support Service Coordination

Recovery support service coordination may be rendered by an employee of a provider organization when:

1. The provider organization, as the employer, pays a salary, social security taxes, worker's compensation, etc.
2. The service(s) are performed under the provider's general supervision
3. The service(s) are authorized by AAIR

Part 6 - Clinic Based Provider Application

List all licensed or certified employees who will be providing clinical services to AAIR clients. Include Provider's Name, Credential, License/Certification Number, and State of Licensure/Certification.