IMPACT Plus
Behavioral Health Professional
New Employee/Contract Screening Form

Applicant Name: _____ **Applicant Social Security #:** _____

Subprovider Name: _____ **Applicant Date of Birth:** _____

Region(s) this applicant will be working: _____

Please check all job descriptions that apply for this applicant (minimum of one box must be checked for Credentialing Committee to start review process):

- ❑ Individual Therapy
- ❑ Group Therapy
- ❑ Collateral Therapy
- ❑ Evaluation
- ❑ Targeted Case Manager Supervisor
- ❑ Therapeutic Child Support Supervisor
- ❑ Parent to Parent Supervisor
- ❑ Therapeutic After School Supervisor
- ❑ Summer Program Supervisor
- ❑ Children's Day Treatment Supervisor
- ❑ Intensive Outpatient Supervisor
- ❑ Therapeutic Foster Care Supervisor
- ❑ Group Residential Supervisor
- ❑ Crisis Stabilization Supervisor
- ❑ Partial Hospitalization Supervisor (Psychiatrist only)

Please check the appropriate license(s) for this applicant (minimum of one box must be checked for Credentialing Committee to start review process):

- ❑ Psychiatrist
  license number _____ expiration date _____
- ❑ Physician licensed in Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the practice of official duties
  license number _____ expiration date _____
- ❑ Psychologist licensed and practicing in accordance with KRS 319.050
  license number _____ expiration date _____
- ❑ Certified Psychologist with autonomous functioning or Licensed Psychological Practitioner certified and practicing in accordance with KRS 319.056
  license number _____ expiration date _____
- ❑ Clinical social worker licensed and practicing in accordance with KRS 335.100
  license number _____ expiration date _____
- ❑ Advanced registered nurse practitioner licensed and practicing in accordance with KRS 314.042
  license number _____ expiration date _____
- ❑ Marriage and Family therapist licensed and practicing in accordance with KRS 335.300
  license number _____ expiration date _____
- ❑ Professional Clinical Counselor licensed and practicing in accordance with KRS 335.500
  license number _____ expiration date _____
- ❑ Professional art therapist certified and practicing in accordance with KRS 309.130
  license number _____ expiration date _____
- ❑ Alcohol and drug counselor certified and practicing in accordance with KRS 309.080
  license number _____ expiration date _____

All of the following boxes must be checked verifying applicable information for each section is included with this form. The Credentialing Committee will not review packets that do not contain all of the required information.

- ❑ Current and legible copy of the applicant's pocket-sized license (or approval letter from Board if pocket-sized license has not been received)
- ❑ Professional liability insurance
- ❑ Current Department for Community Based Services criminal background check results
- ❑ Current Administrative Office of the Courts criminal background check results
- ❑ Current Statement of Disclosure signed by applicant and subprovider

Comments: _____

In accordance with 907 KAR 3:030 and the IMPACT Plus Subprovider Agreement, the undersigned do hereby affirm all information related to this applicant has been reviewed for the Behavioral Health Professional position. References and other documentation submitted have been verified and the undersigned attest to it's accuracy.

In addition, we understand this applicant must be reviewed by the IMPACT Plus Credentialing Committee located in Frankfort, KY, and given "Approval" status before the delivery of IMPACT Plus services can be considered for Medicaid reimbursement.

Subprovider's Signature _____
Name Position Date

Applicant's Signature _____
Name Position Date

Revised 6/18/2007