IMPACT Plus
Behavioral Health Professional under Clinical Supervision
New Employee/Contract Screening Form

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

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

Supervisor's Name & Credentials: _____

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
- ❑ 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

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

- ❑ Psychologist certified and practicing in accordance with KRS 319.056
  license number _____ expiration date _____
- ❑ Psychological associate licensed and practicing in accordance with KRS 319.064
  license number _____ expiration date _____
- ❑ Marriage and family therapist associate licensed and practicing in accordance with 335.300
  license number _____ expiration date _____
- ❑ Social worker certified and practicing in accordance with KRS 335.080
  license number _____ expiration date _____
- ❑ Professional Counselor Associate licensed and practicing in accordance with KRS 335.500
  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 Board-approved Clinical Supervision Contract letter
- ❑ Current Department for Community Based Services background check results
- ❑ Current Administrative Office of the Courts 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 under Clinical Supervision 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