## Northern Michigan Regional Entity

## New Hire Notification

**Please submit the completed form to providersupport@nmre.org**

| | |
|---|---|
| Date of Request: | |
| Program Name: | |
| Location(s): | |

| | |
|---|---|
| First Name: | |
| Middle Initial: | |
| Last Name: | |
| Alias: | |
| SSN (if providing clinical services): | |
| Date of Birth: | |
| NPI Number (if applicable): | |
| Job Title(s): | |
| Work E-Mail: | |
| FTE: | |
| Supervisor: | |

**STAFF TYPE (please check all that apply)**

| **Staff Type:** | **Check** |
|---|---|
| Administrative: | ☐ |
| Billing: | ☐ |
| Clinical: | ☐ |
| Case Management: | ☐ |
| Medical: | ☐ |
| Technician: | ☐ |
| Prevention: | ☐ |
| Recovery Coach: | ☐ |
| Other: | ☐ |

**RECON PERMISSION REQUEST (please check all that apply)**

| **Permissions:** | **Check** |
|---|---|
| RECON Permissions Needed: | ☐ |
| MPDS Permissions Needed: | ☐ |

| | |
|---|---|
| Billable Clinical Service Provider: | ☐ |
| Billable Prevention Service Provider: | ☐ |
| Specialized Prevention Service Provider: | ☐ |

| **RECON Permissions:** | **Check** |
|---|---|
| 270/271 Eligibility Lookup | ☐ |
| EDI Submissions | ☐ |
| Claim Data Entry | ☐ |
| Administrative/Supervisory | ☐ |
| Clinical Data Entry | ☐ |

**EDUCATION (if billable service provider – please check all that apply)**

| Education: | Check | Issue Date |
|---|---|---|
| Masters of Social Work: | ☐ | |
| Bachelors of Social Work: | ☐ | |
| Masters of Counseling: | ☐ | |
| Bachelors of Counseling: | ☐ | |
| Other Masters of Arts: | ☐ | |
| Other Bachelors of Arts: | ☐ | |
| Other Masters of Science: | ☐ | |
| Other Bachelors of Science: | ☐ | |
| Associates Degree: | ☐ | |
| High School Diploma: | ☐ | |
| Other: | ☐ | |

**LICENSURE (if billable service provider – please check all that apply)**

| License: | Check | Issue Date | Expiration Date | License Number |
|---|---|---|---|---|
| Licensed Masters of Social Work: | ☐ | | | |
| Limited Licensed Masters of Social Work: | ☐ | | | |
| Licensed Bachelors of Social Work: | ☐ | | | |
| Limited Licensed Bachelors of Social Work: | ☐ | | | |
| Licensed Practicing Counselor: | ☐ | | | |
| Limited Licensed Practicing Counselor: | ☐ | | | |
| Licensed Psychologist: | ☐ | | | |
| Limited Licensed Psychologist: | ☐ | | | |
| Marriage and Family Therapist: | ☐ | | | |
| Certified Case Manager: | ☐ | | | |
| Doctor of Medicine: | ☐ | | | |
| Doctor of Osteopathic Medicine: | ☐ | | | |
| Physicians Assistant: | ☐ | | | |
| Licensed Practicing Nurse: | ☐ | | | |
| Registered Nurse: | ☐ | | | |
| Nurse Practitioner: | ☐ | | | |
| Other: | ☐ | | | |

**SUBSTANCE USE CERTIFICATION (if billable service provider – please check all that apply)**

| Certification: | Full | Dev Plan |
|---|---|---|
| Certified Advanced Alcohol and Drug Counselor: | ☐ | ☐ |
| Certified Alcohol and Drug Counselor: | ☐ | ☐ |
| Certified Clinical Supervisor: | ☐ | ☐ |
| Certified Prevention Specialist: | ☐ | ☐ |
| Certified Prevention Consultant – Reciprocal: | ☐ | ☐ |
| Certified Criminal Justice Professional: | ☐ | ☐ |
| Certified Peer Recovery Mentor: | ☐ | n/a |

**LANGUAGES (if billable service provider – please check all that apply)**

| | |
|---|---|
| Languages fluent in other than English: | |

**RECOVERY COACH TRAINING (if billable service provider – please check all that apply)**

| Type of Training | Check | Date of Training |
|---|---|---|
| MDHHS Training | ☐ | |
| CCAR Training | ☐ | |

**PROFESSIONAL LIABILITIES (please check all that apply)**

| Professional Liability: | Check |
|---|---|
| Has any litigation been initiated against you within the past ten (10) years alleging malpractice or other professional negligence? | ☐ |
| Have you been given notice within the past five (5) years of claims or potential claims outstanding against you? | ☐ |
| Have you had any complaints registered against you with any licensing or certifying authority? | ☐ |

**DISCIPLINARY ACTIONS (please check all that apply)**

Have any of the following ever been, or are any currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, or voluntarily relinquished, or have you ever withdrawn or failed to proceed with an application for any of the following? If checked yes, please provide a full explanation in the comment box inclusive of relevant state/organization facility information.

| Disciplinary Actions: | Check |
|---|---|
| Professional license in any state: | ☐ |
| DEA Controlled substances registration: | ☐ |
| Academic appointment: | ☐ |
| Membership on hospital staff: | ☐ |
| Clinical privileges: | ☐ |
| Other institutional affiliation: | ☐ |
| Professional office: | ☐ |
| Fellowship board certification: | ☐ |
| Any other type of professional sanctions: | ☐ |
| Professional liability insurance: | ☐ |
| Participation privileges as a Medicare, Medicaid or other third party payment program: | ☐ |

| | |
|---|---|
| Have you ever been convicted of a crime, other than a misdemeanor or minor traffic offense? | ☐ |

Comments:

**CERTIFICATION OF NEW HIRE**

I hereby acknowledge that all information submitted in this document is true to the best of my knowledge and belief. I understand that any misleading statement or omission in this document may constitute grounds for denial.

Signature Date

As supervisor of the staff above, I have reviewed this document and attest that the information is accurate to the best of my knowledge and belief. I confirm that the following has been completed and documentation is retained within the staff file for the staff member.

| Supervisor Initials | Required Document/Task | |
|---|---|---|
| | Primary Source Verification has been conducted | ☐ |
| | Criminal Background Check has been conducted and found to be acceptable | ☐ |
| | Communicable Disease training (Level 1) has been completed | ☐ |
| | Training has been provided for Limited English Proficiency | ☐ |
| | Training has been completed for Deficit Reduction Act | ☐ |
| | Training has been completed for Whistleblower Act | ☐ |
| | Training has been completed for Fraud, Waste and Abuse | ☐ |
| | Training has been completed on the Compliance Plan | ☐ |
| | Training has been completed on Recipient Rights | ☐ |
| | Training has been completed on Grievance and Appeals | ☐ |
| | Training has been completed for RECON, if needed | ☐ |
| | Resume has been collected | ☐ |
| | If for a Recovery Coach position, verify that all criteria has been met (MSA 17-45 and MSA 19-03) | |

Signature of Supervisor Date

**NMRE OFFICE USE ONLY**

| Item | |
|---|---|
| Username: | |
| Entry Date: | |
| Staff Type: | |