INTEGRATED FUNCTIONAL SUPPORTS, LLC
235 E. Chicago St. Coldwater, MI 49036
Phone: 517-924-0733 • Fax: 517-924-1003

INSTRUCTIONS

Integrated Functional Supports, LLC will not discriminate against any applicant solely on the basis of race, gender, ethnicity, disability and/or age.

- Integrated Functional Supports, LLC do not hire family members of clients which we serve.
- Applications should be typed or legibly printed in black or dark blue ink. If more space is needed, attach additional sheets and reference the question being answered. ALL fields are required to be completed unless otherwise directed. **If the section does not apply, please put N/A.**
- Current copies of all applicable documentation requested on page 5 *Attachments*, must accompany this application.
- Failure to legibly complete all sections of this Application and submit current copies of required documentation may result in the Application being returned to the provider without processing.
- Please email applications to: lwilliams@integratedfunctionalsupports.com
- ACCEPTANCE OF THIS APPLICATION DOES NOT GAURNTEE EMPLOYMENT OR AN INTERVIEW

APPLICATION

☐ **Behavior Technician** ☐ **Direct Care Staff/ CLS/Respite**

IDENTIFICATION

First Name:	Middle Name:	Last Name:	Maiden or Former Name:

Address:	City:	State:	Zip:

Birthdate:	Telephone:	National Provider Identifier (NPI) if applicable:

Email Address:	Driver's License #:

Do you consent to a background check?	Do carry auto insurance?
☐ Yes ☐ No	☐ Yes ☐ No

LICENSURE / CERTIFICATION if applicable:

List all current professional licenses / certifications. Please attach valid copies of all licenses and/or certifications with application. (Copies of paper licenses and printouts of electronic licenses are both acceptable).

License / Certification Number	State or City	Licensing / Certification Agency	Initial Issue Date	Renewal Date	Expiration Date

BOARD CERTIFICATION if applicable:

List all current Board certifications. Please attach copy of Board Certificate, including copy of original letter of verification from the conferring body.

Name of Board	Date Certified	Date(s) Re-certified

Have you ever taken and failed a certification examination? Yes ☐ No ☐ If yes, please provide an explanation on separate sheet.

EDUCATIONAL BACKGROUND

By signing this application, primary verification of education in the form of an official transcript or letter issued by the institution conferring your most advanced degree will be obtained by the credentialing department or designee.

High School Education/GED	
Address	
Dates Attended	
Degree Received	
Undergraduate Education-Associates or Bachelor	

Address	
Dates Attended	
Degree Received	
Clinical Graduate Education	
Address	
Dates Attended	
Degree Received	

WORK EXPERIENCE

If you are submitting a CV or Resume that documents professional experience including dates since obtaining licensure you do not need to complete below work experience section.

Employer ***(please list current or most recent first)***	
Address	
Phone Number	
Position	
Dates of Employment	
Supervisor Can we contact them: ☐ YES ☐ NO	
Employer	
Address	
Phone Number	
Position	
Dates of Employment	
Supervisor Can we contact them: ☐ YES ☐ NO	
Employer	
Address	
Phone Number	

Position	
Dates of Employment	
Supervisor Can we contact them: ☐ YES ☐ NO	

PERSONAL REFERENCES

Please include 2 personal references.

Name		
Contact Information	Phone:	Email:
Relationship		
Name		
Contact Information	Phone:	Email:
Relationship		

DISCLOSURE QUESTIONS

Please answer every question.

☐YES ☐NO ☐N/A	1. Has your professional license or certification to practice in your profession ever been denied, suspended, restricted or revoked?
☐YES ☐NO ☐N/A	2. Have you ever been subjected to a fine, reprimand or limitations by any state of professional licensing, registration or certification board?
☐YES ☐NO ☐N/A	3. Have your Federal DEA and/or your State Controlled Dangerous Substance certificates or authorizations ever been challenged, denied, suspended, restricted, revoked or denied renewal?
☐YES ☐NO ☐N/A	4. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid programs, or in regard to other federal or state governmental health plans or programs?
☐YES ☐NO ☐N/A	5. Have you ever had professional liability insurance denied, canceled, issued on special terms or renewal refused?
☐YES ☐NO ☐N/A	6. Have there been, or are there currently pending, any malpractice claims, suits, settlements, or arbitration proceedings involving your professional practice within the past 10 years? If yes please provide information for each case.
☐YES ☐NO ☐N/A	7. Have your clinical privileges or medical staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital, healthcare institution or medical staff committee or governing board?

☐YES ☐NO ☐N/A	8. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action by any managed care organizations including HMOs, PPOs or provider organizations such as IPAs and PHOs?

If you have answered "YES" to any of the above questions, you must include an explanation (attach an additional sheet if necessary. A malpractice explanation template form has been included for question 6):

CRIMINAL HISTORY

Please answer every question

☐YES ☐NO	1. In the last ten (10) years have you been convicted of a felony criminal offense?
☐YES ☐NO	2. In the last ten (10) years have you pled guilty or no contest to any felony criminal charges?
☐YES ☐NO	3. Are there any felony criminal charges currently pending against you?
☐YES ☐NO	4. In the last ten (10) years have you been charged with offenses of a sexual nature?

If you have answered "YES" to any of the above questions, please explain the nature of the charges, relevant dates, and how the matter was disposed (attach an additional sheet if necessary):

MENTAL AND PHYSICAL HEALTH

Please answer every question

☐YES ☐NO	1. Do you presently have a physical or mental health condition, including alcohol/drug dependence, which would affect your ability to provide professional or medical staff duties as requested/required, with or without reasonable accommodations?
☐YES ☐NO	2. Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify that the use of drugs may have an ongoing impact and that it has occurred recently enough to indicate the individual is actively engaged in such conduct.)
☐YES ☐NO	3. Do you have any reason to believe that you would pose a risk to the safety or the well-being of your patients?
☐YES ☐NO	4. Are you ever unable to perform the essential functions of a practitioner in your area of practice, even with reasonable accommodation? We will not discriminate if reasonable accommodation is requested.

If you have answered "YES" to any of the above questions, you must include an explanation (attach an additional sheet if necessary):

ATTACHMENTS

Have you attached <u>all</u> required documents? If not, the processing of your application will be delayed.
Check all documents included with this application.

- ☐ Copy of all State and/or local licenses required to practice
- ☐ Copy of auto insurance certificate
- ☐ Current Resume
- ☐ Completed malpractice explanation form if applicable
- ☐ Release to obtain school transcripts and Consent for Criminal Background Check
- ☐ Other (specify): _____

_____

Please fill this out as it applies to you. These answers help our organization understand our network better to ensure we are meeting all the needs of our members. Please provide evidence of formal certification or training.

LANGUAGES, CULTURAL COMPETENCIES AND/OR EXPERTISE

Language (Select all that apply)					
☐	Spanish	☐	French	☐	German
☐	Italian	☐	Chinese	☐	Arabic
☐	Russian	☐	American Sign Language	☐	Burmese
☐	Portuguese	☐	Hindi	☐	Other (Please Specify):
Cultural Expertise (Select all that apply)					
☐	African American	☐	Arabic/Middle Eastern	☐	Hispanic/Latino
☐	LGBTQA	☐	Native American Indian	☐	Poverty
☐	Racism	☐	Religion	☐	Gender Identity or Expression
☐	Spirituality	☐	Other (Please Specify):		

By signing your signature below, the Applicant agrees to be bound by the following:

1. **Certification of Truth, Accuracy and Completion:** By signing this, I attest that the information provided within the application is complete and accurate to my knowledge. All information submitted by me in this application is warranted to be true, correct and complete. I fully understand that if any matter stated in this application is or becomes false, Integrated Functional Supports. LLC will be entitled to terminate my provider agreement for breach.

2. **Continuing Duties of the Applicant**:
   a) The Applicant is under a continuing duty to promptly advise this organization and participants of any changes, additions or deletions to the information contained in the Application or that would be relevant to his/her provision of services.
   b) Acknowledge an obligation to provide continuous care and supervision to all customers for whom I have responsibility and that I will seek clinical consultation whenever necessary and as directed by Integrated Functional Supports. LLC policies and procedures.
   c) The Applicant agrees to abide by all applicable laws, rules, regulations, policies, by-laws and procedures in effect at the time of this Application, and during the term of the credentialing cycle.

3. **Release of Information:** By submitting this Application and placing an authorized signature below, the Applicant hereby authorizes and consents to the following:
   a) All information contained in the Application and any attachments is subject to verification and review by Integrated Functional Supports. LLC.

   b) Integrated Functional Supports. LLC employees or agents to discuss matters directly related to this Application and any attachments provided with third parties, including but not limited to past/ present malpractice carriers and Community Mental Health Programs outside of SWMBH for the purposes of evaluating the Applicant's professional competence, character and ethical qualifications.

I agree and consent to the requirements stated above:

_____ _____

Signature of Applicant Date

Integrated Functional Supports. LLC Statement to Release Information

I consent to the release of all information that may be relevant to an evaluation of my professional competency, character, moral and ethical qualifications, including information about disciplinary action, suspension or other confidential or privileged information, to Integrated Functional Supports. LLC.

PRINT NAME:_____

SIGNATURE: _____

DATE: _____