CENEVIA
HEALTH BUSINESS SERVICES

Behavioral Health Enrollment Packet

The information requested on this form is required for the accurate completion of provider enrollment. CCNV will not begin enrollment without the required information below. Please complete ALL requested information below and return to CCNV with the application packet.

Please provide an age range of patients you will accept:

Minimum age: _____ Maximum Age: _____

Population(s) Treated (check all that apply):

- ☐ Adult
- ☐ Couples/Marriage Therapy
- ☐ Family Therapy
- ☐ Group Therapy
- ☐ Inpatient
- ☐ Children (Ages 0-12)
- ☐ Adolescents (Ages 12-17)
- ☐ Geriatric

Please check all applicable areas of focus below:

- ☐ Abuse (Physical, Sexual, etc)
- ☐ Addiction Psychiatry
- ☐ Addiction Specialist
- ☐ Adolescent Psychiatry
- ☐ Adoption Issues
- ☐ Anger Management
- ☐ Anxiety Disorders
- ☐ Assertive Community Treatment (ACT)
- ☐ Attention Deficit Disorder
- ☐ Bariatric/Gastric Bypass Evaluation
- ☐ Behavior Modification
- ☐ Bereavement – Grief Counseling
- ☐ Biofeedback
- ☐ Case Management
- ☐ Certified Employee Assistance Professional
- ☐ Certified Pastoral Counselor
- ☐ Child Psychiatry
- ☐ Christian Counseling
- ☐ Codependency Behavioral Therapy
- ☐ Cognitive Behavioral Therapy
- ☐ Community Integration Counseling
- ☐ Community Psych Support and Treatment
- ☐ Co morbidity
- ☐ Compulsive Gambling
- ☐ Co-Occurring Disorders Treatment (Dual Diagnosis)
- ☐ Crisis Intervention
- ☐ Depression
- ☐ Detoxification
- ☐ Developmental Disabilities
- ☐ Dialectic Behavioral Therapy
- ☐ Dissociative Disorder
- ☐ Domestic Violence
- ☐ Eating Disorders
- ☐ Electroconvulsive Therapy (ECT)
- ☐ Evaluation and Assessment – Mental Health
- ☐ Eye Movement Desensitization and Reprocessing (EMDR)
- ☐ Gay-Lesbian Issues
- ☐ Gay-Lesbian Identified Clinician
- ☐ Gender Identity
- ☐ Geriatric Psychiatry
- ☐ Group Therapy
- ☐ Health – Disabilities
- ☐ Hearing Impaired Populations
- ☐ HIV/AIDS/ARC
- ☐ Home Care/Home Visits
- ☐ Hypnotherapy
- ☐ Independent/Qualified Medical Examiner
- ☐ Infertility
- ☐ Intensive Individual Support
- ☐ Learning Disabilities
- ☐ Life Management Counseling
- ☐ Long Term Care
- ☐ Managed Disability
- ☐ Marriage/Family Therapy
- ☐ Men's Issues
- ☐ Medical Illness/Disease Management
- ☐ Medication Management
- ☐ Methadone Maintenance

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- ☐ Military/Veteran's Treatment
- ☐ Mobile Mental Health Treatment
- ☐ Mood Disorders
- ☐ Multi-Systemic Therapy (MST)
- ☐ Neuropsych Testing
- ☐ Nursing Home Visits
- ☐ Obsessive Compulsive Disorder
- ☐ Occupational Issues
- ☐ Opioid Treatment Service (OST)
- ☐ Organic Disorders
- ☐ Outpatient Medically Supervised Withdrawal
- ☐ Pain Management
- ☐ Parent Support and Training
- ☐ Personality Disorders
- ☐ Personalized Recovery Oriented Services
- ☐ Pharmacology Medication Management
- ☐ Phobia
- ☐ Police/Fire Fighters
- ☐ Positive Behavioral Intervention and Supports
- ☐ Post-Partum Depression
- ☐ Post-Traumatic Stress Disorder
- ☐ Psychological Testing
- ☐ Psychosocial Rehabilitation (PSR)
- ☐ Psychotic/Schizophrenic Disorders
- ☐ Rape Issues
- ☐ Regional Behavioral Health Authority (RHBA)
- ☐ Respite Care
- ☐ School Based Services
- ☐ Sex Offender Treatment
- ☐ Sexual Dysfunction
- ☐ Sleep Disorders
- ☐ Somatoform Disorders
- ☐ Stress Management
- ☐ Substance Abuse
- ☐ Targeted Case Management
- ☐ TBI Waiver – Case Management
- ☐ TBI Waiver – Community Integration Counseling
- ☐ TBI Waiver – Positive Behavior
- ☐ Traumatic Brain Injury
- ☐ Weapons Clearance
- ☐ Women's Issues

Printed name: _____

Signature: _____ Date: _____

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Please complete **ALL** sections below. If any section is not applicable, please put "N/A." If this form is incomplete, or if it is not signed and dated, it will be returned with request for completion. Please note that this form is now required in order to complete enrollment with CCNV.

Practitioner Information

Practitioner Name: _____

Practitioner NPI: _____

Are you a PCP? ____ Yes ____ No

Employment Status ____ Full Time ____ Part Time ____ Locum

Practice Information

Current Practice Location: _____

Practice Location Address: _____

Practitioner Hours: Monday: _____. Tuesday: _____. Wednesday: _____.

Thursday: _____. Friday: _____. Saturday: _____.

Sunday: _____.

Malpractice History

Please provide **5 YEARS** of malpractice history in the space below. Dates **must** be in month/year format. If you have a copy of the malpractice certificate(s), please include a copy with this application. If you need more space, please continue on a separate sheet and include with this application.

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By my affixed signature, I, _____ (print name), do hereby attest that I am no longer employed with the entities listed below. Any and all association with said entities has been terminated on the effective date listed below.

Former Employer	Tax ID #	PCP or Specialist	Termination Date
		□ PCP □ Specialist	
		□ PCP □ Specialist	
		□ PCP □ Specialist	

By my affixed signature, I, _____ (print name), do hereby attest that I remain employed by the entities listed below.

Former Employer	Tax ID #	PCP or Specialist	Specialty
		□ PCP □ Specialist	
		□ PCP □ Specialist	
		□ PCP □ Specialist	

Printed name: _____

Signature: _____ Date: _____