New Hire Employee Verification Form

For Substance Use Disorder Treatment Staff

Please complete the following information within 14 days of hire for any staff that provide direct service and submit to the applicable CMHSP(s).

(Entire section beneath staff name must be completed.)

Agency _____

Site: _____

Staff Name: First: _____ MI: _____ Last:_____

Date of Hire: _____ Position: _____

Criminal Background Check: Medicaid Sanctioned List Checked: _____

Communicable Disease Training Completed on: _____

Staff has at least 2,000 hours of experience in SUD services: ☐Yes ☐No ☐NA (non-clinical)
If no, the *MAFE exam must be taken within 90 days* and is scheduled to be taken on: _____
or a MAFE waiver request will be attached to this form.

Type of Staff: ☐Treatment Supervisor with ☐CCS-M or ☐CCS-R or ☐DP-CCS

☐SATS – Please complete information under **items #1, 3, & 4**NPI #_____

☐SATP – Please complete information under **items #2, 3, & 4**NPI #_____

☐Specifically Focused Staff (specify): _____(See items #3, 6 or 7)

☐Treatment Adjunct Staff (specify): _____

☐Intern - Internship Completion Date: _____

1. **Substance Abuse Treatment Specialist:** In order to qualify as a substance abuse treatment specialist an individual must meet the criteria detailed in **any one of** the following three categories **and** be supervised* by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.

   Please select the appropriate category below and provide the information requested below the item:

   ☐ Possess one of the following certifications from the Michigan Certification Board of Addiction Professionals OR a Development Plan for achievement. Please identify which certification and list expiration date:
   ☐ CADC ☐ CADC-M ☐ CAADC ☐ CCJP-R ☐ CCDP ☐ CCDP-D

   MCBAP Certification Expiration Date:_____

   ☐ Individual has a development plan with MCBAP **and** possesses one of the following licensures: MD/DO, PA, NP, RN, LPN, LP, LLP, TLLP, LPC, LLPC, LMFT, LLMFT, LMSW, LLMSW, LBSW, or LLBSW.
   License: _____ License Expiration Date:_____ MCBAP Dev. Plan Expir. Date: _____

   ☐ Individual possesses one of the following alternative certifications. Please identify which certification:

   ☐ ASAM ☐ APA ☐ UMICAD Certification Expiration Date:_____

LAKESHORE REGIONAL PARTNERS

2. **Substance Abuse Treatment Practitioner:** In order to qualify as a substance abuse treatment practitioner an individual must have a MCBAP development Plan in place **and** be supervised* by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.

   MCBAP Development Plan Expected Completion Date: _____

3. **Levels of Care to be provided:** ☐Outpatient ☐IOP ☐Detox ☐Residential ☐Methadone

   Service Categories: ☐ Assessment ☐ Individual ☐ Group ☐ Didactic
   ☐ *Case Management*** ☐ *Peer Recovery Support****

4. This employee has a **Masters** or **Bachelor's** degree in one of the following:
   ☐Social Work
   ☐Guidance & Counseling
   ☐Other counseling related field, please specify:_____
   ☐Clinical Psychology

5. ☐This employee has current licensure as a physician or Ph.D. psychologist.

6. ☐**This employee has additional education, training, or experience qualifications for performing the duties of this position. *Please describe (or attach an additional sheet):*

7. ☐***Peer Recovery Support. Please attach an additional sheet to include responses to ALL of the following:
   - Three (3) references of support;
   - Current support system for PRS staff;
   - Program's selection criteria for hiring PRS staff;
   - How his/her recovery was verified and how recovery will be monitored;
   - Date of his/her last treatment (if applicable);
   - Specify types of services to be provided by PRS Associate or PRS Coach;
   - Documentation of training received.

Supervisor Name and Certification (please print):_____

**Supervision for SATS and SATP staff must be provided by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.*

Program Director's Signature Below attests to the accuracy and completeness of all verification information in compliance with the most recent Staff Qualifications and Credentialing Requirements.

Program Director's Signature:_____ Date: _____