Community Mental Health Services
of Livingston County

Behavioral Health/Substance Abuse Provider Inquiry Form

Livingston County Community Mental Health (LCCMHA) welcomes inquiries from behavioral health/substance abuse providers interested in contracting to provide services within our network. **Please complete the form below and submit to Contracts@cmhliv.org**

Section 1: Referral

Is this an internal referral from LCCMHA staff?
☐Yes ☐No

If yes, please provide the name of the referring staff member:_____

Section 2: Provider Information

Legal Business Name: _____

DBA (if applicable): _____

Address: _____

Phone Number: _____ Website Address: _____

Tax ID Number: _____ NPI Number: _____

Medicaid Provider ID (if applicable):_____

Primary Contract Name and Title: _____

E-Mail Address for Contract: _____

Section 3: Populations Severed

Select **all** populations that apply:

☐Children w/ developmental disability
☐Adults w/ developmental disability
☐Children w/ serious emotional disturbances
☐Adults w/ serious & persistent mental illnesses
☐Older Adults w/ serious; persistent mental illnesses
☐Persons with Substance Abuse Disorders
☐Co-occurring disorders: substance abuse and mental illness
☐ OBRA

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Section 4: Licensed Independent Practitioner

Select all that apply if you are inquiring on your own and not as an organization:

☐ Psychiatrist ☐ Physician's Assistant ☐ Certified Nurse Practitioner ☐ Registered Nurse
☐ Licensed/Limited Licensed Psychologist ☐ Licensed Master Social Worker
☐ Licensed Professional Counselor ☐ Occupational Therapist ☐ Speech/Language Pathologist
☐ Dietitian ☐ Other:_____

Child Waiver Only –
☐ Massage Therapist ☐ Music Therapist ☐ Art Therapist ☐ Recreation Therapist

Section 5: Services Provided

Please describe the services you/organization provide:

Child & Adolescent Services ● Administration Services
622 East Grand River, Howell, MI 48843
517.548.0081 ● 1.800.615.1246 ● Fax 517.548.0498 ● www.cmhliv.org

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Section 6: Accreditations

Please list any accreditations your organization holds:

Section 7: Service Areas and Availability

Does you or your organization currently contract with other CMH's.
☐ Yes ☐ No

If yes, please list the CMH's you serve: _____

Section 9: Disclosure and Signature

Please note that all fields must be completed to the best of your ability for your inquiry to be reviewed. Incomplete forms may not be considered.

Submission of this form does not guarantee a contract with Livingston County Community Mental Health Authority (LCCMHA). All inquiries are subject to review, availability of funding, network needs, and successful completion of the credentialing and contracting process.

By signing this inquiry, you acknowledge and agree to the terms of this disclosure.

Name (Printed): _____

Title: _____

Signature (e-signature is acceptable): _____

Date: _____