Individual Practitioner Application for Privileging to Render Sexual Harm Assessment Services for Children and Adolescents

Complete this application and email it to networkmgt@cardinalinnovations.org or send by fax to 704-939-7513

Please note that to eventually qualify for reimbursement for assessments at the higher rate for Sexual Harm privileging, the assessments should be completed consistent with the template Cardinal Innovations has adopted. Privileging approval, if granted, will be good through the end date of the clinician's active professional license.
Please also note that Sexual Harm privileging is not available to associate level clinicians.

1. Clinician's name, professional license type and number:

   Name _____

   Professional License
   (e.g. MD, LP, LCMHC, LCSW) _____ License No. _____

2. Clinician's Social Security number, National Provider Identification Number (NPI) and Taxonomy:

   _____ _____ _____
   Social Security Number NPI Taxonomy

3. Are you currently associated or employed with an already contracted Cardinal Innovations Healthcare provider?
   ☐ Yes | Proceed to Question 4
   ☐ No | *Please also submit a credentialing registration form along with this Sexual Harm application. The form can be found on our website, www.cardinalinnovations.org, under "Resources" and clicking on "Resource Library" and typing in "**LIP**" in the search box on the left side of the page.*

4. Name and address of Agency/Practice Clinician where clinician intends to render Sexual Harm Privileging:

   _____
   Practice Name

   _____
   Street City State ZIP

   Additional Practice Locations (If Necessary)

   _____
   Practice Name

   _____
   Street City State ZIP

   Is the above address(es) reflected in clinician's record at NCTracks? ☐ Yes ☐ No

   If No | Please submit an MCR in NCTracks to affiliate the address(es) listed above in question 4. (Make sure to print/save a copy and submit with this application if applicable.)

5. Practitioner's Memberships and Trainings: Please indicate (✓) which of the following apply to you.
Where able, include the certificate or other documentation from the trainings.

✓	Type	Documentation
☐	Member of the Association for the Treatment of Sexual Abusers	Attach documentation showing current membership in Association for the Treatment of Sexual Abusers (ATSA)
☐	Completed related trainings offered by Cardinal Innovations	Provide the name of the training and the date attended.
☐	Completed ongoing consultation as part of the collaborative offered by Cardinal Innovations	Provide timeframe and consultations that were participated in
☐	Evidence of 40 hours of training specific to youth with sexual harm (N/A if participated in the collaborative through Cardinal Innovations)	Provide applicable training certificates and documentation to demonstrate how this criteria is met
☐	Evidence of additional 12 hours of training if it has been more than two years since initial trainings	Provide applicable training certificates and documentation to demonstrate how this criteria is met
☐	Other	List any other trainings, certifications, or memberships that are applicable. Attach additional pages as necessary.

6. Do you have fidelity measures for treatment in place? If so, please describe what they are.
   Attach additional pages if necessary.

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7. Describe the target populations (and ages) for whom you plan to conduct assessments.

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8. Describe specific assessment measures that you are using as part of the assessment?
   Attach additional pages if necessary.

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9. Attach a copy of a sample assessment used by you for your sexual harm evaluation assessments.
   This should include a copy of a blank template used for assessments and a copy of an assessment you have completed. Applications submitted without these documents will not be considered.

10. Describe subsequent scales or screenings you are using to measure treatment effectiveness? Attach additional pages if necessary.

11. Indicate the criteria used to determine readiness for discharge and any crisis/safety planning that is completed as a part of this process. Attach additional pages if necessary.

12. Attach a plan for ongoing clinical consultation. LIPs with less than five years of experience with the child and adolescent population must document monthly individual or group supervision. This must be provided by a clinician that meets the criteria and has at least five years of experience with the population.

The undersigned hereby affirms that the information set forth in this application is true and correct to the best of their knowledge, information and belief.

Signature of Practitioner Applicant

Date

Practitioner Email Address for Follow-Up and Decision Notifications