RCH PROVIDER RENEWAL APPLICATION

This application is for the renewal of provider status with the Board. The application must be completed and returned with the appropriate fee of $400.00 for a one year renewal or $700.00 for a two year renewal. Upon review and approval, a new provider number will be sent for the next one or two year period.

Program Sponsor: _____

Provider Number: _____ Renewal Date: _____

Contact Person: _____

Address: _____

_____

Telephone Number:

_____ Fax Number: _____

E-Mail address: _____

Applying for: _____ one year provider status _____ two year provider status

RETURN APPLICATION TO:

Ohio Chemical Dependency Professionals Board
77 South High Street, 16th Floor Columbus, Ohio 43215
614/387-1110 (phone) 614/387-1109 (fax) www.ocdp.ohio.gov
Email: credentialing@ocdp.state.oh.us

OFFICE USE ONLY

Date received: _____ Fee enclosed: _____ Check/MO/CC# _____

_____ Approved _____ Deficient _____ Denied

Explanation: _____

_____

_____

_____

_____ _____

Signature Date

PROVIDER AGREEMENT

By signing this agreement, our organization agrees to all the terms set forth by the Board. We will abide by the terms of the agreement upon acceptance of our Provider Status Renewal Application. I verify that we have provided all the information requested by the Board and agree to provide any additional information requested.

I further affirm that our organization will abide by the following terms:

- submit quarterly reports and all information requested for these reports.
- open our programs free to the Board staff, allow them to monitor these programs and cooperate fully with the Board should an official monitoring be required.
- withdraw the approval number for a specific program if the Board finds that it does not meet the Board's criteria.
- award RCH hours to programs that will benefit counselor and prevention professionals and that cover areas required by the Board.
- accept all the responsibility for verification of attendance, provide certificates of attendance to individuals that verify the actual hours they attend the event and keep the attendance roster for five years for each event.
- determine appropriate letter classifications for each respective program and place all the letter(s) at the end of the provider number for each program.
- understand that if my provider status is revoked due to falsification of forms, failure to remain in compliance with the Board's approved criteria and policies, investigation and verification by the Board of written complaints or charges by consumers or others and refusal to comply with an investigation of the Board, we will cease using my provider number. It will be removed from publicity materials and certificates of attendance distributed after the effective date. If my provider status is revoked, the fee submitted is non-refundable.
- award hours by clock hours for the actual training time. We will subtract breaks, introductory speakers and lunch. (Exception to awarding hours at lunch is if there is an educational speaker.)
- understand our provider date will be the first day of the month my application is received in the Board until the first day of the month at the end of our provider status.
- use the assigned number only for programs presented during the one or two year period for which provider status has been approved.

Additionally we will:

- not charge additional fees for individuals to receive RCH credit or certificates.
- not advertise as having received RCH approval until I have received my provider number.
- not use our provider number on programs presented that do not meet the Board's criteria.

_____ _____

Name (Print) Signature

_____

Date

CHECKLIST

_____ Complete Application

_____ Signed agreement

_____ Application Fee ($400 or $700)
Check/Money Order <u>payable to</u>:
Treasurer, State of Ohio

PROVIDER STATUS
QUARTERLY REPORT
(submit one for each program, make copies as needed)

PROVIDER NAME _____

CONTACT PERSON _____

TELEPHONE NUMBER _____

E-MAIL ADDRESS _____

PROVIDER NUMBER _____

PROVIDER STATUS PERIOD _____ To _____

PROGRAM NAME _____

PROGRAM DATE(S) _____

COST TO THE APPLICANT _____

LOCATION OF PROGRAM _____
City and State

TYPE OF PROGRAM _____ Closed _____ Open _____ Open, limited basis

NUMBER OF CLOCK HOURS AWARDED _____

DESCRIPTION OF PROGRAM _____

_____

_____

_____

PRESENTER NAME & CREDENTIALS _____

Letter classification assigned to program _____

C = Counselor, S = Supervisor, P = Prevention, D= Diagnostic, R= Field Related

I have attached an **AGENDA** and verify that the enclosed information is correct.

_____ _____
Signature Date

Last Updated 06/10

Credit Card Payment Authorization Form

Please check one: ☐ Master Card ☐ Visa

Cardholder Name: _____

Address: _____

City, State, Zip: _____

Telephone #: _____

Email Address (for receipt) _____

Credit Card Number: _____

Expiration Date: _____

CVV2/CID Code # (Three digit number on back of card): _____

Payment Amount: _____

Payment for (exam, application, etc): _____

_____ _____

Signature Date

Credit Card Payments may be mailed, faxed, emailed, or phoned in to the Board office.

Ohio Chemical Dependency Professionals Board
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Email: credentialing@ocdp.state.oh.us

This document will be shredded after your payment is processed.