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:
Chemical Dependency Professionals Board
37 West Broad Street, Suite 785
Columbus, OH 43215
614-387-1110 614-387-1109 (fax)

OFFICE USE ONLY

Date received: ______________ Fee enclosed: __________ Check/MO# _________

_____ 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 payable to:
Treasurer, State of Ohio

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

PROVIDER NAME ____

CONTACT PERSON ____

TELEPHONE NUMBER ____

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

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

____ __________________________
Signature Date

Credit Card Payment Authorization Form

Please circle 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
37 West Broad Street, Suite 785 Columbus, Ohio 43215
614/387-1110 (phone) 614/387-1109 (fax) www.ocdp.ohio.gov
Email: credentialing@ocdp.state.oh.us

For office use only: Approval Code #: ______________________________