

**Instructions for Completion of the PA Department of Health Pre-Approved
Tobacco Cessation Registry Application**

Completing and Submitting the Pre-Approved Tobacco Cessation Registry Application:

1. Enter the required information for all mandatory (*) and applicable optional fields by typing in the grey boxes or clicking the appropriate checkboxes.
2. Print the Pre-Approved Tobacco Cessation Registry Application.
3. Verify that you have agreed to the attestation by checking the box in the attestation section.
4. Have the Organization Representative print, sign, and date the form and include their title.
5. Submit the completed application, along with the *Every Smoker, Every Time* notification e-mail to the Pennsylvania Department of Health.

Applications can be submitted by e-mail, mail, or by fax to:

Email: RA-Registry@pa.gov

Mail: Pre-Approved Tobacco Cessation Registry Program
Division of Tobacco Prevention and Control
Pennsylvania Department of Health
625 Forster Street, Room 1032 H&W Building
Harrisburg, PA 17120

Fax: (717) 214-6690

Required Information Definitions:

Contact Person: Enter the name of the person to be contacted by the Department of Health for questions regarding this application.

Title: Enter the title of the individual identified as the contact person.

Phone: Enter the phone number of the contact person.

Fax: Enter the fax number of the contact person.

E-Mail address: Enter the e-mail address of the contact person.

Health Care Delivery

System/Clinic: Enter the name of the organization applying for inclusion on the Cessation Registry.

Street Address: Enter the street address of the Healthcare Delivery System/Clinic.

City/State/Zip Code: Enter the city, state and zip code of Healthcare Delivery System/Clinic.

Phone: Enter the phone number of the Healthcare Delivery System/Clinic.

Fax: Enter fax number of the Healthcare Delivery System/Clinic.

Cessation Counselor(s): Enter the name(s) of counselors to be involved with cessation services. Cessation Counselors should be licensed or certified health care professionals or tobacco cessation specialists. The individual practice may be the only cessation counselor listed in this section.

Professional Disciplines: Enter the Cessation Counselor's profession discipline. Example: MD, DO, DMD, RN, NP, PA, RRT, LPC, LSW, CAC, RPh, PharmD, CHES, or other -- (please specify).

Provider ID: Each Cessation Counselor should provide their individual PROMISE number or NPI.

Location(s) of

Cessation Services:

Cessation counseling services provided at locations in addition to the above listed organization are to be listed separately. Please enter the location where each is located including street number and name, city, zip code and county. For individuals who offer services at multiple locations, please list each location.

Counseling Services

Provided:

Place a checkmark in the box of how counseling services are provided by the program. Check all that apply. The choices are defined as:

- Group Counseling: Counseling provided by a program designated counselor or facilitator in a group setting;
- Individual Counseling: One-on-one counseling provided by a program designated counselor or facilitator; or
- Phone: Counseling provided by a program designated counselor or facilitator over the phone.

Client Types:

Place a checkmark in the box of the type(s) that the service is designed to serve. Check all that apply. Referrals to services will be made based on identified client types. If the program reaches more than one identified client type, check as many as apply to the service.

Available Language/

Verbal Skills:

Indicate the language or languages used in the cessation counseling service presentation. Check all that apply.

Medical Assistance

Information:

Place a checkmark in the "Yes" box if this information is to be referred to the PA Department of Human Services (DHS) for review, and approval by MA (Medical Assistance) for reimbursement of tobacco cessation services. Individuals or organizations wanting reimbursement for tobacco cessation services must select this option.

-or-

Place a checkmark in the "No" box if information should not be forwarded to DHS for reimbursement by Medical Assistance for services received.

In order for providers to be eligible for reimbursement for tobacco cessation services, they must enroll into DHS's Medical Assistance program.

PROMISE/NPI Number:

If you are currently an enrolled provider with DHS, provide your organization's 13-digit PROMISE number. If you are not an enrolled provider with DHS, leave this field blank.

Printed Name:

Print the name of the organization representative or individual.

Attestations:

Completion of indicated statements confirms your commitment to the Tobacco Cessation Program and your agreement to follow Program requirements.

<https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/index.html>

Signature:

The signature of organization representative.

Title & Date:

Enter the title of the authorized representative and the date when form is signed.

For DOH Use:

This information is to be completed by DOH representative and indicates the approval or disapproval of designated Health Care Delivery System/Clinic/Individual Practice.