

**Pennsylvania Department of Health**

**Pre-Approved Tobacco Cessation Registry**

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| \*Contact Person: | \*Name of Individual/Clinic/Health Care System/Individual Practice: | | | |
| \*Contact Person Title: | \*Street Address: | | | |
| \*Phone: \*Fax:  (   ) -     -      Ext.       (   ) -     - | \*City: | | \*State: | \*Zip Code:       - |
| \*Email Address: | \*Phone: \*Fax:  (   ) -     -      Ext.       (   ) -     - | | | |
| Cessation Counselor(s): (Enter at least one counselor. Add additional page(s) as necessary.)   1. \*Name: \_     \_   Professional Discipline:  Physician/Physician extender/Nurse/Medical Assistant  Pharmacist  Oral Health Professional  Mental Health Professional  Drug & Alcohol Use Professional  Community Health Worker/Social Worker  Other Healthcare Professional  Public or Private Insurance Staff  Medicaid/HealthChoices Insurance Staff  Other not specified above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If available, provide your Provider ID \_     \_  I have attached the *Every Smoker Every Time* Notification E-mail.   1. Name: \_     \_   Professional Discipline:  Professional Discipline:  Physician/Physician extender/Nurse/Medical Assistant  Pharmacist  Oral Health Professional  Mental Health Professional  Drug & Alcohol Use Professional  Community Health Worker/Social Worker  Other Healthcare Professional  Public or Private Insurance Staff  Medicaid/HealthChoices Insurance Staff  Other not specified above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If available, provide your Provider ID \_     \_  I have attached the *Every Smoker Every Time* Notification E-mail.  **To submit more cessation counselor names, add additional pages as necessary.**  **Please indicate professional discipline.** | | | | |
| Location(s) of Cessation Services: (Enter at least one location. Add additional page(s) as necessary.)   1. \*Name of location: \_     \_   Street Address: \_     \_ City: \_     \_ State: \_  \_ Zip Code:      -  County:­­ \_     \_ Phone: (   ) -     -   1. Name of location: \_     \_   Street Address: \_     \_ City: \_     \_ State: \_  \_ Zip Code:      -  County:­­ \_     \_ Phone: (   ) -     -   1. Name of location: \_     \_   Street Address: \_     \_ City: \_     \_ State: \_  \_ Zip Code:      -  County:­­ \_     \_ Phone: (   ) -     - | | | | |
| \*Counseling Services Provided:  Group  Individual  Phone  Virtual | | | | |
| \*Client Type(s):  Adult  Young Adult (18-24)  LGBT  Youth (14-17)  Pregnant Women  Practice Patients  Other: \_     \_ | | \*Practice Language/Verbal Skills:  English  Spanish  Other: \_     \_ | | |
| Medical Assistance Information:  If your program is approved, would you like to be referred to the Department of Human Services (DHS) for review and approval by Medical Assistance for reimbursement of tobacco cessation services?  Yes  No  If available, provide your facility:  13-digit PROMISe number \_     \_and/or  NPI number: \_     \_ | | | | |
| \*Attestation:  I agree with Treating Tobacco Use and Dependence, Clinical Practice Guideline: 2008 Update, for Cessation Program Standards and Regulations:  <https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/index.html> | | | | |
| \*Printed Name of Organization Representative/Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*Signature of Organization Representative/Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Date: \_\_\_\_\_\_\_ | | | | |
| For Department of Health Use:  Approved  Not approved \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Department of Health Representative  Date Applicant Notified: \_\_\_\_\_\_\_\_\_\_ Date DHS Notified: \_\_\_\_\_\_\_\_\_\_ | | | | |

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