

**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 [ ]  NoIf 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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