MID-STATE HEALTH NETWORK

PROVIDER APPLICATION

Thank you for your interest in becoming a provider of the Community Mental Health Affiliation of Mid-Michigan (CMHAMM) provider network of services for persons with serious and persistent mental illness, serious emotional disturbance, developmental disabilities, and substance abuse & addictive disorders. You may request enrollment as a provider for one or more of the members below by submitting your completed application and requested documents to the attention of the Contract Management Department at any of the members & locations listed below.

Bay-Arenac Behavioral Health: 1.800.327.4693

CMH for Clinton-Eaton-Ingham Counties: 1.800.1.517.346.8200

CMH for Central Michigan: 1.800.317.0708

Gratiot County CMH Services: 1.800.633.5582

Huron County Behavioral Health: 1.800.356.5568

Ionia County CMH: 1.888.527.1790

Lifeways CMH Authority: 1.800.284.8288

Montcalm Center for Behavioral Health: 1.800.377.0974

Newaygo County - Mental Health Center: 1.800.968.7330

Saginaw County CMH Authority: 1.800.258.8678

Shiawassee County CMH Authority: 1.800.622-4514

Tuscola Behavioral Health Systems: 1.800.462.6814

DATE: _____

GENERAL INFORMATION

1) Individual Practitioner Information (if applying as an organization/agency only, skip to 2. below):

Last Name: _____ First Name: _____ MI: _____

SSN: #_____ Driver's License #:_____ Sex: ____M ____F

Date of Birth: _____ Country of birth: _____ Race: _____

Email Address: _____ Primary Specialty, if applicable: _____ Language(s) spoken:_____

Address: _____
Street City State Zip

Telephone: (o): _____ (cell): _____ (fax): _____

2. Organization/Agency Information (if applicable):

Organization/Agency Name: _____Tax I.D. #_____

Mailing Address: _____
Street City State Zip

Agency Telephone: _____ Fax: _____ Language(s) Spoken:_____

Name & Title of Executive Director: _____

Email Address: _____ Driver's License Number: _____

Date of Birth:_____ Sex: ___M ___F Race: _____

Other Contact Person: _____Phone: _____ Email Address: _____

3. Indicate the Member Community Mental Health organizations(s) whom you request to receive your application and related documents: [ ] Bay-Arenac [ ] CEI [ ] Central [ ] Gratiot [ ] Huron
[ ] Ionia [ ] Lifeways [ ] Montcalm [ ] Newaygo [ ] Saginaw [ ] Shiawassee
[ ] Tuscola

4. Check the service(s) for which you are qualified to provide:

[ ] Community Living Supports/Home Care
[ ] Specialized Residential/Respite
[ ] Crisis Residential
[ ] Hospital-Inpatient/Partial
[ ] Outpatient Therapy/Counseling Services-Mental Health
[ ] Outpatient/Counseling Services-Substance Abuse
[ ] Psychological/Behavioral Services
[ ] Psychiatric Services
[ ] Occupational/Physical Therapy
[ ] Speech/Language Therapy
[ ] Registered Dietician
[ ] Registered Nursing/LPN/Nursing Services
[ ] Case Management/Supports Coordination
[ ] Vocational Training/Employment Services
[ ] Children's Waiver/Hab Supports
[ ] Other: _____

5. Business Information

Governmental:
[ ] State
[ ] County
[ ] City

Non-Profit:
[ ] Non-Profit Corporation

For-Profit:
[ ] Sole Proprietor
[ ] Partnership
[ ] Corporation

Medicaid #:_____ Medicare #: _____

Blue Cross/Blue Shield #: _____

National Provider Identification (NPI) Number(s): _____

PROFESSIONAL LICENSURE/CERTIFICATION

1. License/Certification

Type: _____ Number:_____ State:_____ Expiration Date: _____

Type: _____ Number:_____ State:_____ Expiration Date: _____

Type: _____ Number:_____ State:_____ Expiration Date: _____
(Attach additional page if needed)

2. Specialty Certification

DEA #: _____
Board Certified: [ ] Yes [ ] No If yes, Certification #: _____
Other: _____

INSURANCE INFORMATION

1. Professional Liability Insurance

Carrier: _____ Policy #: _____
Coverage Amounts: _____

2. General Liability Insurance (if applicable)

Carrier: _____ Policy #: _____
Coverage Amounts: _____

3. Vehicle Insurance (if applicable)

Carrier: _____ Policy #: _____
Coverage Amounts: _____

4. Workers Compensation Insurance (if applicable)

Carrier: _____ Policy #: _____
Coverage Amounts: _____

EDUCATION & TRAINING (To be completed by individual practitioner applicant only)

Complete the following AND attach copy of current resume:

List any specialized education or training you are pursuing or have received that you wish to be considered:

_____
_____
_____
_____
_____
_____

ATTACHMENTS CHECKLIST

The following documents must accompany the completed application. Photocopies are accepted unless otherwise noted:

- [ ] Resume or Curriculum Vitae (must include summary of all prior professional work history)
- [ ] References (provide minimally 3 professional references or previous employers or contract agencies)
- [ ] Copy of accreditation letter(s)/certificate(s)
- [ ] Professional Licensure(s)/Certification(s)
- [ ] DEA Registration
- [ ] Board or Specialty Certifications
- [ ] Professional Liability Insurance
- [ ] General Liability Insurance
- [ ] Vehicle Insurance
- [ ] Workers Compensation Insurance
- [ ] Original transcripts from Educational Institution
- [ ] Copy of Diploma(s)
- [ ] Copy of Driver's License
- [ ] Policy/procedure for conducting staff background checks (if applying as an agency/facility)
- [ ] Other information about the Provider's services (i.e., brochures, policies & procedures, program statements, etc.) that the Provider wishes to share to better explain their services (Optional)

DISCLOSURE, VERIFICATION, AND AUTHORIZATION FOR RELEASE OF INFORMATION

1) For purposes of making this Application for participation in the CMHAMM Provider Network, the Provider certifies that all information provided to the member Community Mental Health Services Program (CMHSP) is complete, true, and correct to the best of the Provider's knowledge and belief. The Provider agrees to promptly notify the CMHSP(s) if there are any material changes in the information provided, whether prior to or after acceptance as a CMHAMM participating provider. The Provider understands and agrees that if the CMHSP(s) determines that this application contains any significant misstatements, misrepresentations or omissions, the acceptance of this application by CMHAMM for participation and any subsequent participating provider agreement which the CMHAMM enters into with the Provider will be null and void at the discretion of the CMHSP.

2) The Provider shall submit upon request a disclosure statement fully disclosing to the requesting CMHSP the nature and extent of any contracts or arrangements between the individuals responsible for the conduct of the Provider's affairs (or their immediate families, or any legal entity in which they or their families have a financial interest exceeding 5% of the stock or assets of the entity) and the CMHSP or a Provider or other person concerning any financial relationship with the CMHSP. The disclosure statements must be signed by each person listed and notarized. The CMHSP must be notified in writing of a substantial change in the facts set forth in the statement not more than thirty (30) days from the date of the change.

3) The person signing this Application on behalf of the Provider hereby certifies by signing to the best of his/her knowledge and belief that:
    a. The Provider and its principals are not presently debarred, suspended, proposed from debarment, declared ineligible, or voluntarily excluded from covered transactions by any state and/or federal Department or Agency, nor has any history of loss of licensure, disciplinary action, or any loss or limitation of privileges.

b. The Provider and its principals have not been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction, violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property, or been convicted of a felony of any type.

c. The Provider and its principals are not presently indicted for, or otherwise criminally or civilly charged by a governmental entity (federal, state, or local), with commission of any of the offenses in a. and b. above.

d. The Provider and its principals have not, within a three (3) year period preceding the commencement of this Application, had one (1) or more public (federal, state, or local) transactions terminated for cause or default.

e. The Provider and its principals are not currently involved in the use or handling of illegal or illicit drugs or the manufacturing of illegal drugs.

4) The Provider hereby authorizes the CMHSP(s) to release any and all sole information from any source including but not limited to information from an individual, an entity or governmental Provider for purposes of verifying information obtained in the attached application or any preferred provider re-application information to the CMHSP(s). The Provider agrees to hold the informant and the CMHSP(s) and CMHAMM harmless from any liability to the Provider for providing such information.

5) The Provider further authorizes the CMHSP(s) to release any and all sole information related in any way to the Provider's professional practice to any person, entity or governmental Provider to the CMHSP(s) which:
   a. provides the CMHSP(s) with an authorization signed by the Provider; or

   b. has a legal right to know under any state or federal law.

   The Provider agrees to hold the CMHSP(s) and CMHAMM harmless from any liability for providing any such information as specified herein.

6) The Provider understands and agrees that the certifications, authorizations, and other provisions contained herein shall remain in force for so long as this application is pending and, if accepted for participation, for so long as the Provider's participating provider agreement with the CMHSP remains in force.

7) The Provider understands and agrees that submission of any application for enrollment in the CMHAMM Provider Network does not guarantee nor is there any obligation on the part of any of the CMHSP(s) to contract with the Provider.

8) The Provider agrees that as a pending or, if instated, participating provider on the CMHAMM network, the Provider shall notify the CMHSP(s) upon its decision that it will no longer be accepting new Medicaid consumers/referrals for services.

9) The Provider further understands and agrees that:
   a. The Provider has the burden of producing all information required or requested by the CMHSP(s) in connection to this Application;

   b. The CMHSP(s) is under no obligation to complete the processing of this Application until all information requested is provided;

   c. The CMHSP(s) have the sole discretion to determine whether or not the Provider will be accepted as a participating provider; and

   d. In the event that the CMHSP(s) decides not to accept the Provider as a participating provider, the Provider may appeal the decision by submitting a letter to the Chief Executive Officer(s) from the CMHSP(s) for which enrollment was denied within ten (10) business days from the date of the determination notice. The letter should concisely state the basis for the appeal along with any supporting documentation. All appeals will be reviewed within fourteen (14) business days of receipt of the appeal letter. The decision issued by the Chief Executive Officer will be final and binding.

10) The Provider understands that contract execution will be contingent also upon successful completion of a background investigation and credentialing procedure. The Provider further understands that such investigation and credentialing may include primary source verification of the following:

- Criminal background check (MI Department of State Police)
- Verification of a Professional license (MI Department of Community Health)
- Medicaid/Medicare Verification (Department of Health &Human Services)
- Driver's License Verification (MI Secretary of State)
- Educational Background check (Individual Educational Institutions)
- Provider Query (National Practitioners Databank/Healthcare Integrity & Protection Database)

By my signature below, I authorize CMHAMM and its member CMHSPs to conduct any or all of the above background checks, as deemed appropriate. I understand that each CMHSP reserves the right to execute a contract or not based upon the findings of its background investigations. I agree, if accepted as a participating Provider, to abide by the requirements of the CMHAMM Provider Network.

_____ _____

Provider Signature & Title Date

_____

Provider Printed Name & Title: