8/14/2015

Thank you for your interest in joining Mid-State Health Network. Enclosed is an application for credentialing, service request, and with related attachments.

The following qualifications must be demonstrated in your application materials in order for us to accept your application:

* License: A current unrestricted, unconditional license to practice mental health and/or substance use disorder services in the State of Michigan;
* Certification (if applicable): Current certifications to provide specialized services as required by the State of Michigan;
* Accreditation (treatment programs only): Current accreditation from a national body approved by the State of Michigan;
* Insurance: Current malpractice insurance and professional liability insurance in the amount required by MSHN (minimum $1,000,000 per occurrence and $3,000,000 aggregate).

The application and attachments may be filled out electronically, however, you must print, date, and sign the application and required attachments. The application and attachments must be dated within 30 days of receipt by the MSHN Provider Credentialing Specialist.

If you have any questions related to the criteria identified above, or questions about completing the application and/or attachments, please feel free to contact me at 517.657.3000.

For your convenience, a checklist has been included on page 6 of the application.

Thank you,



Carolyn T. Watters, MA

Provider Credentialing Specialist

Mid-State Health Network

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| --- | --- | --- | --- | --- | --- |
| **Organizational Information** | | | | | |
| Name of Organization: | | | | | |
| Names of Chief Administrator: | | | | | |
| Office Address #1: | | City: | | St: | Zip: |
| Phone #: | Emergency #: | | Fax #: | | |
| Email Address: | | Website: | | | |
| Check Appropriate Status: Sole Proprietorship Partnership Corporation LLC S-Corp Other | | | | | |

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| **Additional Directory Information -** *attach additional sheets if necessary for multiple sites* | | | | | | | | | | | | | |
| Office Address #2: | | | | | | | Office Address #3: | | | | | | |
| City: | | | State: | | | Zip: | City: | | | St: | | | Zip: |
| Phone: | | | Fax: | | | | Phone: | | | Fax: | | | |
| Hours of Operation: | | | M: | | | | Hours of Operation: | | | M: | | | |
| T: | | W: | | | R: | | T: | | W: | | | R: | |
| F: | | Sa: | | | Su: | | F: | | Sa: | | | Su: | |
| Response time (days) from first point of contact: | | | | | | | # of new referrals you will accept per week: | | | | | | |
| Geographic Regions you Serve: | | | | | | | Arenac | Bay | | | Clare | | |
| Clinton | Eaton | | | Gladwin | | | Gratiot | Hillsdale | | | Huron | | |
| Ingham | Ionia | | | Isabella | | | Jackson | Mecosta | | | Midland | | |
| Montcalm | Newaygo | | | Osceola | | | Saginaw | Shiawassee | | | Tuscola | | |
| Same Day Service?  Yes  No | | | | 24 hr on-call?  Yes  No | | | | ADA Accessible?  Yes  No | | | | | |
| Please specify all fluent communicable languages, including sign language: | | | | | | | | | | | | | |

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| **Billing Information** | |
| EIN: | NPI#: |
| Medicaid #: | Medicare #: |
| Indicate all insurance companies and/or managed care plans you currently participate with or have provider agreements with:  None | |
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| **Organizational Certifications/Licenses***- attach current copies* | | | | | |
| License Specialty: | CAIT | | Case Management | Early Intervention | |
| Inpatient | Integrated Treatment | | Outpatient | Outpatient Methadone | |
| Peer Recovery/Support | Residential | | Residential Detox | SARF | |
| *Indicate all past and current licenses and certifications - attach additional sheets of necessary* | | | | | |
| Certification/License Type | | License # | | | Expiration Date |
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| **Current Professional Liability Insurance Information** - *attach copy of cover sheet* | | | |
| Insurance Carrier: | | | Policy #: |
| Address: | | | Coverage Amount: |
| City: | State: | Zip: | Expiration Date: |

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| **Professional References** | | | |
| Please provide the names and addresses of three (3) individuals who have personal knowledge of your organization over the last five (5) years and can comment on the scope/level of performance, clinical performance, satisfactory professional obligations, ethical performance, clinical judgement, and technical skills in performing procedures and in treating and managing client’s needs. *Professional references only.* | | | |
|  | Reference #1 | Reference #2 | Reference #3 |
| Full Name |  |  |  |
| Title/Occupation |  |  |  |
| Organization |  |  |  |
| Email Address |  |  |  |
| Phone |  |  |  |

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| **Privileges, Licensure, and Malpractice History** | |
| Has your organization had any of the following denied, revoked, suspended, reduced, limited, or placed on probation or have voluntarily relinquished any of the following in anticipation of these actions, or are any of these actions now pending? I*f you answer yes to any of the following, attach full explanation.* | |
| 1. License to operate | Yes  No |
| 1. Accreditation/Certification | Yes  No |
| 1. Medical/Hospital Staff Membership | Yes  No |
| 1. Clinical Privileges | Yes  No |
| 1. Professional Liability Insurance | Yes  No |
| 1. Malpractice suits settled resulting in a judgment against you in the past five (5) year, or currently pending? | Yes  No |
| 1. Are any malpractice judgements pending? | Yes  No |
| 1. Within the past ten (10) years, has your organization ever been convicted of, or plead guilty to, a criminal offense? | Yes  No |
| 1. Are there any medical incidents for which you have been contacted by an attorney regarding potential malpractice liability (settlement request, writ of summons, etc.)? | Yes  No |
| 1. Have your organization had any Medicaid, Medicare, or other governmental or third-party payor sanctions? | Yes  No |
| 1. Have your organization ever been excluded from the Medicaid or Medicare program?   If yes, specify date:       Date of Reinstatement: | Yes  No |
| 1. Have civil and monetary penalties been levied against your organization by Medicare or Medicaid programs? | Yes  No |
| 1. You must provide, at minimum, the prior 5 year’s history of any professional liability claims resulting in a judgement or settlement.   ***Complete Attachment D -Professional Liability Action Detail*** | Attached  N/A |

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| **Statement of Ability to Perform** |
| 1. Do you now, or have you had any physical condition, mental condition, or substance abuse condition (alcohol, illegal or prescription drugs) that has interfered with your ability to practice or perform clinical duties, or led to suspension, termination, or any other disciplinary action?  Yes  No |
| 1. Are you currently engaged in the illegal use of controlled substances?  Yes  No |

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| **Policy & Practices** (attach copies of policies and procedures) | | Pg. # |
| 1. Does the organization have policy/practice for access to services? (Including timeliness of response to referral, availability of services, access to services, emergency services, etc.) | Yes  No |  |
| 1. Does the organization have a credentialing and re-credentialing policy/practice? | Yes  No |  |
| 1. Does the organization conduct primary verification of credentials? | Yes  No |  |
| 1. Does the organization conduct criminal background checks at time of hire and periodically during employment? | Yes  No |  |
| 1. Does the organization assess staff competency on an ongoing basis through performance evaluation? | Yes  No |  |
| 1. Does the organization have a policy/practice regarding ongoing professional development? (Including orientation and ongoing training) | Yes  No |  |
| 1. Does the organization assess the cultural backgrounds of persons served and provide training to staff on any identified cultural issues? | Yes  No |  |
| 1. Does the organization's policy on treatment planning describe person-centered planning? | Yes  No |  |
| 1. Does the organization’s policy on treatment planning include consumer involvement in the development of the plan of service? | Yes  No |  |
| 1. Does the organization have a policy/practice regarding serving persons with Limited English Proficiency? | Yes  No |  |
| 1. Does the organization have a continuous quality improvement (CQI) policy/practice? | Yes  No |  |
| 1. Does the organization have a process to assess customer satisfaction? | Yes  No |  |
| 1. Does the organization have policies and procedures for clinical standards of care? | Yes  No |  |
| 1. Do the clinical standards of care include defined treatment philosophies and orientations? | Yes  No |  |
| 1. Does the organization have policy/procedure describing case records, record review, security, and case record access? | Yes  No |  |
| 1. Does the organization have a corporate compliance policy? | Yes  No |  |
| 1. Does the organization have a safety management plan that includes: | | |
| a. General Safety | Yes  No |  |
| b. Security | Yes  No |  |
| c. Hazardous materials and wastes | Yes  No |  |
| d. Emergency preparedness | Yes  No |  |
| e. Fire | Yes  No |  |
| f. Medical equipment | Yes  No |  |
| g. Utility systems | Yes  No |  |
| h. Physical environment | Yes  No |  |
| i. Infection control | Yes  No |  |

Consent and Release of Liability

Upon the signing of this application, I represent that all of the information now or hereafter given by me in support of my application is true, correct and complete to the best of my knowledge and belief. I agree to promptly notify MSHN if there are any material changes in the information provided, whether prior to or after acceptance as a MSHN participating provider. I hereby authorize the release of any information from any source including but not limited to information from individuals, peers, customers, companies, institutions, agencies, data banks or references who may have information bearing on my moral and ethical qualifications and competence to carry out the privileges I have requested, and I authorize them to release such information as you require, including my prior disciplinary records, for purposes of verifying information obtained in the attached application or any re-application information without any obligation to give me written notice of such disclosure. I agree to hold MSHN and the informant harmless from any liability to me and/or my organization for providing such information.

I hereby further authorize MSHN to release any and all information related in any way to my professional practice to any person, entity or governmental agency which: (a) provides MSHN with an authorization signed by me; or (b) has a legal right to know under any state or Federal law. I agree to hold MSHN harmless from any liability for providing any such information as specified herein.

I release all parties from all liability from any damages, causes of action, including, but not limited to, slander and libel, that may result from furnishing any information to you. I agree that any false information in support of my application may result in action up to and including cancellation of any or all contracts subject to contract provisions regardless of when discovered by MSHN. I release MSHN, the MSHN Credentialing Committee, individually and collectively, from any and all liability from any damages and/or causes of action associated with the MSHN credentialing and privileging process.

I hereby signify my willingness to appear for interviews with MSHN. I fully consent to the inspection of any and all records and documents pertinent to my application for appointment and/or privileges. If there is a doubt as to my competence, morals, or ethics, the burden shall be on me to resolve the same. I understand and agree that if MSHN determines that this application contains any significant misstatements, misrepresentations, or omissions, MSHN’s acceptance of this application for participation and any subsequent participating provider agreement which MSHN enters into with me will be voidable at MSHN’s sole discretion.

I understand and agree that: (a) I have the burden of producing all information required or requested by MSHN in connection with this application; (b) MSHN is under no obligation to complete the processing of this application until all information requested is provided; (c) MSHN has the sole discretion to determine whether or not I or my organization will be accepted as a participating provider; and (d) in the event that MSHN decides not to accept me or my organization as a participating provider, I may initiate administrative appeal procedures as defined in the instructions for completing the application.

I understand and agree 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 my and/or my organizations’ provider agreement with MSHN remains in force.

I understand that MSHN is not obligated to grant any or all requested privileges and that application for such is not a guarantee of a contract with MSHN.

**Applicant Signature: Date:**

**Print Name:**

**Organization:**

Application for Credentialing and Clinical Privileges Checklist

The following items are required:

All applicable items on the application are complete and legible

Signed and dated Consent and Release of Liability

Written explanations attached for any privilege, licensure, or malpractice history questions answered “Yes”

Copy of organization’s Licensure/Certification necessary to support requested services/privileges

Copy of the organization’s Accreditation Certificate and most recent survey report

Copy of the organization’s Credentialing and Privileging Policy

Copy of current Malpractice and Professional Liability Policy

Copy of the organization’s most recent Compliance Plan

Copies of all professional licenses/certifications for all staff

Copy of current Fidelity Bonding Certificate

Federal W-9 Form - Request for Taxpayer Identification Number and Certification

Attachment A – Substance Abuse Treatment Service/Privilege Request Form

Attachment B - Consent to Conduct Criminal Background Investigations (N/A for organizational providers)

Attachment C – Disclosure of Ownership & Controlling Interest Statement

Attachment D – Professional Liability Action Detail (if applicable)

Attachment E – Electronic Funds Transfer Request (if applicable)

Attachment F – Credentialing Information – Licensed Professionals

Attachment G – Credentialing Information – Paraprofessionals

Attachment H – Provider Training Log

Attachment A – Substance Abuse Treatment Service/Privilege Request

Refer to [MDHHS Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services](https://www.michigan.gov/documents/mdch/PIHP-MHSP_Provider_Qualifications_219874_7.pdf) for Provider/Staff Qualifications

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| **Indicate with a checkmark below the services and population(s) for which you are requesting to provide in the Mid-State Health Network. Please check all that apply.** | | | | | | | | | |
| **C/A** – Child/Adolescent (<18 years old) | | | **MO** – Men Only | | | | | | |
| **A** – Adult population (18 - 65 years old) | | | **WO** – Women Only | | | | | | |
| **OA** – Older adult population (>65 years old) | | | **WS** – Women’s Specialty Designated Services | | | | | | |
| **SP** – Special Populations (Please specify in Attachment) | | | **PR** – Prison Resident – Jail or Prison Based Services | | | | | | |
|  | **C/A** | **A** | | **OA** | **SP** | **WO** | **MO** | **WS** | **PR** |
| **Crisis Intervention** |  |  | |  |  |  |  |  |  |
| **Case Management (Refer/Link/Coordination)** |  |  | |  |  |  |  |  |  |
| **Detox/Withdrawal Monitoring** |  | | | | | | | | |
| Ambulatory Detox |  |  | |  |  |  |  |  |  |
| Clinically Managed Detoxification |  |  | |  |  |  |  |  |  |
| Medically Managed Detoxification |  |  | |  |  |  |  |  |  |
| Residential Detox |  |  | |  |  |  |  |  |  |
| **Early Intervention** |  |  | |  |  |  |  |  |  |
| **Medication Assisted Treatment** |  |  | |  |  |  |  |  |  |
| Methadone |  |  | |  |  |  |  |  |  |
| Vivitrol |  |  | |  |  |  |  |  |  |
| Suboxone |  |  | |  |  |  |  |  |  |
| **Medically Managed Supports** |  | | | | | | | | |
| Established Patient Medication Review |  |  | |  |  |  |  |  |  |
| Lab Tests |  |  | |  |  |  |  |  |  |
| Medication Compliance Monitoring |  |  | |  |  |  |  |  |  |
| New Patient Medication Review |  |  | |  |  |  |  |  |  |
| Nursing Services |  |  | |  |  |  |  |  |  |
| Physical Examination |  |  | |  |  |  |  |  |  |
| Physician Encounters |  |  | |  |  |  |  |  |  |
| TB Skin Test |  |  | |  |  |  |  |  |  |
| **Non-Medication Assisted Outpatient** |  |  | |  |  |  |  |  |  |
| **Outpatient/Ambulatory Care** |  | | | | | | | | |
| Family Assessment |  |  | |  |  |  |  |  |  |
| Family Therapy |  |  | |  |  |  |  |  |  |
| Group Therapy |  |  | |  |  |  |  |  |  |
| Individual Assessment |  |  | |  |  |  |  |  |  |
| Individual Therapy |  |  | |  |  |  |  |  |  |
| **Peer Recovery, Recovery Coaching and Support** |  |  | |  |  |  |  |  |  |
| **Residential (Facility Based) Services** |  | | | | | | | | |
| Clinically Managed High Intensity (ASAM 111.5) |  |  | |  |  |  |  |  |  |
| Clinically Managed Medium (ASAM 111.3) |  |  | |  |  |  |  |  |  |
| Clinically Managed Low (ASAM 111.1) |  |  | |  |  |  |  |  |  |
| **Special Assessment Services** |  |  | |  |  |  |  |  |  |
| Health |  |  | |  |  |  |  |  |  |
| Psychiatric Evaluation |  |  | |  |  |  |  |  |  |
| Psychological Testing |  |  | |  |  |  |  |  |  |
| Other Assessments, Tests |  |  | |  |  |  |  |  |  |

By signing below, I verify that       (organization name) is able to perform the above checked services.

**Authorized Applicant Signature: Date:**

Attachment B - Consent to Conduct Background Investigations

In connection with my application for Credentialing/Re-Credentialing and Privileges, I hereby authorize

Mid-State Health Network to obtain a criminal background check from official law enforcement agencies.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name (Last, First, Middle): | | | DOB: | |
| Others Names Used: | | | SS#: | |
| Race: | | | Gender: Male Female | |
| Driver’s License #: | | | State Issued: | |
| **List below all addresses for the last seven (7) years starting with the most current (attach additional page if needed)** | | | | |
| *Street Address* | *City* | *State* | *Zip* | *Dates (MM/YY-MM/YY)* |
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My signature below indicates that the information that I have furnished is true and correct to the best of my knowledge.

**Authorized Applicant Signature:** **Date:**

The Credentialing Specialist has verified the above information to the best of his/her ability.

**Signature:**  **Date:**

Attachment C – Disclosure of Ownership & Controlling Interest Statement

Mid-State Health Network (MSHN) is required to collect disclosure of ownership, controlling interests, and management information from providers that are credentialed or otherwise enrolled to participate in the Medicaid program and/or the Pre-paid Inpatient Health Plan (PIHP). This requirements is pursuant to a Medicaid and/or PIHP State Contract with the State Agency and the federal regulations set forth in 42 CFR Part §455. Required information includes: 1) the identity of all owners and others with a controlling interest of 5% or greater; 2) certain business transactions as described in 42 CFR §455.105; 3) the identity of managers and others in a position of influence or authority; and 4) criminal convictions, sanctions, exclusions, debarment or termination information for the provider, owners or managers. The information required includes, but is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN).

Completion and submission of this Statement is a condition of participating as a credentialed or enrolled provider in the MSHN for services to members under Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Wavier Program. Failure to submit the requests information may result in a refusal of participation in MSHN or denial of a claim.

This statement should be submitted at any of the following times: upon the submission of an application; upon execution of an agreement; during re-credentialing or re-contracting; within 35 days after any change in ownership of the disclosing entity. A Statement must be provided to MSHN within 35 days of a request for information by the US Department of Health and Human Services (HHS) or the State Agency. MSHN maintains policies and practices that protect the confidentiality of personal information, including Social Security numbers, obtained from its providers and associates in the course of its regular business functions. MSHN is committed to protecting information about its providers and associates, especially the confidential nature of their personal information.

*Detailed instructions and a glossary for capitalized terms can be found at the end of this form. If attachments are included, please indicate to which section those attachments refer.*

**Individual Provider Information**

*Please fill out the entire section. Every field must be complete. If fields are left blank, the form will be returned for corrections/completeness. \*These fields cannot be left blank; check appropriate box or use ‘N/A’.*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please choose appropriate category:** | | | **Name of Person Completing the Form** | | | | | | |
| Individual Member of a Medical Group | | |  | | | | | | |
| Individual Contracted Practitioner | | | **Title:** | | | | | | |
| Sole Proprietor | | | **Phone Number:** | | | | | | |
| HCBS Provider | | | **Fax:** | | | | | | |
| Other: | | | **Email:** | | | | | | |
| **Group Affiliation?**  Yes  No | | |  | | | | | | |
| **If yes,** do you have a private practice as well?  Yes  No | | | **In which state(s) do you participate in Medicaid?** | | | | | | |
| **Legal Name of Individual (“Individual Provider”)** | | | **Name of Group (if applicable):** | | | | | | |
| **Street Address:** | | | **City:** | | | **State:** | | | **Zip:** |
| **Additional Addresses (list all Practice Locations) Attaching list?**  Yes  No | | | | | | | | | |
| **\*SSN:** | \*Medicaid ID#: | | | | \*NPI#: | | | **\*CAQH#:** | |
|  | \*Applied for Medicaid ID | | | | \*Applied for NPI# | | |  | |
|  | \*Not applicable | | | | \*Not applicable | | |  | |
| \*If billing under and Entity: Federal Tax Identification#: | | | | \*If billing under an Entity: Billing Entity’s NPI#: | | | | | |
|  | | | | \*Applied for NPI# | | | \*Not applicable | | |
| \*If billing under an Entity: Billing Entity’s Medicaid ID #: | | | | \*If billing under and Entity: Billing Entity’s CAQH #: | | | | | |
| \*Applied for Medicaid ID# | | \*Not applicable | |  | | | | | |

**Section I: Individual Provider Ownership Information**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Are there any individuals or organizations with a Direct or Indirect Ownership Interest of 5% or more in your practice, as an Individual Provider?  Yes  ***No – Skip to #2*** | | | | | | |
| *See instructions for more information and examples* | | | | | | |
| **If yes,** list the name, primary address, date of birth (DOB), and Social Security Number (SSN) for each person having an Ownership Interest in the Individual Provider of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location and P.O. Box address of each organization, corporation, or entity having an Ownership Interest of 5% or greater. (42 CFR §455.104).  Attach additional sheets as necessary -  Yes  No | | | | | | |
| **Name of Owner** | **DOB**  **(mm/dd/yyyy)** | **Complete Address**  **(Street/City/State/Zip)** | | | **\*\*SSN or TIN or both as applicable** | **% Interest** |
|  |  | Street: | | |  |  |
| C: | S: | Z: |
|  |  | Street: | | |  |  |
| C: | S: | Z: |
|  |  | Street: | | |  |  |
| C: | S: | Z: |
|  |  | Street: | | |  |  |
| C: | S: | Z: |

*\*\*SSN and TIN required under §455.104; See Sect 4313 of the Balanced Budget Act of 1997 amended Sect 1124 and Federal Register Vol. 76 No 22*

**Section II: Ownership in Other Providers & Entities**

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| --- | --- | --- |
| 1. Does the *Owner identified in Section I* have an Ownership or Controlling Interest in *any other* provider or entity?   Yes  ***No – Skip to #3***  **If yes,** list the name and the SSN or TIN of the other provider or entity in which the *Owner identified in Section I* also has an Ownership or Controlling Interest (42 CFR §455.104(b)(3)).  Attach additional sheets as necessary - Yes  No | | |
| **Name of Owner from Section I** | **Name of Other Provider or Entity** | **Other Provider or Entity’s SSN (indiv.) or TIN (entity)** |
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**Section III: Subcontractor Ownership**

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| --- | --- | --- | --- |
| 1. Do you, as the Individual Provider, have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor?  Yes  ***No – Skip to #4***   **If yes,** does another individual or organization also have an Ownership or Controlling Interest in the same Subcontractor?  Yes  No  **If yes,** list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which you *also have* Direct or Indirect Ownership Interest of 5% or more (42 CFR §455.104).  Attach additional sheets as necessary - Yes  No | | | |
| **Legal Name of Subcontractor:** | | | |
| **Name of Subcontractors *Other Owner*:** | | ***Other Owner’s*:** | |
| ***Other Owner’s* Address:** | | **City, State, Zip**: | |
| ***Other Owner’s* TIN:** | ***Other Owner’s* SSN:** | | **% Interest:** |

**Section IV: Familial Relationships of All Owners**

|  |  |  |
| --- | --- | --- |
| 1. Are any of the individuals identified in Sections I, II, or III related to each other? Yes  ***No – Skip to #5*** | | |
| **If yes,** list the individuals identified and the relationship to each other (e.g. spouse, domestic partner, sibling, parent, child) (42 CFR §455.104(b)(2). Attach additional sheets as necessary - Yes  No | | |
| **Name of Owner 1** | **Name of Owner 2** | **Relationship** |
|  |  |  |
|  |  |  |

**Section V: Criminal Convictions, Sanctions, Exclusions, Debarment, or Terminations**

|  |  |  |
| --- | --- | --- |
| 1. Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice ever been indicted or convicted of a crime related to that person’s involvement in any program under Medicaid, Medicare, CHIP or Title XX program? Yes  ***No – Skip to #6*** | | |
| **If yes,** list those persons and the required information below. (42 CFR §455.106). Attach additional sheets as necessary - Yes  No | | |
| **Name**: | **DOB:** | |
| **State of Conviction:** | **SSN (indiv.) or TIN (entity):** | |
| **Address:** | **City, State, Zip:** | |
| **Matter of the Offense:** | | |
| **State and Date of Conviction:** | | **Date of Reinstatement:** |

|  |  |  |
| --- | --- | --- |
| 1. Have you or any person who has an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice ever been sanctioned, excluded, or debarred from Medicaid, Medicare, CHIP or Title XX program? Yes  ***No – Skip to #7*** | | |
| **If yes,** list those persons and the required information below. (42 CFR §455.436). Attach additional sheets as necessary - Yes  No | | |
| **Name:** | | |
| **DOB:** | **SSN (indiv.) or TIN (entity):** | |
| **Address:** | **City, State, Zip:** | |
| **Reason for Sanction, Exclusion, or Debarment:** | | |
| **Date(s) of Sanctions, Exclusions, or Debarments**: | | **Date of Reinstatement:** |
| **List all States where currently excluded:** | | |

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| 1. Has the Provider Entity, or any person who has an Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been **terminated** from participation in Medicaid, Medicare, CHIP or a Title XX program? Yes  ***No – Skip to #8*** | |
| **If yes,** list those person and the requirement information below. (42 CFR §455.416). Attach additional sheets as necessary - Yes  No | |
| **Name:** | |
| **DOB:** | **SSN (indiv.) or TIN (entity):** |
| **Address:** | **City, State, Zip:** |
| **Reason for Termination:** | |
| **Date of Termination:** | **Terminated from Medicare?** Yes  No |
| **State that originated Termination:** | **Date of Reinstatement:** |

*\*At any time during the Contract period, it is the responsibility of the Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments and terminations (see Fed. Register, Vol. 44, No. 138)*

**Section VI: Business Transaction Information**

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| 1. **Business Transactions – Subcontractors:** Has the Provider Entity had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period? Yes  ***No – Skip to #9*** | |
| **If yes,** list the information for Subcontractors with whom the Provider Entity has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1)) Attaching additional sheets as necessary - Yes  No | |
| **Name of Subcontractor:** | **Subcontractor’s SSN or TIN:** |
| **Subcontractor Address:** | **City, State, Zip:** |
| **Subcontractors Owner (SO):** | **SO’s SSN or TIN:** |
| **SO’s Address:** | **City, State, Zip:** |

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| 1. **Significant Business Transactions – Wholly Owned Suppliers:** Has the Provider Entity had any Significant Business Transactions with a Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period? Yes  ***No – Skip to #10*** | |
| **If yes,** list the information for any Wholly Owned Supplier with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period (43 CFR §455.105(b)(2)). Attach additional sheets as necessary - Yes  No *See Glossary for definition.* | |
| **Name of Supplier:** | **Suppliers SSN or TIN:** |
| **Suppliers Address:** | **City, State, Zip:** |

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| 1. **Significant Business Transactions – Subcontractors:**  Has the Provider Entity had any Significant Business Transactions with a Subcontractor totaling more than $25,000 in the past five (5) year period? Yes  ***No – Skip to #11*** | |
| **If yes,** list the information for Subcontractors with whom the Provider Entity had any Significant Business Transactions exceeding the $25,000 during the past 5-year period (42 CFR §455.105(b)(2)).  Attach additional sheets as necessary - Yes  No | |
| **Name of Subcontractor:** | **Subcontractor’s SSN or TIN:** |
| **Subcontractor Address:** | **City, State, Zip:** |
| **Subcontractors Owner (SO):** | **SO’s SSN or TIN:** |
| **SO’s Address:** | **City, State, Zip:** |

**This information must be provided and/or updated within 35 days of a request.**  Medicaid payments may be denied for services furnished during the period beginning on the day following the date the information was due until it is received (42 CFR §455.105)

**Section VII: Management and Control**

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| 1. **Managing Employees:** Does the Provider Entity have any Managing Employees? Yes  ***No – Skip to #12*** | | | | |
| **If yes,** list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operations of Provider Entity (general manager, business manager, administrator or director), including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104). Attach additional sheets as necessary - Yes  No | | | | |
| **Name** | **DOB**  **mm/dd/yyyy** | **Complete Address** | **SSN** | **Title** |
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| 1. **Agents:** Does the Provider Entity have any Agents? Yes  ***No – Skip to #13*** | | | |
| **If yes,** list all Agents that have been delegated the authority to obligate or act on behalf of Provider Entity, including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104).  Attach additional sheets as necessary - Yes  No | | | |
| **Name** | **DOB**  **mm/dd/yyyy** | **Complete Address** | **SSN** |
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| 1. **Board of Directors:** Does the Provider Entity have a Board of Directors? Yes  No | | | |
| **If yes,** list each member of the Board of Directors or Governing Board for corporations, including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104).  Attach additional sheets as necessary - Yes  No | | | |
| **Name** | **DOB**  **mm/dd/yyyy** | **Complete Address** | **SSN** |
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Through signature below, I hereby certify that any employees or contractors providing services pursuant to a contract with Mid-State Health Network are screened with the applicable background check including, but not limited to, verification against the OIG’s List of Excluded Individuals & Entities (<https://oig.hhs.gov/exclusions/index/asp>) and the System for Award Management (SAM) [www.sam.gov](http://www.sam.gov) and any applicable state, federal or other governmental exclusion or sanction database and that the information provided herein is true, accurate and complete. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of a claim and/or termination of the contract.

**Signature** **Title**

**Print Name** **Date**

**Phone Number Fax Number Email Address**

**Disclosure Instructions**

*If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the section number that is being continued. For example: Section I Ownership Information, continued. Please see Glossary for definition of capitalized terms.*

**Section I: Provider Entity Ownership Information**

Please list the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more or has a Controlling Interest in your entity. If the Owner is a corporation: the primary business address must be listed and every business location and PO Box address. Provider members of a group practice who have ownership or a controlling interest in Provider Entity must submit a separate Statement.

Providing the SSN and TIN (as applicable) is required under 42 CFR 455.104; please see Section 4313 of the Balanced Budget Act of 1997, amended Section 1124, and the Federal Register Vol. 76 No. 22. Any form without the required SSN and TIN (as applicable) is incomplete and will not be processed.

**Section II: Ownership in Other Providers & Entities**

Please identify the other providers or entities that are owned or controlled at least 5% by the same individual or organization identified in Section I that has an Ownership or Controlling Interest in your entity. This information is to identify shared and interconnected ownership and controlling interests.

**Section III: Subcontractor Ownership**

If your entity has a Direct or Indirect Ownership of 5% or more in a Subcontractor and other individuals or entities also have a Direct or Indirect Ownership of that same Subcontractor, please identify the Subcontractor and provide the required information for the additional owners.

**Section IV: Familial Relationships of All Owners**

Report whether any of the persons listed in Sections I, II, and III are related to each other and identify the parties and their relationship. For the definition of domestic partner, refer to your state’s laws. Provider members of a group practice who are related to the Provider Entity’s owners or those with a controlling interest must submit a separate Statement.

**Section V: Criminal Convictions, Sanctions, Exclusions, Debarment, and Terminations**

List your own criminal convictions, sanctions, exclusions, debarments, and termination, *and* for any person who has an ownership or controlling interest, or is an agent or managing employee of your entity. List all offenses related to each person’s or entity’s involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services since the inception of these programs. Review all of the databases necessary to verify this information:

1. Exclusion status may be verified through the HHS-OIG List of Excluded Individuals/Entities (LEIE) at <https://oig.hhs.gov/exclusions/index.asp>
2. Sanction information is available in the GSA’s SAM (System for Award Management) database [www.sam.gov](http://www.sam.gov).
3. State specific exclusions/sanction databases may be accessed through the State Agency’s website.

**Section VI: Business Transaction Information**

1. List the Ownership of any Subcontractors that you have had business transactions totaling more than $25,000 within the last twelve (12) month period ending on the date of the request.
2. List any ***Significant Business Transactions*** between your entity and any Wholly Owned Supplier during the past 5 years.
3. List any ***Significant Business Transactions*** between your entity and any Subcontractor during the past 5 years.

Remember that a ***Significant Business Transaction*** is defined as any transaction or series of related transactions that exceeds the lesser of $25,000 or 5% of a provider’s operating expenses during any one fiscal year.

This information must be made available within 35 days of a request by the US Department of Health and Human Services (HHS), the State Medicaid Agency, and the Medicaid Managed Care Organization responding to an HHS or State request.

**Section VII: Management & Control**

1. List the required information for all employees that hold a position of Managing Employee within your entity.
2. List the required information for all Agents that have the authority to obligate or act on behalf of your entity.
3. List the required information for all individuals on the governing board or board of directors if your entity is organized as a corporation. CMS requires the identification of officers and directors of a Provider Entity that is organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.

**Disclosure Glossary**

**Agent:** any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

**CHIP:** The Federal insurance program for children, Child Health Insurance Program, in Michigan this is known as MIChild.

**Controlling Interest:** defined as the operational direction or management of a disclosing entity which management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity; the ability or authority to nominate or name members of the Board of Directors or Trustees; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction; the ability or authority, expressed or reserved , to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

**Determination of ownership or control percentages:**

1. *Indirect ownership interest.* The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A’s interest equates to 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B’s interest equates to 4 percent indirect ownership interest in the disclosing entity and need not be reported.
2. *Person with an ownership or controlling interest.* In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity’s assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider’s assets, A’s interest in the provider’s assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider’s assets, B’s interest in the provider’s assets equates to 4 percent and need not be reported.

**Direct Ownership Interest:** the possession of equity in the capital, the stock, or the profits of the disclosing entity.

**HCBS Provider:** a provider of Home and Community Based Services for Medicaid beneficiaries.

**Indirect Ownership Interest:** an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

**Managing Employee:** a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency.

**Other Entity:** any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

1. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
2. Any Medicare intermediary or carrier; and
3. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

**Ownership or Controlling Interest:** an individual or corporation that

1. Has an ownership interest totaling 5 percent or more in a disclosing entity;
2. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
3. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
4. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
5. Is an officer or director of a disclosing entity that is organized as a corporation; or
6. Is a partner in a disclosing entity that is organized as a partnership.

**Provider Entity:** an individual or entity who operates as a Medicaid provider and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services. For purposes of this Statement, the Providing Entity is the individual or entity identified on this form as the disclosing entity.

**Significant Business Transaction:** any business transaction or series of related transactions that, during any one fiscal year, exceeds the lesser of twenty-five thousand dollars ($25,000) or five percent (5%) of a Provider Entity’s total operating expenses.

**Subcontractor:** (a) an individual, agency, or organization to which a Provider Entity has contracted or delegated some of its management functions or responsibilities of providing medical are to its patients; or (b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

**Supplier:** an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g. a commercial laundry, manufacturer of hospital beds, or pharmaceutical firm).

**Wholly Owned Supplier:** a Supplier whose total ownership interest is held by the Provider Entity or by a person(s) or other entity with an ownership or control interest in the Provider Entity.

Attachment D - Professional Liability Action Detail – *Confidential*

|  |
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| Please list any past or current professional liability claim or lawsuit, which has been filed against you. Photocopy this page as needed and submit a separate page for **each** professional liability claim/lawsuit. Please complete each field. |
| Practitioner’s Name (Last, First, Middle): |
| Month/Day/Year of the incident and clinical details: |
| Your role and specific responsibilities in the incident: |
| Subsequent events, including patient’s clinical outcome: |
| Month/Day/Year the suit or claim was filed: |
| Name and Address of insurance carrier/professional liability provider that handled the claim: |
| Your status in the legal action (primary defendant, co-defendant, other): |
| Current status of suit or other action: |
| Month/Day/Year of settlement, judgement, or dismissal: |
| If the case was settled out of court, or with a judgement, settlement amount attributed to you: |

I verify the information contained in this form is correct and complete to the best of my knowledge.

**Applicant Signature:**  **Date:**

**Applicant Print Name:**

Attachment E – Electronic Funds Transfer

If you would like MSHN to electronically deposit our payments to your financial institution, please complete and return this form to:

Mid-State Health Network

530 W. Ionia Street

Lansing, MI 48933

Or

Email: [leslie.thomas@midstatehealthnetwork.org](mailto:leslie.thomas@midstatehealthnetwork.org)

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| **Name of Individual or Organization:** | | | |
| **Address:** | | | |
| **City:** | **State:** | | **Zip:** |
| **Email:** | | **Fax:** | |

I hereby authorize MSHN to deposit my payment into the account identified below and authorize the DFI (Depository Financial Institution) to accept these deposits. Adjusting entries to correct errors are also authorized. It is agreed that these deposits and adjustments may be made electronically and under the Rules of the National Automated Clearing House Association. This authorization will remain in effect until written notice of termination is given to MSHN.

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| **Financial Institution:** | |
| **Routing/Transit Number (9 digits):** | **Account Number:** |
| **Check One:  Savings** **Checking** | |

**Authorized Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_/\_\_\_/\_\_\_\_\_\_\_**

A pre-note will be sent initially to verify routing/transit numbers along with account numbers. This takes up to ten days. The following payment, given the pre-note is correct, will be paid electronically. With this in mind, you may receive one printed check before your electronic payments begin. Also, if a change is made to your direct account numbers after the initial pre­-note has been sent, the change will generate another pre-note to be sent and you may receive a printed check for the following payment. We will e-mail/mail a notification to your address above each time an electronic payment is made. The notice will include the invoice number(s), description(s), and amount(s) transferred.

**QUESTIONS SHOULD BE DIRECTED TO Leslie Thomas 517.253.7546**

Attachment F – Credentialing Information - *Licensed Professionals*

List all currently certified/licensed professionals. *Additional sheets may be attached if needed.* Copies of licenses are acceptable in lieu of this form.

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| Full Name (Last, First, Middle) | Job Title | Degree(s) | MI Professional License # | Expiration Date | | MCBAP Credential | Expiration Date |
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| Name of professional providing supervision to the licensed staff above per licensing requirement as applicable: | | | | | | | |
| Name: | | | | | Credentials: | | |

Attachment G – Credentialing Information - *Paraprofessionals*

List all paraprofessionals who provide direct service to consumers. *Additional sheets may be attached if needed.*

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| Full Name (Last, First, Middle) | Job Title | Date of Last  Background Check |
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Attachment H – Provider Training Log

Please indicate the completed training requirements for Licensed Providers and non-licensed providers providing direct care to consumers. *Attach additional sheets if necessary.* Copies of training records are acceptable in lieu of this form.

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| Provider Name  (Last, First, MI) | Training  Completed | Date  Completed | # hrs.  If applicable |
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