

PROVIDER NETWORK APPLICATION
As A Provider In The
Community Mental Health Affiliation of Mid-Michigan
Provider Network

Thank you for your interest in becoming a preferred provider of the Community Mental Health Affiliation of Mid-Michigan (CMHAMM) Provider Network of services for persons who have serious mental illness, serious emotional disturbance, developmental disabilities or substance abuse and addictive disorders. The Community Mental Health Affiliation of Mid-Michigan is comprised of the following member boards: Clinton-Eaton-Ingham CMHSP, Gratiot County CMHSP, Ionia County CMHSP, Manistee-Benzie CMH and Newaygo County CMHSP. You may request enrollment as a preferred provider for one or more of the member boards by submitting a copy of your application to the attention of the Contract Management Department at any of the locations listed below. The Member Board (s) for which you have requested enrollment will base determination regarding your status as a provider in this system on an evaluation of the contents of your application. In order for your application to be processed it is important that you review and complete the application carefully and submit all requested documents.

Gratiot County CMHSP

608 Wright Avenue
P. O. Box 69
Alma, MI 48801
Phone (989) 463-4971
Fax (989) 466-5470

**Clinton-Eaton-Ingham
CMHSP**

812 E. Jolly Rd.
Lansing, MI 48910
Phone (517) 346-8200
FAX (517) 346-8245

Ionia County CMHSP

5827 N. Orleans Road
Orleans, MI 48865
Phone (616) 761-2026
Fax (616) 761-3992

Manistee-Benzie CMH

310 N. Glocheski Drive
Manistee, MI 49660
Phone (231)723-6516
Fax (231) 723-1504

Newaygo County CMHSP

1049 Newell
P.O. Box 867
White Cloud, MI 49349
(231) 689-7330
Fax (231) 689-7345

Please indicate the Member Board(s) within the CMHAMM in which you are requesting enrollment:

- CEI Gratiot Ionia Manistee-Benzie Newaygo

<p>Please check the service(s) for which you are qualified/credentialed to provide:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Community Living Supports <input type="checkbox"/> Speech/Language Pathology <input type="checkbox"/> Psychiatry <input type="checkbox"/> Registered Nursing <input type="checkbox"/> Behavior Specialist <input type="checkbox"/> 24 Hour Crisis Line Services <input type="checkbox"/> Home and Community Based Integration Training <input type="checkbox"/> Crisis Residential <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Outpatient Therapy 	<ul style="list-style-type: none"> <input type="checkbox"/> Registered Dietician <input type="checkbox"/> Psychological <input type="checkbox"/> Case Management/Supports Coordination <input type="checkbox"/> Fiscal Intermediary/Guardianship/Payee <input type="checkbox"/> Vocational Training/Employment Services <input type="checkbox"/> Specialized Residential <input type="checkbox"/> Hospital – Partial/Inpatient <input type="checkbox"/> Professional/Technical Consultation <input type="checkbox"/> Transportation <input type="checkbox"/> Facility Management (Maintenance/Janitorial) <input type="checkbox"/> Other
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IDENTIFYING INFORMATION

Name of Organization/Provider: _____

Name & Title of Executive Director: _____

Contact Person: _____

Mailing Address

Billing Address

(Address)

(Address)

(City) (State) (Zip)

(City) (State) (Zip)

() _____ () _____
(Phone Number) (Fax Number)

() _____ () _____
(Phone Number) (Fax Number)

E-Mail Address: _____

Type of Organization:

Governmental Agency

State

County

City

For-Profit Sole Proprietor

For-Profit Partnership

For-Profit Corporation

Non-Profit Corporation

Other: _____

Medicaid Number: _____

Tax ID Number: _____

LICENSURE/CERTIFICATION AND/OR ACCREDITATION

List all licenses the organization holds necessary to provide services (Please attach a current copy with number & expiration date.)

State	Type of License	License Number	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____

List the name of the organization's accrediting or certifying body (whichever is applicable)

Certifying/Accrediting Body	Date Certified	Expiration Date
_____	_____	_____

INSURANCE (Please attach a copy of the face sheet of your current policy)

	Company	Amount of Coverage	Expiration Date
Professional Liability	_____	_____	_____
General Liability	_____	_____	_____
Worker's Compensation	_____	_____	_____
Automobile	_____	_____	_____
Property	_____	_____	_____

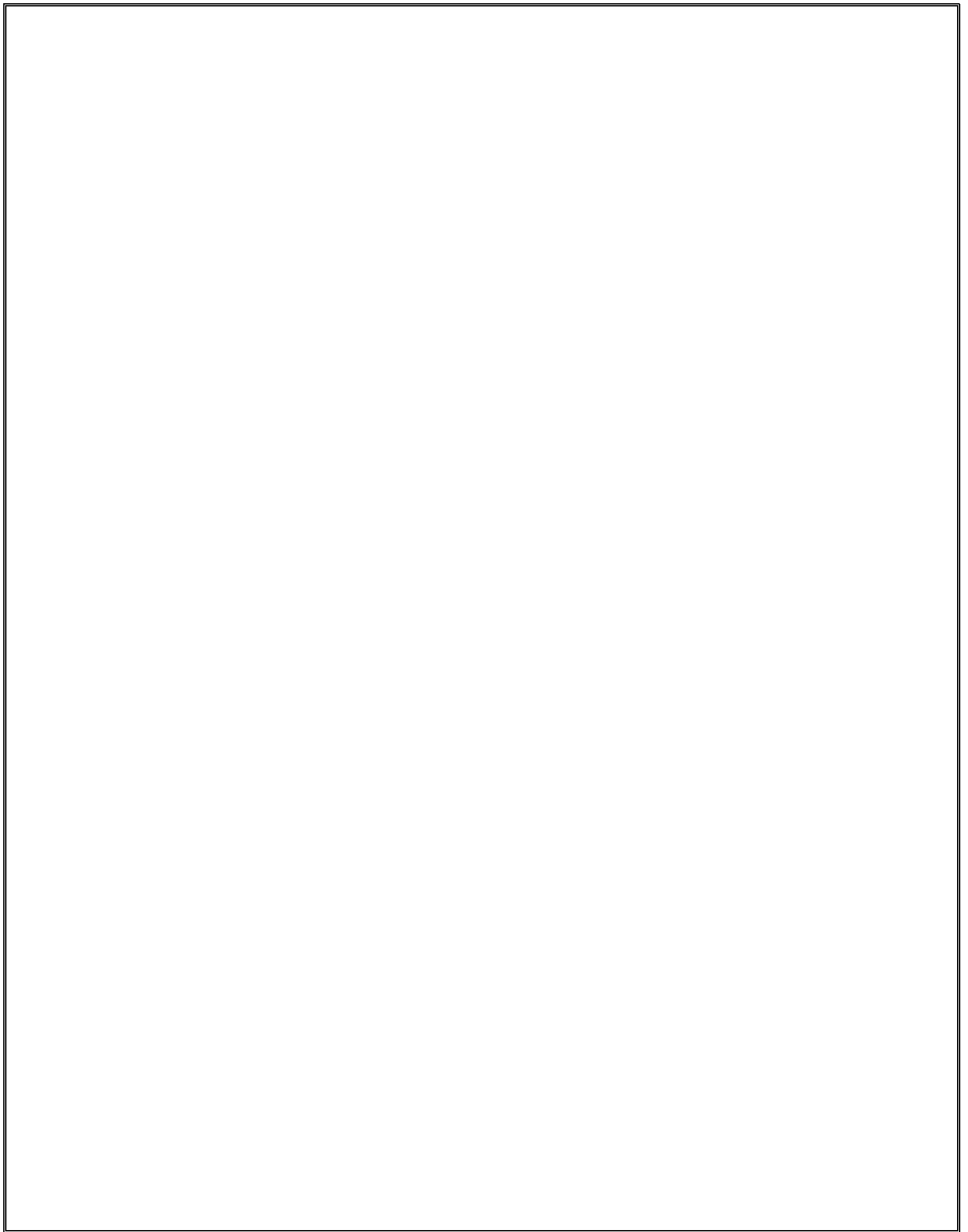
PROVIDER PROFILE

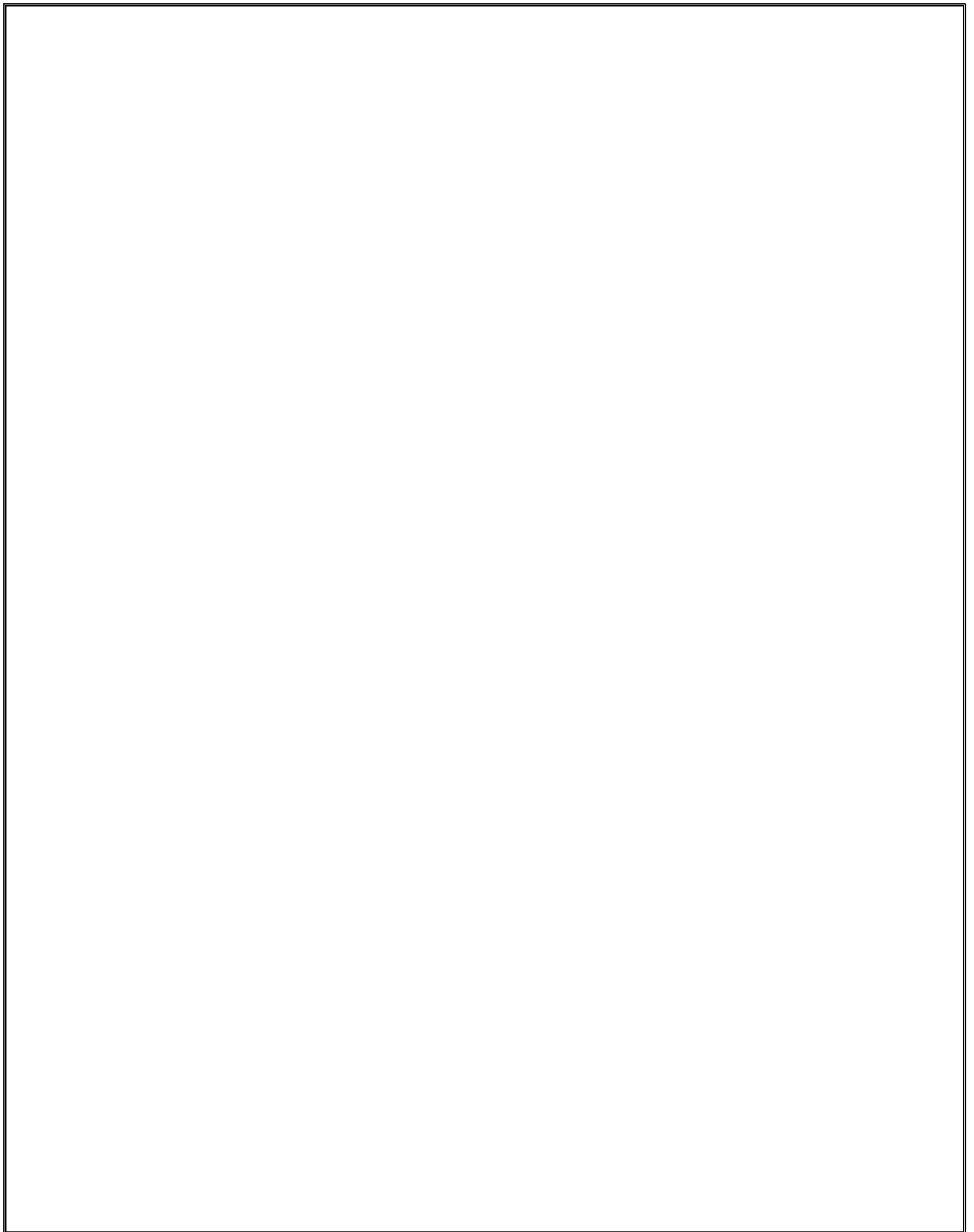
	Yes	No	N/A
1. Has the provider’s state license/certification ever been revoked, suspended or limited?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there action pending to revoke, suspend or limit the provider's license/certification?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the provider ever had its accreditation revoked, suspended or limited?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is there action pending to revoke, suspend or limit the provider's accreditation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the provider ever had any sanctions imposed by Medicare and/or Medicaid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the provider ever been denied professional liability insurance or had its insurance canceled or renewal denied?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the provider ever been a defendant in any lawsuit in regard to the practice of health care, mental health, or substance abuse treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the provider had any malpractice claims in regard to the practice of health care, mental health or substance abuse treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: If you have answered yes to any of the above questions, please provide the current status and details on a separate sheet of paper. Please include a description of the incident, including correspondence with state licensing boards, and/or a detailed description of any litigation, including settlements, court awards, etc. Please feel free to include a personal summary of the events; however, your application will not be processed without the requested documentation for each item.

POLICY AND PRACTICE

	Yes	No	N/A
1. Does the provider have a credentialing policy/practice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the provider conduct primary verification of credentials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the provider have a policy/practice regarding clinical privileging or competencies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the provider have a policy/practice regarding ongoing professional development? (Including orientation, training and retention)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the provider a have policy/practice for access to services? (including timeliness of response to referral, availability of services, access to service site, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the provider have a policy/practice to identify and assist high users of inpatient services?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the provider's policy on treatment planning require person-centered planning?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the provider have a policy on consumer involvement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the provider have a policy/procedure describing case records, record review, security and case record access?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Does the provider have a policy/practice regarding serving multicultural, religious, and/or economically challenged populations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. If medical waste is generated by provider does the provider have a medical waste disposal policy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does the provider have a policy/practice regarding infection control and/or exposure control?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Does the provider have a risk management policy? (including timely and accurate data collection & submission)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Does the provider have a continuous quality improvement (CQI) policy/practice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Does the provider have a mechanism established to monitor the health, safety & welfare of any consumer while under its service supervision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Does the provider have a policy/practice regarding compliance of all Recipient Rights provisions of the Mental Health Code and of the MDCH Rules?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





4C Programs and Services for adults and children with mental illness, developmental disabilities, or substance abuse.
 Please check the programs offered at this site.

Programs/Services	MI Child/ Adolescent Less than 18	MI Adults 18+	MI Older Adult 65+	DD Child	DD Over 17	Substance Abuse
Residential Services:						
Crisis residential programs for respite And stabilization						
Specialized residential services						
Supported independent arrangements						
Community living supports						
Respite care						
Partial Hospital Services						
Inpatient Hospital Services						
Clinical Services:						
Preadmission screening						
Assertive community treatment						
Case management						
Supports coordination						
Psychosocial rehabilitation						
Community integrated services (consumer run)						
Behavioral management services						
Therapy: Individual, group, family and/or child						
Medication, assessment, prescription & management						
Physical, occupational, speech, language, & hearing services						
Psychiatric evaluation/assessment						
Screening, assessment, evaluation, diagnosis, treatment planning						
24-hour crisis line						
Family Support Services:						
Family, consumer, parent information Services						
Family services coordination						
Family Skills Development						
Partial Day Services:						
Prevocational, vocational and integrated employment services & supports						
Community inclusion and integration services						
Specialty services:						
Children's diagnostic & treatment services						
Individual risk reduction						
Information & education						
Prevention and consultation services						
Home-based Services (including Infant Mental Health Services)						
Guardianship/payee services						
Interpreter (Sign/Language)						
Acupuncture						
Substance Abuse/Addictive Disorders						
Residential Substance Abuse						
Methadone Clinic						
Pharmacy						
Other: (specify)						

COMMUNITY MENTAL HEALTH AFFILIATION OF MID-MICHIGAN
PROVIDER APPLICATION
VERIFICATION OF INFORMATION AND
AUTHORIZATION FOR RELEASE OF INFORMATION

For purposes of making this application for participation in the Community Mental Health Affiliation of Mid-Michigan (CMHAMM) Provider Network, the Provider certifies that all information provided to the Member Board(s) is true and correct to the best of the Provider's knowledge and belief. The Provider agrees to promptly notify the Member Board(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 Member Board(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 CMHAMM.

The Provider hereby authorizes the CMHAMM 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 CMHAMM. The Provider agrees to hold the informant and the CMHAMM harmless from any liability to the Provider for providing such information.

The Provider hereby further authorizes the CMHAMM 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 CMHAMM which: (a) provides the CMHAMM 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 CMHAMM harmless from any liability for providing any such information as specified herein.

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 CMHAMM remains in force.

The Provider understands and agrees that submission of an application for enrollment in the CMHAMM Provider Network does not guarantee nor is there any obligation on the part of any of the Member Boards to contract with the Service Provider.

The Provider has reviewed the attached CMHAMM Master Contract and by signing this document below, agrees to participate in the CMHAMM Provider Network, upon acceptance.

The Provider further understands and agrees that: (a) The Provider has the burden of producing all information required or requested by the CMHAMM in connection with this application; (b) The CMHAMM is under no obligation to complete the processing of this application until all information requested is provided; (c) The CMHAMM has the sole discretion to determine whether or not the Provider will be accepted as a participating provider; and (d) in the event that the CMHAMM decides not to accept the Provider as a participating provider, the Provider may appeal the decision.

Appeals Process:

In the event a service provider wishes to appeal a denial of their application the provider must submit a letter to the Chief Executive Officer for which enrollment was denied, within ten (10) days from the date of the determination letter. 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.

Name of Organization: _____

Authorized Representative: _____
(print name) (title)

Signature: _____ Date _____

