LAKESHORE REGIONAL COMMUNITY MENTAL HEALTH SERVICE PROVIDERS
Provider Application and/or Re-Application Packet
(Non-Residential, Residential, SUD, Licensed Independent Practitioners)

CMHSPs: Allegan County Community Mental Health
Community Mental Health of Ottawa County
HealthWest
Network180
West Michigan Community Mental Health

This packet is necessary in order for CMHSPs to have all of the information necessary to contract your services.

Please review/return the forms checked below by: Click here to enter a date.

- ☐ Provider Demographics
- ☐ Specialized Residential – Part A
- ☐ Specialized Residential – Part B
- ☐ All Non-Residential providers – Part A
- ☐ All Non-Residential providers – Part B
- ☐ Insurance Requirements
- ☐ Workers' Compensation Certification
- ☐ Contractor Fiscal Certification Form
- ☐ W-9
- ☐ Disclosure of Ownership & Controlling Interest Statement
- ☐ Policy/Practice Guidelines (completed by all providers except LIP)
- ☐ Attestation Questions (completed by all providers except LIP)
- ☐ Attestation Questions (LIP only)
- ☐ Substance Use Disorder Provider Additional Information (SUD Only)
- ☐ Clinical Application (SUD Only)
- ☐ Training Requirements (review only)
- ☐ Other: _____

Authorized Provider Signature:

Your authorized Provider Signature on this page verifies that you have reviewed the Provider Application and/or Re-Application Packet and attachments, and all information returned to the CMHSP is accurate, complete, and truthful. You may be asked to provide this information during audits through MDHHS, LRE, and/or your local CMHSP.

_____ _____
Provider Signature Date

_____
Provider Printed Name

PROVIDER DEMOGRAPHICS

Provider Legal Name:			
Mailing Address:			City:
State:	Zip:	Phone:	Fax:
Website:			
Primary Contact:			Title:
E-mail Address:			
Authorized Individual to sign contract			
Name:		Title:	
Phone:		E-mail Address:	
Contract Manager (Applicant agency's employee in charge of contracts management and communication.)			
Name:		Title:	
Phone:		E-mail Address:	
Finance/Business Manager (Applicant agency's employee in charge of finance.)			
Name:		Title:	
Phone:		E-mail Address:	

The Vendor/Provider name, address, website, and phone number above will be listed on our Provider Directory along with the services you provide and the population you serve. If you would like a different address or phone number listed, please attach an additional demographics page indicating that information.

☐ Check if Vendor or Provider name has changed in the past year or is referred to by other legal name on insurance or financial documents.
Provide Detail:

☐ Check if accredited –Accreditation Source (CARF, TJC, etc.)

☐ Check if accreditation plan of correction has been required of your agency.

Note: Please attach full accreditation report that includes each location, plans of correction and corrective action reports.

SPECIALIZED RESIDENTIAL – Part A
Demographic and License Information

Provider Name *(Agency that will carry out the project, if different from applicant. Must also be a legal entity):*			
Street:			City:
State:	Zip:	Phone:	Fax:
Primary Contact:			Title:
E-mail Address:			

List Licensed Homes Currently Contracted With CMHSPs
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.

Homes You Would Like to Add to the Contract With CMHSPs
1.
2.
3.
4.
5.

SPECIALIZED RESIDENTIAL – Part B
Demographic and License Information
(Print additional sheets as needed for each home.)

Home Name:		
Street:		City:
State:	Zip:	Phone:
Home License Number:		

Staffing Information			
Supervisor Name:			
Normal Work Schedule (days and hours):			
On-site Phone #:		Alt Phone #:	
Designated back-up Supervisor:			
On-site Phone #:		Alt Phone #:	
Direct Care Staff Information			
Total Number of Full Time Staff:		Number of sleep staff on at night:	
Total Number of Part-Time Staff:		Number of awake staff on at night:	
Total # of Full Time Equivalents (FTEs):			
What is your staffing back-up process for unexpected staff shortages, if any:			
Consumer Information			
Is staff available in home/facility when no consumers are present?		☐Yes ☐No	
If no, describe capacity to meet needs of a consumer who remains or returns home when staff are not scheduled to be present.			
Population(s) Served:	☐ MI ☐ IDD ☐ SUD ☐ SED		
	☐ Child ☐ Adult ☐ Older Adult		

SPECIALIZED RESIDENTIAL – Part B (continued)

Home Specific Service Description and Capacity Information

Please review the Eligibility Guidelines in the Medicaid Provider Manual and describe the services you provide. If you are a current contract provider, please review **Attachment As** to your contract and provide additional detail for completed or anticipated changes to that description:

Michigan Medicaid Provider Manual
http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

Home Demographics *Mark all that are applicable.*		
Total # of bedrooms ___	Total # of singles ___	Total # of doubles ___
Home/facility is barrier free		☐Yes ☐No
Bedrooms located on main floor		☐Yes ☐No
Are pets allowed?		☐Yes ☐No
Ability to provide:		
Locking bedroom doors		☐Yes ☐No
Locking bathroom doors		☐Yes ☐No
Kitchen available/access to food at all times		☐Yes ☐No
Residents sign an individual lease		☐Yes ☐No
Choice of roommates		☐Yes ☐No
Ability to decorate		☐Yes ☐No
Visitors allowed at all times		☐Yes ☐No
Average # of opportunities for community integration per week:		
Home/facility includes special physical/medical equipment:		
Wheelchair ramp		☐Yes ☐No
Walk-in showers		☐Yes ☐No
Staff availability	☐awake staff ☐sleep staff	
Residence serves	☐Male ☐Female ☐Coed	
Population(s) Served:	☐MI ☐IDD ☐SUD ☐ SED	
Speciality	☐Hearing Impaired ☐Visually Impaired ☐Speech Impaired ☐TBI ☐Autism ☐Behavioral ☐Medical ☐Other _____	
Location	☐Rural ☐Suburban ☐Urban	
Additional Detail:		

ALL NON-RESIDENTIAL PROVIDERS – Part A
Demographic and License Information

Provider Name *(Agency that will carry out the project, if different from the applicant. It must also be a legal entity.)*:			
Street:			City:
State:	Zip:	Phone:	Fax:
Primary Contact:			Title:
E-mail Address:			
Clinical Supervisor (if applicable):			Title:
E-mail Address:			

Licensure/Certification:			
Do you have professional staff who are State licensed/certified?			☐ Yes ☐ No
(If yes, complete the following license information for each State licensed/certified individual.)			
Staff Name:		Type:	
MI License #:		Exp. Date:	
NPI #:			
Staff Name:		Type:	
MI License #:		Exp. Date:	
NPI #:			
Staff Name:		Type:	
MI License #:		Exp. Date:	
NPI #:			
Staff Name:		Type:	
MI License #:		Exp. Date:	
NPI #:			
Staff Name:		Type:	
MI License #:		Exp. Date:	
NPI #:			
Staff Name:		Type:	
MI License #:		Exp. Date:	
NPI #:			

ALL NON-RESIDENTIAL PROVIDERS – Part B
Demographic and License Information
(Print additional sheets as needed for each program/facility.)

Program/Facility Name:		
Street:		City:
State:	Zip:	Phone:
License Number *(if applicable)***:**		**Expiration date:**

Staffing Information	
Supervisor Name:	
Normal Work Schedule (days and hours):	
On-site Phone #:	Alt Phone #:
Designated back-up Supervisor:	
On-site Phone #:	Alt Phone #:
Staff Information	
Total Number of Full Time Staff:	
Total Number of Part-Time Staff:	
Total # of Full Time Equivalents (FTEs):	
Consumer Information	
Population(s) Served:	☐ MI ☐ IDD ☐ SUD ☐ SED ☐ Child ☐ Adult ☐ Older Adult
Facility Information *Mark all that are applicable.*	
Home/Facility is barrier free	☐Yes ☐No
Home/Facility includes special physical/medical equipment (lifts, etc). If yes, describe:	☐Yes ☐No
All consumer areas are located on the main floor. If no, describe:	☐Yes ☐No

ALL NON-RESIDENTIAL PROVIDERS – Part B (continued)

Service Description

Please review the Eligibility Guidelines in the Medicaid Provider Manual and describe the services you provide. If you are a current contract provider, please review **Attachment A** to your contract and provide additional detail for completed or anticipated changes to that description:

Michigan Medicaid Provider Manual
http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

Type of Service(s) provided: *(check all that apply)*

☐	Assertive Community Treatment (ACT)	☐	OBRA PASSAR
☐	Applied Behavioral Analysis	☐	Peer-Delivered or Operated Support Serv
☐	Assessments	☐	Personal Care – Residential Setting
☐	Behavior Treatment Review	☐	Private Duty Nursing
☐	Children's Waiver	☐	Psychiatric Services
☐	Clinical Services (OT, PT, SHL)	☐	Respite
☐	Community Living Supports	☐	SED Waiver
☐	Clubhouse	☐	Skill Building - Nonvoc/Prevoc
☐	Crisis Intervention	☐	SUD Community-Based Treatment
☐	Crisis Residential	☐	SUD Medication Assisted Treatment
☐	Direct Prevention	☐	SUD Outpatient
☐	Enhanced Pharmacy	☐	SUD Residential Treatment and Recovery
☐	Family Support & Training	☐	SUD Residential Withdrawal Management
☐	Fiscal Intermediary	☐	Supported Employment
☐	Health Services	☐	Supports Coordination
☐	Home-Based Services	☐	Targeted Case Management
☐	Housing Assistance	☐	Transportation
☐	Individual/Group Therapy	☐	Treatment Planning
☐	Intensive Crisis Stabilization	☐	Wraparound
☐	Nursing Facility MH Monitoring	☐	Other _____

INSURANCE REQUIREMENTS

Certification of the following required insurance, which is written by (an) insurer(s) licensed or authorized to do business in Michigan and which have one of the four "A" ratings by The A.M. Best Company as of the date of this Service Contract, must be provided prior to execution of this contract and maintained as current throughout the term of the contract.

The Contractor agrees to maintain the following insurance pertaining to the operation of the program funded under this contract which shall include at least (check all that apply):

☐ Workers' Compensation:
Required for all Providers who meet the Federal requirements. Includes Employers' Liability Coverage, in accordance with all applicable Statutes of the State of Michigan.
(Complete attached Waiver of Workers' Compensation, if you meet criteria.)

☐ Commercial General Liability:

☐ Category I: Comprehensive form including premises/operations and blanket contractual Liability and products and completed operations. *Minimum amounts:* $1,000,000/occurrence and/or $3,000,000 aggregate for Personal Injury, Bodily Injury and Property Damage: (Broad Form). Required for group homes, residential facilities, hospitals, etc., and anyone serving CMHSP clients in their facilities.

☐ Category II: Comprehensive form including premises/operations and blanket contractual liability. *Minimum amounts:* $100,000.00/occurrence and/or $300,000.00 aggregate for Personal Injury, Bodily Injury and Property Damage. Only acceptable for family home with licensee residing on site.

☐ Automobile Liability:
Michigan No-Fault coverage and residual liability. Comprehensive form covering owned, non-owned and hired automobiles. Minimum amounts: No-fault coverage statutory. Combined single limit of $1,000,000.

☐ Employee Dishonesty Insurance (SUD only):
Anyone who handles the funds of any individual served by CMHSP will be covered by Employee Dishonesty insurance up to $100,000 per loss. This coverage shall extend to loss of or damage to money, securities or other property of any individual served by CMHSP if the property is in the care, custody, or control of the Provider or of a subcontractor, or if the Provider or subcontractor, is legally liable for such money, securities, or other property.

☐ Professional Liability: Coverage to extend to all operations and all employees hired or retained by the Provider and shall include contractual liability.

☐ Category I: (Psychiatrists, social workers, psychologists, RNs, Residential facilities with professional staff including Child Caring Institutions, hospitals, partial hospitalization programs, crisis residential programs, and Day Programs with professional staff including vocational and skill-building programs.) Minimum $1,000,000 per occurrence and $3,000,000 aggregate.

☐ Category II: (i.e., interpreters/translators, consulting physicians) Minimum $100,000 per occurrence and $300,000 aggregate.

INSURANCE REQUIREMENTS (continued)

☐ Umbrella/Excess Liability:
Corporations leasing vehicles from CMHSP to transport individuals served by CMHSP will carry $1,000,000 per occurrence umbrella/excess liability coverage.

☐ Contracted Non-Professionals: (e.g., consultants, trainers, software contractors, actuarial services, etc.) No insurance required.

ADDITIONAL INSURED
The CMHSP shall be identified as an Additional Insured as necessary to protect its interests on any insurance policies referenced in the above paragraphs.

EXPIRATION OF POLICY
If, during the term of this Contract, any of the insurance coverages required above expire, otherwise terminate, or change substantially as to scope so as to make it no longer compliant with these requirements, the Provider shall deliver renewal certificates to the CMHSP at least fifteen (15) business days prior to the date of termination or change.

WORKERS' COMPENSATION CERTIFICATION

Provider hereby certifies by the execution of this Attachment that at the time of this Agreement, it was not an employer or an employee subject to the Michigan Worker's Disability Compensation Act of 1969.

Provider specifically certifies:

A. It is a private employer who does not employ three (3) or more employees at a time, or

B. It is a private employer who does not employ a worker for thirty-five (35) or more hours per week for any thirteen (13) weeks during the fifty-two (52) weeks of this contract, or

C. It never had more than two (2) employees at once and zero (0) employees for forty (40) of the fifty-two (52) weeks of this contract.

Provider understands and agrees that any changes in the facts to the certification as listed in this Attachment and during the term of this Agreement must be communicated to the Payor immediately, or in no event later than forty-eight (48) hours after the change occurs.

Signature	Date
Name and Title	Telephone Number

CONTRACTOR - FISCAL CERTIFICATION FORM

(Page 1 of 3)

1. Organization Legal Name:	

2. Organization Type:	☐	Private Organization
	☐	For Profit Organization
	☐	Non-Profit Organziation
	☐	Corporation (Type):
	☐	Other:

3. Provide date your organization or business was established:	

4. Federal ID Number or Social Security Number:	

5. Provide the following:	Agency NPI Number:	
	Agency Medicaid Number:	
	Agency Mediare Number:	

6. ☐ Attached a completed W-9 Form?

7. Does your organization use the services of an accountant?		☐Yes ☐No
If "yes", provide name and address of accounting firm or person handling the records.		
Name:		
Address:		
City:	State:	Zip Code:

8. Organization is under audit or investigation by private or public Federal, State or Local Agency?	☐Yes ☐No
If "yes", provide detail:	

9. Accounting Certification (please provide the following):	
☐	Contractor receiving $750,000 or more of contract funding shall ensure the completion of annual audit by a Certified Public Accountant (CPA).
☐	Contractor receiving under $750,000 and more than $100,000 of contract funding shall ensure the completion of annual audit by a Certified Public Accountant (CPA) or Accountant Certification Letter (See attached form, if preferred): (Must be an Accountant outside of your agency/company.)
☐	Other contractors may be requested to provide a completed budget.

CONTRACTOR - FISCAL CERTIFICATION FORM

(Page 2 of 3)

Please identify contact person we may call to discuss this questionnaire:			
Name:		Telephone Number:	
Title:			

To be completed by CMHSP staff:

Date of Review: **Click here to enter a date.**

Review Comment(s)/Recommendations: _____

CMH Finance Staff Reviewer: _____

Contractor
ACCOUNTANT CERTIFICATION FORM
(Page 3 of 3)

Vendor/Organization Name: _____

I have reviewed the accounting system the above named organization has established. In my opinion, the organization: has internal controls adequate to safeguard its assets; maintains accurate and reliable accounting data; promotes operating efficiency; encourages compliance with its prescribed management policies, and is financially capable of managing the services of this contract.

Please indicate date of last audit: _____

_____ _____
Signature of Accountant Date

_____
Printed Name

_____
Address

_____
City State Zip code

_____
Telephone Number

_____
Fax Number

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
___ - ___ - ____

or

Employer identification number
__ - _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person ▶** | **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Cat. No. 10231X — Form **W-9** (Rev. 12-2014)

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

*Note. Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

LAKESHORE REGIONAL ENTITY

Disclosure of Ownership & Controlling Interest Statement

Lakeshore Regional Entity (LRE) 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 Prepaid Inpatient Health Plan (PIHP). This requirement 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 LRE managed care network for services to members under Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program. Failure to submit the requested information may result in a refusal of participation in LRE 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 (at least every two years); within 35 days after any change in ownership of the disclosing entity. A Statement must be provided to LRE within 35 days of a *request* for this information by the U.S. Department of Health and Human Services (HHS) or the State Agency. LRE 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. LRE is committed to protecting information about its providers and associates, especially the confidential nature of their personal information.

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

Provider/Provider Entity 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'.

<table>
<tr><td rowspan="8">Please choose appropriate category:
☐ Provider Entity
☐ Licensed Independent Practitioner
☐ Managing Employee
☐ HCBS Provider
☐ Other:

Group Affiliation? ☐Yes ☐No
If yes, do you have a private practice as well?
☐Yes ☐No</td><td colspan="2">Name of Provider/Provider Entity:</td></tr>
<tr><td colspan="2">Name of Person Completing form:</td></tr>
<tr><td colspan="2">Title:</td></tr>
<tr><td colspan="2">Phone Number:</td></tr>
<tr><td colspan="2">Fax Number:</td></tr>
<tr><td colspan="2">Email:</td></tr>
<tr><td colspan="2">In which state(s) do you participate in Medicaid?</td></tr>
<tr><td colspan="3">Additional Addresses (list all Practice Locations):
Attaching list? ☐Yes ☐No</td></tr>
<tr><td>SSN # (if individual Provider): ☐ N/A</td><td>☐ Medicaid ID #:
☐ Applied for Medicaid ID
☐ Not applicable</td><td>☐ NPI #:
☐ Applied for NPI #
☐ Not applicable</td></tr>
<tr><td>Federal Tax ID# (if Entity): ☐ N/A</td><td colspan="2"></td></tr>
</table>

LAKESHORE REGIONAL ENTITY

Disclosure of Ownership & Controlling Interest Statement

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 entity/practice? ☐ Yes ☐ No - Skip to #2 ☐ N/A - 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 disclosing entity 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:		

*** 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

2. Does the *Owner identified in Section I* have an Ownership or Controlling Interest in *any other* provider entity? ☐ Yes ☐ No - Skip to #3 ☐ N/A - 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)

Section II: Ownership in Other Providers & Entities

3. Do you, as the Provider Entity, have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor? ☐ Yes ☐ No - Skip to #4 ☐ N/A - 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

4. Are any of the individuals identified in Sections I, II, or III related to each other?
☐ Yes ☐ No - Skip to #5 ☐ N/A - 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

5. Have you or any person who has Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Provider Entity ever been indicted or convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, CHIP, or Title XX programs?
☐ Yes ☐ No - Skip to #6 ☐ N/A - 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:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**State and Date of Conviction:**
Matter of the Offense:	**Date of Reinstatement:**

6. Have you or any person who has Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Provider Entity ever been sanctioned, excluded, or debarred from Medicaid, Medicare, CHIP, or Title XX programs?
☐ Yes ☐ No - Skip to #7 ☐ N/A - 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:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**List all states where currently excluded:**
Reason for Sanction, Exclusion, or Debarment:	
Date(s) of Sanctions, Exclusions, or Debarments:	**Date of Reinstatement:**

7. Has the Provider Entity, or any person who has 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 Title XX programs? ☐ Yes ☐ No - Skip to #8 ☐ N/A - Skip to #8

If yes, list those persons and the required information below (42 CFR §455.416).

Attach additional sheets as necessary ☐Yes ☐No

Name:	**DOB:**
Address:	**SSN (indiv.) or TIN (entity):**
City, State, Zip:	**Terminated from Medicare?** ☐Yes ☐No
Reason for Termination:	**Date of Termination:**
State that originated Termination:	**Date of Reinstatement:**

**At any time during the Contract period, it is the responsibility of the Provider/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

8. **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 ☐ N/A - 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:**

9. **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 ☐ N/A - 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:**

10. **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 ☐ N/A - 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

11. **Managing Employees:** Does the Provider Entity have any Managing Employees?
☐ Yes ☐ No - Skip to #12 ☐ N/A - 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

12. **Agents:** Does the Provider Entity have any Agents? ☐ Yes ☐ No ☐ N/A

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

Through signature below, I hereby certify that any employees or contractors providing services pursuant to a contract with Lakeshore Regional Entity 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 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:		**Email:**	

LAKESHORE REGIONAL ENTITY

Disclosure of Ownership & Controlling Interest Statement

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.
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.

LAKESHORE REGIONAL ENTITY

Disclosure of Ownership & Controlling Interest Statement

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:

a) *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.

b) *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:

a) 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);

b) Any Medicare intermediary or carrier; and

c) 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

a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

d) 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;

e) Is an officer or director of a disclosing entity that is organized as a corporation; or

f) 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 care 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.

POLICY AND PRACTICE GUIDELINES

(To be completed by all provider types except Licensed Independent Practitioners)

Listed below are MDHHS/CMHSP mandatory policies. You must have approved policies in place to be a CMHSP provider. **You may choose to adopt the CMHSP policies as they appear in the CMHSP Provider Manual or you may write your own and attach each to this section of your application.**

Please check the CMHSP Provider Manual located on the CMHSP website for periodic revisions of CMHSP policies.

All providers are required to develop and implement procedures to assure compliance with each required policy. Evidence of staff training and compliance must be available for MDHHS, LRE, and/or CMHSP audit.

Instructions: Check "CMHSP" box only if you have adopted the CMHSP policy. Check "Vendor" box if you have developed your own policy. *If you checked "Vendor" you must attach your policy.*

CMHSP	Vendor	Policy
☐	☐	Recipient Rights
☐	☐	Person-Centered Planning/Treatment Planning
☐	☐	Corporate Compliance Program
☐	☐	Policies Regarding Credentialing and Re-Credentialing of Staff
☐	☐	Accommodations/Limited English Proficiency
☐	☐	Cultural Competency
	☐	Environment of Care: ☐ Life Safety ☐ Clinical Equipment ☐ Utilities ☐ Security ☐ Emergency Preparedness ☐ Hazardous Materials ☐ Waste and Chemicals ☐ Not Applicable – check this box if you do not provide services at an office/facility site. If checked, skip E.O.C.
☐	☐	Infection Control
☐	☐	Criminal Background Checks
☐	☐	Practice Guidelines - *MDHHS Practice Guidelines website: http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_4899---,00.html*

ATTESTATION QUESTIONS

(To be completed by all provider types except Licensed Independent Practitioners.)

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? *If you answer yes to any of the following, attach full explanation.*	
1. License/Certificate to operate in the State of Michigan	☐ Yes ☐ No
2. Accreditation (treatment providers only)	☐ Yes ☐ No
3. Professional Liability Insurance	☐ Yes ☐ No
4. Malpractice suits settled resulting in a judgment against your in the past five (5) year, or currently pending?	☐ Yes ☐ No
5. Are any malpractice judgements pending?	☐ Yes ☐ No
6. Within the past ten (10) years, has your organization ever been convicted of, or plead guilty to, a criminal offense?	☐ Yes ☐ No
7.	
8. 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
9. Have your organization had any Medicaid, Medicare, or other governmental or third-part payor sanctions?	☐ Yes ☐ No
10. Has your organization ever been excluded from the Medicaid or Medicare program? *If yes, specific date:* *Date of reinstatement:*	☐ Yes ☐ No
11. Have civil and monetary penalties been levied against your organization by Medicare or Medicaid programs?	☐ Yes ☐ No
12. You must provide, at minimum, the prior 5 year's history of any professional liability claims resulting in a judgement or settlement.	☐Attached ☐N/A

ATTESTATION QUESTIONS

(To be completed by Licensed Independent Practitioners only.)

Privileges, Licensure, and Malpractice History *(If you answer yes to any of the following, attach full explanation.)*	
1. Have you ever had any privileges revoked, suspended, or restricted?	☐ Yes ☐ No
2. Have you ever been dismissed from a hospital or behavioral healthcare organization staff?	☐ Yes ☐ No
3. Have you ever had a hospital initiate suspension, restriction, dismissal or been refused or denied privileges?	☐ Yes ☐ No
4. Have you ever voluntarily surrendered any privileges?	☐ Yes ☐ No
5. Have you ever surrendered privileges upon threat of censure, restriction, suspection, or revocation of privileges?	☐ Yes ☐ No
6. Have any of your licenses or certifications been suspended, revoked, placed on probation or conditional status, restricted, or voluntarily surrendered?	☐ Yes ☐ No
7. Is any action currently pending to suspend, revoke, or restrict any of your licenses or certifications?	☐ Yes ☐ No
8. Have you been subject to any disciplinary proceedings by any local, state, or national professional organization?	☐ Yes ☐ No
9. Have any malpractice claims ever been filed against you, or to the best of your knowledge, are there any claims currently pending in regard to the practice of mental health or substance use treatment?	☐ Yes ☐ No
10. Have any malpractice allegations involving your work been settled by you or your carrier prior to the filing of a claim?	☐ Yes ☐ No
11. Have you ever been denied professional liability insurance, had your insurance cancelled, or your renewal denied?	☐ Yes ☐ No
12. Have you ever been a defendant in any lawsuit in regard to the practice of health or substance use treatment?	☐ Yes ☐ No
13. You must provide, at minimum, the prior 5 year's history of any professional liability claims resulting in a judgement or settlement.	☐Attached ☐N/A

SUD PROVIDER ADDITIONAL INFORMATION

(To be completed by SUD providers only.)

Please indicate which services you are applying for: ☐ Block Grant ☐ Medicaid

SPECIALITY DESIGNATION					
☐	Coexisting Mental Disorders	☐	Hispanic	☐	Older Adult
☐	Adolescent	☐	African American	☐	Native American
☐	Women and Families	☐	Deaf/Hearing Impaired	☐	Other_____

DRUG ENFORCEMENT AGENCY (Narcotics) LICENSE (If applicable) *Please attach a copy of current license.*		
DEA Registration Number	Date Issued	Expiration Date

PROFESSIONAL LIABILITY INSURANCE (If not covered by agency's insurance) *Please attach a copy of current policy face sheet indicating coverage and expiration date.*		
Present Carrier:	**Carrier Address/City/State/Zip:**	
Policy Number:	**Level of Coverage:** _____Per Occurrence/_____Per Aggregate	**Expiration Date:**

MEDICAL DIRECTOR	
Name and Title:	**Employment Status with Agency:** ☐ Consulting ☐ Salaried ☐ Contractual Number of hours available weekly

Hospital Affiliation

List hospital where medical director currently has staff privileges and type of privilege.
If privilieges are restricted or other is indicated, please provide explanation on an attached sheet.

Hospital Name/City	Type of Privilege Full Courtesy Restricted Other				Type of Facility Psychiatric	General/Medical
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

Medical Specialty:

Secondary Specialty:

Medical Training

	Institution and City	Type	Date Completed
Internship			
Residencies			
Fellowships/ Preceptorships			

Board Certification

Board Name	Date Certified	Date Recertified

If currently not certified, please explain on a separate sheet and attach.

Community Mental Health of Ottawa County HealthWest West Michigan Community Mental Health

CLINICAL APPLICATION

(To be completed by SUD providers only.)
(Page 1 of 2)

Entire section beneath staff name must be completed.				
Agency and Site:				
Staff Name:	*First:*	*MI:*	*Last:*	
	Date of Hire:	Position:		
	Date Began Providing Services to CMH clients:			
	Date of Criminal Background Check:			
	Date Medicaid Sanctioned List Checked:			
	Date Communicable Disease Training Completed:			
	Staff has at least 2,000 hrs of experience in SUD services:			☐ Yes ☐ No ☐ N/A
Type of Staff:	☐	Treatment Supervisor with CCS-M: or CCS-R: or DP-CCS:		
	☐	SATS - Complete information under items # 1, 3, & 4		NPI#:
	☐	SATP - Complete information under items # 2, 3, & 4		NPI#:
	☐	Specifically Focused Staff (specify): *(See items # 3, 6, or 7)*		
	☐	Treatment Adjunct Staff (specify):		
	☐	Intern – Internship Completion Date:		

1) **Substance Abuse Treatment Specialist:** In order to qualify as a substance abuse treatment specialist an individual must meet the criteria detailed in **any one of** the following three categories **and** be supervised* by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.

Please select the appropriate category below and provide the information requested below the item:

☐	Possesses one of the following certifications from the Michigan Certification Board of Addiction Professionals OR a Development Plan for achievement. Please identify which certification and list expiration date: ☐ CADC ☐ CADC-M ☐ CAADC ☐ CCJP-R ☐ CCDP ☐ CCDP-D ☐ Dev. Plan MCBAP Certification Expiration Date:
☐	Individual has a development plan with MCBAP **and** possesses one of the following licensures: MD/DO, PA, NP, RN, LPN, LP, LLP, TLLP, LPC, LLPC, LMFT, LLMFT, LMSW, LLMSW, LBSW, or LLBSW. License: License Expiration Date: MCBAP Dev. Plan Expir. Date:
☐	Individual possesses one of the following alternative certifications. Please identify which certification: ☐ ASAM ☐ APA ☐ UMICAD Certification Expiration Date:

2) **Substance Abuse Treatment Practitioner:** In order to qualify as a substance abuse treatment practitioner an individual must have a MCBAP development Plan in place **and** be supervised* by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.

MCBAP Development Plan Expected Completion Date:

CLINICAL APPLICATION

(Page 2 of 2)

3) **Levels of Care to be Provided:** ☐ Outpatient ☐ IOP ☐ Detox ☐ Residential ☐ Methadone
Service Categories: ☐ Assessment ☐ Individual ☐ Residential ☐ Methadone ☐ *Case Management * * (See # 6, if marked)* ☐ *Peer Recovery Support * * * (See # 7, if marked)*

4) **This employee has a** ☐ Masters **or** ☐ Bachelors **degree in one of the following:**	
☐	Social Work
☐	Guidance & Counseling
☐	Other counseling related field, please specify:
☐	Clinical Psychology

5) **This employee has current licensure as a phsyican or Ph.D. psychologist.**	☐ Yes ☐ No

6) *** * This employee has additional education, training, or experience qualifications for performing the duties of this position.**	☐ Yes ☐ No
If yes, please describe (attach additional sheet(s) if necessary:	

7) *** * * Peer Recovery Support.** Please attach an additional sheet to include responses to ALL of the following:	
☐	Three (3) references of support;
☐	Current support system for PRS staff;
☐	Program's selection criteria for hiring PRS staff;
☐	How his/her recovery was verified and how recovery will be monitored;
☐	Date of his/her last treatment (if applicable);
☐	Specify types of services to be provided by PRS Asssociate orPRS Coach;
☐	Documentation of training received.

Supervisor Name and Certification (please type or print): _____

**Supervision for SATS and SATP staff must be provided by an individual with a CCS-M, CCS-R certification, or who has a registered development plan to obtain one of these certifications.*

Program Director's Signature Below attests to the accuracy and completeness of all verification information in compliance with the most recent Treatment and Prevention Staff Qualifications and Credentialing Requirements Policy for the following:

Community Mental Health of Ottawa County
HealthWest (formerly known as CMHS of Muskegon County)
West Michigan Community Mental Health

Program Director's Signature: _____ Date:

TRAINING REQUIREMENTS BY SERVICE

	Applied Behavioral Analysis	ACT	Assessment	Behavior Treatment Review	Children's Waiver	Clinical Services –(OT/PT/SLP)	Clubhouse	CLS (Non-Specialized setting)	Crisis Intervention	Crisis Residential	Direct Prevention	Enhanced Pharmacy	Family Support and Training	Fiscal Intermediary	Health Services	Home Based	Housing Assistance	Intensive Crisis Stabilization	Ind. Adult/Family/Group Tx.	Nursing Facility MH Monitor.
1. Advance Directives		x							x	x										x
2a. Behavioral Treatment/Crisis Intervention (MANDT) - **Relational**		R					R		x	x±						R		x		
2b. Behavioral Treatment/Crisis Intervention (MANDT) - **Conceptual**		R					R			x±						R				
2c. Behavioral Treatment/Crisis Intervention (MANDT) - **Technical**										x*±										
3. Corporate Compliance	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x
4. Cultural Competence	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x		x	x	x
5. Emergency Preparedness										x										
6. Knowledge of First Aid					x			x												
7. First Aid Certification	x									x										
8. CPR Certification					x					x										
9. Grievance and Appeals	x	x	x	x	x	x	x	x	x	x			x		x	x		x	x	x
10. Health & Wellness										x										
11. HIPAA	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x
12. Introduction to Human Services										x										
13. Limited English Proficiency (LEP)	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x		x	x	x
14. Medication Series										x										
15. Nutrition & Food Safety										x										
16. Person-Centered Planning & Self-Determination	x	x	x	x	x	x	x	x	x	x						x		x	x	x
17. Recipient Rights	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
18. Standard Precautions	x	x	x		x	x	x	x	x	x	x		x		x	x		x	x	x
19. Trauma Informed Care		x	x	x	x	x	x	x	x	x	x		x		x	x		x	x	x

R Recommended
¥ Adult population only
For Self-Directed Arrangements, please refer to S.D. Agreement

** Waiver from participation in MANDT **Conceptual or Technical** session is available upon request and approval from the contracting CMHSP.*
± Waiver from participation in MANDT for Children's Specialized Residential Settings or residential settings where there are multiple payors is available upon request and approval from contracting CMHSP

TRAINING REQUIREMENTS BY SERVICE

	OBRA PAS/SAR	Peer Delivered Services	Personal Care/CLS in Specialized Res. Setting	Private Duty Nursing	Psychiatric Services	Respite	Skill Building	SUD Community Based Tx	SUD Medication Assisted Tx.	SUD Outpatient Tx.	SUD Residential Treatment	SUD Res. Withdrawal Mgmt.	Supported Employment	Supports Coordination	Targeted Case Management	Transportation	Treatment Planning	Wraparound
1. Advance Directives								X	X	X	X	X		X¥	X¥		X	
2a. Behavioral Treatment/Crisis Intervention (MANDT) - **Relational**			X±					R			R	R		R	R			
2b. Behavioral Treatment/Crisis Intervention (MANDT) - **Conceptual**			X±					R			R	R		R	R			
2c. Behavioral Treatment/Crisis Intervention (MANDT) - **Technical**			X±															
3. Corporate Compliance	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
4. Cultural Competence	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
5. Emergency Preparedness			X															
6. Knowledge of First Aid						X	X											
7. First Aid Certification			X															
8. CPR Certification			X															
9. Grievance and Appeals	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
10. Health & Wellness			X															
11. HIPAA	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X
12. Introduction to Human Services			X															
13. Limited English Proficiency (LEP)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
14. Medication Series			X															
15. Nutrition & Food Safety			X															
16. Person-Centered Planning & Self-Determination		X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X
17. Recipient Rights	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
18. Standard Precautions	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
19. Trauma Informed Care	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

R Recommended
¥ Adult population only
For Self-Directed Arrangements, please refer to S.D. Agreement

** Waiver from participation in MANDT **Conceptual or Technical** session is available upon request and approval from the contracting CMHSP.*
± Waiver from participation in MANDT for Children's Specialized Residential Settings or residential settings where there are multiple payors is available upon request and approval from contracting CMHSP

LAKESHORE REGIONAL ENTITY
TRAINING REQUIREMENTS: FREQUENCY AND METHOD

TRAINING	DESCRIPTION	FREQUENCY	WHEN	HOW TO OBTAIN	REQUIREMENT
1. Advance Directives	This training will cover: • the types of Advance Directives (AD) • Why have an AD • Who may create an AD • The powers of a patient advocate • The role of the clinician in AD • Where to find additional information about AD	Initial & Every 2 years	Initial • < 30 days of hire and prior to working independently with individuals served Ongoing • Every 2 years	Initial & Ongoing • CMH classroom training if available • Lakeshore LMS online course (being developed) • As otherwise approved by CMH	• MDHHS Contract section 6.8.6 on Advance Directives
2a. Behavioral Treatment / Crisis Intervention (MANDT) **RELATIONAL**	Mandt Relational stresses the importance of building positive, healthy relationships with everyone. Chapters include: • Healthy Relationships • Healthy Communication • Healthy Conflict Management	Initial & Annual	Initial • < 60 days of hire Ongoing • As per certification or otherwise required NOTE • MANDT must be taken sequentially and within a consecutive 2-month period.	Initial & Ongoing • classroom training by a certified Mandt trainer	• MDHHS Contract Technical Requirement for Behavior Treatment Plan Review Committee. • Administrative Rule 330.7001 (z) • OSHA Publication 3148-06 R (2016)
2b. Behavioral Treatment / Crisis Intervention (MANDT) **CONCEPTUAL**	Mandt Conceptual introduces additional information to help how we think about things, people, and situations. Chapters include: • Trauma Informed Cultures • Positive Behavior Interventions and Supports • Medical Risk Factors	Initial & Annual	Initial • < 60 days of hire Ongoing • As per certification or otherwise required NOTE • MANDT must be taken sequentially and within a consecutive 2-month period.	Initial & Ongoing • classroom training by a certified Mandt trainer	• MDHHS Contract Technical Requirement for Behavior Treatment Plan Review Committee. • Administrative Rule 330.7001 (z) • OSHA Publication 3148-01 R (2004)
2c. Behavioral Treatment / Crisis Intervention (MANDT) **TECHNICAL**	Mandt Technical provides staff with technical physical skills to keep people safe while working with them. Chapters include: • Assisting • Separating • Physical Techniques	Initial & Annual	Initial • < 60 days of hire Ongoing • As per certification or otherwise required NOTE • MANDT must be taken sequentially and within a consecutive 2-month period.	Initial & Ongoing • classroom training by a certified Mandt trainer	• MDHHS Contract Technical Requirement for Behavior Treatment Plan Review Committee. • Administrative Rule 330.7001 (z) • OSHA Publication 3148-01 R (2004)

LAKESHORE REGIONAL ENTITY TRAINING REQUIREMENTS: FREQUENCY AND METHOD					
TRAINING	**DESCRIPTION**	**FREQUENCY**	**WHEN**	**HOW TO OBTAIN**	**REQUIREMENT**
3. Corporate Compliance	This training will acquaint staff members with the general laws and regulations governing waste, fraud, and abuse, and other compliance issues in both the CMHSP and the provider organization.	Initial & Annual	Initial • <60 days of hire Ongoing • Annual update	Initial • CMH classroom training if available • Lakeshore LMS online course • As otherwise approved by CMH Ongoing • CMH classroom training if available • Lakeshore LMS online course • As otherwise approved by CMH	• Medicaid Integrity Program (MIP) Section 33 • Medicaid False Claims Act of 1977 • Michigan False Claims Act, Act 72 of 1977 • Deficit Reduction Act of 2005 • Affordable Care Act of 2010 • CARF 1. A. 7 if applicable • Code of Federal Regulations 42 CFR 438 608
4. Cultural Competence	This training will cover: effect of culture and how it affects our perception of life, various aspects of culture, understanding that every individual has the right to receive culturally proficient services, steps in providing culturally responsive services, and realizing that being culturally competent/proficient is a continual process.	Initial & Annual	Initial • ≤ 60 days of hire Ongoing • Annual update	Initial • CMH Classroom Training if available • Lakeshore LMS online course • As otherwise approved by CMH Ongoing • Lakeshore LMS online course • As otherwise approved by CMH	• Code of Federal Regulations 42 CFR 438.206(c)(2) Cultural Considerations • MDHHS Contract Part II 3.0, Access Assurance Section 3.4.2 on Cultural Competence • MDHHS Contract Part I, 15.7 (LEP) • CARF 1.I.5 if applicable • Medicaid Provider Manual 4.5

LAKESHORE REGIONAL ENTITY TRAINING REQUIREMENTS: FREQUENCY AND METHOD					
TRAINING	**DESCRIPTION**	**FREQUENCY**	**WHEN**	**HOW TO OBTAIN**	**REQUIREMENT**
5. Emergency Preparedness	The goal of this course is to provide information that helps increase employee awareness and knowledge of various emergency situations to promote effective response practices. At the completion of this program, participants should be able to: identify risk factors that lead to emergency situation; implement proper safety and prevention practices; report emergencies promptly to proper authorities; respond to various emergency situations in an effective manner.	Initial	Initial • ≤ 60 days of hire • Staff working independently or as lead workers need to complete all training prior to any direct care assignment	Initial • CMH Classroom Training if available • Lakeshore LMS online course	• R330.1806 • R400.14204 (Small Group Homes) • R400.15204 (Large Group Home) • R400.2122 (Congregate Settings) • CARF 1.H.4 if applicable
6. Knowledge of First Aid	This training will provide staff with information about basic first aid action principles and situations requiring first aid.	Initial and 2-year Update	Initial • ≤ 60 days of hire and prior to working independently with individuals served Ongoing • Update every 2 years	Initial & Ongoing • Lakeshore LMS online course • Options as approved by CMH	• Medicaid Provider Manual 2.4, 14.5.A, and 15.2.C
7. First Aid Certification	This training will provide staff with certification in basic first aid action principles, situations requiring first aid, and basic first aid skills in areas including: • Medical Emergencies • Injury Emergencies • Environmental Emergencies	Initial and Ongoing	Initial • Current certification ≤ 60 days of hire and prior to working independently with individuals served Ongoing • As per certificate	Initial & Ongoing • CMH or Community Classroom Training which must include return demonstration • Through an American Red Cross, American Heart Association, OR National Safety Council certified trainer which must include return demonstration	• R330.1806 (Specialized Residential) • R400.14204 (Small Group Homes) • R400.15204 (Large Group Home) • R400.2122 (Congregate Settings) • CARF 3.G.22; 2.F.3.d

LAKESHORE REGIONAL ENTITY TRAINING REQUIREMENTS: FREQUENCY AND METHOD					
TRAINING	**DESCRIPTION**	**FREQUENCY**	**WHEN**	**HOW TO OBTAIN**	**REQUIREMENT**
8. CPR Certification	This class provides certification in the basics skills for cardio-pulmonary resuscitation for adults and children including checking a conscious or unconscious victim, conscious choking, CPR (30 – 2), unconscious airway obstruction, and automated external defibrillators (AED) as determined by certifying organizations (American Red Cross, American Heart Association, National Safety Council).	Initial and Ongoing	Initial • Current certification ≤ 60 days of hire and prior to working independently with individuals served Ongoing • As per certificate	Initial & Ongoing • CMH or Community Classroom Training which must include return demonstration • Through an American Red Cross, American Heart Association, OR National Safety Council certified trainer which must include return demonstration	• Medicaid Provider Manual 14.5.A • R330.1806 (Specialized Residential) • R400.14204 (Small Group Homes) • R400.15204 (Large Group Home) • CARF 3.G.22; 2.F.3.d
9. Grievance & Appeals	This class demonstrates that due process/grievance and appeals are the right of every person seeking or receiving mental health or developmental disability services from a Community Mental Health Service Program or its contracted agencies. All individuals have the right to a fair and efficient process for resolving complaints regarding their services and supports.	Initial and Annual	Initial • ≤ 30 days of hire and prior to working independently with individuals served Ongoing • Annual update	Initial & Ongoing • LRE classroom training if applicable • Options as approved by CMHSP	• MDHHS Contract Attachment 6.3.2.1 • Lakeshore Regional Entity Policy 6.2
10. Health & Wellness	This course provides staff with the information and skills to work as a health coach. Necessary skills include: promoting wellness, understanding the role of treatment options, monitoring a person's current health status, and responding to changes in healthcare needs.	Initial	Initial • ≤ 60 days of hire and prior to working independently with individuals served	Initial • CMH classroom training if available • Lakeshore LMS online hybrid course (both online AND classroom portions)	• MCL 330.1806 • R400.14204 (Small Group Homes) • R400.15204 (Large Group Home) • R400.2122 (Congregate Settings)

LAKESHORE REGIONAL ENTITY TRAINING REQUIREMENTS: FREQUENCY AND METHOD					
TRAINING	**DESCRIPTION**	**FREQUENCY**	**WHEN**	**HOW TO OBTAIN**	**REQUIREMENT**
11. HIPAA	This training will provide staff with information about HIPAA privacy and HIPAA security, confidentiality and informed consent, applying it in appropriate contexts, how to release information legally, when information can be discussed and what information cannot be discussed, HIPAA requirements, and Michigan Mental Health Code requirements.	Initial and Annual	Initial • ≤ 60 days of hire Ongoing • Annual update	Initial & Ongoing • CMH Classroom Training if available • Lakeshore LMS online course • As otherwise approved by CMH	• Code of Federal Regulations – 45CFR 164.308(a)(5)(i) and 164.530 (b)(1) • CARF 1.I.5
12. Introduction to Human Services	This course provides an overview of Developmental Disabilities, Mental Illness, Substance Use Disorders, and provides information about documentation and the role of staff.	Initial	Initial • ≤ 30 days of hire and prior to working independently with individuals served	Initial • Lakeshore LMS online course • CMH Classroom Training if available	• MCL 330.1806 • R400.14204 (Small Group Homes) • R400.15204 (Large Group Homes) • R400.2122 (Congregate Settings)
13. Limited English Proficiency (LEP)	This course will provide information on the language assistance entitlements available to individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.	Initial and Annual	Initial • ≤ 60 days of hire Ongoing • Annual update	Initial • CMH Classroom Training if available • Lakeshore LMS online course • As otherwise approved by CMH Ongoing • Lakeshore LMS online course • As otherwise approved by CMH	• Code of Federal Regulations 42 CFR 438.206(c)(2) Cultural Considerations • MDHHS Contract Part I, 15.7 (LEP) • Medicaid Provider Manual 18.1.6 & 6.3.2

LAKESHORE REGIONAL ENTITY TRAINING REQUIREMENTS: FREQUENCY AND METHOD					
TRAINING	**DESCRIPTION**	**FREQUENCY**	**WHEN**	**HOW TO OBTAIN**	**REQUIREMENT**
14. Medication Series **May include:** **Lakeshore course series that includes online and classroom demo portions (see How to Obtain column)** **OR** **Standalone CMH classroom training(s) if available**	This training series provides an overview of the rights of medication administration; legal, ethical, and liability considerations of medication administration; commonly prescribed medications for individuals receiving services; special considerations of administering psychotropic and other medications; correct drug routes, dosages; pharmacy labels and physician orders; drug information sheets; possible side effectives, possible adverse effects of, and contraindications; transcription of medication orders; medication storage; how to document medication refusal and inability to administer medications as scheduled; how to document medication errors; disposal of discontinued, expired and/or contaminated medications per agency policy and procedure and FDA guidelines. This series provides preliminary information about this topic. Providers will work with staff to build and develop competency.	Initial	Initial • ≤ 60 days of hire and prior to working independently with individuals served	Initial • Lakeshore LMS course series that includes these online AND classroom portions: 1. Medications: Types, Uses & Effects (online) 2. Medication Administration & Monitoring (online) 3. Medication & Health Skills Demonstration (classroom) Medication Administration & Monitoring online module MUST be completed BEFORE the classroom Skills Demo. • Standalone CMH classroom training(s) if available	• MCL 330.1806 • R400.14204 (Small Group Homes) • R400.15204 (Large Group Home) • R400.2122 (Congregate Settings)

LAKESHORE REGIONAL ENTITY TRAINING REQUIREMENTS: FREQUENCY AND METHOD					
TRAINING	**DESCRIPTION**	**FREQUENCY**	**WHEN**	**HOW TO OBTAIN**	**REQUIREMENT**
15. Nutrition & Food Safety	This course provides staff information so they may: understand the effect of food intake on health and wellness; identify and help people understand healthy food options; recognize and implement menus which encourage healthy meals and snacks based on setting; be able to shop in accordance with dietary and budgetary considerations; describe the link between improper food handling, poor personal hygiene, and food-borne illness; list signs/symptoms of food-borne illness; list criteria for safe food handling, storing, and serving; and, Identify appropriate response to food recalls.	Initial	Initial • ≤ 60 days of hire and prior to working independently with individuals served	Initial • CMH classroom training if available • Lakeshore LMS online course	• MCL 330.1806 • R400.14204 (Small Group Homes) • R400.15204 (Large Group Home) • R400.2122 (Congregate Settings)
16. Person-Centered Planning and Self-Determination	This training provides information on the core principles of person-centered planning (PCP), self-determination, and the Individual Plan of Service (IPOS). Emphasis is placed on discovering the preferences of the individuals being served and improving ability to implement the IPOS accordingly; understanding what the person wants to achieve with each goal and objective in his/her IPOS; and understanding that the IPOS is the prescription for the services that staff provide.	Initial & Annual	Initial • < 60 days of hire Ongoing • Annual update for all staff	Initial • CMH classroom training if available • Lakeshore LMS online course • As otherwise approved by CMH Ongoing • As otherwise approved by CMH • Lakeshore LMS online course	• MDHHS contract Part 3.4.1.1.IV.A.4 • Administrative Rule R 330.1700 (G)
17. Recipient Rights	This course will provide a basic understanding of recipient rights and reporting requirements. When a person receives behavioral health services, Michigan's Mental Health Code and other state and federal laws safeguard their rights. Staff are responsible to protect these rights.	Initial & Annual	Initial • ≤ 30 days of hire Ongoing • Annual update	Initial • CMH classroom training • Options as approved by CMH Office of RR Ongoing • CMH classroom training • Options as approved by CMH Office of RR	• MH Code: Sec 330.1755(5)(f)

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TRAINING	**DESCRIPTION**	**FREQUENCY**	**WHEN**	**HOW TO OBTAIN**	**REQUIREMENT**
18. Standard Precautions	This course provides information on: the epidemiology and symptoms of infectious diseases; how infectious diseases are transmitted; exposure control plans; recognizing what job activities may present a risk for potentially infectious situations; appropriate engineering controls, work practices, and personal protective equipment; an emergency involving blood or other potentially infectious material; appropriate response to an exposure incident including immediate care, documentation, and medical follow up; and, appropriate cleaning and disinfecting following a biohazard incident.	Initial & Annual	Initial • Prior to working with individuals served Ongoing • Annual update	Initial & Ongoing • CMH Classroom Training if available • Lakeshore LMS online course • OSHA approved Standard Precautions curriculum	• OSHA 1910.1030 • Administrative Rule R325.7000 • Administrative Rule R 325.70016 (7)(a) – specifies initial training and annual retraining • Administrative Rule R330.2807 (10) • CARF 1.H.11.b.
19. Trauma Informed Care	This course addresses the nature of trauma and its effects on people. Being able to provide trauma informed services to individuals receiving services is a crucial skill set for staff. Recognizing that an alarming majority of people receiving services have had trauma in their lives, it is staff's responsibility to work with them in a manner which supports and does not worsen the impact of previous trauma.	Initial & Ongoing	Initial • < 6 months of hire Ongoing • As identified by MDHHS contract	Initial • CMH classroom training (Mandt Conceptual) • Other CMH classroom training if available • As otherwise approved by CMH Ongoing • CMH classroom training (Mandt Conceptual) • Other CMH classroom training if available • As otherwise approved by CMH	• MDHHS/CMHSP Contract Attachment C6.9.9.1

- Additionally: If through the Quality Monitoring Review or MDHHS Site Review deficiencies are noted in this area, additional training may be required. *When applicable laws and/or regulations change CMHSP may require a training update
- Specialized Res: Staff working independently or as lead workers need to complete all training prior to any direct care assignment.
- For Self-Directed Arrangements, please see training requirements documented in the Self-Determination Agreement.