

## FY10 PROVIDER APPLICATION COMMUNITY LIVING SUPPORT (CLS) SERVICES

**(CLS Medicaid Definition: Community Living Supports are used to increase or maintain self-sufficiency, facilitating an individual’s achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant’s residence or in community settings. Service coverage areas include: Staff assistance, reminding, observing, support and/or training with activities; reminding, observing and/or monitoring of medication administration; staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.)**

Provider Name \_\_\_\_\_ Application Date \_\_\_\_\_

Tax ID/SSN: \_\_\_\_\_

Provider Legal Entity Type: Check one of the following:

- Sole Proprietors and partnerships: Individual providers including practitioners who file taxes on the 140 series of tax forms
- For-profit corporations: Those companies that typically file a tax form 1120 with the IRS.
- Governmental units: Includes transportation authorities, intermediate school districts, public universities and community colleges.
- Non-Profit organizations or corporations: Typically those organizations that have 501c.3 status and report on the IRS 990 form.

Provider Full Address \_\_\_\_\_

Provider Telephone Number \_\_\_\_\_ Fax# \_\_\_\_\_  
Cell# \_\_\_\_\_ Email \_\_\_\_\_

Location and telephone where services are to be provided, if different than provider address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Individual Providers Only:** Please complete the following items needed for Provider Criminal, Driver's & Recipient Rights Background check:

Provider Date of Birth \_\_\_\_\_

Provider Social Security # \_\_\_\_\_

Provider Race \_\_\_\_\_

Provider Gender (circle one)    Male    Female

Drivers License Number \_\_\_\_\_

I hereby give authorization to SCCMHA to check my recipient rights, criminal history, driver's license record and references, to verify my eligibility to be a provider for Community Living Support Services for persons with mental illness and/or developmental disabilities. Furthermore, I acknowledge having read the SCCMHA Guidelines for Community Living Support from the SCCMHA.org website located under tab Community Partners, SCCMHA Provider Application section, Guidelines for Community Living Supports (CLS):

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

Describe your experience providing personal care, medical and/or behavioral interventions for persons with developmental disabilities or persons with mental illness needs: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What days and hours are you available to work?: \_\_\_\_\_  
\_\_\_\_\_

Do you hold a current foster care license through the State of Michigan?     Yes     No  
If yes, describe the type and when you received it: \_\_\_\_\_

Do you have access to a vehicle which is in good operating condition?     Yes     No  
If no, describe how you would intend to provide emergency transportation if needed: \_\_\_\_\_  
\_\_\_\_\_

**Does the home where services will be provided meet the following standards?**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| Yes                      | No                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Clean, and safe from any hazards, such as: unsanitary conditions; high crime areas; and dangerous machinery, equipment and/or chemicals? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have enough space to provide the consumer with a private bed and a personal care area?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have identified fire exits and a written fire evacuation plan?   |

- Have all toxic materials, sharps, firearms, and any other items commonly recognized as weapons kept under lock and key?
- Have the capacity to provide three meals per day which are nutritious and well balanced, and meet the dietary requirements of the consumer?

**Describe any SCCMHA recipient rights violations of which you have been accused which were substantiated:**

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**Indicate which training requirements have been met:**

	Date of Completion
Advance Directives	_____
Basic Medications	_____
Blood borne Pathogens/ Infection Control	_____
CPR	_____
Cultural Diversity	_____
Environmental Emergencies/ Fire Safety	_____
Ethics of Touch	_____
First Aid	_____
HIPAA Privacy	_____
HIPAA Security	_____
Limited English Proficiency	_____
Nutrition and Food Safety	_____
Person Centered Planning/ Natural Supports	_____
Recipient Rights	_____
Working with People I	_____
Working with People II	_____
Physical Intervention*	_____

\* Physical intervention is required if physical intervention is part of the consumer's plan

**Please provide three references who can speak to your experience providing care for persons with special needs, developmental disabilities or mental illness and your general character:**

	Name	Address	Telephone(s)
1.	_____	_____	_____
	_____	_____	_____
2.	_____	_____	_____
	_____	_____	_____
3.	_____	_____	_____

