SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

FY19 INDIVIDUAL PROVIDER APPLICATION
COMMUNITY LIVING SUPPORT (CLS) SERVICES

A SCCMHA CLS Provider Application must be completed or renewed by the provider for each SCCMHA fiscal year and must be on file for contract initiation, continuation or revision. This application is provided to maintain accurate provider demographics, secure signed releases for annual background/monthly OIG checks, and provide an opportunity for you to make SCCMHA aware of current information regarding your services being offered. All responses are subject to an audit by SCCMHA.

Please complete the following list of items. If you need extra space, please feel free to attach another sheet or additional literature such as brochures that would assist SCCMHA to further understand service(s).

If changes occur during the fiscal year in legal name, tax identification, address, or key contact information these changes MUST be reported with written notice to SCCMHA Contracts & Properties Manager in a timely manner.

(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 Legal Name (including aliases):_____

Tax ID/SSN: _____

Provider Legal Entity Type: Check one of the following:

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

Provider Legal Address (**No P.O. Box numbers please**)_____

Provider Telephone Number _____ Fax# _____
Cell#_____Email _____

Location and telephone number where services are to be provided, if different than provider address_____

_____

_____

_____

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

Provider Date of Birth _____
Provider Race_____
Provider Gender (circle one) Male Female

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 Printed Name:

_____ _____
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:_____

_____

_____

_____

_____

Do you employ or are you able to accommodate persons with limited English proficiency (translation or interpretation)? Yes_____ No_____ If yes, please describe:

_____

_____

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:_____

_____

_____

If services are provided in your home, does your home or Provider site meet the following standards?

Yes	No	
☐	☐	Clean, and safe from any hazards, such as: unsanitary conditions; high crime areas; and dangerous machinery, equipment and/or chemicals?
☐	☐	Have enough space to provide the consumer with a private bed and a personal care area?
☐	☐	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 recipient rights violations of which you have been accused which were substantiated:

_____

_____

_____

Indicate which minimum training requirements have been met:

Date of Completion

Advanced Physical Intervention* _____

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

Basic Medications (Med Administration) _____

Blood borne Pathogens _____

Corporate/Regulatory Compliance _____

CPR _____

Cultural Diversity _____

Environmental Emergencies/Fire Safety _____

First Aid _____

HIPAA Privacy _____

HIPAA Security _____

Limited English Proficiency _____

Nutrition and Food Safety _____

Person Centered Planning (PCP) _____

Physical Intervention _____

Recipient Rights _____

Trauma Training _____

Working with People I (Includes Ethics of Touch) _____

Working with People II (Gentle Teaching) _____

For new applicants please provide three references who can speak to your experience providing care for persons with special needs, developmental disabilities or mental illness:

	Name	Address	Phone
1.	_____	_____ _____	_____
2.	_____	_____ _____	_____
3.	_____	_____ _____	_____

APPLICATION SUBMISSION INSTRUCTIONS/CHECK LIST

1) Attach proof of the following to your application:
   _____ Valid Auto Insurance Coverage
   _____ Valid Michigan Driver's License
   _____ Valid Prof. Liab. or Homeowners/Renters Insurance (If services are being provided in applicant's home)

2) Ensure all items on this application are completed fully. Incomplete applications may be rejected.

3) Sign below and forward this application and all required items listed in item #1 above to:

   Saginaw County Community Mental Health Authority
   Contracts Department
   500 Hancock
   Saginaw, MI, 48602

I fully understand that any misstatements in, or omissions from, this application may constitute cause for denial of membership to the provider network of Saginaw County Community Mental Health Authority. All information submitted by me in this application is true to the best of my knowledge and belief. I verify that I am in good-standing with any applicable respective licensing and/or certifying board or agency. I understand that any contractual relationship with Saginaw County Community Mental Health Authority may be subject to termination if I fail to comply with any of the regulations or policies specified.

DECLARING THAT THE STATEMENTS MADE IN THIS SCCMHA CLS INDIVIDUAL SERVICE PROVIDER APPLICATION ARE TRUE, I HEREBY GIVE AUTHORIZATION TO SCCMHA TO CHECK MY RECIPIENT RIGHTS HISTORY, CRIMINAL BACKGROUND HISTORY, DRIVER'S LICENSE RECORD, OIG, AND REFERENCES TO VERIFY MY ELIGIBILITY IN BECOMING OR MAINTAINING ACTIVE STATUES AS A PARTICIPATING PROVIDER:

_____ _____
Signature of Applicant: Date