HealthWest
Muskegon's Behavioral Wellness Connection

Facility/Organization Provider Application

The application and supporting documents are required to credential you as a Lakeshore Regional Entity provider according to the National Committee for Quality Assurance (NCQA) standards.

Community Mental Health Services Program Requesting Credentialing:

- ☐ Allegan County Community Mental Health Services
- ☒ HealthWest
- ☐ Network180
- ☐ Ottawa County Community Mental Health
- ☐ West Michigan Community Mental Health

To ensure timely processing of your application, please return the following:

- ☐ Completed Facility/Organizational Provider Application (Attached)
- ☐ Completed Service Location Addendum(s) - **One per Service Location** (Attached)
- ☐ Completed Workers Compensation Certificate (Attached)
- ☐ Completed Conflict of Interest Compliance Certificate (Attached)
- ☐ Completed Contractor Fiscal Certification Form (Attached)
- ☐ Completed Disclosure of Ownership Form (Attached)
- ☐ Copy of all applicable program state licenses
- ☐ Copy of Insurance ACORD with all Insurances marked in Attachment C (Attached)
- ☐ Copy of a completed W-9 form or IRS letter
- ☐ Copy of Staff Roster (when applicable)
- ☐ Accreditation Certificate(s)
  - ☐ TJC – The Joint Commission
  - ☐ HFAP – Healthcare Facilities Accreditation Program
  - ☐ CARF – Council on Accreditation of Rehabilitation Facilities AOA – American Osteopathic Association
  - ☐ COA – Council on Accreditation
  - ☐ CHAP – Community Health Accreditation Program
  - ☐ AAAHC – Accreditation Association for Ambulatory Health Care NCQA – National Committee for Quality Assurance
- ☐ Certification(s):
  - ☐ Other State licensure reports

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NON ACCREDITED ORGANIZATIONS:
If your organization is not accredited by TJC, CARF, COA, AOA, CHAP, AAAHC, NCQA or HFAP, then a site review of your Facility/Program will need to be conducted based upon the need for providers in your area. A site survey preparation document will be sent to you in advance of the site survey which will be scheduled at a mutually agreed upon date. A copy of a CMS Certification letter or on site survey results performed by the State may be accepted in lieu of an on-site review by LRE. Please provide this information with your application if applicable.

INDIVIDUAL TAX IDENTIFICATION NUMBERS AND NPI NUMBERS:
LRE Credentials and Contracts facilities based on single Tax Identification Numbers (TIN's/EIN's). If your organization bills under multiple Tax Identification Numbers, you will need to complete multiple application packets. However, if your organization has multiple NPI (National Provider Identification) numbers, please include that information in this application with an explanation to which programs and/or locations to which the multiple NPI numbers apply.

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I. GENERAL INFORMATION (Please print/type) **NPI #:** _____

A. TIN Owner Name/Legal Name: _____

DBA/Trade Name: _____

Primary Mailing Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Phone #: ( ) _____ TAX ID#: _____

NPI # _____

B. Facility/Program points of contact

Chief Executive Officer: _____ Phone: _____

Finance / Business Manager: _____ Phone: _____

Clinical/ Medical Records Manager: _____

Phone: _____ Fax: _____ Email: _____

Contracting Contact Person / Title: _____

Phone: _____ Fax: _____

Billing/Claims Contact Person: _____ Phone: _____

Person Completing application / Title: _____

Phone: _____ Fax: _____ Email: _____

Authorized Signatory Name: _____ Phone: _____ Email: _____

Website Address of Facility: _____

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C. Please complete if facility/program is part of a corporate health system:

Corporate Name: _____

Contact Name: _____ Title: _____

Primary Mailing Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Fax: _____

D. Select one description from the following list that best describes the facility:

- ☐ General Hospital
- ☐ Free standing Acute Psychiatric Facility
- ☐ Adult Foster Care
- ☐ Community Mental Health Center
- ☐ Other: _____
- ☐ Free standing Partial/Day Treatment Facility
- ☐ Agency (all other)
- ☐ Home Health Agency
- ☐ Free standing Substance Abuse Rehabilitation Facility

E. Business Classification (Please Check only one box for Ownership and only one box for Status)

1. Ownership: ☐ Private ☐ Public ☐ Government Program
2. Status: ☐ For-Profit ☐ Not-for-Profit

F. This organization is accredited or certified by one or more of the following:

☐ NCQA ☐ CARF ☐ AOA ☐ COA ☐ CHAP ☐ AAAHC ☐ TJC ☐ HFAP

☐ OTHER: _____ ☐ None

☐ MEDICARE #_____ **(Please provide supporting documentation)**

☐ MEDICAID #_____ **(Please provide supporting documentation)**

☐ IBHS # _____

G. The following information is required for the Provider Directory:

1. Languages available: _____
2. Accepting new patients: YES☐ NO☐
3. Cultural competency training completed: YES☐ NO☐

Facility/Organizational Provider Application

II. PROVIDER PROFILE / MALPRACTICE CLAIM HISTORY

PLEASE ATTACH A DETAILED EXPLANATION FOR ANY QUESTIONS BELOW (1-5) THAT WERE ANSWERED "YES"

A. Please answer the following questions regarding your organization's **behavioral health program(s):**

1. Has the facility/program had professional liability insurance refused, revoked, declined or accepted on special terms in the past five years? ☐ Yes ☐ No

2. Has any government agency suspended, revoked, or taken other action against the facility/ program's license to conduct business in the past five years? (To include Medicaid /Medicare) ☐ Yes ☐ No

3. Have any memberships in professional organizations and/or accreditations been revoked, reduced, denied, or suspended by others or voluntarily given up by the facility/program in the last five years, or are any actions now under way which may lead to such sanctions? ☐ Yes ☐ No

4. Have any owners, officers, or shareholders of the facility/program **ever** been convicted of a crime, excluding misdemeanors? ☐ Yes ☐ No

5. Has the facility/program **ever** been previously denied acceptance into the LRE Network, disenrolled from the LRE Network, or withdrawn from LRE Network participation? ☐ Yes ☐ No

6. Has the facility/program had any settled claims or judgments relating to sexual misconduct or civil rights violations in the past five years? If Yes, enter the total number:_____ ☐ Yes ☐ No

7. If the facility / program is not TJC and/or NCQA accredited
Please answer the following question: Has the facility /program been a defendant in five (5) Or more lawsuits within the past five (5) years in regards to the practice of behavioral health Treatment, or any lawsuits in the past five (5) years where there has been awards or payments Of $250,000.00 or more? If yes, please enter the total number _____ ☐ Yes ☐ No

PLEASE COMPLETE THE MALPRACTICE CLAIM INFORMATION WORKSHEET ON THE FOLLOWING PAGE FOR ANY QUESTIONS ABOVE (6-7) THAT WERE ANSWERED "YES"

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PLEASE ATTACH A DETAILED EXPLANATION FOR ANY QUESTION 8 IF ANSWERED "NO"

8. Does the facility/program comply with §1128 of the Social Security Act by not hiring, continuing to employ, or contracting with individuals listed on the Office of Inspector General's List of Excluded Individuals/Entities (to include owners, officers, employees, subcontractors, and others identified in §1128)?

☐ Yes ☐ No

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MALPRACTICE CLAIM INFORMATION WORKSHEET

B. Please attach information on what the organization's response was to the allegations and what steps were taken to prevent any future incidents for each claim listed below. This page can be copied to accommodate additional claim information.

1. Date of Occurrence:_____ Date Claim Filed:_____ Date of Settlement: _____
Allegations and Action Taken: _____

Case Settled: ☐ In Court With Prejudice ☐ Out-of-Court Without Prejudice Total Amount Paid to Claimant on Behalf of Facility/Program: $_

2. Date of Occurrence:_____ Date Claim Filed:_____ Date of Settlement: _____
Allegations and Action Taken: _____

Case Settled: ☐ In Court With Prejudice ☐ Out-of-Court Without Prejudice Total Amount Paid to Claimant on Behalf of Facility/Program: $_

3. Date of Occurrence:_____ Date Claim Filed:_____ Date of Settlement: _____
Allegations and Action Taken: _____

Case Settled: ☐ In Court With Prejudice ☐ Out-of-Court Without Prejudice Total Amount Paid to Claimant on Behalf of Facility/Program: $_

4. Date of Occurrence:_____ Date Claim Filed:_____ Date of Settlement: _____
Allegations and Action Taken: _____

Case Settled: ☐ In Court With Prejudice ☐ Out-of-Court Without Prejudice Total Amount Paid to Claimant on Behalf of Facility/Program: $_

5. Date of Occurrence:_____ Date Claim Filed:_____ Date of Settlement: _____
Allegations and Action Taken: _____

Case Settled: ☐ In Court With Prejudice ☐ Out-of-Court Without Prejudice Total Amount Paid to Claimant on Behalf of Facility/Program: $_

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IV. PARTICIPATION STATEMENT

The Facility grants (i) Lakeshore Regional Entity (LRE) and its credentialing verification organizations (CVO) (individually and collectively as "LRE Entity") permission and consent to obtain and verify information contained in this application and, as part of this process, to consult with State licensing agencies, accreditation agencies, malpractice insurance carriers, and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain or verify information concerning the Facility's professional competence and qualifications.

The Facility also grants permission and consent for all persons, organizations, or other entity to release to LRE all information they have in their control that relates to the Facility's competence or ability to render clinical services in a professional, cost effective manner. The Facility releases LRE and each of their respective employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating the Facility's application.

The Facility further authorizes LRE (other than CVO) to release to any of their affiliates, any information that is included in this application or obtained during such investigation related to my application, but only to the extent permitted by law and only for the limited purposes of credentialing being undertaken by or on behalf of the receiving LRE in regard to the Facility's credentialing status before that LRE.

The signatory of this application represents and warrants that it is authorized to bind the Facility to the terms of this application without the requirement of any further action being undertaken. The signatory certifies that the information in this application is true, correct and complete, and that s/he understands and agrees that any information entered in this application, which subsequently is found to be false, may result in the termination of the contract.

_____
Facility Name

_____ Dated (mm/dd/yy):_____/_____/_____
Authorized Signature

_____
Name (Please Print)

_____
Title

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CONFLICT OF INTEREST COMPLIANCE CERTIFICATE

ATTACHMENT J

The CMHSP intends to avoid Conflict(s) of Interest or the appearance of Conflict(s) of Interest. A Conflict of Interest occurs when an individual puts his or her own personal interests in conflict with CMHSP's interest or creates a situation where the CMHSP is at a disadvantage with its funding agencies, regulators, accrediting bodies, customers, Provider, suppliers or competitors. Thus, the CMHSP reserves the right to determine, at its sole discretion, whether any information received from any source indicates the existence of a Conflict of Interest.

Conflict of Interest means:

1. A Provider, a sub-contractor, any management officials or affiliated business entities of a Provider or sub-contractor; or any employees and agents who will perform services under a proposed or existing contract with CMHSP has one or more personal, business or financial interests or relationships which would cause a reasonable individual with knowledge of the relevant facts to question the integrity or impartiality of those who are or will be acting under a proposed or existing CMHSP contract; or
2. A Provider, a sub-contractor, any management officials or affiliated business entities of a Provider or sub-contractor who will perform services under a proposed or existing contract with CMHSP is an adverse party to a lawsuit with CMHSP; or
3. Any other facts exist which the CMHSP, in its sole discretion, determines may, through performance of a proposed or existing CMHSP contract, provide a Provider or sub-contractor with an unfair competitive advantage which favors the interests of the Provider or sub-contractor or any person with whom the Provider or sub-contractor has or is likely to have a personal or business relationship; or sub-contractor, any management officials or affiliated business entities of a Provider or sub-contractor, or any employees and agents who will perform services under a proposed or existing contract with CMH refers any portion of the services to a family member.

Representations as to Conflicts of Interest:
Answers to the following questions are provided for the Provider or sub-contractor, its officers, directors, any management officials, any persons that own or control you or you own or control; and any employees or agents who will perform services under the contract: You have a conflict of interest when you, any person that owns or controls you, or any entity you own or control answers "yes" to any of the following four (4) questions:

1. Have any such person(s) a personal, business or financial interest or relationships that relate to the services the Provider performs under this contract?	☐ YES ☐ NO
2. Has the Contractor been removed from or prohibited from participating in any Federal, State or Local Programs?	☐ YES ☐ NO
3. Are any such person(s) a party to litigation against the CMHSP, or represents a party that is?	☐ YES ☐ NO
4. Does the Provider make any referrals to family members when performing services under the contract?	☐ YES ☐ NO

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CONFLICT OF INTEREST COMPLIANCE CERTIFICATE

The Provider or sub-contractor agrees that if it is awarded a contract, throughout the life of the contract, immediate notification will be provided to the CMHSP Contract Manager if at any time a potential or actual conflict of interest becomes known.

The undersigned hereby affirms that: (check one)

☐ I have read the above statements and declare no conflict of interest exists that would jeopardize the ability of the Contractor or subcontractor to perform under a CMH contract.

☐ A suspected or potential conflict of interest does exist and additional information is attached along with a plan to address the suspected or potential conflict of interest.

Provider Name: _____

Signature: _____ Date: _____

Name and Title

Printed Name of Authorized Representative: _____

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CONTRACTOR - FISCAL CERTIFICATION FORM

1. Does your organization/business 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:

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

3. Accounting Certification (please provide the following):	
☐	Provider receiving $750,000 or more total fiscal year revenue from all sources shall ensure the completion of annual audit by a Certified Public Accountant (CPA).
☐	Provider receiving under $750,000 and more than $250,000 of total fiscal year revenue from all sources shall ensure the completion of an annual financial review by a Certified Public Accountant. If an audit is conducted for other reasons, provider must submit the audit and is not required to have a financial review.
☐	Providers with less than $250,000 in total fiscal year revenue from all sources provide income statement and balance sheet. New providers also attach budget.

Facility/Organizational Provider Application

WORKERS' COMPENSATION CERTIFICATION

(Completion of this form is for employers who claim exemption from MI Workers' Comp Statute)

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

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.

Attestation of Complete and Accurate Information

Please complete this section if there have been no changes to the information requested herein since the last time this form was completed and returned to the requesting agency. If any relevant information has changed since then, please complete the rest of this form in its entirety.

Name of Provider/Provider Entity:	
The above Provider/Provider Entity has previously submitted all information requested below, and all information submitted to the requesting agency is complete and accurate at this time. ☐ Yes ☐ No	
If yes, complete this section only and return this form to the requesting agency. If no, please complete this form in its entirety.	
I attest that all information requested below has been previously provided to the requesting agency, and there are no changes or additions to report at this time.	
Signature:	Date:
Printed Name:	Title:

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'.*

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	Name of Provider/Provider Entity: Name of Person Completing this Form: Title: Phone Number: Fax: Email: In which state(s) do you participate in Medicaid?
Additional Addresses (list all Practice Locations) Attaching list? ☐ Yes ☐ No	

*SSN (if Individual Provider): ☐ N/A *Federal Tax ID# (if Entity): ☐ N/A	☐ *Medicaid ID#: ☐ *Applied for Medicaid ID ☐ *Not applicable	☐ *NPI #: ☐ *Applied for NPI # ☐ *Not applicable

Section I: Individual Provider Ownership Information

1. Are there any individuals or organizations with a Direct or Indirect Ownership Interest of 5% or more in your 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 III: Subcontractor Ownership

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: _____ Fax: _____ Email: _____

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.

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.

HealthWest
Muskegon's Behavioral Wellness Connection

FACILITY LOCATIONS AND SERVICES FORM (LSF)

Complete one form per service location (copy as needed)

SERVICE LOCATION:

Site Name:_____

Address Line 1:_____

Address Line 2:_____

City, State, ZIP:_____

Phone Number:_____

Site Medicare Number:_____

Site Medicaid Number:_____

Site NPI Number:_____

Languages Available: _____

BILLING ADDRESS: (Please confer with your Billing Dept.)

Tax ID Number: _____

Payable To: _____

Address Line 1: _____

Address Line 2: _____

City, State, ZIP: _____

This Location is:

Americans with Disabilities Act Compliant ☐ Yes ☐ No

Accessible by Public Transportation ☐ Yes ☐ No

Accepting New Patients: ☐ Yes ☐ No

PLEASE COMPLETE BELOW BASED ON THE BEHAVIORAL HEALTH SERVICES OFFERED AT THE SITE.

SERVICES	TOTAL #BEDS	CHILD 0-12	ADOL 13-17	ADULT 18-64	GERI 65+	NOTES/ RESTRICTIONS
WRAPAROUND SERVICES						
TREATMENT PLANNING						
TRANSPORTATION						
TARGETED CASE MANAGEMENT						
SUPPORTS COORDINATION						
SUPPORTED EMPLOYMENT						
SKILL BUILDING NONVOCATIONAL PREVOCATIONAL						
SED WAIVER						
RESPITE SERVICES						
PSYCHIATRIC SERVICES						
PRIVATE DUTY NURSING						
PERSONAL CARE RESIDENTIAL SETTING						
PEER DELIVERED OR PEER OPERATED SUPPORT SERVICES						
OBRA PAS - ARR						
NURSING FACILITY MENTAL HEALTH MONITORING						
INTENSIVE CRISIS STABILIZATION						
INDIVIDUAL – GROUP THERAPY						
HOUSING ASSISTANCE						
HOME BASED SERVICES						
HEALTH SERVICES						
FISCAL INTERMEDIARY						
FAMILY SUPPORT AND TRAINING						

FACILITY LOCATIONS AND SERVICES FORM (LSF)

Complete one form per service location (copy as needed)

SERVICES	TOTAL # BEDS	CHILD 0-12	ADOL 13-17	ADULT 18-64	GERI 65+	NOTES/RESTRICTIONS
ENHANCED PHARMACY						
DIRECT PREVENTION						
CRISIS RESIDENTIAL						
CRISIS INTERVENTION						
CLUBHOUSE						
CLS						
CLINICAL SERVICES (OT, PT, SHL)						
CHILDRENS WAIVER						
BHT SERVICES						
BEHAVIOR TREATMENT REVIEW						
ASSESSMENTS						
ACT						

SUBSTANCE USE TREATMENT SERVICES	SERVICE: YES/NO	# DAYS PER WEEK	AGE RANGE	NOTES/ RESTRICTIONS
SUD RESIDENTIAL WITHDRAWAL MANAGEMENT			TO	
SUD RESIDENTIAL TREATMENT AND RECOVERY RESIDENCES			TO	
SUD OUTPATIENT TREATMENT			TO	
SUD MEDICATION ASSISTED TREATMENT			TO	
SUD COMMUNITY BASED TREATMENT			TO	

The listing of a service above does not guarantee that the service will be covered under every health plan. To be reimbursed, a service provided to a member must be a covered benefit under the member's health plan and the member must be eligible for coverage on the date of service.

Attestation Statement:

I hereby attest that the location listed above is licensed to render the services indicated herein. I also attest that the information provided in this document is true, accurate and complete to the best of my knowledge as of this date and I understand that falsification, omission, or concealment of material fact may subject me to rejection or termination as a network provider, in addition to any administrative, civil or criminal penalties provided by law. I further agree to inform promptly LRE and/or its affiliate(s) of all material changes to the information I have provided.

Name:_____ Title: _____

Signature:_____ Date: _____

HealthWest
Muskegon's Behavioral Wellness Connection

PROVIDER DIRECTORY AND REQUEST FOR INFORMATION
All Sections Must Be Completed

The Provider Directory is posted for consumers on the HealthWest website and contains general information on our contracted services. In addition, we are asking for information required by your contract that we will be tracking internally but may not be posted on the Provider Directory. Some of this information may have been provided by your agency in the past. This information is collected periodically so we can ensure that our records are as current and accurate as possible. Thank you for your cooperation and timely completion of this form.

Once your information has been submitted to HealthWest and the Provider Directory has been updated, it will be available at:

SECTION I: AGENCY/PROVIDER INFORMATION			
Provider Legal Name:			
Address:			City:
State:	Zip:	Phone:	Fax:
Website:			
TAX ID/SSN:	AGENCY NPI:		CHAMPS ID:
List all languages available to consumers:			
Cultural Competency training completed: *(for staff who work with WMCMH Consumers)*	☐ Yes ☐ No		

ADA-compliant accommodations available to consumers at this location *(mark all that apply)*:

☐ ADA Barrier-Free Wheelchair Accessibility	☐ ADA Accessible Vehicle(s) – van/bus with lift/ramp	☐ Brail Signage on Exam Room(s)
☐ ADA Ramp(s) – at curb	☐ ADA Accessible Sleeping Room(s)	☐ Assistive Listening Device(s) or Qualified Interpreter(s)
☐ ADA Ramp(s) – at building entrance	☐ ADA Accessible Drinking Fountain(s)	☐ Qualified Reader(s) – brail, screen readers, or qualified interpreters
☐ Exterior Barrier-Free Door(s)	☐ ADA Restroom(s) – wheelchair-accessible with handrails/grab bars	☐ Video Remote Interpreting Service (VRI)
☐ Interior Barrier-Free Door(s)	☐ ADA Shower(s) – wheelchair-accessible with handrails/grab bars	☐ Passenger Loading Zone(s)
☐ Wheelchair(s) – available for patient use	☐ Elevator(s)	☐ Handicap Parking Space(s)

Accepting new patients:	☐ Yes ☐ No
Population Served by agency: *(mark all that apply)*	☐ MI ☐ DD ☐SUD ☐Child ☐Adult
Check which insurance types your agency can currently bill:	☐ Medicaid ☐ Medicare ☐Commercial Insurance
Accreditation Source:	☐ ACA ☐ CARF ☐ CHAP ☐ COA ☐ DNV-GL ☐ JACHO ☐ Joint Commission ☐ MARR ☐ NCQA ☐ Other:
Accreditation Expiration Date(s):	
Copies of all insurance requirements are attached: *(Provide current copies of all required insurance policies for WMCMH)*	☐ Yes ☐ No

SECTION II: CONTACT INFORMATION		
Authorized Individual to Sign Contract *(Executive Director, CEO, President, etc.)*		☐ Check if primary contact
Name:	Title:	
Phone:	E-mail Address:	
Contract Manager *(Employee in charge of contract management)*		☐ Check if primary contact
Name:	Title:	
Phone:	E-mail Address:	
Finance/Business Manager *(Employee in charge of finance and billing)*		☐ Check if primary contact
Name:	Title:	
Phone:	E-mail Address:	
Clinical/Medical Records Manager *(Employee in charge of Credentialing and Background Checks)*		☐ Check if primary contact
Name:	Title:	
Phone:	E-mail Address:	
Any Additional Individuals		☐ Check if primary contact
Name:	Title:	
Phone:	E-mail Address:	

SECTION III: ALL ADDITIONAL FACILITIES/HOMES CURRENTLY CONTRACTED WITH HEALTHWEST FOR SERVICES

(Attach additional sheets for Section III as necessary for all facilities used by HealthWest consumers)

Facility/Home Name:			
Address:			City:
State:	Zip:	Phone:	Fax:
TAX ID/SSN:		FACILITY/HOME NPI:	
LARA LICENSE # *(attached copy of license)*:			
TAXONOMY CODE:	CHAMPS ID:		IBHS #:
List all languages available to consumers at this facility/home:			

Select all ADA-compliant accommodations available to consumers at this location:

☐ ADA Barrier-Free Wheelchair Accessibility	☐ ADA Accessible Vehicle(s) – van/bus with lift/ramp	☐ Brail Signage on Exam Room(s)
☐ ADA Ramp(s) – at curb	☐ ADA Accessible Sleeping Room(s)	☐ Assistive Listening Device(s) or Qualified Interpreter(s)
☐ ADA Ramp(s) – at building entrance	☐ ADA Accessible Drinking Fountain(s)	☐ Qualified Reader(s) – brail, screen readers, or qualified interpreters
☐ Exterior Barrier-Free Door(s)	☐ ADA Restroom(s) – wheelchair-accessible with handrails/grab bars	☐ Video Remote Interpreting Service (VRI)
☐ Interior Barrier-Free Door(s)	☐ ADA Shower(s) – wheelchair-accessible with handrails/grab bars	☐ Passenger Loading Zone(s)
☐ Wheelchair(s) – available for patient use	☐ Elevator(s)	☐ Handicap Parking Space(s)

Accepting new patients:	☐ Yes ☐ No
Population Served by agency: *(mark all that apply)*	☐ MI ☐ DD ☐SUD ☐Child ☐Adult
Check which insurance types your agency can currently bill:	☐ Medicaid ☐ Medicare ☐Commercial Insurance

SECTION IV: CERTIFICATION AND SIGNATURE

By signing below, the agency listed certifies that all information included and attached to this form is accurate and up to date.

Signature:	Date:
Print Name:	
Title:	

HCBS RESIDENTIAL PROVIDER GUIDANCE

This document is intended to assist providers in a self -assessment of their level of compliance with the HCBS rule. If you do not have policies and procedures as identified below you are advised that they are *required* in order to maintain approval to provide HCBS services. Compliance verification will be ongoing and is required in order to receive HCBS Medicaid funding for services.

The setting must have a current signed copy of the IPOS for every individual they serve

This document should not be returned to MDHHS HCBS staff

Any deviation from the policies identified below must be based on the individual's IPOS. Restrictions required for one resident may not impact the freedoms of any other resident. Settings may not have setting wide restrictions as a requirement to live in the setting.

Section 1: Community Integration of Residential Setting

- ☐ Individuals live and/or receive services and supports in a setting where there is regular (*more than once per week*) opportunity for contact with people not receiving services
- ☐ The residence allows friends and family to visit without rules on hours or times

Section 2: Individual Rights within Residential Setting

- ☐ Each individual will have a lease or residential care agreement for the residential setting
  - The lease will explain how a discharge happens and what to do
- ☐ Individuals are provided with information on how to request new housing
- ☐ Information about filing a complaint is posted in a way individuals can understand and use
- ☐ Individuals will receive information regarding who to call to file an anonymous complaint
- ☐ Policies in place require that the staff talk about individuals' personal issues in private only
- ☐ Policies are in place to ensure individuals have access to their personal funds
- ☐ Policies are in place to ensure individuals have control over their personal funds
- ☐ Individuals have a place to store and secure their belongings away from others
- ☐ Individuals choose the agency who provides their residential services and supports
- ☐ Individuals can choose the direct support workers (direct care workers) who provide their services and supports
- ☐ Individuals can change their services and supports as they wish

Section 3: Individual Experience within Residential Setting (Part A)

- ☐ Individuals have the option of having their own bedroom if consistent with their resources
- ☐ Individual can pick their roommate(s)
- ☐ Individuals have a keyed lock on their bedroom door
- ☐ Individuals can close and lock their bathroom door
- ☐ Policies are in place to ensure staff ask before entering individuals' living areas (bedroom, bathroom)
- ☐ Policies are in place to ensure individuals choose what they eat
- ☐ Policies are in place to ensure individuals choose to eat alone or with others

- ☐ Policies are in place to ensure individuals have access to food they like at any time
- ☐ Policies are in place to ensure individuals can choose what clothes to wear
- ☐ Policies are in place to ensure individuals have access to a communication device
- ☐ Policies are in place to ensure individuals can use the communication device in a private place
- ☐ The inside of the residence is free from cameras, visual monitors, or audio monitors
    - Fixed cameras may be present in offices or medication distribution areas as long as they are fixed, directed at staff, and there is no risk that resident's images will be captured. Providers must work with their PIHP lead to ensure their compliance with this requirement.
- ☐ Policies ensure if an individual needs help with personal care, the individual receives this support in privacy
- ☐ Policies ensure individuals (with or without support) arrange and control their personal schedule of daily appointments and activities (e.g. personal care, events, etc.)

Section 4: Individual Experience within Residential Setting (Part B)

- ☐ Policies are in place to ensure individuals have full access to the Kitchen
- ☐ Policies are in place to ensure individuals can access the kitchen at any time
- ☐ Policies are in place to ensure individuals have full access to the dining area
- ☐ Policies are in place to ensure individuals can access the dining area at any time
- ☐ Policies are in place to ensure individuals have full access to the laundry area
- ☐ Policies are in place to ensure individuals have full access to the comfortable seating area
- ☐ Policies are in place to ensure individuals have access to the comfortable seating area at any time
- ☐ Policies are in place to ensure individuals have full access to the bathroom
- ☐ Individuals can access the bathroom at any time
- ☐ Policies are in place that ensure there is space within the home for individuals to meet with visitors and have private conversations
- ☐ Policies are in place that ensure individuals can choose to come and go from the home when they choose unless there is a restriction in the persons IPOS
- ☐ Policies are in place that ensure individuals are free to move inside and outside the home when they choose unless there is a restriction in the persons IPOS
- ☐ The home is physically accessible to all individuals
- ☐ Policies are in place that ensure individuals can reach and use the home's appliances as desired
- ☐ Policies are in place to ensure the home is free of gates, locked doors, or other ways to block individuals from entering or exiting certain areas of their home
- ☐ Accessible transportation is available for individuals to make trips to the community
- ☐ Individuals have a way to access the community where public transit is limited or unavailable

Attachment C
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.

Provider 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):

	Required Limits	Additional Requirements
Worker's Compensation		
☐	Coverage according to applicable laws governing work activities.	Waiver of subrogation, except where waiver is prohibited by law.
Commercial General Liability		
☐	$1,000,000 each occurrence $1,000,000 Personal & Advertising Injury $2,000,000 Products/Completed Operations $2,000,000 General Aggregate	Providers who interact with children, schools, or the cognitively impaired, must maintain appropriate insurance coverage related to sexual abuse and molestation liability.
Automobile Liability		
☐	If a Motor Vehicle is used in relation to Provider's performance, Provider must have vehicle liability insurance on the motor vehicle for bodily injury and property damage at $1,000,000 single limit.	Comprehensive form covering owned, non-owned, and hired vehicles. No-fault coverage of statutory and residual liability.
Privacy and Security Liability (Cyber Security)		
☐	$1,000,000 each occurrence $1,000,000 annual aggregate	Provider must have their policy cover information security and privacy liability, privacy notification costs, regulatory defense, and penalties, and website media content liability.
Professional Liability (Errors and Omissions)		
☐	$3,000,000 each occurrence $3,000,000 annual aggregate	
Employers Liability Insurance		
☐	$500,000 Each Accident $500,000 Each Employee by Disease $500,000 Aggregate Disease	Or Governmental Self-Insurance

Insurance coverage as checked in above grid is required as written. For items un-checked, provider shall acknowledge that the insurance coverage is recommended by CMHSP and provider remains solely responsible for risk undertaken.

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.

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

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

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

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

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

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

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 instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* 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 for Part II, later.

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

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

Muskegon County
Accounting Services
1903 Marquette Ave, Ste. A106
Muskegon, MI 49442

Phone: (231) 724-3544
Fax: (231) 724-4459
E-mail: Accounting.AccountsPayable@co.muskegon.mi.us

Dear Vendor:

We appreciate your interest in receiving payment(s) from Muskegon County electronically. ACH payments are easy, convenient, and we safeguard your bank information. To participate, please fill out the form below and forward it to the County's accounting team. You can use this form if you would like to begin electronic payments to your checking or savings account. In addition to this form, please include a copy of a voided check or deposit slip. Allow up to 14 days for your request to be processed. Please e-mail (gentryma@co.muskegon.mi.us) or call Mary Jo Gentry, (231) 724-3544, with any questions you may have about automatic payments.

County of Muskegon, Accounting Services

Authorization for Direct Deposit (ACH) Payment(s)

Name and Address as it appears on the Bank Account

Name: _____

Address: _____

_____

Contact Name: _____

Phone Number: _____

E-mail Address: _____

Payment Details:

Bank Name: _____

Account Number: _____

Routing Number: _____

Account Type: _____ **Checking**

_____ **Savings**

Upon Completion, Mail To:
Muskegon County
Accounting Services
1903 Marquette Ave
Suite A106
Muskegon, MI 49442

_____ I hereby authorize the County of Muskegon to electronically credit the account, and, if necessary, to electronically debit the account to correct erroneous credits, at the financial institution indicated above. Transactions will be completed according to payment details provided above. Michigan Law governs fund transactions authorized by this Agreement in all respects except as otherwise superseded by Federal Law. I agree that ACH transactions I authorize comply with all applicable laws.

_____ **I understand this authorization will remain in full force and effect until I notify the County of Muskegon, Accounting Services in writing that I wish to revoke this authorization. Furthermore, I understand that Muskegon County, Accounting Services requires at least 14 days to process my request. IF A PAYMENT IS RETURNED DUE TO AN ERROR NOT CAUSED BY THE COUNTY OF MUSKEGON OR ITS BANK, I UNDERSTAND I AM RESPONSIBLE FOR THE RESULTING FEES, UP TO $35. AFTER THREE (3) RETURNED PAYMENTS TO MUSKEGON COUNTY, THE ACH AGREEMENT WILL BE PROMPTLY CANCELED.**

Signature _____

Date _____

For Office Use Only
Received by: _____
Date Received: _____