MSHN

Mid-State Health Network

REQUEST FOR PROPOSAL

Substance Use Disorder (SUD) Adolescent Treatment Services

Issued Monday, September 14, 2026

Proposals Are Due to MSHN Office No Later Than:

Friday November 13, 2026, at 5:00 p.m.

https://www.midstatehealthnetwork.org/

Contents

REQUEST FOR PROPOSAL

Issued By

Mid-State Health Network

Project Title:	Adolescent Treatment Services (SUD)
RFP Issue Date:	Monday, September 14, 2026
Intent to Bid Due Date:	Monday, September 28, 2026
Questions Due Date:	Monday, October 5, 2026
MSHN Responses to Questions:	Monday, October 12, 2026
Proposal Due Date:	Friday, November 13, 2026 (5:00 p.m.)
Contact Person:	Leslie Thomas, Chief Financial Officer
MSHN Website:	www.midstatehealthnetwork.org

Section I - GENERAL INFORMATION

I. Introduction

a. Mid-State Health Network, Prepaid Inpatient Health Plan (hereinafter referred to as "MSHN") manages public services for Substance Use Disorder (hereinafter referred to as "SUD") Services, in twenty-one counties designated by the Michigan Department of Health and Human Services as Region 5. The CMHSP Participants include Bay-Arenac Behavioral Health Authority, Clinton-Eaton-Ingham Community Mental Health Authority, Community Mental Health for Central Michigan, Gratiot Integrated Health Network, Tuscola Behavioral Health Systems, Huron County Community Mental Health Authority, The Right Door for Hope, Recovery & Wellness, LifeWays Community Mental Health Authority, Montcalm Care Network, Newaygo County Community Mental Health Authority, Saginaw County Community Mental Health Authority, and Shiawassee Health & Wellness. MSHN operates within this region to manage public services for SUD services under the provisions of Act 500 of the Michigan Public Acts of 2012, as amended. As such, MSHN's mission is to ensure access to high-quality, locally delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members. MSHN's mission statement can be found on MSHN's website.

II. Purpose

a. Adolescent substance use remains a significant behavioral health concern nationally and requires developmentally appropriate treatment capacity across the continuum of care. Recent national data continue to demonstrate meaningful levels of substance use disorder among adolescents and a substantial overlap between substance use and mental health needs, reinforcing the importance of accessible, integrated, and developmentally responsive treatment services (2025 National Survey on Drug Use and Health (NSDUH)).

b. MSHN is committed to operating in a Recovery Oriented System of Care (ROSC). The network of services shall be comprised of a continuum of care for prevention, treatment recovery, and overdose prevention and infectious disease control supports. A ROSC is a coordinated network of community-based services and supports that are person-centered, build on the strengths and resiliencies of individuals, families, and communities to improve health, wellness, and quality of life for those with substance use disorders, and are at risk.

c. MSHN expects adolescent SUD treatment services to be developmentally appropriate, person- and family-centered, strength-based, trauma-informed, culturally and linguistically responsive, and recovery-oriented. Services shall recognize the unique cognitive, emotional, physical, social, educational, family, and developmental needs of adolescents and shall promote coordination with the systems that commonly intersect with the adolescent's care, including behavioral health, primary and specialty healthcare, education, child welfare, juvenile justice, and community-based recovery and family supports, as clinically appropriate and consistent with applicable confidentiality requirements.

d. This Request for Proposal (RFP) provides interested Providers with sufficient information to enable them to prepare and submit proposals for consideration by MSHN to satisfy its need for SUD Treatment services specific to adolescents. MSHN is seeking sealed proposals from interested and qualified Providers that possess the capacity, infrastructure, and organizational competence to deliver to eligible individuals, SUD Treatment Services as provided at an identified location within MSHN's 21 county region, specifically.

e. MSHN is specifically seeking new Providers to provide SUD Treatment Services specific to adolescents across MSHN's 21 county region and/or a current PIHP Network Provider who is interested in expanding or re-locating to the identified region.

f. It is expected that services provided pursuant to this RFP shall comply with all applicable federal and state statutes, regulations, rules, policies, technical advisories, Medicaid requirements, and

MSHN contractual requirements in effect during the contract period, including but not limited to the MDHHS/PIHP Contract, Michigan Medicaid Provider Manual, LARA Substance Use Disorder Administrative Rules, MDHHS Treatment Policy #14 – Adolescent Substance Use Treatment Services, applicable MDHHS level-of-care treatment policies, the Michigan Mental Health Code, and applicable MSHN policies and provider requirements.

III. Issuing Office

a. This RFP is issued by MSHN. The issuing office is the sole point of contact for this RFP. Information related to this RFP shall be posted on MSHN's website at the web address identified on *Attachment H – Source References*.

IV. Remote/Virtual Presentation

a. Providers who submit a proposal may be required to make a remote/virtual (Zoom or similar meeting platform) presentation of their proposal.

V. Contract Award

a. It is anticipated that a contract shall be awarded on or after the contract award date identified in Section I, Timeline. Providers who are awarded contracts shall not assign any duties or obligations under the contract without written permission of MSHN.

VI. Amendment

a. In the event it becomes necessary to revise any part of this RFP, information shall be posted on the MSHN website at the web address identified.

VII. Withdrawal / Modification

a. Providers who submit a proposal may later request a withdrawal or modification in writing prior to the closing date and time specified therein. The written request shall be signed by an authorized representative of the Provider. If a previously submitted proposal is withdrawn before the proposal closing date and time, the Provider may submit another proposal at any time up to the proposal closing date and time. Bids/proposals may not be modified after the fixed closing date and time specified therein.

VIII. Late Proposals

a. Late proposals, those submitted after the fixed closing date and time specified therein, shall not be accepted, or reviewed. Proposals submitted after the fixed closing date and time shall not be considered and shall be discarded. MSHN shall not be held responsible for technical difficulty or delivery complications that result in the bidding Provider being unable to meet the timeline requirements specified herein.

IX. Rejection of Proposals

a. MSHN reserves the right to reject any and/or all proposals received as a result of this RFP, or to negotiate separately with any source whatsoever in any manner necessary to serve the best interests of MSHN. This RFP has been developed for information and planning purposes only. MSHN reserves the right to re-solicit/re-advertise as MSHN deems necessary.

Section II - TERMS AND CONDITIONS

I. Incurring Costs

a. MSHN is not liable for any cost incurred by Providers prior to the issuance of a contract.

II. Proposal Disclosure

a. All information in the Provider's proposal is subject to the provisions of Public Act 442 of 1976, known as the Freedom of Information Act.

III. Funding Period

a. It is anticipated that any resulting offered contract shall begin on a date to be identified following the RFP Award process and shall be valid through September 30, 2027, contingent upon availability of funding from MDHHS. It is anticipated that contracts may be renewed annually (each fiscal year ending September 30) based on funding availability, Provider performance and MSHN satisfaction with Provider services.

IV. Conflict of Interest

a. Providers shall affirm that no principal, representative, agent or other person acting on behalf of or legally capable of acting on its behalf, is currently an employee of MSHN; nor is he/she privy to insider information which would tend to give, or give the appearance of tending to give, an unfair advantage to the Provider, which may constitute a conflict of interest.

b. Within the proposal response, all Providers shall disclose any known direct or indirect financial interests (including but not limited to ownership, investment, or any other form of remuneration) that may exist between the Provider, his/her potential subcontractors and MSHN.

c. Providers shall complete a Disclosure of Ownership, Controlling Interest, and Criminal Conviction (detail outlined in Required Narrative / Documents section of this RFP and *Attachment G*).

d. Provider shall complete and sign Certificate of Compliance with PA517 form (identified as *Attachment I* in this RFP).

e. Provider will be subject to the federal and State conflict of interest statutes and regulations that apply to the Contractor under a contract with MSHN, including Section 1902(a)(4)(C) and (D) of the Social Security Act: 41 U.S.C. Chapter 21 (formerly Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. §423): 18rovidersS.C. §207)): 18 U.S.C. §208: 42 CFR §438.58: 45 CFR Part 92: 45 CFR Part 74: 1978 PA 566: and MCL 330.1222; the provisions of P.A. 317 of 1968, as amended, MCL 15.321 et seq, MSA 4.1700(51) et seq, and 1973 PA 196, as amended, MCL 15.341 et seq, MSA 4.1700(71) et seq.

f. Provider assures, in addition to compliance with P.L. 103-227, any services or activity funded in whole or in part through MSHN will be in a smoke-free facility or environment. Smoking shall not be permitted anywhere in the facility, or those parts of the facility under the control of the Contractor. If activities or services are delivered in facilities or areas that are not under the control of the Contractor (e.g., a mall, restaurant, or private work site), the activities or services shall be smoke-free.

g. Provider shall not discriminate against or grant preferential treatment to any employee or applicant for employment with respect to hire, tenure, terms, conditions, or privileges of employment, programs and service provided, or any matter directly or indirectly related to employment, in contract solicitations, or in the treatment of any consumer, recipient, patient or referral, on the basis of race, color, religion, national origin, age, disability or sex including discrimination based on pregnancy, gender identity and sex stereotyping or otherwise as required by the Michigan Constitution, Article I, Section 26, the Elliott Larsen Civil Rights Act, 1976 PA 453, as amended, MCL 37.1101 et seq., PWDCRA and ADA and Section 504 of the Federal Rehabilitation Act of 1973, PL 93-112, 87 Stat 394, ACA Section 1557.

Provider will be subject to the federal Anti-Kickback and Stark Law restrictions (42 U.S.C. §1395 and 42 U.S.C. §1320)

V. Relationship of the Parties/Independent Contractor

a. The relationship between MSHN and any selected Provider is that of the Provider being an independent contractor for MSHN. No agent, employee, or representative of the Provider shall be deemed an employee, agent, or representative of MSHN for any reason. The Provider shall be solely and entirely responsible for its acts and the acts of its agents, employees, and servants during the performance of a contract resulting from this RFP.

VI. No Waiver of Default

a. The failure of MSHN to insist upon strict adherence to any term of a contract resulting from this RFP shall not be considered a waiver or deprive MSHN of the right thereafter to insist upon strict adherence to that term, or any other term, of the contract.

VII. Disclaimer

a. All the information contained within this RFP and its attachments reflect the best and most accurate information available to MSHN at the time of RFP preparation. No inaccuracies in such information shall constitute a basis for legal recovery of damages, either real or punitive.
b. All proposals submitted pursuant to this RFP become the sole property of MSHN.

Section III - MINIMUM QUALIFICATIONS

Provider Requirements: Interested Providers shall meet the following minimum requirements to be considered for funding and attest to the following using *Attachment J – Minimum Qualifications Attestation*:

a. Have the necessary systems in the areas of administration and clerical support for the program. This includes the necessary computer equipment, compatible software and Internet connections to be able to electronically request authorization for services and submit data and billing; a valid, active and maintained email account that can receive and submit communications is also required.

b. Have an established financial system in operation which meets generally accepted accounting principles and systems (i.e., maintains fiscal solvency).

c. For services requiring licensure under Michigan law, Provider shall hold and maintain the applicable current LARA Substance Use Disorder program license for each service category proposed, including residential and/or residential withdrawal management services, as applicable. If licensure is pending, Provider shall provide documentation of the applicable licensing application and anticipated timeline for approval. Any contract award shall be contingent upon the Provider obtaining all required licensure prior to service delivery.

d. Provider shall obtain and maintain MDHHS approval/designation for each ASAM level of care proposed under this RFP in accordance with the current ASAM Criteria as adopted by MDHHS, MDHHS enrollment/designation requirements, and MiCAL processes in effect at the time services are provided. Provider shall submit documentation of current designation or, if designation is pending, documentation demonstrating completion or active pursuit of the applicable enrollment/designation process. Any contract award for a specific level of care shall be contingent upon successful MDHHS designation for that level of care.

    - Withdrawal Management – ASAM 3.2 & 3.7 LOC for adolescents
        - Open to all 21 counties in MSHN Region
    - Residential – ASAM 3.5 & 3.7 LOC for adolescents
        - Open to all 21 counties in MSHN Region
    - Outpatient – ASAM 1.0, 1.5, 1.7, 2.1, 2.5, & 2.7 LOC's for adolescents
        - Open to all 21 counties in MSHN Region, but prioritized for: Arenac; Clare; Gladwin; Gratiot; Hillsdale; Ionia; Isabella; Mecosta; Midland; Newaygo and Osceola

    i. If bidder has received MDHHS ASAM LOC Designation approval, attach a copy of the completed enrollment application and letter from MDHHS indicating approval.
    ii. If bidder has not completed the MDHHS ASAM enrollment process, complete ASAM LOC Designation enrollment process. Any contract award will be contingent upon successful designation by MDHHS for the ASAM LOC contemplated within this RFP through the MiCal system.

e. In addition to all applicable Medicaid, LARA, licensure, certification, and credentialing

requirements, Provider shall ensure that staff delivering direct services to adolescents meet applicable MDHHS adolescent-specific qualification requirements. Provider shall maintain documentation demonstrating the adolescent-specific education, training, supervised experience, and/or competency of direct-service staff and shall provide appropriate supervision for staff working toward required adolescent-specific qualifications.

f. Provider shall demonstrate the capacity to deliver developmentally appropriate, culturally and linguistically responsive, gender-responsive, inclusive, and accessible services to adolescents with diverse racial, ethnic, cultural, socioeconomic, disability, sexual orientation, gender identity, language, and communication needs. Provider shall describe how these competencies are incorporated into assessment, treatment planning, staffing, service delivery, family engagement, physical environment, quality improvement, and outcomes monitoring.

g. Agree to comply with Federal Confidentiality, Privacy and Security Regulations, and State Confidentiality laws. This includes compliance with Title 42 (Public Health) of the Code of Federal Regulations (CFRs) (see web address identified on *Attachment H – Source References*). Provider shall maintain written policies and staff competency regarding adolescent consent, parent/guardian involvement, confidentiality, access to records, and disclosure of information in accordance with applicable federal and Michigan law. Policies shall address circumstances in which a minor may independently consent to SUD treatment, circumstances in which a parent or guardian may seek treatment for a minor, emergency and withdrawal-management situations, and the conditions under which information may be disclosed to parents, guardians, other providers, schools, courts, or other involved systems.

h. Provider shall maintain appropriately trained staff and organizational capacity to administer the current MDHHS-required adolescent assessment instrument, including the GAIN-I Core when required, and shall demonstrate how assessment results are incorporated into ASAM level-of-care determination, individualized treatment planning, identification of co-occurring needs, continuing-service decisions, and discharge or transition planning.

Section IV - PROPOSAL SUBMISSION

I. Economy of Preparation

a. Proposals shall be prepared simply, economically, and according to the format delineated elsewhere in this RFP. The Provider is expected to provide a straight-forward, concise description of the Provider's ability to meet the requirements of the RFP. Fancy bindings, colored displays, promotional materials, etc., are not desired. Emphasis shall be on the completeness and clarity of content.

II. Provider Responsibilities

a. Utilization of technology to obtain needed RFP documents and inform MSHN of questions.
b. Carefully review the entire RFP prior to submitting a response. The Provider, by submitting a response, attests to its full understanding of all details and specifications related to this RFP.
c. Be responsive in a manner that utilizes the order specified on the Provider Checklist (*Attachment A*) to aid proper consideration of each section of the proposal.
d. Use concise, persuasive language (see Economy of Preparation above). Clearly identify any best or evidence-based practice to be utilized.
e. Ensure all related required documents/narratives are addressed for each proposed service.
f. Providers are encouraged to be creative in the development of their proposed delivery of services. Collaboration with community partners is encouraged and shall be described where appropriate.
g. Submission of documents in a timely manner via delivery mechanisms as indicated in the RFP.
h. By submission of a proposal, the selected Provider attests it shall meet current MSHN Board Procedure and Policy requirements for the duration of the contract. This information can be found on the MSHN website.
i. By submission of a proposal, the selected Provider attests that it shall adhere to the specifications for services herein. Service descriptions shall be made part of Provider contracts and monitored accordingly.
j. Successful Providers shall agree to accept and serve all individuals referred by MSHN or its agent under the contract.

III. Proposal Submission

a. Proposal and all required attachments shall be provided electronically to MSHN no later than 5:00 p.m. on Friday, November 13, 2026, to be considered. Proposal content shall be organized in a manner that directly corresponds with the RFP (e.g., use of same headings as within RFP). Electronic submissions MUST be organized in a manner that corresponds with the RFP and RFP submission. Electronic documents shall be labeled by RFP section, subpart and document name (e.g., VI_I_Provider Profile).
b. Proposals shall be accepted until 5:00 p.m. on Friday, November 13, 2026. Proposals must be received by the specified closing date and time to be reviewed. Proposals submitted after the closing date and time shall not be considered and shall be declared invalid.
c. An official authorized to bind the Provider to its provisions shall sign the proposal submission (see *Provider Cover Sheet – Attachment B*).
d. All proposals shall identify a primary point of contact for the provider.
e. All Proposals shall be delivered electronically by e-mail at the following address:
    i. Attention: leslie.thomas@midstatehealthnetwork.org

ii. The following title shall appear on the subject line of the e-mail message for proper delivery:
    1. CONFIDENTIAL RESPONSE – SUD Adolescent Treatment Services RFP

Section V - NOTIFICATION OF INTENT TO BID / PROVIDER QUESTIONS

I. Notification of Intent to Bid Requested

a. The bidding Provider is requested to inform MSHN of their intent to bid for the services outlined in this RFP. The Provider shall inform MSHN of their intent to bid by the Intent to Bid deadline identified in Section I, Timeline via email to Leslie Thomas at lesliethomas@midstatehealthnetwork.org. The email shall be clearly labeled with subject line "SUD Adolescent TREATMENT SERVICES RFP INTENT TO BID." The content of the email shall contain the name and address of the Provider as well as the services they intend to bid for.

II. Provider Questions

a. Provider questions can be submitted Attn. Leslie Thomas (by email only to lesliethomas@midstatehealthnetwork.org with the subject line "SUD Adolescent TREATMENT RFP QUESTIONS") until the Provider Questions deadline identified in Section I, Timeline. All responses to questions shall be disseminated by MSHN on the response date identified in Section I, Timeline to all parties that have submitted an Intent to Bid notice, as described. RFP related or specific questions shall not be accepted for response in any format other than described in this paragraph.

Section VI – BIDDER REQUIRED NARRATIVE/DOCUMENTS

Documentation Requirements

Interested Providers shall meet and provide documentation for the following to be considered. Provider narrative shall include the Provider name on each page. Responses shall be double spaced, Arial font size 11. Failure to include complete responses for each of the applicable sections shall result in a loss of points. For any of the following, if the required narrative and/or document is not available (such as for a recently licensed entity), Provider may indicate "not applicable" and provide an explanation.

I. **Provider Profile (50 points)**: Provider shall provide a narrative description and any supporting documentation to address the following:
   a. Provider Cover Sheet (see *Attachment B*).
   b. History of Provider organization and explanation of the purpose or mission of the Provider and how it relates to the RFP.
   c. Business status: Proof of Business Entity - Documentation and proof of business entity as recognized by the Internal Revenue Service (IRS).
   d. Describe the rationale for the Provider pursuing this opportunity.
   e. Describe future plans/issues facing the Provider.
   f. List experiences with developing and sustaining collaborative relationships with other agencies and/or where mergers have occurred.
   g. Describe the Provider's experience in this or related field. Be sure to detail specific experience related to providing SUD services for adolescents.
   h. MDHHS ASAM LOC Designation Letter or completed Application for ASAM LOC Designation, if not already enrolled.
   i. MSHN Provider Application (see *Attachment F*).
   j. Disclosure of Ownership, Controlling Interest, and Criminal Convictions (see *Attachment G*). All sections within the Attestation must be completed regardless of status of the organization (e.g., Non-Profit, Government, Corporation). This includes full addresses, dates of birth and social security numbers for all identified management staff and/or Board Members as outlined in PIHP Policy and the Code of Federal Regulations (*see Attachment H – Source References*).

II. **Organization/Management:** Provider shall provide a narrative description and any supporting documentation to address the following:
   a. **General (5 points):**
      i. Provide a current, dated, program specific Organizational Chart which includes administrative structure.
   b. **Personnel Management (10 points):**
      i. Provide assurances that bidder meets MSHN Minimum Training Requirements. Refer to *Attachment H – Source References*.
      ii. Description of process and frequency for training staff and evaluating staff performance.
   c. **Financial Management (25 points):**
      i. Financial Audit: The Provider shall attach a copy of its Audited Financial Statements for the previous two (2) years of operation. This shall include auditor notes and comments as well as any Management Letters.
      ii. Explain if there are any pending or unresolved issues that relate to the last two (2)

years of fiscal audits and/or if the Provider has made a plan of correction addressing those areas. Include corrective action steps taken. Note: Provider may indicate "not applicable" if the Provider does not have any unresolved issues and/or has not had identified areas which would require corrective action steps.

iii. Include a completed MSHN Provider Services Cost Summary.
iv. Providers will be reimbursed for services based on MSHN's regional rate schedule. If requesting startup funds to assist with costs related to starting new program, the Provider shall submit "MSHN Services Cost Summary" (*Attachment C*).
v. If requesting startup funds to assist with costs related to starting a new program, the Provider shall submit a sustainability plan to ensure the ability to maintain operations.

d. Information Systems (15 points):
   i. Description of information system (including data entry process, data disaster recovery and adherence to the Health Insurance Portability and Accountability Act (HIPAA) standards).
   ii. Description of system for monitoring and processing authorizations and claims of services being provided.
   iii. Description of capacity to complete a HIPAA Risk Assessment and Security Management Plan.
e. Quality Management (30 points):
   i. Description of Quality Improvement Plan (this shall include information on how reports are utilized and methods used to measure outcomes and utilization).
   ii. If a new provider, explain how a Quality improvement Plan and/or MSHN's Quality Assessment Performance Improvement Plan will be followed and/or used.
   iii. Provider's Quality Improvement Plan shall include adolescent-specific measures addressing, at minimum, timely access, initiation and engagement, retention, successful transition between levels of care, discharge and continuing-care linkage, co-occurring behavioral health needs, family engagement when appropriate, recipient/youth satisfaction, and clinical outcomes. Provider shall describe how data will be reviewed for disparities in access, engagement, retention, service utilization, and outcomes among relevant demographic and geographic populations and how identified disparities will inform quality improvement activities.
   iv. Provider shall describe how youth voice and, when appropriate, family/caregiver feedback are incorporated into program planning and quality improvement. The Provider shall demonstrate how satisfaction, complaints, engagement experiences, environmental safety, cultural responsiveness, welcoming practices, and barriers to care are evaluated and used to improve adolescent services.
   v. Include the most recent Quality Improvement Plan.
   vi. Include the most recent Customer Satisfaction Survey.
f. Community Involvement (20 points):
   i. Description of how Provider utilizes participation from individuals served in policy development, program planning and routine decision making.
   ii. Description of process to utilize community resources from existing entities in program planning.
   iii. Description of Provider's capacity to have Coordination Agreements in place with Community Mental Health Services Programs (CMHSP) and also in place with one

(1) or more licensed medical service facilities for the provision of emergency inpatient and ambulatory medical services.

iv. Provider shall describe established or planned coordination and referral relationships with organizations important to the adolescent system of care, including CMHSPs and behavioral health providers, pediatric and primary care providers, hospitals and emergency departments, schools and educational systems, child welfare/foster care agencies, juvenile justice partners, family support organizations, recovery support providers, and other community resources relevant to the population served.

g. Corporate Compliance (5 points):
   i. Description of Corporate Compliance Plan process and include a copy of the most recent Plan if applicable. Note: The Federal Medicaid Integrity Program (MIP) requires entities receiving more than five million dollars ($5 million) in Medicaid funds to have a Corporate Compliance Plan. Note: Provider may indicate "not applicable" if the Provider does not have its own Compliance Plan.

h. Recipient Rights (10 points):
   i. Description of procedures relating to the Recipient Rights process.
   ii. Provide the following information for the previous two (2) years:
      1. Number of Recipient Rights complaints
      2. Number of substantiated complaints by category
      3. Description of what corrective actions were taken to address the substantiated Rights violations

III. Facility License (5 points): The Provider shall attach evidence of current State of Michigan License and/or any applicable application under review (required: licensed SUD Treatment services, approved by MDHHS to provide SUD Treatment related services). Note: If the Provider is not licensed, the Provider shall provide information pertinent to pending state licensing application(s).

IV. Insurance (30 points): The Provider shall attach evidence of current:

a. Worker's Compensation insurance coverage in accordance with applicable and required law governing work activities; Waiver of subrogation, except where waiver is prohibited by law.
b. Professional Liability insurance coverage (errors and omissions) in a sum of not less than $1,000,000 per claim and $3,000,000 in annual aggregate.
c. Commercial General Liability insurance coverage with broad form endorsement or equivalent, if not in the policy proper, $1,000,000 each occurrence; $1,000,000 Personal & Advertising Injury; $2,000,000 Products/Completed Operations; $2,000,000 General Aggregate.
d. Automobile Liability insurance coverage including all owned, non-owned, and hired vehicles. If a motor vehicle is used in relation to the Contractor's performance, the Contractor must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law. Note: Provider may indicate "not applicable" if the Provider shall not be transporting individuals.
e. Employers Liability Insurance in a sum of not less than $500,000 each accident; $500,00 each employee by disease; $500,000 aggregate disease
f. Privacy & Security Liability (Cyber Liability) insurance coverage policy must cover information security, privacy liability, privacy notification costs, regulatory defense &

penalties, and website media content liability with limits not less than $1,000,000 each occurrence and $1,000,000 annual aggregate.

V. **Implementation Planning (30 points):** Provider shall submit an implementation plan which shall be put into place if awarded a contract for services including:

a. Provider shall identify each evidence-based or evidence-informed intervention proposed for adolescent services and describe the target population, evidence supporting its use with adolescents, staff training and qualification requirements, supervision expectations, implementation plan, and process for monitoring fidelity. Adult treatment models shall not be presumed appropriate for adolescents solely because they have been adapted for use with younger populations. If the provider is submitting a proposal for SUD outpatient services for ASAM 2.1 and/or 2.5, residential services for ASAM 3.5 and/or 3.7, then please submit the weekly schedule for each level of care with your proposal.
b. Estimated timeframe for hiring, onboarding, and training new program staff (if applicable) to meet the minimum staffing requirements for SUD Treatment related services as outlined in the MDHHS Michigan Medicaid Provider Manual (refer to *Attachment H – Source References*).
c. Describe who in your organization shall be responsible for reporting to MSHN.
d. Describe the Provider's plan for addressing program service capacity regarding PIHP referrals.
e. Procurement of any organization or staff required license and/or certification.
f. Timeframe in which the Provider plans to assume contractual obligations.

VI. **References (10 points):** Provider shall submit two (2) letters of reference/support from various community agencies and/or professional individuals with whom the Provider has collaborated within the last five years.

Section VII - TREATMENT SERVICES REQUIRED NARRATIVE / DOCUMENTS

Documentation Requirements

Interested Providers shall meet and provide documentation for the following to be considered. Provider narrative shall include the Provider name on each page. Responses shall be double spaced, Arial font size 11. Failure to include complete responses for each of the applicable sections shall result in a loss of points. For any of the following, if the required narrative and/or document is not available (such as for a recently licensed entity), Provider may indicate "not applicable" and provide an explanation.

I. Treatment Services Overview (10 points)

a. MSHN expects adolescent SUD treatment services to be evidence-based, individualized, developmentally appropriate, recovery-oriented, trauma-informed, culturally and linguistically responsive, and integrated with the adolescent's broader system of care. Services shall be provided at the clinically appropriate intensity, duration, and scope based on medical necessity, comprehensive assessment, applicable diagnostic criteria, and the current ASAM Criteria as adopted by MDHHS. Treatment shall consider developmental stage, strengths, substance use history, physical and behavioral health, trauma history, family and caregiver context, educational or vocational functioning, social and recovery environment, safety needs, and other clinically relevant factors.

b. Adolescent services shall not consist solely of adult treatment programming made available to adolescents. Programming, clinical interventions, educational materials, group content, milieu, recreational activities, behavioral expectations, family involvement, and treatment approaches shall be designed for adolescent developmental needs. When adolescent and adult services are co-located, the Provider shall describe how adolescent safety, confidentiality, programming, therapeutic milieu, and interactions with adult participants are appropriately separated and managed.

II. Core Requirements Across All Levels of Care (55 Points)

a. *Assessment and Individualized Treatment Planning*: Provider shall maintain appropriately trained staff and organizational capacity to administer the current MDHHS-required adolescent assessment instrument, including the GAIN-I Core when required. Assessment findings shall inform level-of-care determination, individualized treatment planning, co-occurring needs, continuing-service decisions, and discharge or transition planning. Treatment plans shall actively involve the adolescent and include parents, guardians, caregivers, physicians, and other involved professionals when clinically appropriate, legally permissible, and consistent with consent and confidentiality requirements.

b. *Evidence-Based and Developmentally Appropriate Practice*: Provider shall use evidence-based or evidence-informed interventions appropriate for adolescents and maintain processes for staff training, supervision, implementation, and fidelity monitoring.

c. *Family and Natural Supports*: Provider shall describe how parents, guardians, caregivers, family members, and other natural supports are engaged in assessment, treatment, family counseling or education, recovery planning, and community re-entry when clinically appropriate and legally permissible.

d. *Co-Occurring Behavioral Health Needs*: Provider shall demonstrate capacity to identify and address co-occurring mental health and substance use disorders through screening and assessment, integrated treatment planning, access to mental health clinicians and

psychiatric consultation, medication management when indicated, suicide/self-harm risk response, crisis intervention, and coordination with behavioral health providers.

e. *Engagement, Retention, and Welcoming Practices*: Provider shall describe strategies to engage and retain adolescents and reduce barriers, including first-contact engagement, flexible scheduling when applicable, transportation, school-related barriers, family/caregiver engagement, outreach after missed appointments, and re-engagement following disengagement or return to use.

f. *Clinical Response to Return to Use or Change in Status*: Return to substance use, difficulty engaging, behavioral challenges, psychiatric symptoms, or other changes in clinical status shall prompt clinically appropriate reassessment and treatment-plan modification and/or transfer when indicated. Administrative discharge shall not substitute for appropriate reassessment, engagement, safety planning, or care transition.

g. *Education, Life Skills, and Development*: Programming shall incorporate developmentally appropriate education, life-skills development, recreation, prosocial activities, and preparation for age-appropriate independent functioning. Providers shall support educational continuity and appropriate GED, vocational, or employment linkages.

h. *Medication Assisted Treatment (MAT)/Medication for Opioid Use Disorder (MOUD)*: Provider shall describe its approach to MAT/MOUD for adolescents when clinically indicated, including qualified prescribers, continuation of existing medications, external coordination when necessary, informed consent, family involvement when legally appropriate, monitoring, and continuity during transitions.

i. *Communicable Disease Prevention*: Provider shall maintain processes for communicable disease screening, testing, education, referral, documentation, staff training, and follow-up consistent with applicable MDHHS requirements.

j. *Care Coordination, Continuing Care, and Community Re-entry*: Planning shall begin at admission and include warm transitions, receiving-provider coordination, follow-up appointments when feasible, authorized information transfer, medication continuity, transportation planning, family/caregiver involvement, educational re-entry, and linkage to treatment, medical care, and recovery supports.

k. *Health Equity and Population Health*: Provider shall identify, monitor, and address disparities in adolescent access, engagement, retention, utilization, transitions, and outcomes and describe how findings inform outreach, program design, service delivery, partnerships, and quality improvement.

III. Withdrawal Management Services (35 Points)

a. Provider proposing adolescent withdrawal management services shall operate in a properly licensed and accredited setting and demonstrate clinical, medical, nursing, staffing, facility, monitoring, and emergency-response capability consistent with each specific withdrawal management level of care proposed, the current ASAM Criteria as adopted by MDHHS, MDHHS Treatment Policy, LARA requirements, Michigan Medicaid requirements, and MSHN requirements.

b. Identify each withdrawal management level of care proposed and demonstrate current or pending MDHHS designation and capacity to meet all applicable requirements.

c. Maintain written protocols for adolescents whose withdrawal severity, biomedical condition, psychiatric condition, behavioral instability, or other needs exceed program

capability, including timely consultation, escalation, emergency intervention, direct transfer, and established transfer relationships.

d. Residential withdrawal management services shall operate twenty-four (24) hours per day, seven (7) days per week with staffing, supervision, observation, medical oversight, nursing availability, and on-call coverage consistent with the specific level of care provided.

e. Maintain developmentally appropriate procedures for suicide/self-harm, acute psychiatric symptoms, behavioral instability, aggression, elopement/runaway risk, abuse/neglect, exploitation/human trafficking, withdrawal complications, and other immediate safety risks, including safety planning, crisis intervention, mandated reporting, emergency transfer, and post-crisis review.

f. Comply with communicable disease requirements applicable to residential withdrawal management, including tuberculosis screening/testing upon admission and required screening, education, referral, and follow-up for other communicable disease risks.

g. Withdrawal management shall function as part of a continuum of care, with treatment and continuing-care needs identified at admission and timely transition to ongoing SUD treatment and recovery supports secured.

IV. Residential Services (35 Points)

a. Provider proposing adolescent residential services shall operate in a properly licensed and accredited setting and demonstrate compliance with all current requirements applicable to each adolescent residential level of care proposed, including the current ASAM Criteria as adopted by MDHHS, MDHHS Treatment Policy, applicable MDHHS residential treatment requirements, Michigan Medicaid requirements, LARA Administrative Rules, and MSHN contractual standards. References to adult residential treatment policies shall apply only to the extent MDHHS identifies those requirements as applicable to adolescent services or MSHN expressly incorporates them into the resulting contract.

b. Identify each adolescent residential level of care proposed and demonstrate current or pending MDHHS designation and capacity to meet all applicable requirements.

c. Describe adolescent-specific residential curriculum and programming, including therapeutic interventions, individual and group services, family services, education, life skills, recreation, recovery supports, and therapeutic milieu.

d. Describe how educational continuity will be maintained during treatment and how youth will be supported in returning to school, GED, vocational programming, or another appropriate educational setting at discharge.

e. Maintain trauma-informed processes for adverse childhood experiences, abuse, neglect, violence exposure, trauma-related symptoms, exploitation, and human trafficking, including staff training, safety planning, mandated reporting, intervention, and referral.

f. Demonstrate twenty-four (24) hour staffing and supervision and all medical, nursing, clinical, behavioral health, direct-care, supervisory, emergency, and on-call coverage required for the specific residential level of care proposed.

g. Residential services shall function as part of a continuum of care, with coordination and community re-entry planning beginning at admission.

V. Outpatient Services (25 Points)

a. Provider proposing adolescent early intervention, outpatient, or intensive outpatient

services shall meet all current MDHHS enrollment/designation, Medicaid provider qualification, accreditation, credentialing, and other regulatory requirements applicable to each level of care proposed. Where state facility licensure is required, Provider shall maintain the applicable LARA license.

b. Identify each adolescent outpatient level of care proposed and demonstrate current or pending MDHHS designation and capacity to meet applicable requirements.

c. Describe the service model, frequency and intensity of services, individual and group interventions, family services, care coordination, co-occurring capability, and processes for adjusting service intensity based on changing clinical need.

d. Describe scheduling and service-delivery strategies that reduce barriers related to school, transportation, family obligations, geography, and other factors affecting adolescent access and retention.

e. Outpatient services shall function as part of a continuum of care and include warm transitions to higher or lower levels of care when clinically indicated.

VI. Required Treatment Services Narrative / Documents (65 Points):

a. Provider shall submit a concise response addressing the following. Responses should avoid duplicating information provided elsewhere in the proposal and may cross-reference another section when the requested information is fully addressed there.

    a. *Treatment Philosophy and Clinical Model*: Describe how the proposed program operationalizes developmentally appropriate, evidence-based, recovery-oriented, trauma-informed, culturally responsive, and family-inclusive care.

    b. *Evidence-Based Practices and Outcomes*: Identify proposed interventions, target adolescent populations, staff training/supervision, fidelity monitoring, and available outcome data or evidence supporting their use.

    c. *Progress Monitoring*: Describe the method and frequency used to evaluate progress and how findings modify treatment, service intensity, or level of care.

    d. *Co-Occurring Capability*: Describe integrated behavioral health screening, treatment planning, mental health/psychiatric supports, medication management, crisis response, and coordination.

    e. *Engagement and Access*: Describe first-contact engagement, retention, scheduling, transportation, school-related barriers, family engagement, outreach, re-engagement, and monitoring of access and retention.

    f. *Safety and Crisis Management:* Residential and withdrawal management bidders shall describe suicide/self-harm, psychiatric deterioration, aggression/violence, elopement/runaway risk, medical emergencies, withdrawal complications, abuse/neglect, exploitation/human trafficking, mandated reporting, emergency transfer, and post-crisis review.

    g. *Family and Caregiver Engagement*: Describe orientation, communication, family counseling/education, visitation where applicable, treatment/recovery planning participation, community re-entry preparation, and caregiver supports consistent with consent and confidentiality.

    h. *Education Continuity*: Residential bidders shall describe educational participation during treatment and transition to school, GED, vocational, or

employment programming following discharge.

i. *Medication Assisted Treatment (MAT)/Medication for Opioid Use Disorder (MOUD)*: Describe access to and continuity of clinically indicated MAT/MOUD, including qualified prescribers, external coordination, informed consent, monitoring, and transitions.

j. *Communicable Disease Prevention*: Describe applicable screening, testing, education, referral, documentation, staff training, and follow-up.

k. *Transitions and Continuing Care*: Describe warm transitions between levels of care and discharge/community re-entry coordination.

l. *Health Equity and Population Health*: Describe how disparities in access, engagement, retention, utilization, transitions, and outcomes will be identified, monitored, addressed, and incorporated into quality improvement.

m. *Clinical Staffing*: Submit a level-of-care-specific staffing plan identifying each position, FTE, credential/licensure/qualification, adolescent-specific qualification or experience, existing versus vacant status, supervision structure, shift coverage, on-call coverage, and recruitment timeline. Residential and withdrawal management plans shall separately identify medical, nursing, clinical, behavioral health, direct-care, supervisory, and emergency coverage.

Section VIII - PRE-CONTRACT REVIEW

I. Delegated Functions

a. Managed care administrative functions that shall be performed by MSHN are specifically defined within the Code of Federal Regulations (CFRs). MSHN has overall responsibility to manage these functions. Prior to delegating specific managed care functions to any treatment services Provider, MSHN shall conduct a Pre-Contract Assessment to determine the Provider's capacity to carry out those specific functions.

b. Prior to contract start date, the Provider shall comply or have an implementation plan in place to comply with standards and requirements as identified in the Pre-Contract Site Review. The required information shall be reviewed only if the Provider is awarded a contract. At that time, additional clarification and/or documents may be requested of the Provider by MSHN as part of the Pre-Contract evaluation.

Section IX - RATES

I. Cost Documentation

a. Providers will be reimbursed for services based on MSHN's regional rate schedule. If the Provider anticipates requesting an advance to assist with the costs related to starting up a new program, please complete MSHN Provider Services Cost Summary form (*Attachment C*) along with a sustainability plan to ensure the ability to maintain operations at or below the max fee screen shall be submitted.

Section X - SUBMISSION EVALUATION

I. Evaluation Process

a. Award recommendations are contingent upon evaluation of the responses submitted.

b. A Review Committee for the RFP shall be formed by MSHN who shall evaluate each proposal through the use of the evaluation rating criteria (see *Attachment D*).

c. Any additional proposal evaluation shall be completed by MSHN staff and recommendations shall be made to the MSHN Board based on overall evaluation results, service need and network capacity. It is the objective of MSHN to acquire needed services and supports at fair and economical prices, with appropriate attention to quality of care and maintenance of existing – care relationships and service networks currently utilized. The following is an overview of the criteria which MSHN shall utilize when evaluating proposals:

   i. All minimum requirements identified within the RFP have been met;
   ii. Suitability of the Proposal
   iii. Proposal aligns with MSHN's mission;
   iv. Proposed solution meets the needs and criteria set forth in the RFP;
   v. Qualifications necessary to undertake service project. Attain and retain qualified staff to deliver services throughout the time frame needed;
   vi. Proposal provides evidence of Providers competency and capacity to perform the functions defined within the RFP;
   vii. Expertise in delivery of appropriate clinical solutions. Successful delivery of similar services;
   viii. Evaluation and review of compliance, quality and customer service reviews within MSHN and/or other PIHPs (existing providers only).
   ix. Identified budget consistent with program objectives and demonstrates alignment with quality of service.

d. The MSHN Board shall make the final decision.

Section XI - ATTACHMENTS

ATTACHMENT A: PROVIDER CHECKLIST

ATTACHMENT B: PROVIDER COVER SHEET

ATTACHMENT C: MSHN PROVIDER SERVICES COST SUMMARY

ATTACHMENT D: PROPOSAL EVALUATION/RATING CRITERIA

ATTACHMENT E: APPLICATION FOR ASAM LOC DESIGNATION

ATTACHMENT F: MSHN PROVIDER NETWORK APPLICATION

ATTACHMENT G: DISCLOSURE OF OWNERSHIP, CONTROLLING INTEREST, CRIMINAL CONVICTION

ATTACHMENT H: SOURCE REFERENCES

ATTACHMENT I: CERTIFICATE OF COMPLIANCE WITH PA517 OF 2012 FORM

ATTACHMENT J: MINIMUM QUALIFICATIONS ATTESTATION FORM

NOTE:

All Attachments are listed separately from the RFP main document on MSHN's website at https://midstatehealthnetwork.org/stakeholders-resources/about-us/news

ATTACHMENT A - PROVIDER CHECKLIST

SECTION VI REQUIRED NARRATIVE / DOCUMENTS				
SUB-SECTION	INFORMATION	REQUIRED	OPTIONAL	NOTES
VI(I) PROVIDER PROFILE	Provider Cover Sheet (Att. B)	x		
	Narrative Description (5 items)	x		
	Proof of Business Entity	x		
	MSHN Provider Network Application (Att. F)	x		
	Disclosure of Ownership, Controlling Interest, and Criminal Convictions (Att. G)	x		
	MDHHS ASAM LOC Designation Letter, if available or completed Application (Att. E)	x		
VI(II) ORGANIZATION MANAGEMENT	GENERAL			
	Narrative Description (1 item)	x		
	Organizational Chart	x		
	PERSONNEL MANAGEMENT			
	Narrative Descriptions (2 items)	x		
	FINANCIAL MANAGEMENT			
	Narrative Description (2 items)	x		
	Audited Financial Statements (include Auditor Notes & Management Letters)	x		
	MSHN Provider Services Cost Summary (Att. C)	x		
	Sustainability Plan		X – *only if requesting startup funds*	
	INFORMATION SYSTEMS			
	Narrative Description (3 items)	x		
	QUALITY MANAGEMENT			
	Narrative Description (1 item)	x		
	Quality Improvement Plan	x		
	Customer Satisfaction Survey	x		
	COMMUNITY INVOLVEMENT			
	Narrative Descriptions (3 items)	x		
	CORPORATE COMPLIANCE			
	Narrative Description (1 item)	x		
	Corporate Compliance Plan		X - *Only for Providers receiving more than five (5) million dollars in Medicaid Funds (all sources)*	
	RECIPIENT RIGHTS			
	Narrative Descriptions (2 items)	x		
VI(III) FACILITY LICENSE	Facility License	x		
VI(IV) INSURANCE	Worker's Compensation Insurance Coverage	x		
	Professional Liability Insurance Coverage	x		
	Commercial General Liability Insurance Coverage	x		
	Automobile Liability Insurance Coverage		X - *Only if Provider will be transporting individuals*	
	Employers Liability Insurance Coverage	x		

	Privacy & Security Liability Insurance Coverage (Cyber Liability)	x		
VI(V) ORG. TRANSITION PLANNING	Narrative Description (5 items)	x		
VI(VI) REFERENCES	Letters of Reference (2)	x		
SECTION VII TREATMENT SERVICES				
SUB-SECTION	INFORMATION	REQUIRED	OPTIONAL	NOTES
VII(I) TREATMENT SERVICES PROGRAM OVERVIEW	TREATMENT SERVICES PROGRAM OVERVIEW			
	Narrative Description (8 items)	x		
	CRISIS RESIDENTIAL SERVICES			
	Narrative Description (6 items)	x		
	STAFFING REQUIREMENTS			
	Narrative Description (1 item)	x		
SECTION VIII Precontract Evaluation				
SUB-SECTION	INFORMATION	REQUIRED	OPTIONAL	NOTES
VIII (I) Pre-Contract Review	Pre-Contract Evaluation	x		

Section IV (Proposal Submission):

One (1) electronic copy (via email) of the proposal shall be submitted by the end of business day (5:00 P.M.) on Friday, December 15, 2023 and labeled by RFP section, subpart and document name. All Proposals shall be delivered electronically by e-mail at the following address: kyle.jaskulka@midstatehealthnetwork.org

The following title shall appear on the subject line of the e-mail message for proper delivery:
CONFIDENTIAL RESPONSE – SUD Adolescent Treatment Services RFP

Section V (Notification of Intent to Bid):

The Provider is requested to inform MSHN of their intent to bid by the end of business day (5:00 P.M.) on Friday, November 3, 2023 via an email to kyle.jaskulka@midstatehealthnetwork.org. The email shall be clearly labeled with subject line "SUD ADOLESCENT TREATMENT SERVICES RFP INTENT TO BID."

The Provider is requested to submit questions to MSHN by the end of business day (5:00 p.m.) on Friday, November 10, 2023 via an email to kyle.jaskulka@midstatehealthnetwork.org. The email shall be clearly labeled with subject line "SUD ADOLESCENT TREATMENT SERVICES RFP QUESTIONS."

ATTACHMENT B - PROVIDER COVER SHEET

Legal Business Name: _____

DBA (if applicable): _____

Federal Tax ID Number: _____

Address: _____

Executive Director: _____

Chief Financial Officer: _____

Chief Operations Officer _____

Recipient Rights Advisor: _____

SIGNED STATEMENT OF AUTHORITY

I _____ AM THE _____
Name of Official Title of Official

OF _____
Name of Bidding Organization

I AM AUTHORIZED TO MAKE THE FOLLOWING PROPOSAL ON BEHALF OF THE ORGANIZATION NAMED ABOVE.

I HEREBY CERTIFY: The bidding organization understands and will comply with the specific assurances and certifications contained in this proposal, and further; that the bidding organization understands and will comply with the rules, regulations and policies of the Michigan Department of Health and Human Services (MDHHS). All responses to this Request for Proposal (RFP) concerning the respondent organization, its operation and proposed program are true and accurate. The bidding organization understands that this proposal is an application for funding and does not ensure subsequent funding. If selected for funding, the bidding organization will be bound by the information contained herein as well as the terms and conditions of the resultant contract.

_____
Signature Date

COST SUMMARY INSTRUCTIONS – RFP

Row 6: Number of Months Start-up Expense – Please enter the number of months the expenses below will cover.

PLEASE NOTE: ALL EXPENSE ENTRIES BELOW SHOULD BE ENTERED FOR THE NUMBER OF MONTHS LISTED FOR START-UP. ALSO, FIELDS HIGHLIGHTED IN ORANGE CONSISTS OF BUILT IN FORMULA THUS NO ENTRY IS NEEDED.

DIRECT COSTS

A. Salaries & Fringes
    a. Direct Program Salaries – Enter salaries for all employees engaged in service delivery.
    b. All other payroll costs – Enter payroll taxes, employee benefits, and all other related payroll costs for staff noted in item a.
B. Operations
    a. Supplies – Enter costs for general office supplies.
    b. Contractual – Enter expenses for contractual staff providing services.
    c. Equipment – Enter costs associated with materials needed to furnish office space such as desks, chairs, printers, etc. All individual items must be less than $5,000. Capital items such as costs associated with office reconfiguration (moving walls), adding HVAC systems, and other significant improvements are the responsibility of the bidder.
    d. Non-fringe insurance – Enter liability insurance expense and any other insurance employee insurance requirements.
    e. Training – Enter cost of training needed to meet MSHN contractual requirements for service delivery.
    f. Travel – If applicable, enter estimated travel reimbursement to employees at the current calendar year's Federal mileage rate.
C. Overhead – Direct (Building related)
    a. Lease Expenses – Enter monthly lease expense times the number of start-up months requested.
    b. Repairs and Maintenance – Enter minor repairs and maintenance costs such as replacing a broken sink or fixing an existing door.
    c. Insurance – Enter insurance associated with building.
    d. Other Costs – Enter costs not noted in items a-c of this section.

INDIRECT COSTS

A. Administration
    a. Salaries – Enter salaries for administrative employees performing roles other than service delivery.
    b. All other payroll costs - Enter payroll taxes, employee benefits, and all other related payroll costs for staff noted in item a.
B. Other Allocated Costs – bidders should note administrative expenses allocated to the line of business listed in the RFP. For example, 5% of the CEO's time may be allocated.

MSHN PROVIDER SERVICES COST SUMMARY

Provider		**Program Name**	
Provider Address		**Program Address if different from Provider**	
Number of Months Start-up expense			

DIRECT COSTS	
A. Salaries & Fringes	
Direct Program Salaries	
All other payroll costs	
B. Operations	
Supplies	
Contractual	
Equipment	
Non-fringe Insurance	
Training	
Travel	
C. Overhead - Direct	
Building Related	
Lease Expenses	
Repairs & Maint.	
Insurance	
Other Costs	
Total Direct Costs	-
INDIRECT COSTS	
A. Administration	
Administrative Salaries	
All other payroll costs	
B. Other Allocated Costs - Bidder please list	
Total Indirect Costs	-
Total Costs	-
Total Indirect % of Cost	#DIV/0!

ATTACHMENT D – EVALUATION/RATING CRITERIA

Bidder: Click or tap here to enter text.

Date Reviewed: Click or tap to enter a date.

Reviewer: Click or tap here to enter text.

Rating Criteria	Points Awarded	Max Points	Reviewer Comments
I. PROVIDER PROFILE			
a. Provider Coversheet	Choose an item.	5	Click or tap here to enter text.
b. History of provider organization and explanation of the purpose or mission of the provider and how it relates to the RFP	Choose an item.	5	Click or tap here to enter text.
c. Proof of Business Entity status: documentation to support business as recognized by the IRS	Choose an item.	5	Click or tap here to enter text.
d. Describe rationale for the provider pursing this RFP	Choose an item.	5	Click or tap here to enter text.
e. Describe future plans/issues facing provider	Choose an item.	5	Click or tap here to enter text.
f. List experiences with developing and sustaining collaborative relationships with other agencies and/or where mergers have occurred.	Choose an item.	5	Click or tap here to enter text.
g. Describe the Provider's experience in this or related field.	Choose an item.	5	Click or tap here to enter text.
h. MDHHS ASAM LOC Designation Letter **OR** completed ASAM LOC Designation Application if not already enrolled *(Attachment E)*	Choose an item.	5	Click or tap here to enter text.
i. MSHN Provider Application (*Attachment F*).	Choose an item.	5	Click or tap here to enter text.
j. Disclosure of Ownership, Controlling Interest, and Criminal Convictions (*Attachment G*). All sections within the Attestation must be completed regardless of status of the organization (e.g., Non- Profit, Government, Corporation). This includes full addresses, dates of birth and social security numbers for all identified management staff and/or Board Members as outlined in PIHP Policy and the Code of Federal Regulations.	Choose an item.	5	Click or tap here to enter text.
PROVIDER PROFILE TOTAL POINTS		50	
II. ORGANIZATION/MANAGEMENT			

a. General: Provide a current, dated, program specific Organizational Chart which includes administrative structure.	Choose an item.	5	Click or tap here to enter text.
b. Personnel Management: I. Provide assurances that bidder meets MSHN Minimum Training Requirements. Refer to *Attachment H - References.* II. Description of process and frequency for training staff and evaluating staff performance.	Choose an item.	10	Click or tap here to enter text.
c. Financial Management: I. Financial Audit: The Provider shall attach a copy of its Audited Financial Statements for the previous two (2) years of operation. This shall include auditor notes and comments as well as any Management Letters. II. Explain if there are any pending or unresolved issues that relate to the last two (2) years of fiscal audits and/or if the Provider has made a plan of correction addressing those areas. Include corrective action steps taken. Note: Provider may indicate "not applicable" if the Provider does not have any unresolved issues and/or has not had identified areas which would require corrective action steps. III. Include a completed MSHN Provider Services Cost Summary. IV. If requesting startup funds to assist with costs related to starting new program, the Provider shall submit a separate detailed budget of startup funding needs (see the tab "Start-up Only" in the MSHN Services Cost Summary. V. If requesting startup funds to assist with costs related to starting new program, the Provider shall submit a sustainability plan to ensure the ability to maintain operations.	Choose an item.	25	Click or tap here to enter text.
d. Information Systems: I. Description of information system (including data entry process, data disaster recovery and adherence to the Health Insurance Portability and Accountability Act (HIPAA) standards). II. Description of system for monitoring and processing authorizations and claims of services being provided.	Choose an item.	15	Click or tap here to enter text.

III. Description of capacity to complete a HIPAA Risk Assessment and Security Management Plan.			
e. Quality Management: I. Description of Quality Improvement Plan (this shall include information on how reports are utilized and methods used to measure outcomes and utilization). II. If a new provider, explain how a Quality improvement Plan and/or MSHN's Quality Assessment Performance Improvement Plan will be followed and/or used. III. Provider's Quality Improvement Plan shall include adolescent-specific measures addressing, at minimum, timely access, initiation and engagement, retention, successful transition between levels of care, discharge and continuing-care linkage, co-occurring behavioral health needs, family engagement when appropriate, recipient/youth satisfaction, and clinical outcomes. Provider shall describe how data will be reviewed for disparities in access, engagement, retention, service utilization, and outcomes among relevant demographic and geographic populations and how identified disparities will inform quality improvement activities. IV. Provider shall describe how youth voice and, when appropriate, family/caregiver feedback are incorporated into program planning and quality improvement. The Provider shall demonstrate how satisfaction, complaints, engagement experiences, environmental safety, cultural responsiveness, welcoming practices, and barriers to care are evaluated and used to improve adolescent services. V. Include the most recent Quality Improvement Plan. VI. Include the most recent Customer Satisfaction Survey.	Choose an item.	30	Click or tap here to enter text.
f. Community Involvement: I. Description of how Provider utilizes participation from individuals served in policy development, program planning and routine decision making. II. Description of process to utilize community resources from existing entities in program planning.	Choose an item.	20	Click or tap here to enter text.

III. Description of Provider's capacity to have Coordination Agreements in place with Community Mental Health Services Programs (CMHSP) and also in place with one (1) or more licensed medical service facilities for the provision of emergency inpatient and ambulatory medical services. IV. Provider shall describe established or planned coordination and referral relationships with organizations important to the adolescent system of care, including CMHSPs and behavioral health providers, pediatric and primary care providers, hospitals and emergency departments, schools and educational systems, child welfare/foster care agencies, juvenile justice partners, family support organizations, recovery support providers, and other community resources relevant to the population served.			
g. Corporate Compliance: I. Description of Corporate Compliance Plan process and include a copy of the most recent Plan if applicable. Note: The Federal Medicaid Integrity Program (MIP) requires entities receiving more than five million dollars ($5 million) in Medicaid funds to have a Corporate Compliance Plan. Note: Provider may indicate "not applicable" if the Provider does not have its own Compliance Plan.	Choose an item.	5	Click or tap here to enter text.
h. Recipient Rights: I. Description of procedures relating to the Recipient Rights process. II. Provide the following information for the previous two (2) years: 1. Number of Recipient Rights complaints 2. Number of substantiated complaints by category 3. Description of what corrective actions were taken to address the substantiated Rights violations	Choose an item.	10	Click or tap here to enter text.
ORGANIZATION/MANAGEMENT TOTAL POINTS		105	
III. FACILITY LICENSE			
The Provider shall attach evidence of current State of Michigan License and/or any applicable application under review. **Note:** If the Provider is not licensed and is planning to become licensed, the Provider shall provide	Choose an item.	5	Click or tap here to enter text.

information pertinent to pending state licensing application(s).			
FACILITY LICENSE TOTAL POINTS		5	
IV. INSURANCE			
a. **Worker's Compensation** insurance coverage in accordance with applicable and required law governing work activities; Waiver of subrogation, except where waiver is prohibited by law.	Choose an item.	5	Click or tap here to enter text.
b. **Professional Liability** insurance coverage (errors and omissions) in a sum of not less than $3,000,000 per claim and $3,000,000 in annual aggregate.	Choose an item.	5	Click or tap here to enter text.
c. **Commercial General liability** insurance coverage with broad form endorsement or equivalent, if not in the policy proper, $1,000,000 each occurrence; $1,000,000 Personal & Advertising Injury; $2,000,000 Products/Completed Operations; $2,000,000 General Aggregate.	Choose an item.	5	Click or tap here to enter text.
d. **Automobile liability** insurance coverage including all owned, non-owned, and hired vehicles. If a motor vehicle is used in relation to the Contractor's performance, the Contractor must have vehicle liability insurance on the motor vehicle for bodily injury and property damage as required by law. **Note:** Provider may indicate "not applicable" if the Provider shall not be transporting individuals.	Choose an item.	5	Click or tap here to enter text.
e. **Employers Liability** Insurance in a sum of not less than $500,000 each accident; $500,00 each employee by disease; $500,000 aggregate disease.	Choose an item.	5	Click or tap here to enter text.
f. **Privacy & Security Liability (Cyber Liability)** insurance coverage Policy must cover information security, privacy liability, privacy notification costs, regulatory defense & penalties, and website media content liability with limits not less than $1,000,000 each occurrence and $1,000,000 annual aggregate.	Choose an item.	5	Click or tap here to enter text.
INSURANCE TOTAL POINTS		30	
V. IMPLEMENTATION PLANNING			
a. Provider shall identify each evidence-based or evidence-informed intervention proposed for adolescent services and describe the target population, evidence supporting its use with adolescents,	Choose an item.	5	Click or tap here to enter text.

staff training and qualification requirements, supervision expectations, implementation plan, and process for monitoring fidelity. Adult treatment models shall not be presumed appropriate for adolescents solely because they have been adapted for use with younger populations. If the provider is submitting a proposal for SUD outpatient services for ASAM 2.1 and/or 2.5, residential services for ASAM 3.5 and/or 3.7, then please submit the weekly schedule for each level of care with your proposal.			
b. Estimated timeframe for hiring, onboarding, and training new program staff (if applicable) in order to meet the minimum staffing requirements for crisis residential services as outlined in the MDHHS Michigan Medicaid Provider Manual (refer to Attachment H - References)		5	
c. Describe who in your organization shall be responsible for reporting to MSHN.	Choose an item.	5	Click or tap here to enter text.
d. Describe the Provider's plan for addressing program service capacity regarding PIHP referrals.	Choose an item.	5	Click or tap here to enter text.
e. Procurement of any organization or staff required license and/or certification.	Choose an item.	5	Click or tap here to enter text.
f. Timeframe in which the Provider plans to assume contractual obligations.	Choose an item.	5	Click or tap here to enter text.
IMPLEMENTATION PLANNING TOTAL POINTS		30	
VI. REFERNCES			
Provider shall submit two (2) letters of reference/support from various community agencies and/or professional individuals with whom the Provider has collaborated.	Choose an item.	10	Click or tap here to enter text.
REFERENCES TOTAL POINTS		10	

Rating Criteria	Points Awarded	Max Points	Comments
I. TREATMENT SERVICES PROGRAM OVERVIEW			
a. MSHN expects adolescent SUD treatment services to be evidence-based, individualized, developmentally appropriate, recovery-oriented, trauma-informed, culturally and linguistically responsive, and integrated with the adolescent's broader system of care. Services shall be provided at the clinically appropriate intensity, duration, and scope based on medical necessity, comprehensive assessment, applicable diagnostic criteria, and the current ASAM Criteria as adopted by MDHHS. Treatment shall consider developmental stage, strengths, substance use history, physical and behavioral health, trauma history, family and caregiver context, educational or vocational functioning, social and recovery environment, safety needs, and other clinically relevant factors.	Choose an item.	5	Click or tap here to enter text.
b. Adolescent services shall not consist solely of adult treatment programming made available to adolescents. Programming, clinical interventions, educational materials, group content, milieu, recreational activities, behavioral expectations, family involvement, and treatment approaches shall be designed for adolescent developmental needs. When adolescent and adult services are co-located, the Provider shall describe how adolescent safety, confidentiality, programming, therapeutic milieu, and interactions with adult participants are appropriately separated and managed.	Choose an item.	5	Click or tap here to enter text.
TREATMENT SERVICES TOTAL POINTS		10	
II. CORE REQUIREMENTS ACROSS ALL LEVELS OF CARE			
a. *Assessment and Individualized Treatment Planning*: Provider shall maintain appropriately trained staff and organizational capacity to administer the current MDHHS-required adolescent assessment instrument, including the GAIN-I Core when required. Assessment findings shall inform level-of-care determination, individualized treatment planning, co-occurring needs, continuing-service decisions, and discharge or transition planning. Treatment plans shall actively involve the adolescent and include parents, guardians, caregivers, physicians, and other		5	

involved professionals when clinically appropriate, legally permissible, and consistent with consent and confidentiality requirements.			
b. *Evidence-Based and Developmentally Appropriate Practice*: Provider shall use evidence-based or evidence-informed interventions appropriate for adolescents and maintain processes for staff training, supervision, implementation, and fidelity monitoring.		5	
c. *Family and Natural Supports*: Provider shall describe how parents, guardians, caregivers, family members, and other natural supports are engaged in assessment, treatment, family counseling or education, recovery planning, and community re-entry when clinically appropriate and legally permissible.		5	
d. *Co-Occurring Behavioral Health Needs*: Provider shall demonstrate capacity to identify and address co-occurring mental health and substance use disorders through screening and assessment, integrated treatment planning, access to mental health clinicians and psychiatric consultation, medication management when indicated, suicide/self-harm risk response, crisis intervention, and coordination with behavioral health providers.		5	
e. *Engagement, Retention, and Welcoming Practices*: Provider shall describe strategies to engage and retain adolescents and reduce barriers, including first-contact engagement, flexible scheduling when applicable, transportation, school-related barriers, family/caregiver engagement, outreach after missed appointments, and re-engagement following disengagement or return to use.		5	
f. *Clinical Response to Return to Use or Change in Status*: Return to substance use, difficulty engaging, behavioral challenges, psychiatric symptoms, or other changes in clinical status shall prompt clinically appropriate reassessment and treatment-plan modification and/or transfer when indicated. Administrative discharge shall not substitute for appropriate reassessment, engagement, safety planning, or care transition.		5	

g. *Education, Life Skills, and Development*: Programming shall incorporate developmentally appropriate education, life-skills development, recreation, prosocial activities, and preparation for age-appropriate independent functioning. Providers shall support educational continuity and appropriate GED, vocational, or employment linkages.		5	
h. *Medication Assisted Treatment (MAT)/Medication for Opioid Use Disorder (MOUD)*: Provider shall describe its approach to MAT/MOUD for adolescents when clinically indicated, including qualified prescribers, continuation of existing medications, external coordination when necessary, informed consent, family involvement when legally appropriate, monitoring, and continuity during transitions.		5	
i. *Communicable Disease Prevention*: Provider shall maintain processes for communicable disease screening, testing, education, referral, documentation, staff training, and follow-up consistent with applicable MDHHS requirements.		5	
j. *Care Coordination, Continuing Care, and Community Re-entry*: Planning shall begin at admission and include warm transitions, receiving-provider coordination, follow-up appointments when feasible, authorized information transfer, medication continuity, transportation planning, family/caregiver involvement, educational re-entry, and linkage to treatment, medical care, and recovery supports.		5	
k. *Health Equity and Population Health*: Provider shall identify, monitor, and address disparities in adolescent access, engagement, retention, utilization, transitions, and outcomes and describe how findings inform outreach, program design, service delivery, partnerships, and quality improvement.		5	
CORE REQUIREMENTS TOTAL POINTS		55	
III. WITHDRAWAL MANAGEMENT OF CARE			
a. Provider proposing adolescent withdrawal management services shall operate in a properly licensed and accredited setting and demonstrate clinical, medical, nursing, staffing, facility, monitoring, and emergency-response capability consistent with each specific withdrawal management level of care proposed, the		5	

current ASAM Criteria as adopted by MDHHS, MDHHS Treatment Policy, LARA requirements, Michigan Medicaid requirements, and MSHN requirements.			
b. Identify each withdrawal management level of care proposed and demonstrate current or pending MDHHS designation and capacity to meet all applicable requirements.		5	
c. Maintain written protocols for adolescents whose withdrawal severity, biomedical condition, psychiatric condition, behavioral instability, or other needs exceed program capability, including timely consultation, escalation, emergency intervention, direct transfer, and established transfer relationships.		5	
d. Residential withdrawal management services shall operate twenty-four (24) hours per day, seven (7) days per week with staffing, supervision, observation, medical oversight, nursing availability, and on-call coverage consistent with the specific level of care provided.		5	
e. Maintain developmentally appropriate procedures for suicide/self-harm, acute psychiatric symptoms, behavioral instability, aggression, elopement/runaway risk, abuse/neglect, exploitation/human trafficking, withdrawal complications, and other immediate safety risks, including safety planning, crisis intervention, mandated reporting, emergency transfer, and post-crisis review.		5	
f. Comply with communicable disease requirements applicable to residential withdrawal management, including tuberculosis screening/testing upon admission and required screening, education, referral, and follow-up for other communicable disease risks.		5	
g. Withdrawal management shall function as part of a continuum of care, with treatment and continuing-care needs identified at admission and timely transition to ongoing SUD treatment and recovery supports secured.		5	
WITHDRAWAL MANAGEMENT REQUIREMENTS TOTAL POINTS		35	
IV. RESIDENTIAL SERVICES			
a. Provider proposing adolescent residential services shall operate in a properly licensed and accredited setting and		5	

	demonstrate compliance with all current requirements applicable to each adolescent residential level of care proposed, including the current ASAM Criteria as adopted by MDHHS, MDHHS Treatment Policy, applicable MDHHS residential treatment requirements, Michigan Medicaid requirements, LARA Administrative Rules, and MSHN contractual standards. References to adult residential treatment policies shall apply only to the extent MDHHS identifies those requirements as applicable to adolescent services or MSHN expressly incorporates them into the resulting contract.			
b.	Identify each adolescent residential level of care proposed and demonstrate current or pending MDHHS designation and capacity to meet all applicable requirements.		5	
c.	Describe adolescent-specific residential curriculum and programming, including therapeutic interventions, individual and group services, family services, education, life skills, recreation, recovery supports, and therapeutic milieu.		5	
d.	Describe how educational continuity will be maintained during treatment and how youth will be supported in returning to school, GED, vocational programming, or another appropriate educational setting at discharge.		5	
e.	Maintain trauma-informed processes for adverse childhood experiences, abuse, neglect, violence exposure, trauma-related symptoms, exploitation, and human trafficking, including staff training, safety planning, mandated reporting, intervention, and referral.		5	
f.	Demonstrate twenty-four (24) hour staffing and supervision and all medical, nursing, clinical, behavioral health, direct-care, supervisory, emergency, and on-call coverage required for the specific residential level of care proposed.		5	
g.	Residential services shall function as part of a continuum of care, with coordination and community re-entry planning beginning at admission.		5	
	RESIDENTIAL SERVICES REQUIREMENTS TOTAL POINTS		35	
	V. OUTPATIENT SERVICES REQUIREMENTS			

a. Provider proposing adolescent early intervention, outpatient, or intensive outpatient services shall meet all current MDHHS enrollment/designation, Medicaid provider qualification, accreditation, credentialing, and other regulatory requirements applicable to each level of care proposed. Where state facility licensure is required, Provider shall maintain the applicable LARA license.		5	
b. Identify each adolescent outpatient level of care proposed and demonstrate current or pending MDHHS designation and capacity to meet applicable requirements.		5	
c. Describe the service model, frequency and intensity of services, individual and group interventions, family services, care coordination, co-occurring capability, and processes for adjusting service intensity based on changing clinical need.		5	
d. Describe scheduling and service-delivery strategies that reduce barriers related to school, transportation, family obligations, geography, and other factors affecting adolescent access and retention.		5	
e. Outpatient services shall function as part of a continuum of care and include warm transitions to higher or lower levels of care when clinically indicated.		5	
OUTPATIENT REQUIREMENTS TOTAL POINTS		25	
VI. REQUIRED TREATMENT SERVICES NARRATIVE/DOCUMENTS			
a. *Treatment Philosophy and Clinical Model*: Describe how the proposed program operationalizes developmentally appropriate, evidence-based, recovery-oriented, trauma-informed, culturally responsive, and family-inclusive care.		5	
b. *Evidence-Based Practices and Outcomes*: Identify proposed interventions, target adolescent populations, staff training/supervision, fidelity monitoring, and available outcome data or evidence supporting their use.		5	
c. *Progress Monitoring*: Describe the method and frequency used to evaluate progress and how findings modify treatment, service intensity, or level of care.		5	
d. *Co-Occurring Capability*: Describe integrated behavioral health screening, treatment planning, mental health/psychiatric		5	

	supports, medication management, crisis response, and coordination.			
e.	*Engagement and Access*: Describe first-contact engagement, retention, scheduling, transportation, school-related barriers, family engagement, outreach, re-engagement, and monitoring of access and retention.		5	
f.	*Safety and Crisis Management:* Residential and withdrawal management bidders shall describe suicide/self-harm, psychiatric deterioration, aggression/violence, elopement/runaway risk, medical emergencies, withdrawal complications, abuse/neglect, exploitation/human trafficking, mandated reporting, emergency transfer, and post-crisis review.		5	
g.	*Family and Caregiver Engagement*: Describe orientation, communication, family counseling/education, visitation where applicable, treatment/recovery planning participation, community re-entry preparation, and caregiver supports consistent with consent and confidentiality.		5	
h.	*Education Continuity*: Residential bidders shall describe educational participation during treatment and transition to school, GED, vocational, or employment programming following discharge.		5	
i.	*Medication Assisted Treatment (MAT)/Medication for Opioid Use Disorder (MOUD)*: Describe access to and continuity of clinically indicated MAT/MOUD, including qualified prescribers, external coordination, informed consent, monitoring, and transitions.		5	
j.	*Communicable Disease Prevention*: Describe applicable screening, testing, education, referral, documentation, staff training, and follow-up.		5	
k.	*Transitions and Continuing Care*: Describe warm transitions between levels of care and discharge/community re-entry coordination.		5	
l.	*Health Equity and Population Health*: Describe how disparities in access, engagement, retention, utilization, transitions, and outcomes will be identified, monitored, addressed, and incorporated into quality improvement.		5	

m. *Clinical Staffing:* Submit a level-of-care-specific staffing plan identifying each position, FTE, credential/licensure/qualification, adolescent-specific qualification or experience, existing versus vacant status, supervision structure, shift coverage, on-call coverage, and recruitment timeline. Residential and withdrawal management plans shall separately identify medical, nursing, clinical, behavioral health, direct-care, supervisory, and emergency coverage.		5	
CORE REQUIREMENTS TOTAL POINTS		65	

BIDDER GRAND TOTAL		420	Click or tap here to enter text.

Bidder:_____Click or tap here to enter text._____

Reviewer:_____Click or tap here to enter text._____

Michigan Department of Health and Human Services
American Society of Addiction Medicine (ASAM) Residential Level of Care Designation

The Michigan Department of Health and Human Services (MDHHS) is required to designate the ASAM level of care for all licensed residential treatment facilities. In order to make this determination, the following questionnaire is required to be filled out for each licensed facility seeking to provide publicly funded services. The information provided and submitted with this questionnaire will allow MDHHS to assign an ASAM level for the program.

Program/Facility Name:

Facility Address:

City/State/Zip:

License Number:

Treatment Capacity:

Please indicate the ASAM Level being applied for:

- ☐ 3.1 Clinically Managed Low Intensity
- ☐ 3.3 Clinically Managed Population Specific High Intensity
- ☐ 3.5 Clinically Managed High Intensity
- ☐ 3.7 Medically Monitored Intensive Inpatient Services

Please indicate the population served by the program:

☐ Adolescent ☐ Adult

Please indicate which Pre-paid Inpatient Health Plan(s) the program is currently contracted with or planning to contract with to provide services: (check all that apply)

- ☐ Community Mental Health Partnership of Southeast Michigan
- ☐ Detroit Wayne Mental Health Authority
- ☐ Lakeshore Regional Entity
- ☐ Macomb County Community Mental Health Services
- ☐ Mid-State Health Network
- ☐ Northcare Network
- ☐ Northern Michigan Regional Entity
- ☐ Oakland County Community Mental Health Authority
- ☐ Region Pre-paid Inpatient Health Plan
- ☐ Southwest Michigan Behavioral Health

SERVICE DELIVERY and SETTING

Please indicate the type of setting where services are provided.

1) ☐ Freestanding community setting.

2) ☐ Unit within a licensed health care facility.

3) ☐ Secure community setting in the criminal justice system.

4) On average, over the past 90 days, what percentage of residents were treated for moderate or severe substance use disorders: (Total must equal 100%)

    a. Without a co-occurring mental health disorder – %
    b. Combined with a co-occurring mental health disorder – %
    c. Combined with functional limitations that were primarily cognitive in nature? (For example: Traumatic Brain Injury, Dementia, Memory Problems) – %

SUPPORT SYSTEMS

Please select "yes" or "no" for each of the following questions:

1) Telephone or in-person consultation with physician and emergency services available 24/7? ☐Yes ☐No

2) Direct affiliations with other levels of care and/or close coordination for referrals to other services? ☐Yes ☐No

3) Ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures. ☐Yes ☐No

4) Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications. ☐Yes ☐No

5) Psychiatric/psychological consultation available as needed. ☐Yes ☐No

STAFF

Please select "yes" or "no" for each of the following questions:

1) Professional staff available on-site 24 hours a day.
   ☐Yes ☐No

2) Treatment team consists of medical, addiction and mental health professionals.
   ☐Yes ☐No

3) One or more clinicians available on site or by telephone 24 hours a day.
   ☐Yes ☐No

4) Please indicate program staff conducting each service.

   Check all that apply on the following table:

License or Certification/ Registration	Individual Counseling Sessions	Group Counseling Sessions	Didactic/ Educational Sessions	COD Treatment Services	Medical RX Services
MD/DO	☐	☐	☐	☐	☐
LP/LLP/TLLP	☐	☐	☐	☐	☐
LMFT/LLMFT	☐	☐	☐	☐	☐
LPC/LLPC	☐	☐	☐	☐	☐
RN,NP,LPN	☐	☐	☐	☐	☐
PA	☐	☐	☐	☐	☐
LMSW/LLMSW	☐	☐	☐	☐	☐
LBSW/LLBSW	☐	☐	☐	☐	☐
CADC-M/CADC	☐	☐	☐	☐	☐
CAADC	☐	☐	☐	☐	☐
CCJP-R	☐	☐	☐	☐	☐
CCDP	☐	☐	☐	☐	☐
CCDP-D	☐	☐	☐	☐	☐
CCS-M	☐	☐	☐	☐	☐
CCS-R	☐	☐	☐	☐	☐
DP-S	☐	☐	☐	☐	☐
DP-C	☐	☐	☐	☐	☐
Recovery Coach	☐	☐	☐	☐	☐

THERAPIES

Please describe the therapy services that are available:

1) Planned clinical program activities (professionally directed) hours per week:

2) Focus of counseling and clinical program activities:

3) Recovery support services available:

4) Involvement of family members and significant others?
☐Yes ☐No

5) Medication assisted treatment available?
☐Yes ☐No

6) Monitoring of medication adherence (for behavioral health and physical health)?
☐Yes ☐No

7) Use of random drug screens to monitor compliance?
☐Yes ☐No

8) Please submit a weekly schedule of services with the individual, group, educational and/or other treatment services labeled to verify hours reported above. Attach other programmatic documentation that will support the ASAM Level being sought.

ASSESSMENT/ TREATMENT PLAN REVIEW

Does the program's assessment & treatment plan review include:

1) Individualized, comprehensive bio-psychosocial assessment utilized?
☐Yes ☐No

2) Individualized treatment plan, developed in collaboration with client and reflects client's personal goals?
☐Yes ☐No

3) Daily assessment of progress and treatment changes?
☐Yes ☐No

4) Physical examination by (MD/DO, PA, NP) performed as part of initial assessment/admission process?
☐Yes ☐No

5) Ongoing transition/continuing care planning?
☐Yes ☐No

I CERTIFY THAT THE INFORMATION PROVIDED REGARDING THE OPERATION OF THIS PROGRAM IS ACCURATE, TRUE, AND COMPLETE IN ALL MATERIAL ASPECTS. (Electronic signatures are acceptable)

AUTHORIZED INDIVIDUAL	TITLE	SIGNATURE	DATE

ENTER THE CONTACT INFORMATION OF THE PERSON THAT CAN BE REACHED FOR FOLLOW-UP IF NEEDED.

NAME	TITLE	EMAIL	TELEPHONE

Please submit the completed, signed form and any attachments to QMPMeasures@michigan.gov

Michigan Department of Health and Human Services
American Society of Addiction Medicine (ASAM) Withdrawal Management Level of Care Designation

The Michigan Department of Health and Human Services (MDHHS) is required to designate the ASAM level of care for all licensed withdrawal management treatment facilities. In order to make this determination, the following questionnaire is required to be filled out for each licensed facility seeking to provide publicly funded services. The information provided and submitted with this questionnaire will allow MDHHS to assign an ASAM level for the program.

Program/Facility Name:

Facility Address:

City/State/Zip:

License Number:

Treatment Capacity:

Please indicate the ASAM Level being applied for: (Select Only One)

- ☐ Level 1-WM – Ambulatory Withdrawal Management without Extended On-site Monitoring (Outpatient Withdrawal Management)
- ☐ Level 2-WM – Ambulatory Withdrawal Management with Extended On-site Monitoring (Outpatient Withdrawal Management)
- ☐ Level 3.2-WM – Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management)
- ☐ Level 3.7-WM – Medically Monitored Inpatient Withdrawal Management (Residential Withdrawal Management)

Please indicate the population served by the program:

☐ Adolescent ☐ Adult

Please indicate which Pre-paid Inpatient Health Plan(s) the program is currently contracted with or planning to contract with to provide services: (check all that apply)

- ☐ Community Mental Health Partnership of Southeast Michigan
- ☐ Detroit Wayne Mental Health Authority
- ☐ Lakeshore Regional Entity
- ☐ Macomb County Community Mental Health Services
- ☐ Mid-State Health Network
- ☐ Northcare Network
- ☐ Northern Michigan Regional Entity
- ☐ Oakland County Community Mental Health Authority
- ☐ Region 10 Pre-paid Inpatient Health Plan
- ☐ Southwest Michigan Behavioral Health

Michigan Department of Health and Human Services
American Society of Addiction Medicine (ASAM) Withdrawal Management Level of Care Designation

SERVICE DELIVERY and SETTING

Please indicate the type of setting where services are provided:

1) ☐ Client Home
2) ☐ Office or agency setting
3) ☐ Healthcare facility
4) ☐ Day hospital or residential type setting
5) ☐ Freestanding withdrawal management facility

Please indicate how services are provided in the program:

☐ Regularly scheduled services
☐ Services delivered under physician approved policies and procedures or clinical protocols.

SUPPORT SYSTEMS

Please select “yes” or “no” for each of the following questions:

1) Available specialized psychological and psychiatric/clinical consultation and supervision. ☐Yes ☐No

2) Comprehensive medical history and physical examination completed as part of admission. ☐Yes ☐No

3) Affiliation with other levels of care, including other specialty substance use disorder treatment. ☐Yes ☐No

4) Ability to conduct and or arrange for laboratory/toxicology tests.
☐Yes ☐No

5) 24 hour access to emergency medical consultation services.
☐Yes ☐No

6) Ability to provide/assist with access to safe transportation services.
☐Yes ☐No

Michigan Department of Health and Human Services
American Society of Addiction Medicine (ASAM) Withdrawal Management Level of Care Designation

STAFF

Please select "yes" or "no" for each of the following questions:

1) Physicians and/or nurses present as needed. ☐Yes ☐No
2) Physicians and/or nurses readily available. ☐Yes ☐No
3) Physicians and/or nurses present at all times. ☐Yes ☐No
4) Counseling staff available or accessed through affiliation relationships.
   ☐Yes ☐No
5) Recovery coach/peer support staff available or accessed through affiliation relationships. ☐Yes ☐No

6) Please indicate program staff conducting each service. Check all that apply:

License or Certification/ Registration	Individual Counseling Sessions	Group Counseling Sessions	Didactic/ Educational Sessions	COD Treatment Services	Medical RX Services
MD/DO	☐	☐	☐	☐	☐
LP/LLP/TLLP	☐	☐	☐	☐	☐
LMFT/LLMFT	☐	☐	☐	☐	☐
LPC/LLPC	☐	☐	☐	☐	☐
RN,NP,LPN	☐	☐	☐	☐	☐
PA	☐	☐	☐	☐	☐
LMSW/LLMSW	☐	☐	☐	☐	☐
LBSW/LLBSW	☐	☐	☐	☐	☐
CADC-M/CADC	☐	☐	☐	☐	☐
CAADC	☐	☐	☐	☐	☐
CCJP-R	☐	☐	☐	☐	☐
CCDP	☐	☐	☐	☐	☐
CCDP-D	☐	☐	☐	☐	☐
CCS-M	☐	☐	☐	☐	☐
CCS-R	☐	☐	☐	☐	☐
DP-S	☐	☐	☐	☐	☐
DP-C	☐	☐	☐	☐	☐
Recovery Coach	☐	☐	☐	☐	☐

Michigan Department of Health and Human Services
American Society of Addiction Medicine (ASAM) Withdrawal Management Level of Care Designation

THERAPIES

Please describe the therapy services that are available:

1) Medication supported withdrawal management.
   ☐Yes ☐No
2) Self-administered withdrawal management medications.
   ☐Yes ☐No
3) Supervised self-administered withdrawal management medications.
   ☐Yes ☐No
4) Non-medication supported withdrawal management.
   ☐Yes ☐No
5) Education/didactics.
   ☐Yes ☐No
6) Involvement of family members and significant others.
   ☐Yes ☐No
7) Discharge/transfer planning.
   ☐Yes ☐No
8) Physician/nurse monitoring/management of intoxication and/or withdrawal.
   ☐Yes ☐No
9) Range of therapies available in group and/or individual format (cognitive, behavioral, medical).
   ☐Yes ☐No
10) Please submit a weekly schedule of services with the individual, group, educational and/or other treatment services labeled to verify what is reported above and attach other programmatic documentation that will support the ASAM Level being sought.

ASSESSMENT/TREATMENT PLAN REVIEW

Does the program's assessment and treatment plan review include:

1) Addiction focused history part of initial assessment and conducted or reviewed by physician. ☐Yes ☐No

2) Physical examination (by MD/DO, PA, NP) performed as part of initial assessment.
   ☐Yes ☐No

3) Biopsychosocial screening assessments used to determine level of care and to address treatment priorities in ASAM dimensions 2-6.
   ☐Yes ☐No

Michigan Department of Health and Human Services
American Society of Addiction Medicine (ASAM) Withdrawal Management Level of Care Designation

4) Interdisciplinary team available to participate in treatment and to obtain and interpret information regarding client needs.
   ☐Yes ☐No

5) Individual treatment plan, with problem identification for ASAM dimensions 2-6, with treatment goals and measureable objectives.
   ☐Yes ☐No

6) Daily assessment of progress and treatment changes.
   ☐Yes ☐No

7) Transfer/discharge planning beginning at point of admission.
   ☐Yes ☐No

8) Referral and linking arrangements for continuing care.
   ☐Yes ☐No

9) Medical assessments, using appropriate measures of withdrawal.
   ☐Yes ☐No

I CERTIFY THAT THE INFORMATION PROVIDED REGARDING THE OPERATION OF THIS PROGRAM IS ACCURATE, TRUE, AND COMPLETE IN ALL MATERIAL ASPECTS. (Electronic signatures are acceptable)

AUTHORIZED INDIVIDUAL	TITLE	SIGNATURE	DATE

ENTER THE CONTACT INFORMATION OF THE PERSON THAT CAN BE REACHED FOR FOLLOW-UP IF NEEDED.

NAME	TITLE	EMAIL	TELEPHONE

Michigan Department of Health and Human Services
American Society of Addiction Medicine (ASAM) Outpatient Level of Care Designation

The Michigan Department of Health and Human Services (MDHHS) is required to designate the ASAM level of care for all licensed outpatient treatment programs. In order to make this determination, the following questionnaire is required to be filled out for each licensed program seeking to provide publicly funded services. The information provided and submitted with this questionnaire will allow MDHHS to assign an ASAM level for the program.

Program/Facility Name:

Facility Address:

City/State/Zip:

License Number:

Treatment Capacity:
(If Applicable)

Please indicate the ASAM Level being applied for (select only one):

- ☐ 0.5 Early Intervention
- ☐ 1.0 Outpatient Services
- ☐ 2.1 Intensive Outpatient Services
- ☐ 2.5 Partial Hospitalization Services

Please indicate the population served by the program:

☐ Adolescent ☐ Adult

Please indicate which Pre-paid Inpatient Health Plan(s) the program is currently contracted with (or planning to contract with for new programs)to provide services: (check all that apply)

- ☐ Community Mental Health Partnership of Southeast Michigan
- ☐ Detroit Wayne Mental Health Authority
- ☐ Lakeshore Regional Entity
- ☐ Macomb County Community Mental Health Services
- ☐ Mid-State Health Network
- ☐ Northcare Network
- ☐ Northern Michigan Regional Entity
- ☐ Oakland County Community Mental Health Authority
- ☐ Region 10 Pre-paid Inpatient Health Plan
- ☐ Southwest Michigan Behavioral Health

SERVICE DELIVERY and SETTING

Please indicate the type of setting where services are provided.

- ☐ Behavioral health clinic/office based program
- ☐ Primary care office/clinic
- ☐ Integrated care clinic (combined physical and behavioral health)
- ☐ Work sites
- ☐ School
- ☐ Community based
- ☐ Individuals home

On average, over the past 90 days, what percentage of clients with a substance use disorder were served **(Level 0.5 programs can skip this)**: (Total must equal 100%)

a. Without a co-occurring mental health disorder – %
b. Combined with a co-occurring mental health disorder – %

SUPPORT SYSTEMS

Please select "yes" or "no" for each of the following questions:

1) Does your program provide referral and linking to ongoing treatment?
☐Yes ☐No

2) Does your program provide referral for community social services?
☐Yes ☐No

3) Are emergency services available 24/7 outside normal program hours?
☐Yes ☐No

4) Does your program have direct affiliations with other levels of care and/or close coordination for referrals to other services?
☐Yes ☐No

5) Does your program have the ability to conduct and/or arrange for laboratory/toxicology tests or other needed procedures?
☐Yes ☐No

6) Does your program have the ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications?
☐Yes ☐No

7) Are psychiatric and medical consultation available within 24 hours by phone and in person based on severity of condition (Level 1)?
☐Yes ☐No

8) Are psychiatric and medical consultation available within 24 hours by phone and 72 hours in person (Level 2.1)?
☐Yes ☐No

9) Are psychiatric and medical consultation available within 8 hours by phone and 48 hours in person (Level 2.5)?
☐Yes ☐No

STAFF

Please select “yes” or “no” for each of the following questions:

1) Do you employ trained personnel who are knowledgeable about substance use and addiction?
☐Yes ☐No

2) Is counseling/therapy provided by appropriately licensed and credentialed professionals?
☐Yes ☐No

3) Is there a generalist physician(s) and/or physician assistant(s) available?
☐Yes ☐No

4) Are nursing staff available?
☐Yes ☐No

5) Is the physician(s) or physician assistant specially trained in addiction medicine?
☐Yes ☐No

6) Are staff cross-trained in mental health, psychotropic medications and interactions with addictive substances?

☐Yes ☐No

7) Please indicate program staff conducting each service.

Check all that apply on the following table:

License or Certification/ Registration	Screening and/or Assessments	Individual Counseling Sessions	Group Counseling Sessions	Didactic/ Educational Sessions	COD Treatment Services	Medical RX
MD/DO	☐	☐	☐	☐	☐	☐
LP/LLP/TLLP	☐	☐	☐	☐	☐	☐
LMFT/LLMFT	☐	☐	☐	☐	☐	☐
LPC/LLPC	☐	☐	☐	☐	☐	☐
RN,NP,LPN	☐	☐	☐	☐	☐	☐
PA	☐	☐	☐	☐	☐	☐
LMSW/LLMSW	☐	☐	☐	☐	☐	☐
LBSW/LLBSW	☐	☐	☐	☐	☐	☐
Occupational Therapist	☐	☐	☐	☐	☐	☐
Recreational Therapist	☐	☐	☐	☐	☐	☐
CADC-M/CADC	☐	☐	☐	☐	☐	☐
CAADC	☐	☐	☐	☐	☐	☐
CCJP-R	☐	☐	☐	☐	☐	☐
CCDP	☐	☐	☐	☐	☐	☐
CCDP-D	☐	☐	☐	☐	☐	☐
CCS-M	☐	☐	☐	☐	☐	☐
CCS-R	☐	☐	☐	☐	☐	☐
DP-S	☐	☐	☐	☐	☐	☐
DP-C	☐	☐	☐	☐	☐	☐
Recovery Coach	☐	☐	☐	☐	☐	☐
Specifically trained staff	☐	☐	☐	☐	☐	☐

Specifically trained staff explanation:

THERAPIES

Please describe the following in reference to the program:

1) Focus of program activities for the level of care requested in this application:

2) Recovery support services:

Please select "yes" or "no" for each of the following questions:

3) Individual therapy/counseling/psychotherapy provided?
☐Yes ☐No

4) Group therapy provided?
☐Yes ☐No

5) Family therapy provided?
☐Yes ☐No
   a. If provided is there involvement of family members, guardians and significant others in the assessment, treatment and continuing care of the client?
   ☐Yes ☐No

6) Educational/didactic services provided?
☐Yes ☐No

7) Occupational therapy?
☐Yes ☐No

8) Recreational therapy available?
☐Yes ☐No

9) Medication management (SUD) available?
☐Yes ☐No

10) Medication management (mental health) available?
☐Yes ☐No

11) Monitoring of medication adherence (for behavioral health and physical health)?
☐Yes ☐No

12) Use of laboratory and toxicology services (on-site/consultation/referral)?
☐Yes ☐No

13) For **Levels 2.1 and 2.5** please submit a weekly schedule of services with the individual, group, educational and/or other treatment services labeled to verify the minimum amount of hours of skilled treatment services for the level are available.

ASSESSMENT/ TREATMENT PLAN REVIEW

Indicate if the program's assessment & treatment plan review processes include the following?

1) Screening to rule in or out substance related addictive disorders?
☐Yes ☐No

2) Assessment of ASAM dimensional risk and severity of need performed prior to and throughout the process of delivering services?
☐Yes ☐No

3) Individualized, comprehensive bio-psychosocial assessment utilized?
☐Yes ☐No

4) Physical examination by (MD/DO, PA, NP) available for conditions as warranted based on physician approved protocols?
☐Yes ☐No

5) Individualized treatment plan, developed in collaboration with client and reflects client's personal goals?
☐Yes ☐No

6) Treatment plan reviews are conducted at specified times, as noted in the plan or with a frequency as determined by appropriately credentialed staff?
☐Yes ☐No

7) Documentation of mental health problems and relationship to substance use disorder?
☐Yes ☐No

8) Documentation of progress and treatment changes?
☐Yes ☐No

9) Ongoing recovery/continuing care planning?
☐Yes ☐No

I CERTIFY THAT THE INFORMATION PROVIDED REGARDING THE OPERATION OF THIS PROGRAM IS ACCURATE, TRUE, AND COMPLETE IN ALL MATERIAL ASPECTS. (Electronic signatures are acceptable)

Michigan Department of Health and Human Services
American Society of Addiction Medicine (ASAM) Outpatient Level of Care Designation

AUTHORIZED INDIVIDUAL	TITLE	SIGNATURE	DATE

ENTER THE CONTACT INFORMATION OF THE PERSON THAT CAN BE REACHED FOR FOLLOW-UP IF NEEDED.

NAME	TITLE	EMAIL	TELEPHONE

Please submit the completed, signed form and any attachments to QMPMeasures@michigan.gov

MSHN
Mid-State Health Network

Application for Credentialing
Organizational Providers

Agency Contact Information	
Agency Name:	Website:
Chief Administrator Contact/Title: Phone #:	email:
Finance Contact: Phone #:	email:
Site Review/Quality Contact: Phone #:	email:
Check Appropriate Status: ☐ Sole Prop. ☐ Partnership ☐ Corp. ☐ LLC ☐ Non-Profit ☐ Other: ☐ Governmental entity (i.e., government, governmental subdivision or agency, or public corporation)	
Federally Qualified Health Center: ☐ Yes ☐ No	

Program Information - *attach additional sheets if necessary for multiple sites*			
Facility/Program #1 Name:		SA License #: *Gov. Entities: provide previously issued SA#, if not previously issued use 'NA'*	
Address #1:	City:	Zip:	County:
Primary Contact/Title: Phone:		email: Fax:	
Same Day Service? ☐ Yes ☐ No		Accepting new enrollees? ☐ Yes ☐ No	
24 hr on-call? ☐ Yes ☐ No		ADA Accessible? ☐ Yes ☐ No	
Please specify all ADA accessible/compliant accommodations:			
Please specify all fluent communicable languages, including sign language:			
Women's Specialty Designation, if applicable: ☐ Designated ☐ Enhanced			
MARR Certification (Recovery Housing Providers): ☐ Level III ☐ Level IV			
ASAM LOC Designation(s) – SUD Providers			
Early Intervention ☐ 0.5		Outpatient ☐ 1.0 ☐ 2.1 ☐ 2.5	
Withdrawal Management ☐ 3.2 ☐ 3.7		Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7	
Opioid Treatment Program ☐ Level 1		Hours of Operation:	

Facility #2 Name:		SA License #: *Gov. Entities: provide previously issued SA#, if not previously issued use 'NA'*	
Address #2:	City:	Zip:	County:
Primary Contact/Title: Phone:		email: Fax:	
Same Day Service? ☐ Yes ☐ No		Accepting new enrollees? ☐ Yes ☐ No	
24 hr on-call? ☐ Yes ☐ No		ADA Accessible? ☐ Yes ☐ No	
Please specify all ADA accessible/compliant accommodations:			
Please specify all fluent communicable languages, including sign language:			
Women's Specialty Designation, if applicable: ☐ Designated ☐ Enhanced			
MARR Certification (Recovery Housing Providers): ☐ Level I ☐ Level II ☐ Level III ☐ Level IV			
ASAM LOC Designation(s) – SUD Providers			
Early Intervention ☐ 0.5		Outpatient ☐ 1.0 ☐ 2.1 ☐ 2.5	
Withdrawal Management ☐ 3.2 ☐ 3.7		Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7	

Opioid Treatment Program ☐ Level 1	Hours of Operation:

Facility #3 Name:		SA License #: *Gov. Entities: provide previously issued SA#, if not previously issued use 'NA'*	
Address #3:	City:	Zip:	County:
Primary Contact/Title: Phone:		email: Fax:	
Same Day Service? ☐ Yes ☐ No		Accepting new enrollees? ☐ Yes ☐ No	
24 hr on-call? ☐ Yes ☐ No		ADA Accessible? ☐ Yes ☐ No	
Please specify all ADA accessible/compliant accommodations:			
Please specify all fluent communicable languages, including sign language:			
Women's Specialty Designation, if applicable: ☐ Designated ☐ Enhanced			
MARR Certification (Recovery Housing Providers): ☐ Level I ☐ Level II ☐ Level III ☐ Level IV			
ASAM LOC Designation(s) – SUD Providers			
Early Intervention ☐ 0.5		Outpatient ☐ 1.0 ☐ 2.1 ☐ 2.5	
Withdrawal Management ☐ 3.2 ☐ 3.7		Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7	
Opioid Treatment Program ☐ Level 1		Hours of Operation:	

Accreditation - *attach a copy of the most recent accreditation certificate*	
Accrediting Body: ☐ CARF ☐ COA ☐ TJC ☐ AAAHC ☐ AOA ☐ NCQA ☐ N/A	Expiration Date:

Billing Information	
EIN:	NPI#:
Medicaid #:	Medicare #:
Indicate all insurance companies and/or managed care plans you currently have provider agreements with:	

Current Professional Liability Insurance Information - *attach copy of cover sheet (1 million/3 million minimum)*		
Insurance Carrier:		Policy #:
Address:		Coverage Amount:
City:	State: Zip:	Expiration Date:

Privileges, Licensure, and Malpractice History	
Has the agency 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? I*f 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 you 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. 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
8. Have your organization had any Medicaid, Medicare, or other governmental or third-party payor sanctions?	☐ Yes ☐ No
9. Have your organization ever been excluded from the Medicaid or Medicare program? If yes, specify date: Date of Reinstatement:	☐ Yes ☐ No
10. Have civil and monetary penalties been levied against your organization by Medicare or Medicaid programs?	☐ Yes ☐ No
11. You must provide, at minimum, the prior 5 year's history of any professional liability claims resulting in a judgement or settlement. ***Complete Attachment B -Professional Liability Action Detail***	☐ Attached ☐ N/A

Non-Discrimination/Diversity Assurances
MSHN is committed to identifying and encouraging the participation of minority-owned, women-owned, and handipcapper-owned businesses within its provider network. Please check all that apply (optional): ☐ Minority-owned ☐ Women-owned ☐ Handicapper-owned

Policy & Practices *attach copies of policies and procedures*		Pg. #
1. Does the organization have policy/practice for access to services? (Including timeliness of response to referral, availability of services, access to services, emergency services, etc.)	☐ Yes ☐ No	
2. Does the organization have a credentialing and re-credentialing policy/practice, including primary source verification?	☐ Yes ☐ No	
3. Does the organization conduct criminal background checks at time of hire and periodically during employment?	☐ Yes ☐ No	
4. Does the organization assess staff competency on an ongoing basis through performance evaluation?	☐ Yes ☐ No	
5. Does the organization have a policy/practice regarding ongoing professional development? (Including orientation and ongoing training)	☐ Yes ☐ No	
6. Does the organization assess the cultural backgrounds of persons served and provide training to staff on any identified cultural issues?	☐ Yes ☐ No	
7. Does the organization's policy on treatment planning describe individualized treatment?	☐ Yes ☐ No	
8. Does the organization's policy on treatment planning include consumer involvement in the development of the plan of service?	☐ Yes ☐ No	
9. Does the organization have a policy/practice regarding serving persons with Limited English Proficiency?	☐ Yes ☐ No	
10. Does the organization have a continuous quality improvement (CQI) policy/practice?	☐ Yes ☐ No	
11. Does the organization have a process to assess customer satisfaction?	☐ Yes ☐ No	
12. Does the organization have policy/procedure describing case records, record review, security, and case record access?	☐ Yes ☐ No	

13. Does the organization have a corporate compliance policy?	☐ Yes ☐ No	
14. Does the organization have a safety management plan that includes: General Safety, Security, Hazardous Materials, Emergency Preparedness, Fire, Infection Control, etc.	☐ Yes ☐ No	

Consent and Release of Liability

Upon the signing of this application, I represent that all of the information now or hereafter given by me in support of this application is true, correct and complete to the best of my knowledge and belief. I agree to promptly notify MSHN if there are any material changes in the information provided, whether prior to or after acceptance as a MSHN participating provider. I hereby authorize the release of any information from any source including but not limited to information from individuals, peers, customers, companies, institutions, agencies, data banks or references who may have information bearing on my moral and ethical qualifications and competence to carry out the privileges I have requested, and I authorize them to release such information as you require, including my prior disciplinary records, for purposes of verifying information obtained in the attached application or any re-application information without any obligation to give me written notice of such disclosure. I agree to hold MSHN and the informant harmless from any liability to me and/or my organization for providing such information.

I hereby further authorize MSHN to release any and all information related in any way to agency professional practice to any person, entity or governmental agency which: (a) provides MSHN with an authorization signed by an agency designee; or (b) has a legal right to know under any state or Federal law. I agree to hold MSHN harmless from any liability for providing any such information as specified herein.

I release all parties from all liability from any damages, causes of action, including, but not limited to, slander and libel, that may result from furnishing any information to you. I agree that any false information in support of this application may result in action up to and including cancellation of any or all contracts subject to contract provisions regardless of when discovered by MSHN. I release MSHN, the MSHN Credentialing Committee, individually and collectively, from any and all liability from any damages and/or causes of action associated with the MSHN credentialing and privileging process.

I hereby signify my willingness to appear for interviews with MSHN. I fully consent to the inspection of any and all records and documents pertinent to agency application for appointment and/or privileges. I understand and agree that if MSHN determines that this application contains any significant misstatements, misrepresentations, or omissions, MSHN's acceptance of this application for participation and any subsequent participating provider agreement which MSHN enters into with me will be voidable at MSHN's sole discretion.

I understand and agree that: (a) I have the burden of producing all information required or requested by MSHN in connection with this application; (b) MSHN is under no obligation to complete the processing of this application until all information requested is provided; (c) MSHN has the sole discretion to determine whether or not my organization will be accepted as a participating provider; and (d) in the event that MSHN decides not to accept my organization as a participating provider, I may initiate administrative appeal procedures as defined in the MSHN provider appeal policy.

I understand and agree that the certifications, authorizations and other provisions contained herein shall remain in force for so long as this application is pending and, if accepted for participation, for so long as my organizations' provider agreement with MSHN remains in force.

Applicant Signature:_____ Date:_____

Print Name:_____

Organization:_____

Application Checklist

The following items are required to be completed and/or submitted:

Yes	NA	
☐	☐	All applicable items on the application are complete and legible
☐	☐	Signed and dated Consent and Release of Liability (pg. 4)
☐	☐	Written explanations attached for any privilege, licensure, or malpractice history questions answered "Yes"
☐	☒	Copy of Physicians DEA/Controlled Substances License (MAT providers only)
☐	☒	Copy of SAMHSA Certification for Opioid Treatment Program (MAT Providers only)
☐	☒	Copy of Accreditation Certificate and most recent survey report (SUD treatment only)
☐	☒	Copy of ASAM LOC Designation Application(s) or letter from MDHHS (SUD treatment only)
☐	☐	Copy of current Malpractice and Professional Liability Policy
☐	☐	Completed and Signed Federal W-9 Form
☐	☐	Attachment A – Staff Credentialing & Training Information
☐	☐	Attachment B – Professional Liability Action Detail (if applicable)
☐	☐	Attachment C – Disclosure of Ownership & Controlling Interest Statement
☐	☐	Attachment D – Electronic Funds Transfer Form
☐	☐	REMI Multiple User Request Form
☐	☐	Copy of most recent program audit conducted by home PIHP (if applicable)
☐	☒	Copy of MDHHS/OROSC SUD Women's Specialty designation letter (if applicable)
☐	☒	Copy of MARR Certification Letter (Recovery Residences only)

Application can be emailed to Carolyn.Tiffany@MidstateHealthNetwork.Org
Or mailed to 530 W. Ionia, Suite C | Lansing, MI 48933

ATTACHMENT G - DISCLOSURE OF OWNERSHIP & CONTROLLING INTEREST STATEMENT

Mid-State Health Network (MSHN) 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 Pre-paid 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 MSHN for services to members under Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Wavier Program. Failure to submit the requests information may result in a refusal of participation in MSHN 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; within 35 days after any change in ownership of the disclosing entity. A Statement must be provided to MSHN within 35 days of a request for information by the US Department of Health and Human Services (HHS) or the State Agency. MSHN 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. MSHN is committed to protecting information about its providers and associates, especially the confidential nature of their personal information.

Detailed instructions and a glossary for capitalized 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'.*

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 Person Completing the Form** **Name of Provider/Provider Entity:** **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 corporation 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 Individual Provider 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(b)(1)(i)). 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 or disclosing 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 Individual Provider, 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(b)(1)(iii)).

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*

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 an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice ever been indicted or convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, CHIP or Title XX program? ☐ Yes ☐ *No-Skip to #6* ☐ *N/A-Skip to #6*

If yes, list those persons and the required information below. (42 CFR §455.106(1)(2)). 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 an Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Individual Provider practice ever been sanctioned, excluded, or debarred from Medicaid, Medicare, CHIP or Title XX program? ☐ Yes ☐ *No-Skip to #7* ☐ *N/A-Skip to #7*

If yes, list those persons and the required information below. (42 CFR §455.106(1)(2) and 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 an 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 a Title XX program? ☐ Yes ☐ *No-Skip to #8* ☐ *N/A-Skip to #8*

If yes, list those persons and the requirement information below. (42 CFR §455.106(1)(2) and 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 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

(NOTE: Pursuant to 42 CFR 455.105 Information shall be submitted within 35 days of request from the PIHP)

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 Section (VI) is not required to be completed at this time; however, 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(b)(4).
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 §455.101).
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 Mid-State Health Network 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 Number Fax Number Email Address

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: means any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

CHIP: means the Federal insurance program for children, Child Health Insurance Program, in Michigan this is known as MIChild.

Controlling Interest: means 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.

Ownership Interest: means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

HCBS Provider: means a provider of Home and Community Based Services for Medicaid beneficiaries.

Indirect Ownership Interest: means 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: means 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 Disclosing Entity: means 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.

Person with an Ownership or Controlling Interest: means a person 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: means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of twenty-five thousand dollars ($25,000) and five percent (5%) of a Provider's total operating expenses.

Subcontractor: means;

a) an individual, agency, or organization to which a disclosing 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 (or leases of real property) 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: means a supplier whose total ownership interest is held by the provider or by a person(s) or other entity with an ownership or control interest in the provider.

Attachment H - REFERENCES

ENTITY	DOCUMENT / INFORMATION/ LINK
Mid-State Health Network	Mission, Vision & Values Request for Proposal (RFP) Information Regional Training Grid – Minimum Requirements MSHN SUD Provider Manual MSHN SUD Contract & Rates Policies/Procedures
Code of Federal Regulations	Title 42 Public Health Title 2 Grants & Agreements Title 42 Subpart B
Michigan Department of Health and Human Services (MDHHS)	Medicaid Provider Manual Provider Qualifications Chart Policies & Practice Guidelines
Michigan Department of Licensing & Regulatory Affairs (LARA)	Program Licensing Rules Administrative Rules
American Society *of* Addiction Medicine (ASAM)	ASAM ASAM LOC Certification Program
Office of Management & Budget (OMB)	OMB 2 CFR Part 200 Subpart E Cost Principles

ATTACHMENT I - CERTIFICATE OF COMPLIANCE WITH PUBLIC ACT 517 OF 2012

I certify that neither _____ (Company), nor any of its successors, parent companies, subsidiaries, or companies under common control, are an "Iran Linked Business" engaged in investment activities of $20,000,000.00 or more with the energy sector of Iran, within the meaning of Michigan Public Act 517 of 2012. In the event it is awarded a Contract as a result of this Request for Proposals, Company will not become an "Iran Linked Business" during the course of performing the work under the Contract.

NOTE: IF A PERSON OR ENTITY FALSELY CERTIFIES THAT IT IS NOT AN IRAN LINKED BUSINESS AS DEFINED BY PUBLIC ACT 517 OF 2012, IT WILL BE RESPONSIBLE FOR CIVIL PENALTIES OF NOT MORE THAN $250,000.00 OR TWO TIMES THE AMOUNT OF THE CONTRACT FOR WHICH THE FALSE CERTIFICATION WAS MADE, WHICHEVER IS GREATER, PLUS COSTS AND REASONABLE ATTORNEY FEES INCURRED, AS MORE FULLY SET FORTH IN SECTION 5 OF ACT NO. 517, PUBLIC ACTS OF 2012.

_____
(Name of Company)

By: _____ Title: _____

Date: _____

ATTACHMENT J - MINIMUM QUALIFICATIONS ATTESTATION FORM

Legal Business Name: _____

DBA (if applicable): _____

Address: _____

Executive Director: _____

SIGNED STATEMENT OF AUTHORITY

I _____ AM THE _____
Name of Official Title of Official

OF _____
Name of Bidding Organization

Through signature below, I hereby certify that our organization meets the following minimum requirements (check applicable boxes):

☐ Necessary systems in the areas of administration and clerical support for the program. This includes the necessary computer equipment, compatible software and Internet connections to be able to electronically request authorization for services and submit data and billing; a valid, active and maintained email account that can receive and submit communications.

☐ An established financial system in operation which meets generally accepted accounting principles and systems (i.e., maintains fiscal solvency).

☐ A current program license or ability to obtain a program license through the state of Michigan as required for federal and state funding (if licensed).

☐ A current agency Accreditation Certificate from a nationally recognized accrediting body (i.e., CARF, TJC, COA, etc.)

☐ An approved ASAM LOC Designation Letter from MDHHS for all services bid.

☐ Capacity to obtain and retain program staff who meet the minimum qualifications/ credentialing requirements (see MDHHS Medicaid Provider Manual, the Michigan Department of Licensing and Regulatory Affairs (LARA) – and Provider Qualifications Chart - web addresses identified on Attachment H (References) as they pertain to services being bid for).

☐ The ability to understand, relate to, and operate within an ethnic, racial, age, and economically diversified population. In addition, have the capacity to provide services in settings accessible and acceptable to individuals and communities intended to be served.

☐ Agree to comply with Federal Confidentiality, Privacy and Security Regulations and State Confidentiality laws, which includes compliance with Title 42 (Public Health) of the Code of Federal Regulations (CFRs).

Signature Date