

ATTACHMENT K - 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).
- An approved enrollment 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 I (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