

RAI/MDS Transmission System Facility Information Form

Instructions

The facility administrator or their designate should fill out this form. The facility administrator must sign the form for the confidentiality agreement.

The information you provide on this form will be stored on the state database. It will be used to verify your facility's identity during data transmissions. The administrator and the MDS Coordinator indicated here are the only people from your facility who are authorized to request confidential information from the database. Please update this information as often as necessary.

Items 1-22. Facility Information

These items will become the facility contact information that is stored on the database. PLEASE KEEP THE FACILITY CONTACT INFORMATION CURRENT BY UPDATING THE MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS WHEN CHANGES OCCUR. REPORT THESE CHANGES TO YOUR LICENSING OFFICER.

1. Write the name of your facility as it appears in your licensing application.
2. Write the name of the county in which your facility resides.
3. Write today's date.
- 4-7. Write your facility's physical address, city, state and zip code.
- 8-11. Write your facility's mailing address, city, state and zip code, if different from the physical address.
12. Write the facility's email address, if any.
13. Write the facility's fax number.
- 14-15. Write the facility administrator's name and phone number, with extension (if any).
- 16-17. Write the facility's computer technical contact person's name and phone number, with extension (if any).
- 18-19. Write the MDS Coordinator's name and phone number, with extension (if any).
- 20-21. Write the facility's Medicaid and Medicare ID numbers. If these are not known at this time, leave blank. When the facility Medicaid and Medicare ID numbers are known, update the department with this information.
22. Write the facility's MDS encoding software vendor's name or indicate that you are using jRAVEN..

Items 23. Minimum System Requirements

23. Check the box to indicate agreement to meet the minimum CMS computer configuration requirements described in the document *Minimum and Recommended Client Requirements: New and Existing Equipment*. This document is available on the QIES Technical Support Office web site at: <https://www.qtso.com>

Item 24 Confidentiality Agreement

24. The facility administrator must sign and date the agreement that governs access to the CMS System, as well as use and maintenance of individual MDS User IDs and passwords. NOTE: Details about the process and access request forms for obtaining individual MDS User accounts are available on the QIES Technical Support Office web site at: <https://www.qtso.com>

Please return the completed and signed information form to:

**Sheila Bonam, MDS Automation Coordinator
MI Department of Licensing and Regulatory Affairs
Bureau of Health Systems, Division of Nursing Home Monitoring
3026 West Grand Boulevard, Suite 11-150
P.O. Box 02981
Detroit, MI 48202**

Phone: (313) 456-0309

Fax: (313) 456-0348

RAI/MDS Transmission System Facility Information Form

Please type or print

Items 1-22. Facility Information

1. Facility Name	2. County Name	3. Date
4. Address		
5. City	6. State	7. ZIP
8. Mailing Address (if different from above)		
9. City	10. State	11. ZIP
12. Email address	13. Facility FAX Number	
14. Facility Administrator	15. Phone/Extension	
16. Technical Contact	17. Phone/Extension	
18. MDS Contact	19. Phone/Extension	
20. Medicaid ID	21. Medicare ID	
22. MDS Software System Vendor		

Item 23. Minimum System Requirements

<p>23. Check box to indicate agreement.</p> <p><input type="checkbox"/> I agree to meet the minimum CMS computer configuration requirements described in the document <i>Minimum and Recommended Client Requirements: New and Existing Equipment</i> that is available on the QIES Technical Support Office web site at: https://www.gtso.com</p>
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Item 24. Confidentiality Agreement

<ul style="list-style-type: none"> As a representative of our facility, I understand that everything done under our individual user accounts is recorded as being done by our facility and that we are responsible for these actions. We will hold all information obtained in connection with access to the CMS System for MDS data in the strictest confidence. 		
<ul style="list-style-type: none"> We agree NOT to share individual MDS User IDs and passwords and that an individual user account will be obtained for each authorized user. <p>NOTE: Details about the process and access request forms for obtaining individual MDS User Accounts are available on the QIES Technical Support Office web site at: https://www.gtso.com</p>		
<ul style="list-style-type: none"> I also agree to notify QTSO and submit the appropriate forms to remove access for facility users no longer authorized to access the CMS system. 		
<table border="1"> <tr> <td>Facility Administrator Signature</td> <td>Date</td> </tr> </table>	Facility Administrator Signature	Date
Facility Administrator Signature	Date	

Please return this signed form to: Sheila Bonam, MDS Automation Coordinator, MI. Dept. of Community Health, Bureau of Health Systems, Division of Nursing Home Monitoring, P.O. Box 02981, Detroit, MI 48260, Phone: (313) 456-0309, Fax: (313) 456-0348