RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

New Agency Provider Enrollment Instructions

"Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time."

-Provider Relations

New Provider Enrollment Instructions

- Anyone becoming a *new* Home Help agency provider
- Fill out the 8 Step Provider Enrollment Application
- Track Your Application

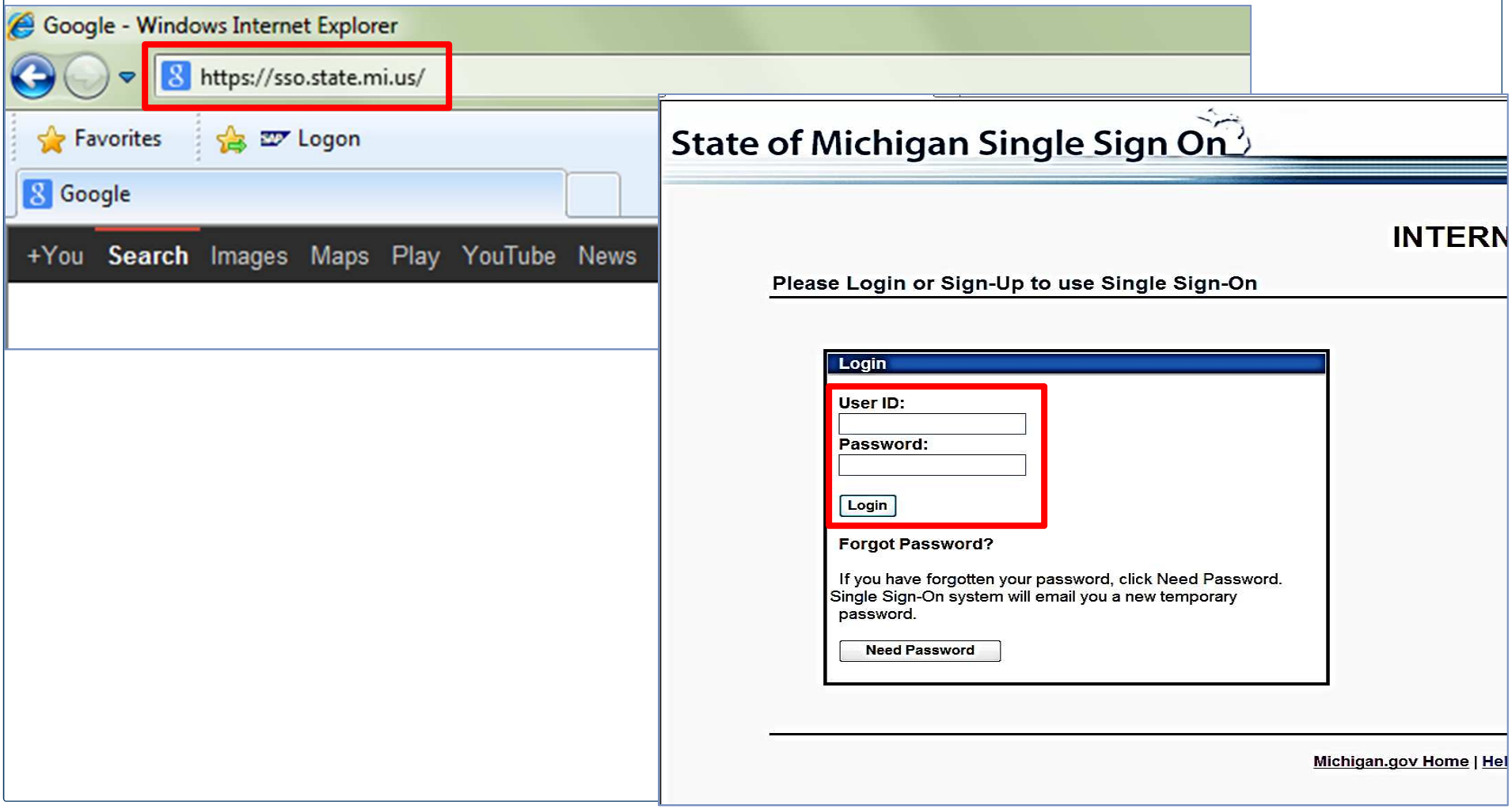
***Have paper and a writing utensil nearby

***You must complete the application within **30 days** of beginning

Call the Provider Support Helpline if you need assistance:

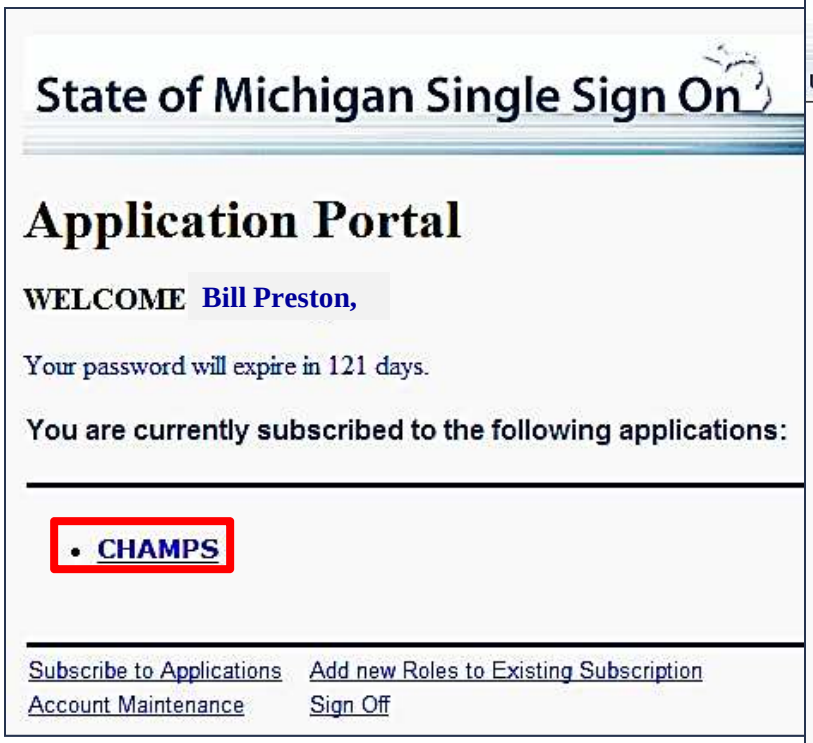
1-800-979-4662

Sign into the State of Michigan Single Sign On by going to **http://sso.state.mi.us** and entering your User ID and Password. This will take you to the Single Sign On Application Portal.



Below is the display of the Application Portal.
Click on the **CHAMPS** hyperlink.
Read the MDCH Systems Use Notification on the next page and click **Acknowledge/Agree.**

***NOTE: You will have to do this every time you access CHAMPS



Below is the display of the CHAMPS homepage for a brand new provider. Click on **New Enrollment** (in blue).

Choose **Atypical (non-medical) provider.**
Choose **Agency (Child Care Institution, Home Help/Personal Care…)**
Click the **Submit** button.

Scott,Sarah ▾ | Quick Find | Note Pad | External Links ▾ | My Favorites ▾ | Print | Help

› MyInbox › New Enrollment › ESV Member List › New Enrollment

Enrollment Type

Select the Applicable Enrollment Type

- Individual/Sole Proprietor
  - Regular Individual/Sole Proprietor (Choose this option to be a Medicaid Individual/Sole Proprietor, you may participate in the EHR-MIPP.)
  - EHR-MIPP Only Provider (Choose this option to participate only in EHR-MIPP.)
  - Managed Care Network Provider Only
  - Managed Care Network Provider and EHR
- Group Practice (Corporation, Partnership, LLC, etc.)
- Billing Agent
- Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)
- Contractor/MCO
- Atypical (non-medical) provider (Choose this option if you do not have a NPI)
  - Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
  - Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, etc.)

Submit

Enter the required information, indicated by the asterisk (*).
Click **Confirm** to verify the EIN/TIN.
Click **Finish**.

Welcome to MMIS - Windows Internet Explorer

Print Help

Basic Information(Home Help)

Legal Entity Name: (As shown on the Income Tax Return)

Entity Business Name: Helping Hands Chore Services * (Doing Business As)

EIN/TIN: 10021052 *

Contact Email Address:

Email-1

Email-2

Email-3

NPI:

Please note that all providers are subject to a criminal background screening that could affect your ability to be paid through the Home Help program.

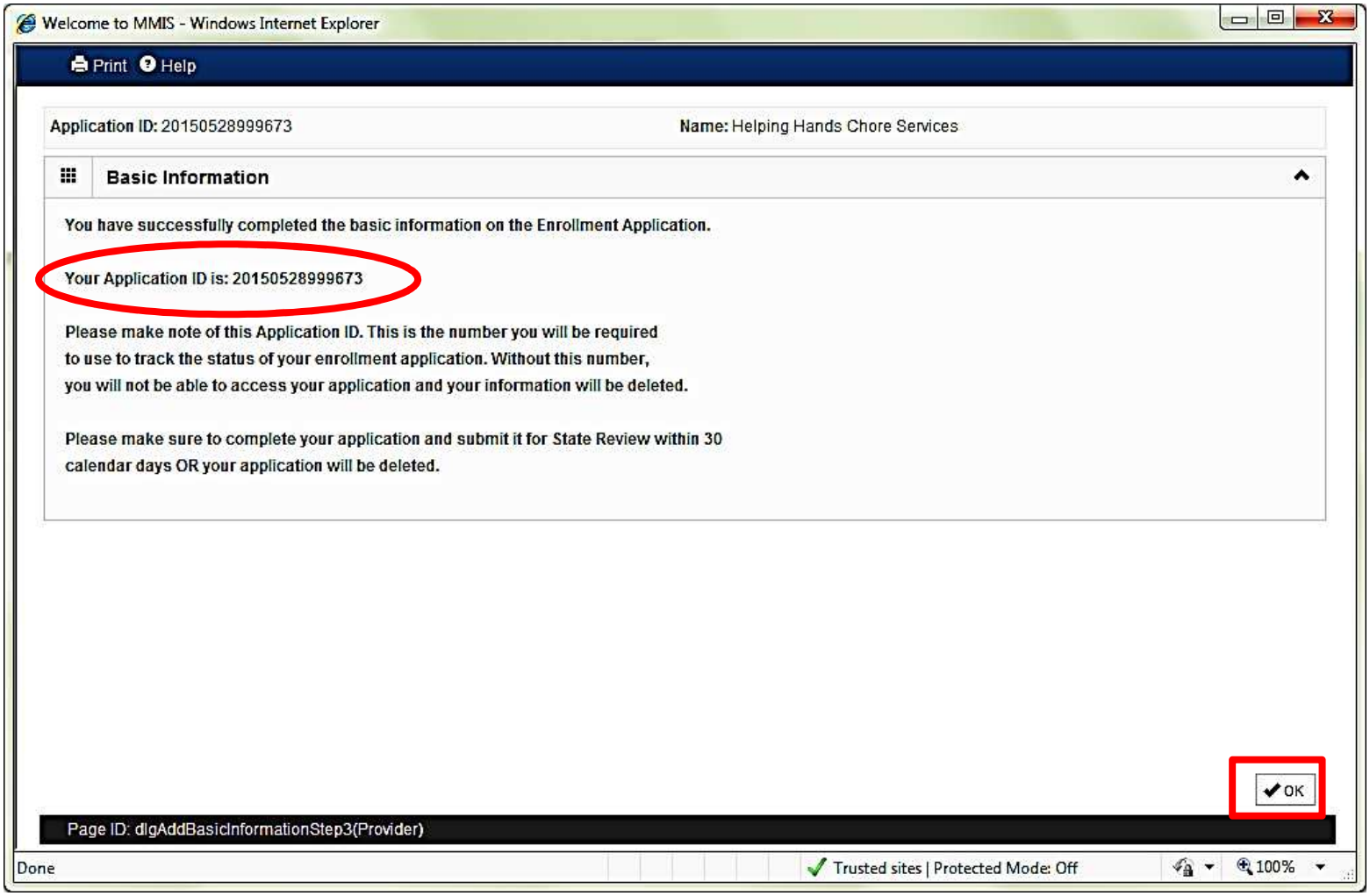
Confirm Finish Cancel

Page ID: dlgAddBasicInformationStep1(Provider)

Done Trusted sites | Protected Mode: Off 100%

Write down the **Application ID** number for future reference.
Click **OK**.

***NOTE: Be sure to complete and submit your application within 30 days or your application will be deleted.



Notice the **Status** for **Step 1: Provider Basic Information** is designated *Complete.*

Click on the **Step 2: Add Locations** hyperlink.

Application ID: 20150709666544 **Name:** Helping Hands Chore Services

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/09/2015	07/09/2015	Complete	
Step 2: Add Locations	Required	07/09/2015		Incomplete	Please add/validate Location.
Step 3: Add Specialties	Required			Incomplete	
Step 4: Add License/Certification/Other	Optional			Incomplete	
Step 5: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 6: Associate Billing Agent	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 8: Add Taxonomy Details	Optional			Incomplete	
Step 9: Associate MCO Plan	Optional			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Go Page Count : 1 SaveToXLS Viewing Page: 1 First Prev Next Last

Click **Add.**

> Provider Portal > New Enrollment > HIPAA-Exempt Individual Enrollment

Application ID: 20150528999673 **Name:** Helping Hands Chore Services

Close | Add | To add/modify Pay To, Correspondence and Remittance Advice addresses, click on Location Type hyperlink.

Locations List

Filter By | Go

	Doing Business As	Location Type
		No Records

Enter the required information, indicated by an asterisk (*).
Click **Validate Address** (you *cannot* go any further without clicking this)**.**

***NOTE: **Location Type** will always by *Primary Practice Location.*
***NOTE: Entering the **Zip Code** will automatically update **State, City/Town,** and **County**

Print Help

Application ID: 20150528999673 Name: Helping Hands Chore Services

For all locations, Correspondence address is required. For Primary Practice Location, Pay-To address is required. Enter Remittance Advice address only to receive a paper Remittance Advice

Add Provider Location

Location Type: Primary Practice Location *
Doing Business As:
End Date:
If a department or drawer number is required enter the information in line TWO.
(For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111)
If an attention line is required, please enter the information in Line THREE.
(For example: ATTN: Billing Dept.)

Address validation successful

Address Line 1: 320 S WALNUT ST *
(Enter Street Address or PO Box Only)
Address Line 2:
Address Line 3:
City/Town: LANSING *
State/Province: MICHIGAN *
County: INGHAM
Country: UNITED STATES *
Zip Code: 48933 - 2014
Validate Address

Phone Number: (517) 373-2076 * Extn:
Fax Number:
Email Address:
Web Page:
Office Hours:
Communication Preference: CHAMPS Notice

Handicap Accessible: No
Accept 835 (reported at EIN/TIN level): No
Language(s) Spoken: English, Arabic, Chinese (For Multiple Selection, use Ctrl Key)

OK Cancel

Page ID: dlgEnrlAddLocation(Provider)

Scroll to the bottom of the previous screen.
Enter the **Fiscal Year End Date** relevant to your agency.
Indicate the **Distinct Part Unit**.
Click **OK.**

Office Hours:
Communication Preference: CHAMPS Notice
Handicap Accessible: No
Accept 835 (reported at EIN/TIN level): No
Language(s) Spoken: English, Arabic, Chinese (For Multiple Selection, use Ctrl Key)

Facility Details

State Facility ID:
Licensed Medicaid Bed(s):
Licensed Medicaid/Medicare Bed(s): (Dual Certified)
Swing Bed(s):
Licensed LTC Unit(s): (Long Term Care)
Distinct Part Unit: None * — None, Psych, Skilled Nursing
Fiscal Year End Date: 12/31 * (mm/dd)
Licensed Medicare Bed(s):
Ventilator Dependent Unit(s):
Acute Care Bed(s):
Temporarily Non Available:

OK Cancel

Page ID: dlgEnrlAddLocation(Provider)

Click on the **Primary Practice Location** hyperlink (in blue).
Click **Add Address**.

Application ID: 20150528999673 Name: Helping Hands Chore Services

Close Add To add/modify Pay To, Correspondence and Remittance Advice addresses, click on Location Type hyperlink.

Locations List

Filter By Go Save Filters My Filters

Doing Business As	Location Type	Location Details	End Date
	Primary Practice Location	320 S WALNUT ST, LANSING, MICHIGAN 48933	12/31/2999

Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

Application ID: 20150528999673 Name: Helping Hands Chore Services

Close Save To add additional addresses, click 'Add Address' button.

Location Details

Doing Business As:
Phone Number: (999) 999-9999 * Extn:
Web Page:
Handicap Accessible: No
Accept 835(reported at EIN/TIN level): No
End Date: 12/31/2999
Location Code: 01
Fax Number:
Office Hours:
Language(s) Spoken: English, Arabic, Chinese (For Multiple Selection, use Ctrl Key)
Location Type: Primary Practice Location
Email Address:
Communication Preference: CHAMPS Notice

Add Address

Address List

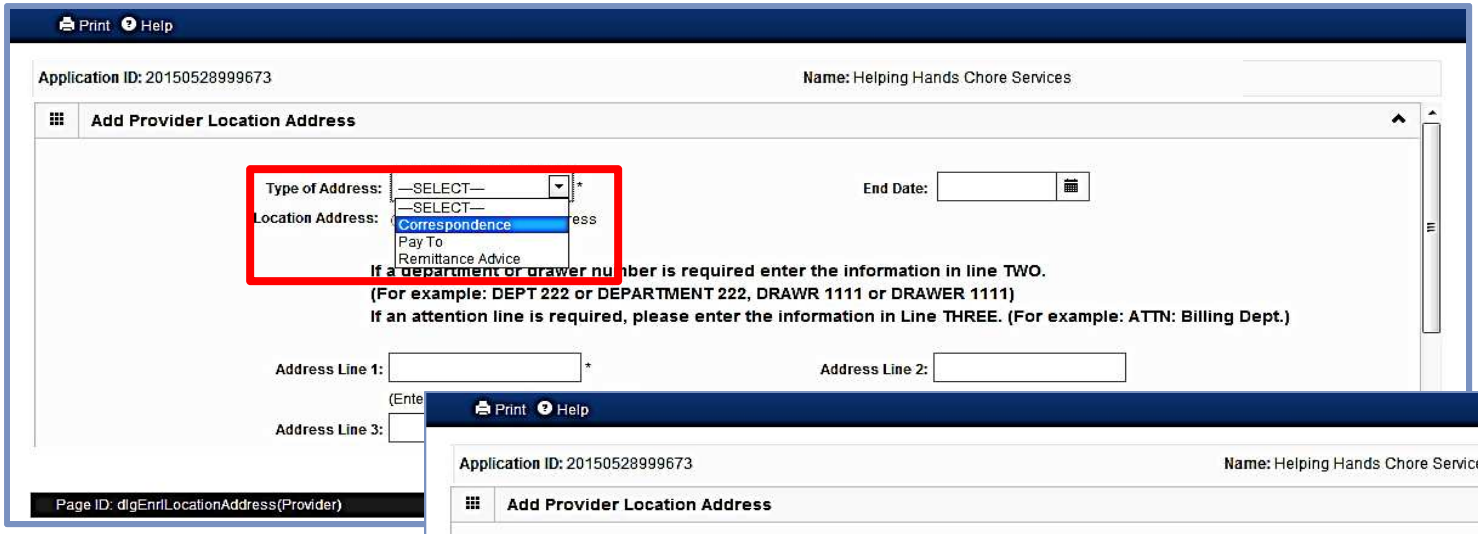
Address Type	Address	End Date
Location	320 S WALNUT ST, LANSING, MICHIGAN 48933	12/31/2999

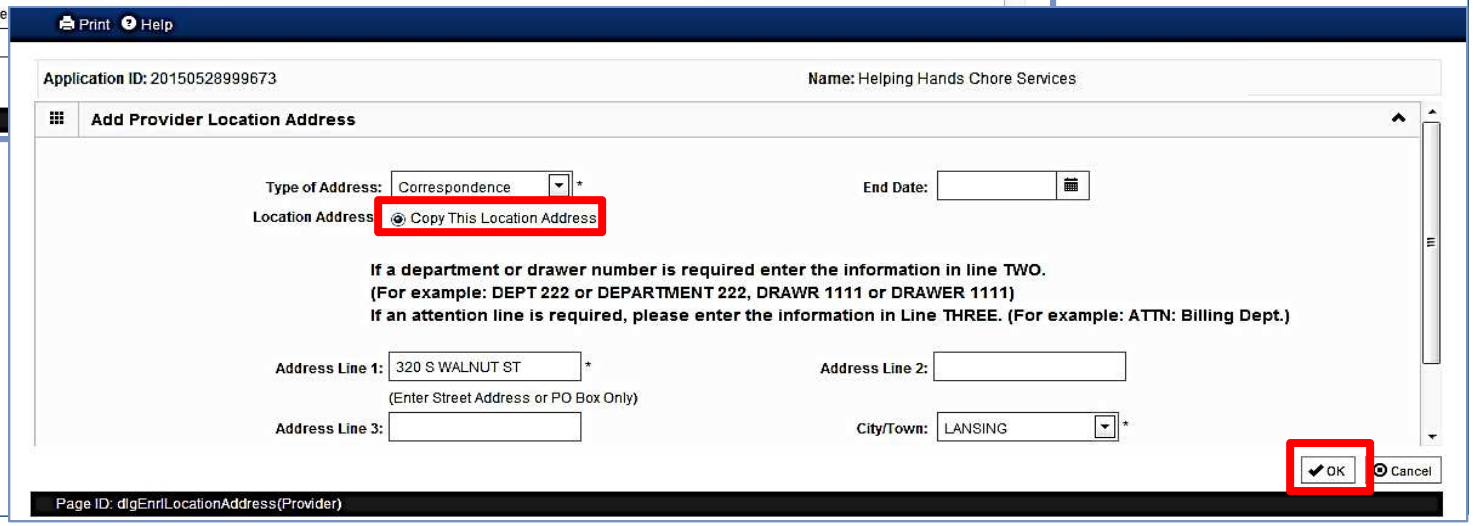
Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

In the **Type of Address** drop down menu, select **Correspondence.**

***All correspondences from the Home Help program will be sent to the address entered here; therefore, enter the address where your agency regularly receives mail.*

If that address is the same as the one entered previously, simply select **Copy This Location Address** next to the **Location Address.**
Click **OK**.





Click **Add Address**.
Select **Pay To** in **Type of Address.**
Click **OK.**

CHAMPS | My Inbox | Provider
Scott,Sarah | Quick Find | Note Pad | External Links | My Favorites | Print | Help
> MyInbox > New Enrollment > Atypical Agency Enrollment > General

Application ID: 20150716126201 Name: Helping Hands Chore Services

Close | Save | To add additional addresses, click "Add Address" button.

Location Details

Doing Business As:
Location Code: 01
Location Type: Primary Practice Location
Phone Number: (517) 373-2076 * Extn:
Fax Number:
Email Address:
Web Page:
Office Hours:
Communication Preference:
Handicap Accessible: No
Accept 835(reported at EIN/TIN level): No
Language(s) Spoken: English, Arabic, Chinese (For Multiple Selection, use Ctrl Key)
End Date: 12/31/2999

Facility Details

State Facility ID:
Fiscal Year End Date: (mm/dd) 12/31 *
Licensed Medicaid Bed(s):
Licensed Medicare Bed(s):
Licensed Medicaid/Medicare Bed(s): (Dual Certified)
Ventilator Dependent Unit (s):
Swing Bed(s):
Acute Care Bed(s):
Licensed LTC Unit(s):
Temporarily Non A

Address List

Add Address

Address Type
Correspondence
Location

Page ID: pgEnrollmentLocationGeneral(

Print | Help

Application ID: 20150716126201 Name: Helping Hands Chore Services

Add Provider Location Address

Type of Address: Pay To (–SELECT– / Correspondence / Pay To / Remittance Address)
End Date:
Location Address:
If a department or drawer is required, please enter the information in line TWO.(For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

Address Line 1: 320 S WALNUT ST *
(Enter Street Address or PO Box Only)
Address Line 2:
Address Line 3:
City/Town: *
State/Province: *
County:
Country: UNITED STATES *
Zip Code: 48933 - 2014 | Validate Address

OK | Cancel

Page ID: dlgEnrlLocationAddress(Provider)

Notice the Correspondence, Location and Pay To rows have addresses.
Click **Save**.
Click **Close** on the next two screens to go back to the list of steps (Not shown).
The **Close** button is on the top left corner.

CHAMPS | My Inbox | Provider

Scott,Sarah | Quick Find | Note Pad | External Links | My Favorites | Print | Help

MyInbox > New Enrollment > Atypical Agency Enrollment > General

Application ID: 20150716126201 Name: Helping Hands Chore Services

Close | Save | o add additional addresses, click "Add Address" button.

Doing Business As: | Location Code: 01 | Location Type: Primary Practice Location

Phone Number: (517) 373-2076 * Extn: | Fax Number: | Email Address:

Web Page: | Office Hours: | Communication Preference:

Handicap Accessible: No

Accept 835(reported at EIN/TIN level): No | Language(s) Spoken: (For Multiple Selection, use Ctrl Key) English, Arabic, Chinese

End Date: 12/31/2999

Facility Details

State Facility ID: | Fiscal Year End Date: (mm/dd) 12/31 * | Licensed Medicaid Bed(s):

Licensed Medicare Bed(s): | Licensed Medicaid/Medicare Bed(s): (Dual Certified) | Ventilator Dependent Unit (s):

Swing Bed(s): | Acute Care Bed(s): | Licensed LTC Unit(s): (Long Term Care)

Temporarily Non Available: | Distinct Part Unit: None *

Address List

Add Address

Address Type	Address	End Date
Correspondence	320 S WALNUT ST, LANSING, MICHIGAN 48933	12/31/2999
Location	320 S WALNUT ST, LANSING, MICHIGAN 48933	12/31/2999
Pay To	320 S WALNUT ST, LANSING, MICHIGAN 48933	12/31/2999

Delete | View Page 1 | Go | Page Count : 1 | SaveToXLS | Viewing Page: 1 | First | Prev | Next | Last

Click on **Step 3: Add Specialties** hyperlink
Click **Add.**

Application ID: 20150709666544 **Name:** Helping Hands Chore Services

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/09/2015	07/09/2015	Complete	
Step 2: Add Locations	Required	07/09/2015	07/09/2015	Complete	
Step 3: Add Specialties	Required			Incomplete	
Step 4: Add License/Certification/Other	Optional			Incomplete	
Step 5: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete	
Step 6: Associate Billing Agent	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 8: Add Taxonomy Details	Optional			Incomplete	
Step 9: Associate MCO Plan	Optional			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Cor					
Step 12: Sub					

View Page

Application ID: 20150528999673 **Name:** Helping Hands Chore Services

Close Add

Specialty/Subspecialty List

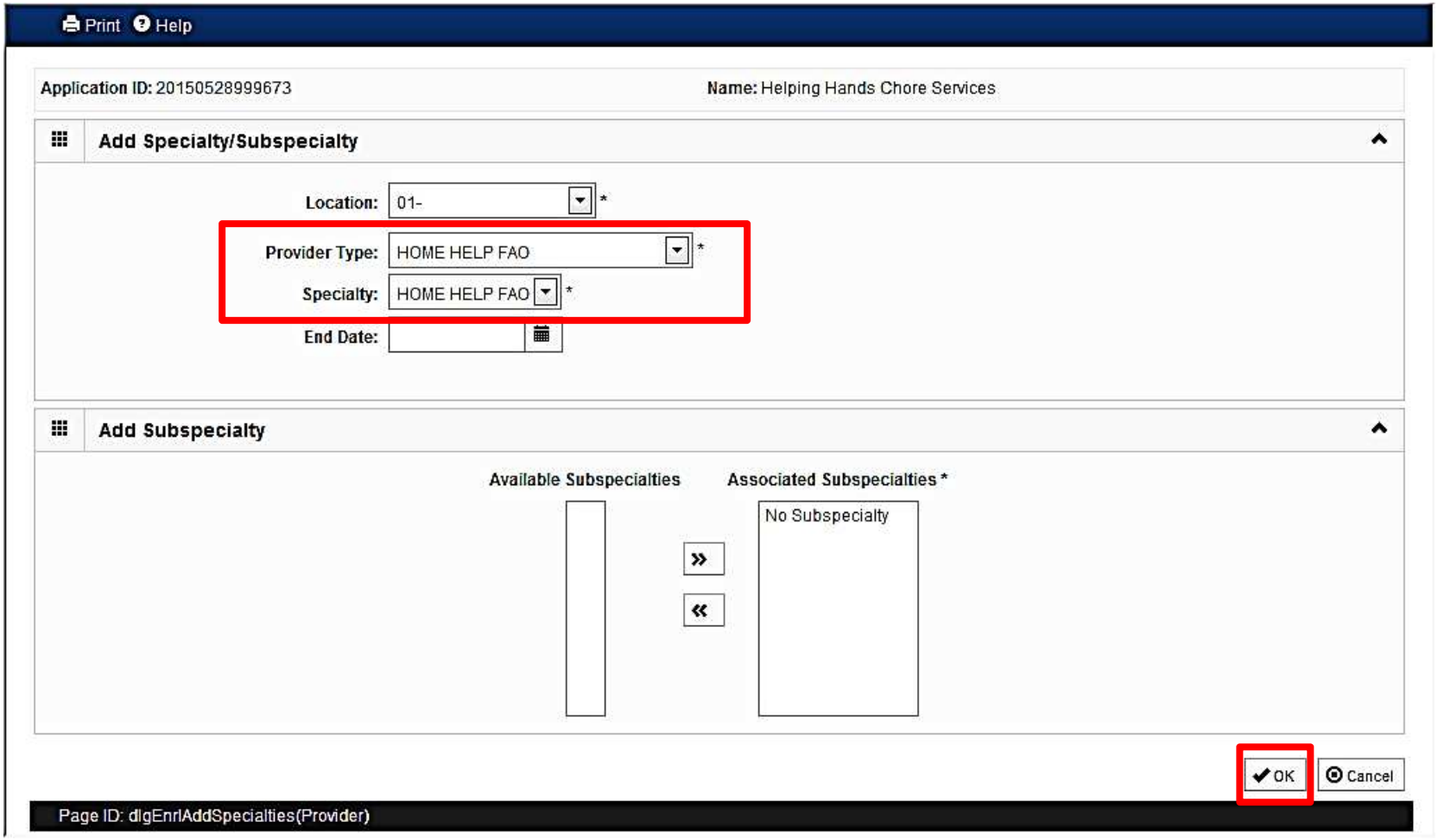
Filter By Go Save Filters My Filters

	Specialty/Subspecialty	Provider Type	End Date

No Records Found !

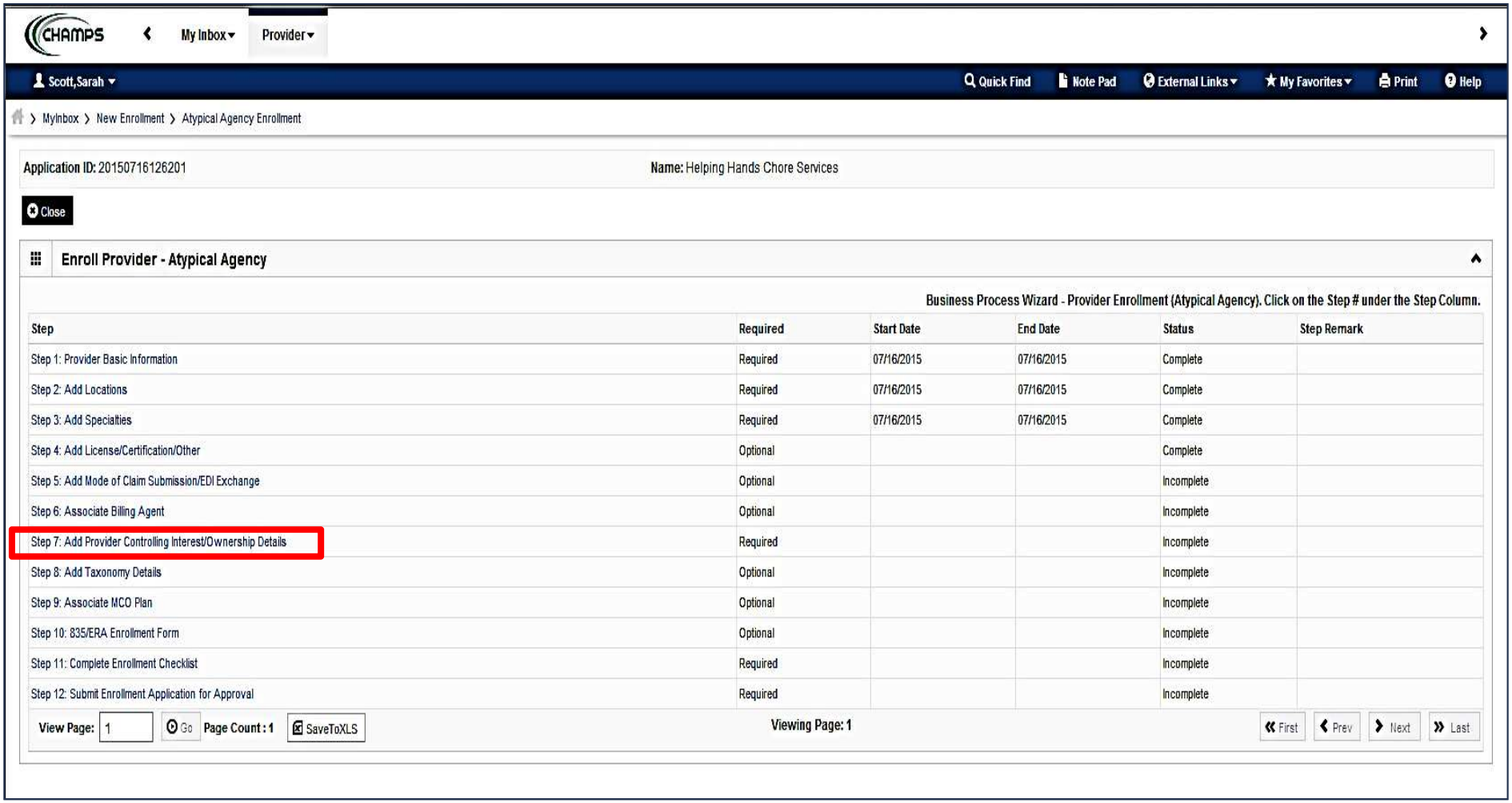
Choose **01-** for **Location**.
For both **Provider Type** and **Specialty**, choose **Home Help FAO.**
Click **OK**.

***NOTE: FAO is an acronym for Facility/Agency/Organization.



Steps 4-6 are optional; most agencies do not need to complete these steps.

Click **Step 7: Add Provider Controlling Interest/Ownership Details** hyperlink.



Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/16/2015	07/16/2015	Complete	
Step 2: Add Locations	Required	07/16/2015	07/16/2015	Complete	
Step 3: Add Specialties	Required	07/16/2015	07/16/2015	Complete	
Step 4: Add License/Certification/Other	Optional			Complete	
Step 5: Add Mode of Claim Submission/EDI Exchange	Optional			Incomplete	
Step 6: Associate Billing Agent	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 8: Add Taxonomy Details	Optional			Incomplete	
Step 9: Associate MCO Plan	Optional			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

Click on the **Add** button to add a Managing Employee owner.

CHAMPS | My Inbox | Provider

Scott,Sarah | Quick Find | Note Pad | External Links | My Favorites | Print | Help

MyInbox > New Enrollment > Atypical Agency Enrollment > General

Application ID: 20150716126201 **Name:** Helping Hands Chore Services

Close | Add

Owners List

Filter By | Go | Save Filters | My Filters

Owner SSN/EIN/TIN	Owner Information	Type	Start Date	End Date
No Records Found !				

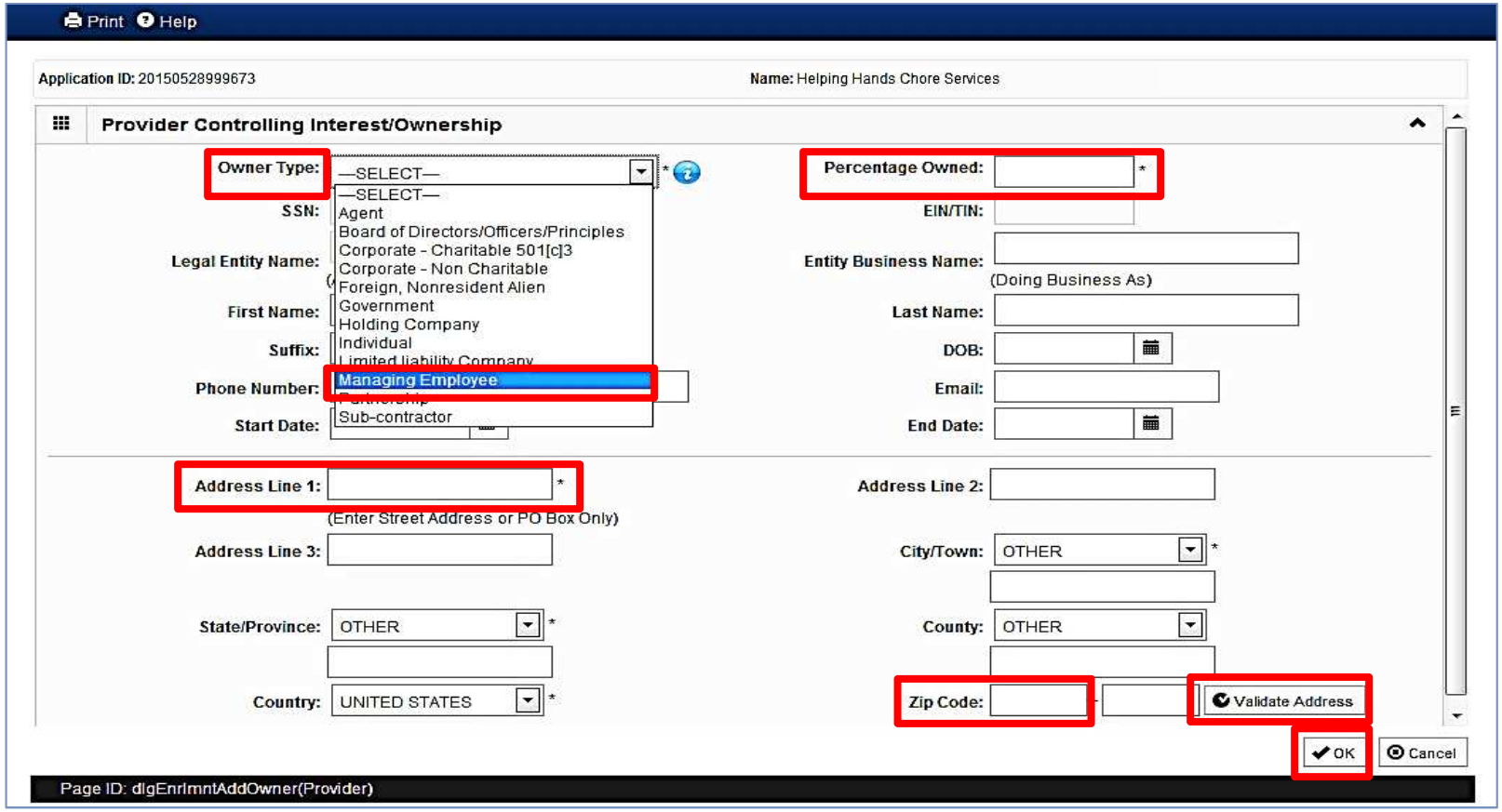
Add Other Owned Entity | **List Ownership Interest in other Entities reimbursible by Medicaid and/or Medicare.**

Filter By | Go | Save Filters | My Filters

Other Owner EIN/TIN	Other Owner Information	Address
No Records Found !		

Choose **Managing Employee** in the **Owner Type** drop down menu.
Enter the required information, indicated by the asterisk (*).
Click **Validate Address** button (you *cannot* go any further without this).
Click **OK.**

***NOTE: Enter the percentage of the agency owned by the Managing Employee.
***NOTE: Entering the **Zip Code** will automatically update **State, City/Town,** and **County**.



Click on the **Add** button to add a Board of Director, Officer, or Principle Owner.

CHAMPS | My Inbox | Provider

Scott,Sarah | Quick Find | Note Pad | External Links | My Favorites | Print | Help

MyInbox > New Enrollment > Atypical Agency Enrollment > General

Application ID: 20150716126201 **Name:** Helping Hands Chore Services

Close | Add

Owners List

Filter By | Go | Save Filters | My Filters

Owner SSN/EIN/TIN	Owner Information	Type	Start Date	End Date
123456789	Preston,Bill	Managing Employee	07/16/2015	12/31/2999

Delete | View Page: 1 | Go | Page Count : 1 | SaveToXLS | Viewing Page: 1 | First | Prev | Next | Last

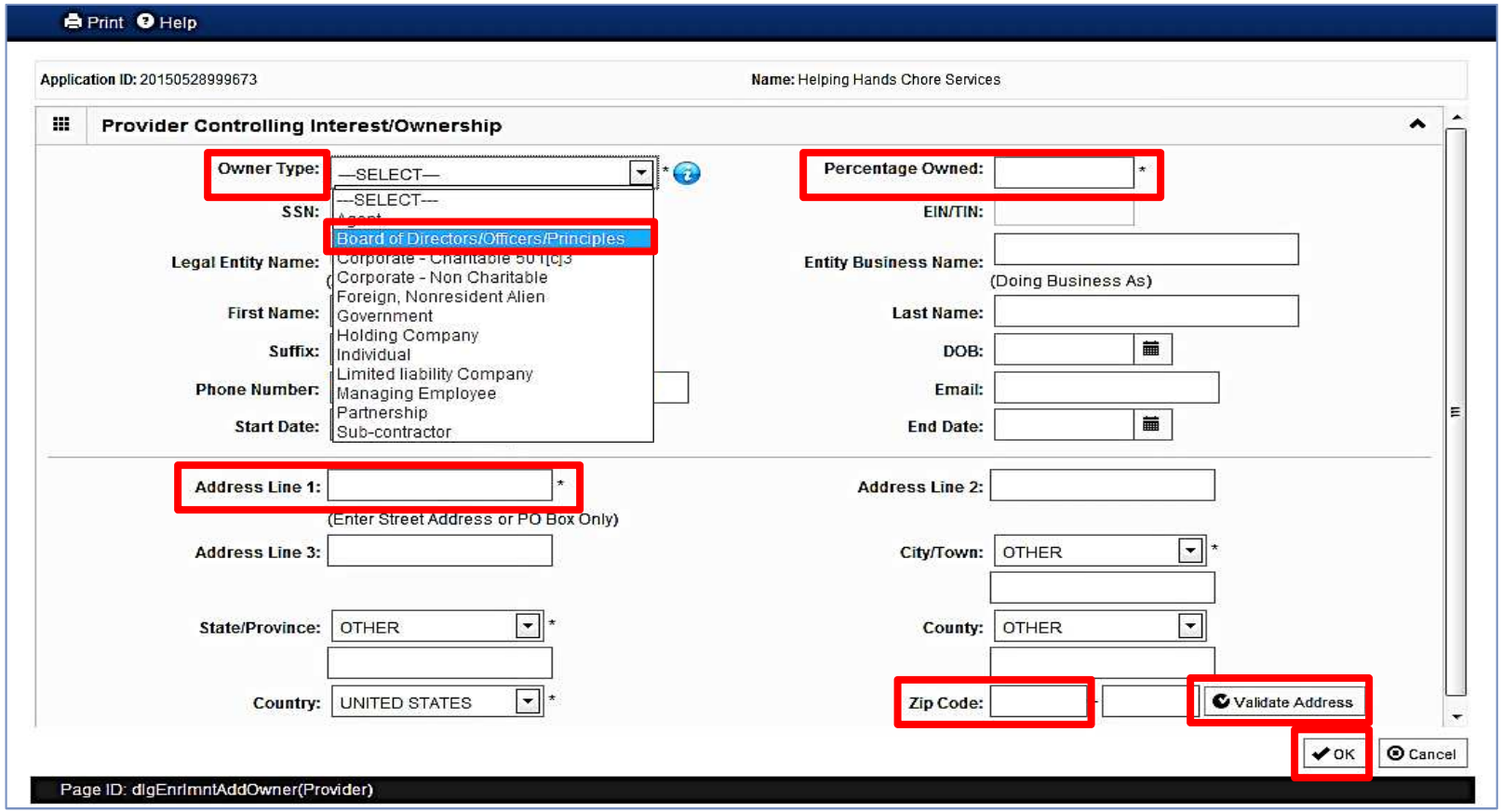
Add Other Owned Entity | List Ownership Interest in other Entities reimbursible by Medicaid and/or Medicare.

Filter By | Go | Save Filters | My Filters

Other Owner EIN/TIN	Other Owner Information	Address
No Records Found !		

Choose **Board of Directors/Officers/Principles** in the **Owner Type** drop down menu.
Enter the required information, indicated by the asterisk (*).
Click **Validate Address** button (you *cannot* go any further without this).
Click **OK.**

***NOTE: Enter the percentage of the agency owned by the BoD/Officers/Principles.
***NOTE: Entering the **Zip Code** will automatically update **State, City/Town,** and **County**



Click on the **Add** button to add either an Individual or Corporate Owner.

CHAMPS | My Inbox | Provider

Scott,Sarah | Quick Find | Note Pad | External Links | My Favorites | Print | Help

MyInbox > New Enrollment > Atypical Agency Enrollment > General

Application ID: 20150716126201 **Name:** Helping Hands Chore Services

Close | Add

Owners List

Filter By | Go | Save Filters | My Filters

Owner SSN/EIN/TIN	Owner Information	Type	Start Date	End Date
123456789	Preston,Bill	Managing Employee	07/16/2015	12/31/2999
123456789	Preston,Bill	Board of Directors/Officers/Principles	07/16/2015	12/31/2999

Delete | View Page: 1 | Go | Page Count : 1 | SaveToXLS | Viewing Page: 1 | First | Prev | Next | Last

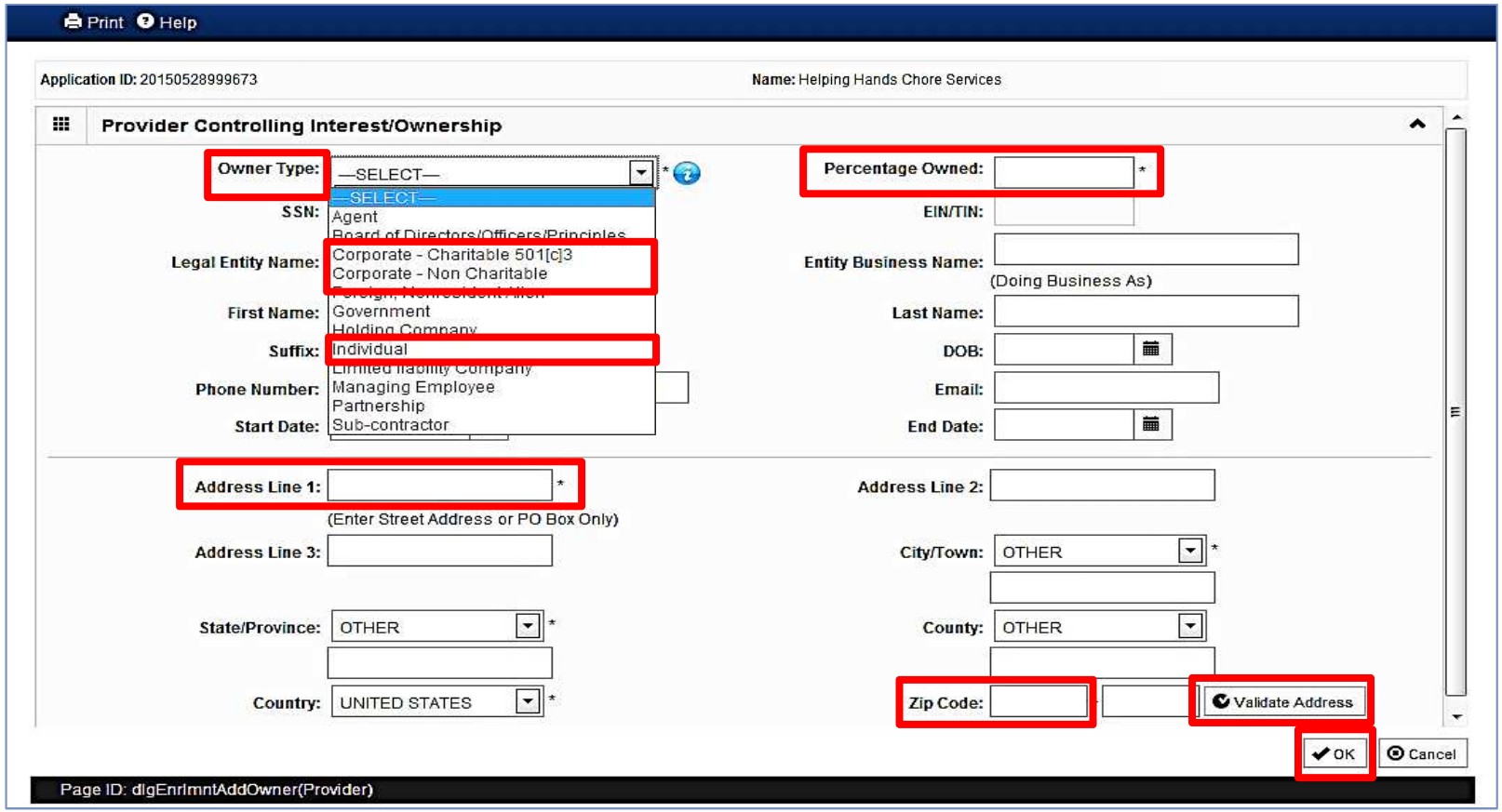
Add Other Owned Entity | **List Ownership Interest in other Entities reimbursible by Medicaid and/or Medicare.**

Filter By | Go | Save Filters | My Filters

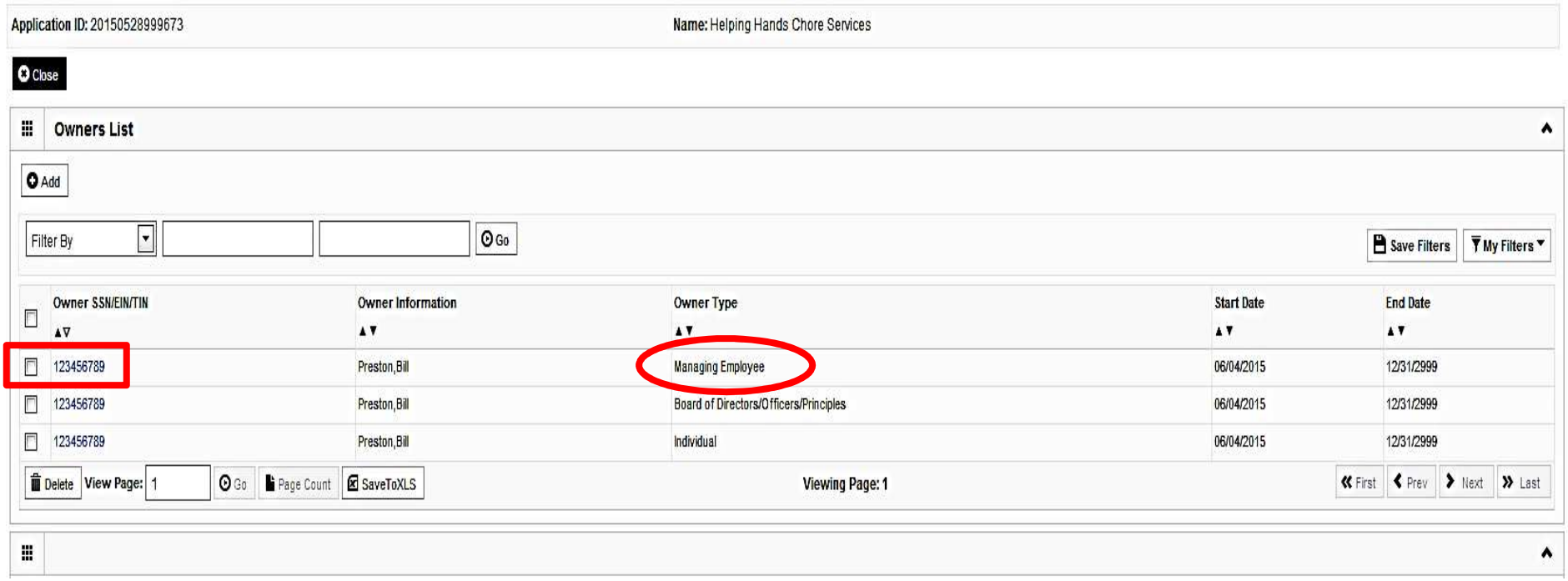
Other Owner EIN/TIN	Other Owner Information	Address
No Records Found !		

Choose either a **Corporate** option OR **Individual** option in the **Owner Type** drop down menu.
Enter the required information, indicated by the asterisk (*).
Click **Validate Address** button (you *cannot* go any further without this).
Click **OK.**

***NOTE: Enter the percentage of the agency owned by the Corporate/Individual Owner.
***NOTE: Entering the **Zip Code** will automatically update **State, City/Town,** and **County**

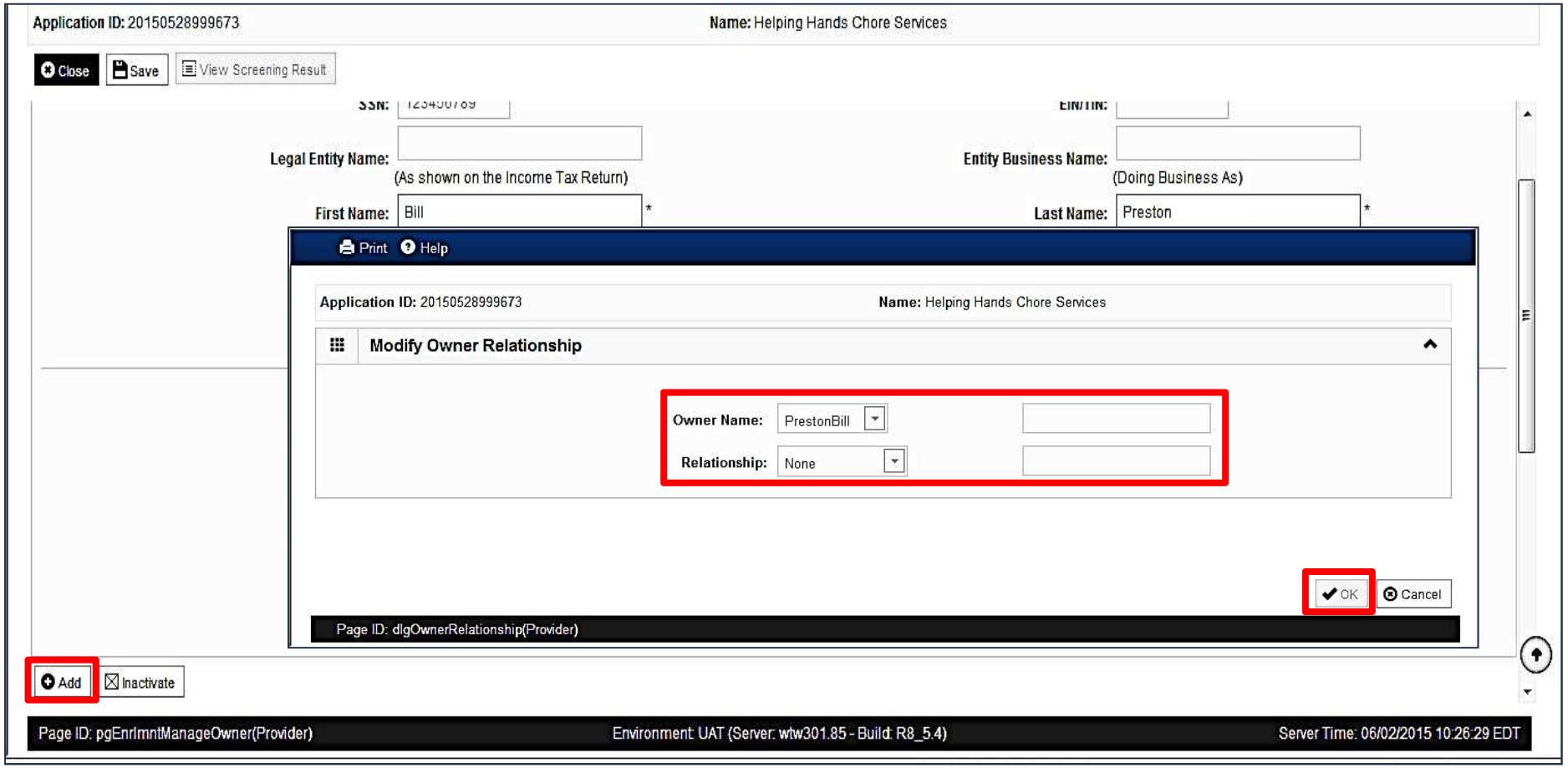


Click on the **Managing Employee** SSN hyperlink (in blue).

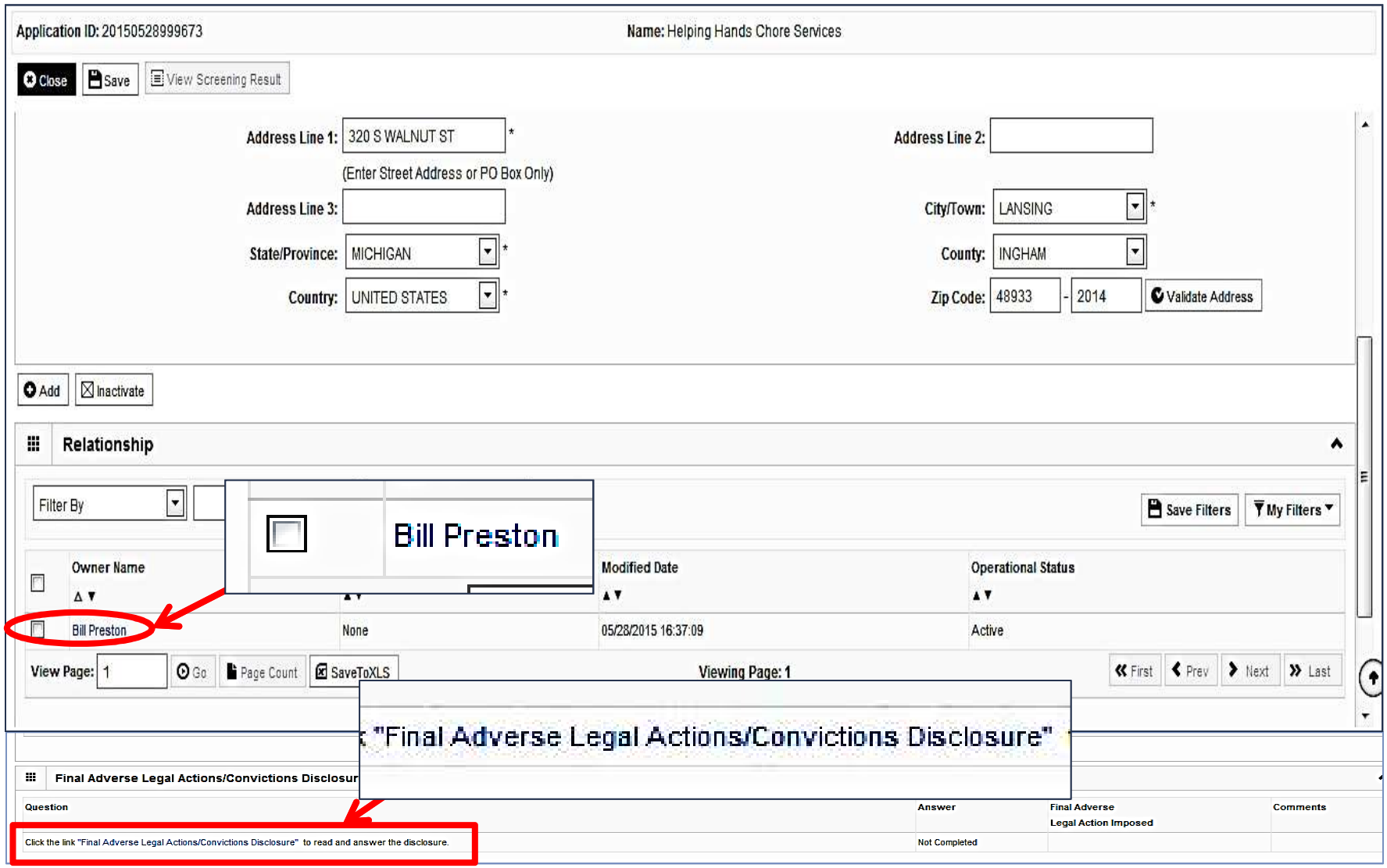


Click **Add.**
Select **Your Name** under the **Owner Name** drop down menu.
Select **None** under the **Relationship** drop down menu.
Click **OK.**

***NOTE: If more than one name is listed under **Owner Name**, you will have to repeat these steps for the other names [i.e., click **Add**, select next name in **Owner Name**, choose the relationship].



Your name will be added to the **Owner Name** column.
At the bottom of the page, click on the **"Final Adverse Legal Actions/Convictions Disclosure"** hyperlink.



Read the **Final Adverse Legal Actions/Convictions** statement.
Answer the question at the bottom by choosing **yes** or **no** and comment if necessary.
Click **OK.**

Print Help

Application ID: 20150716126201 **Name:** Helping Hands Chore Services

FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

CONVICTIONS

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicaid or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

EXCLUSIONS, REVOCATIONS, or SUSPENSIONS

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicaid payment suspension under any Medicaid enrollment.
5. Any Medicaid revocation of any Medicaid provider billing number.

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you?

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you? ◯ **Yes** ◯ **No**

Comments (optional):

Ok Cancel

Page ID: dlgOwnerCheckList(Provider)

Click **Close** to go back to the **Owner's List** screen.
Click on the **BoD/Officers/Principles** SSN hyperlink (in blue).

Application ID: 20150528999673 Name: Helping Hands Chore Services

Close Save View Screening Result

SSN: 123456789 EIN/TIN:

Legal Entity Name: (As shown on the Income Tax Return) Entity Business Name: (Doing Business As)

First Name: Bill * Last Name: Preston *

Suffix: DOB: 01/01/1960 *

Phone Number: (517) 373-2076 * Extn: Email:

Start Date: 05/28/2015 * End Date: 12/31/2999

Address Type: Home Address

Address Line 1: 320 S WALNUT ST * Address Line 2:

(Enter Street Address or PO Box Only)

Add Inacti

Page ID: pgEnrlm

Application ID: 20150528999673 Name: Helping Hands Chore Services

Close

Owners List

Add

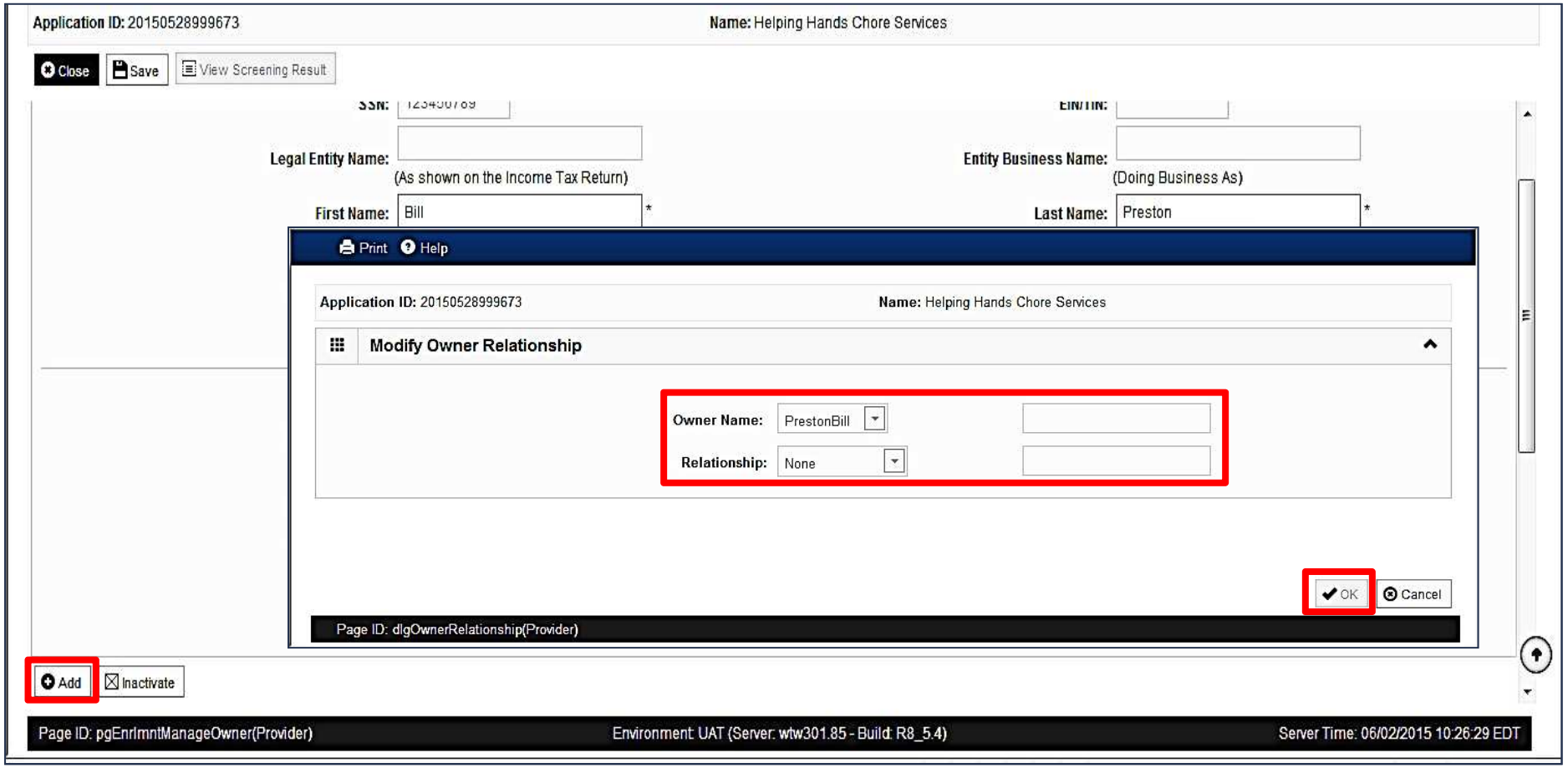
Filter By Go Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Start Date	End Date
123456789	Preston,Bill	Managing Employee	06/04/2015	12/31/2999
123456789	Preston,Bill	Board of Directors/Officers/Principles	06/04/2015	12/31/2999
123456789	Preston,Bill	Individual	06/04/2015	12/31/2999

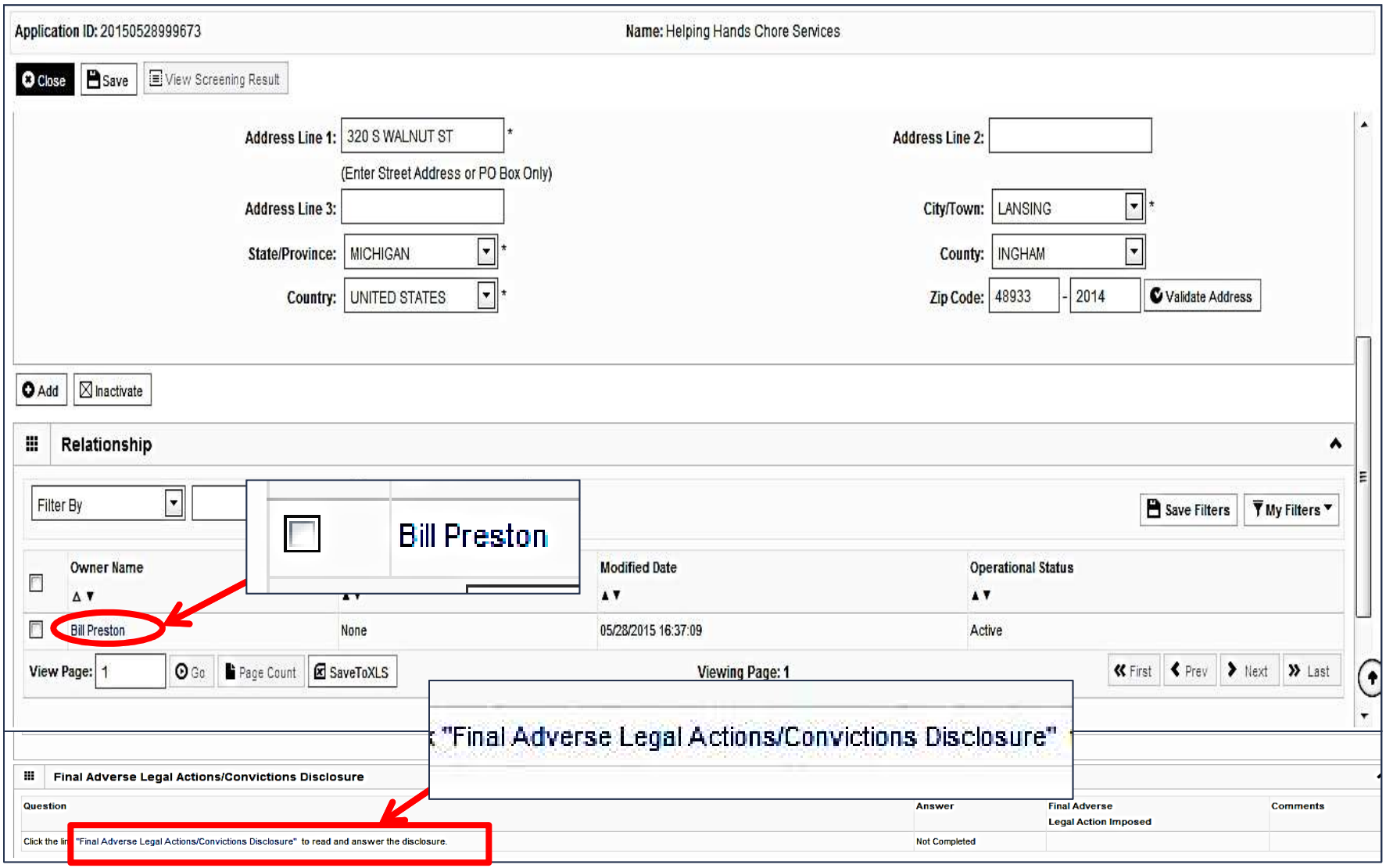
Delete View Page: 1 Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

Click **Add.**
Select **Your Name** under the **Owner Name** drop down menu.
Select **None** under the **Relationship** drop down menu.
Click **OK.**

***NOTE: If more than one name is listed under **Owner Name**, you will have to repeat these steps for the other names [i.e., click **Add**, select next name in **Owner Name**, choose the relationship].



Your name will be added to the **Owner Name** column.
At the bottom of the page, click on the **"Final Adverse Legal Actions/Convictions Disclosure"** hyperlink.



Read the **Final Adverse Legal Actions/Convictions** statement.
Answer the question at the bottom by choosing **yes** or **no** and comment if necessary.
Click **OK.**

Print Help

Application ID: 20150528999673 **Name:** Helping Hands Chore Services

FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

CONVICTIONS

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicaid or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

EXCLUSIONS, REVOCATIONS, or SUSPENSIONS

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicaid payment suspension under any Medicaid enrollment.
5. Any Medicaid revocation of any Medicaid provider billing number.

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you?

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you? ◯ Yes ◯ No Comments (optional):

OK Cancel

Page ID: dlgOwnerCheckList(Provider)

Click **Close** to go back to the **Owner's List** screen.
Click on the **Individual/Corporate** SSN hyperlink (in blue).

Application ID: 20150528999673 Name: Helping Hands Chore Services

Close Save View Screening Result

SSN: 123456789 EIN/TIN:

Legal Entity Name: (As shown on the Income Tax Return) Entity Business Name: (Doing Business As)

First Name: Bill * Last Name: Preston *

Suffix: DOB: 01/01/1960 *

Phone Number: (517) 373-2076 * Extn: Email:

Start Date: 05/28/2015 * End Date: 12/31/2999

Address Type: Home Address

Address Line 1: 320 S WALNUT ST * Address Line 2:

(Enter Street Address or PO Box Only)

Add Inacti

Page ID: pgEnrlm

Application ID: 20150528999673 Name: Helping Hands Chore Services

Close

Owners List

Add

Filter By Go Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Start Date	End Date
123456789	Preston,Bill	Managing Employee	06/04/2015	12/31/2999
123456789	Preston,Bill	Board of Directors/Officers/Principles	06/04/2015	12/31/2999
123456789	Preston,Bill	Individual	06/04/2015	12/31/2999

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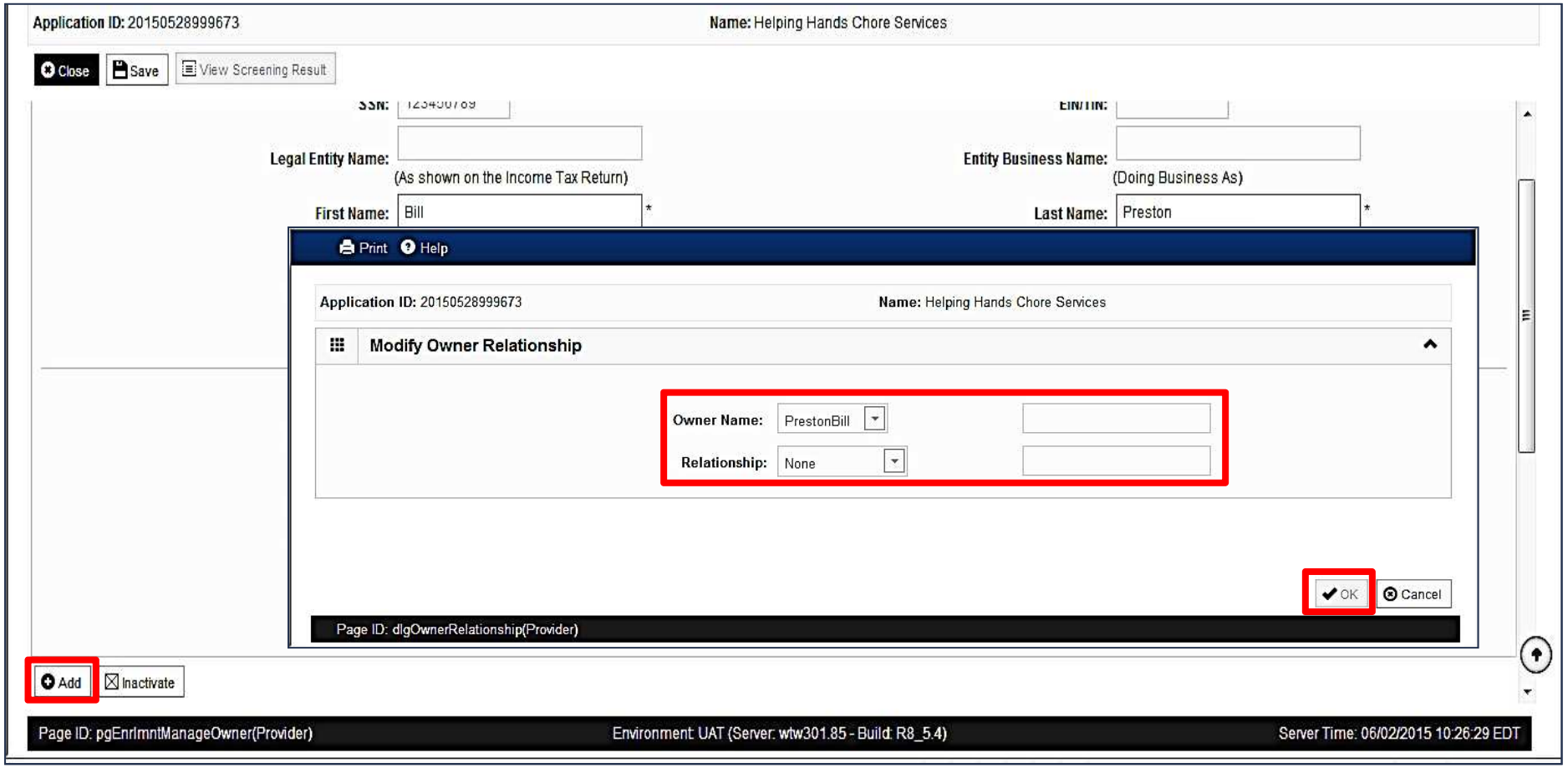
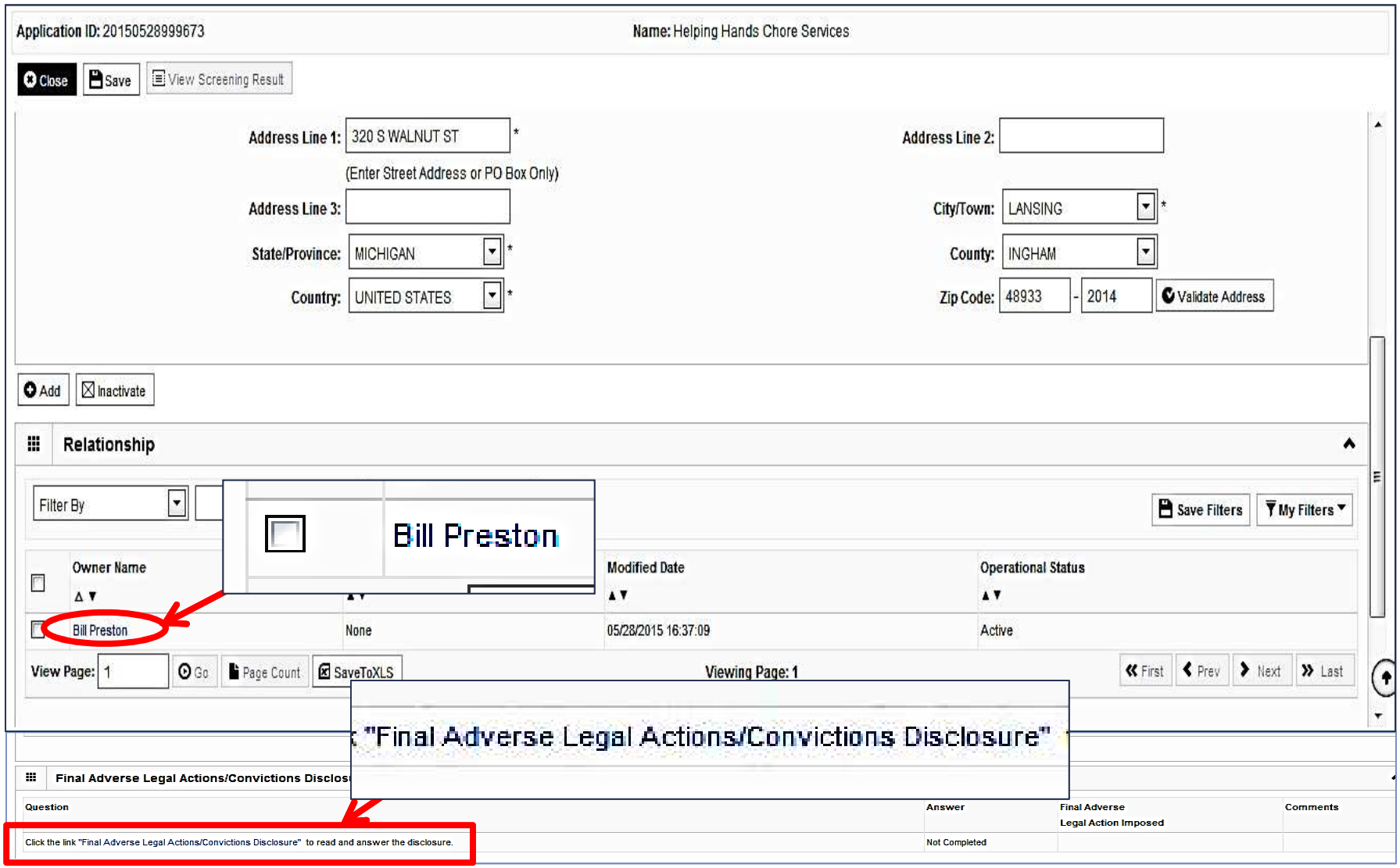
Click **Add.**
Select **Your Name** under the **Owner Name** drop down menu.
Select **None** under the **Relationship** drop down menu.
Click **OK.**

***NOTE: If more than one name is listed under **Owner Name**, you will have to repeat these steps for the other names [i.e., click **Add**, select next name in **Owner Name**, choose the relationship].



Your name will be added to the **Owner Name** column.
At the bottom of the page, click on the **"Final Adverse Legal Actions/Convictions Disclosure"** hyperlink.



Read the **Final Adverse Legal Actions/Convictions** statement.
Answer the question at the bottom by choosing **yes** or **no** and comment if necessary.
Click **OK.**

Print Help

Application ID: 20150528999673 **Name:** Helping Hands Chore Services

FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

CONVICTIONS

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include: Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicaid or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

EXCLUSIONS, REVOCATIONS, or SUSPENSIONS

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicaid payment suspension under any Medicaid enrollment.
5. Any Medicaid revocation of any Medicaid provider billing number.

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you?

FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

1. Have you, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against you? ◯ Yes ◯ No Comments (optional):

OK Cancel

Page ID: dlgOwnerCheckList(Provider)

Click **Save.**
Click **Close.**
Click **Close.**

Application ID: 20150528999673 Name: Helping Hands Chore Services

Close Save View Screening Result

SSN: 123450789 EIN/TIN:

Legal Entity Name: (As shown on the Income Tax Return)

Entity Business Name: (Doing Business As)

First Name: Bill *

Last Name: Preston *

Suffix:

DOB: 01/01/1960 *

Phone Number: (517) 373-2076 * Extn:

Email:

Start Date: 05/28/2015 *

End Date: 12/31/2999

Application ID: 20150528999673 Name: Helping Hands Chore Services

Close

Owners List

Add

Filter By Go

Save Filters My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Start Date	End Date
123456789	Preston,Bill	Managing Employee	06/04/2015	12/31/2999
123456789	Preston,Bill	Board of Directors/Officers/Principles	06/04/2015	12/31/2999
123456789	Preston,Bill	Individual	06/04/2015	12/31/2999

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Steps 8-10 are optional. Only complete if necessary.

Click on the **Step 11: Complete Enrollment Checklist** hyperlink.

Application ID: 20150709666544 **Name:** Helping Hands Chore Services

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/09/2015	07/09/2015	Complete	
Step 2: Add Locations	Required	07/09/2015	07/09/2015	Complete	
Step 3: Add Specialties	Required	07/09/2015	07/09/2015	Complete	
Step 4: Add License/Certification/Other	Optional			Incomplete	
Step 5: Add Mode of Claim Submission/EDI Exchange	Required	07/09/2015	07/09/2015	Complete	
Step 6: Associate Billing Agent	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required	07/09/2015	07/09/2015	Complete	
Step 8: Add Taxonomy Details	Optional			Incomplete	
Step 9: Associate MCO Plan	Optional			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required			Incomplete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

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Answer the **Provider Checklist** questions by choosing **Yes** or **No** in the drop down menus of the **Answer** column.
Click **Save.**
Click **Close.**

Application ID: 20150528999673 **Name:** Helping Hands Chore Services

Close Save

Provider Checklist

Question	Answer	Comments
Are you interested in working for other Home Help clients? (If you say no this will not affect your current work.)	Yes (No / Not Completed / Yes)	
If you are interested in working for other clients do you authorize us to put your contact information on our Provider Registry List so that you can be contacted for additional work?		
Do you want your name removed from our Provider Registry?	No	
Have you ever been removed or told that you cannot participate in a State funded program? If yes, please tell us what program and why.	No	
Have you ever been removed or told that you cannot participate in a Federally funded program? If yes, please tell us what program and why.	No	
Have you ever had any criminal convictions? If yes, please tell us what for?	No	
Are you providing services as a Business? If yes, what is the name of the business.	No	
Do you perform services as an agency with 2 or more employees?	Yes	
What county do you plan to work in?	No	
What is the name of the Adult Services Worker you are working with?	No	
Are you a Medicare certified home health agency?	Yes	
I understand that my information will be used to conduct a review of my criminal history I may have and the results of that review could possibly make me ineligible to work as a provider in the Home Help program. I also understand that the results of my criminal history screening will be shared with necessary MDCH and MDHS staff, as well as any potential client.	Yes	
I also acknowledge that I am required to update any changes in the enrollment within 10 days of that change.	Yes	

View Page: 1 Go Page Count SaveToXLS **Viewing Page: 1** First Prev Next Last

Click on the **Step 12: Submit Enrollment Application for Approval** hyperlink.
By clicking the **Next** button, you "agree that the information submitted as a part of the application is correct (Private and Confidential)".

Application ID: 20150709666544 **Name:** Helping Hands Chore Services

Close

Enroll Provider - Atypical Agency

Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/09/2015	07/09/2015	Complete	
Step 2: Add Locations	Required	07/09/2015	07/09/2015	Complete	
Step 3: Add Specialties	Required	07/09/2015	07/09/2015	Complete	
Step 4: Add License/Certification/Other	Optional			Incomplete	
Step 5: Add Mode of Claim Submission/EDI Exchange	Required	07/09/2015	07/09/2015	Complete	
Step 6: Associate Billing Agent	Optional			Incomplete	
Step 7: Add Provider Controlling Interest/Ownership Details	Required	07/09/2015	07/09/2015	Complete	
Step 8: Add Taxonomy Details	Optional			Incomplete	
Step 9: Associate MCO Plan	Optional			Incomplete	
Step 10: 835/ERA Enrollment Form	Optional			Incomplete	
Step 11: Complete Enrollment Checklist	Required	07/09/2015	07/09/2015	Complete	
Step 12: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: Viewing Page: 1

Application ID: 20150528999673 **Name:** Helping Hands Chore Services

Close Next

Final Submission

Application ID: 20141203023112 Enrollment Type: HIPAA-Exempt Individual/Sole Proprietor

The information submitted for enrollment shall be verified and reviewed by the State.
During this time, any changes to the information shall not be accepted.

I agree that the information submitted as a part of the application is correct (Private and Confidential).

Application Document Checklist

Forms/Documents	Special Instructi

I agree that the information submitted as a part of the application is correct (Private and Confidential).

Read the **Terms and Conditions (Enrollment Process)** statement.
Check the box at the *bottom* indicating you have read and agree to the terms.
Click **Submit Application**.

Application ID: 20150528999673 **Name:** Helping Hands Chore Services

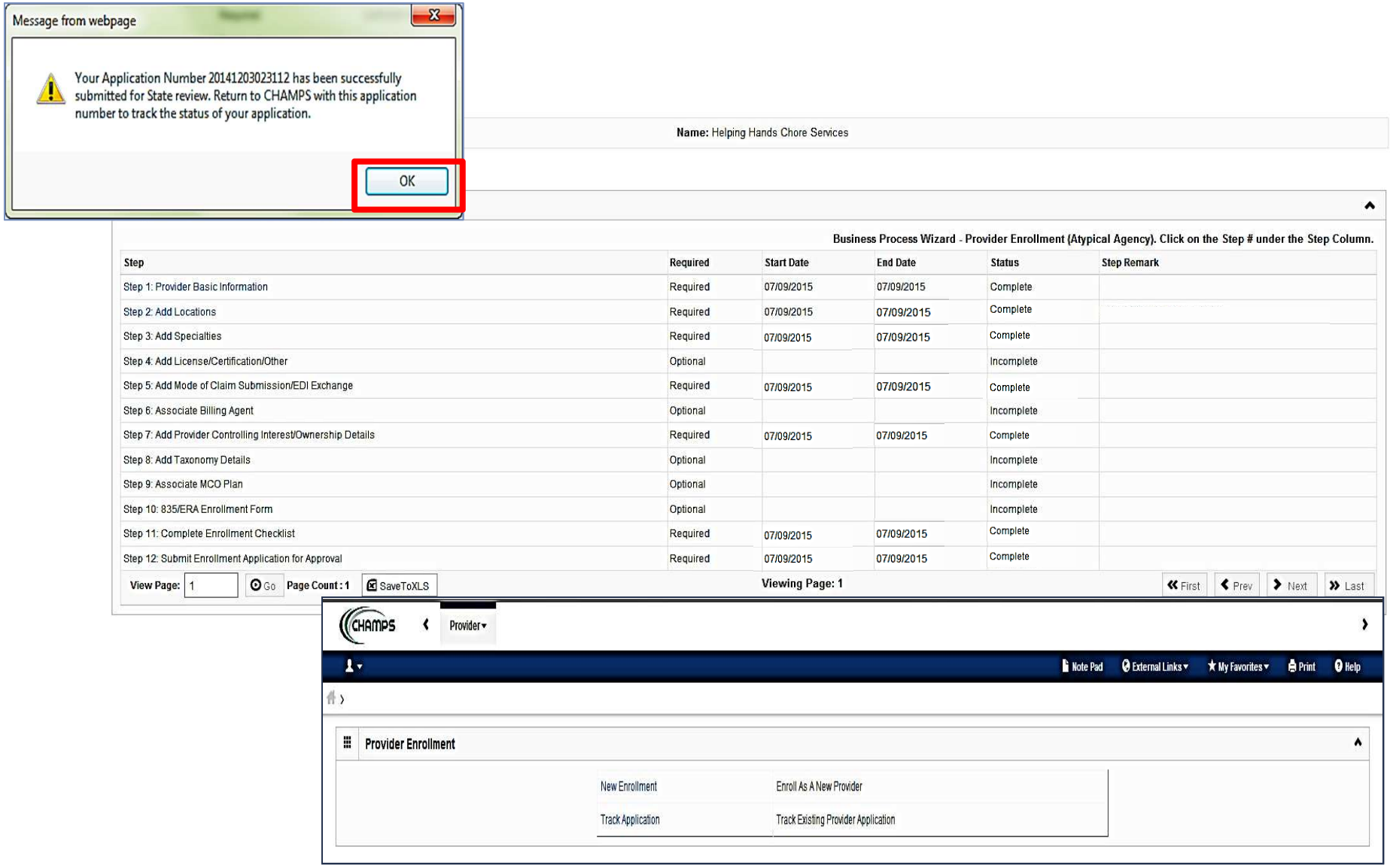
Close | Submit Application | **After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.**

Terms and Conditions (Enrollment Process)

1. As an individual provider of Home Help services, I agree that the Medicaid beneficiary is considered the employer. I am not employed by the Michigan Department of Community Health (MDCH), the Department of Human Services (DHS), or the State of Michigan.
2. As a Home Help provider agency, I agree that the agency contract is with the Medicaid beneficiary. The agency contract is not with the Michigan Department of Community Health (MDCH), the Department of Human Services or the State of Michigan.
3. I agree that personal care services will be provided for a Michigan Medicaid beneficiary, as authorized by the Michigan Department of Human Services (DHS) according to the DHS Adult Services Comprehensive Assessment.
4. Under Section 3504 of the Internal Revenue Code, I agree to accept the Michigan Department of Community (MDCH) as the acting agent of the beneficiary for the deduction of withholding of FICA taxes. I understand that federal, state and city taxes are not withheld. I further agree to accept payments issued by MDCH as payment in full and not to seek or accept additional payments from the beneficiary or any other source.
5. I agree to return any payments received for Home Help services not provided. I understand that accepting payment for services I did not provide is fraudulent and could result in criminal charges.
6. I understand that the Home Help program is funded by Medicaid and payments will not be approved by the Department if the beneficiary¿s Medicaid eligibility is inactive.
7. In order to receive payment, I agree to keep and submit to MDCH, DHS or their designee, any and all records necessary to disclose the extent of services provided to the beneficiary.
8. Upon request, I agree to provide MDCH, DHS or their designee, any information regarding services or purchases for which payment was made.
9. Upon request, I agree to provide MDCH, DHS or their designee, any business transaction information as specified by 42 CFR 455.105.
10. I understand I will be subject to a criminal history screening and may not qualify to be a home help provider.
11. I agree to cooperate with MDCH, DHS or their designee, regarding any audits, investigations or inquiries related to Home Help services provided.
12. I agree to report any changes relative to the beneficiary including but not limited to hospitalizations, nursing home stays or discontinuation of services.
13. I agree to comply with the privacy, security and confidentiality provisions of all applicable laws governing the use and disclosure of protected health information (PHI), including the privacy regulations adopted by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Public Acts 104-191 (45 CFR parts 106 and 164, Subparts A, C, and E).
14. I agree to comply with the provisions of 42 CFR 431.107 and Act No. 280 of the Public Acts of 1939, as amended, which state the conditions and requirements under which participation in the Medical Assistance Program is allowed.

☑ **By checking this, I acknowledge that I have read the terms and agreement and I agree to fully comply with all program requirements.**

Click **OK** in the textbox that will pop up.
You will be sent back to the **Enroll Provider** page.
Click **Close**.
This will return you to the CHAMPS home page.



Tracking Your Application

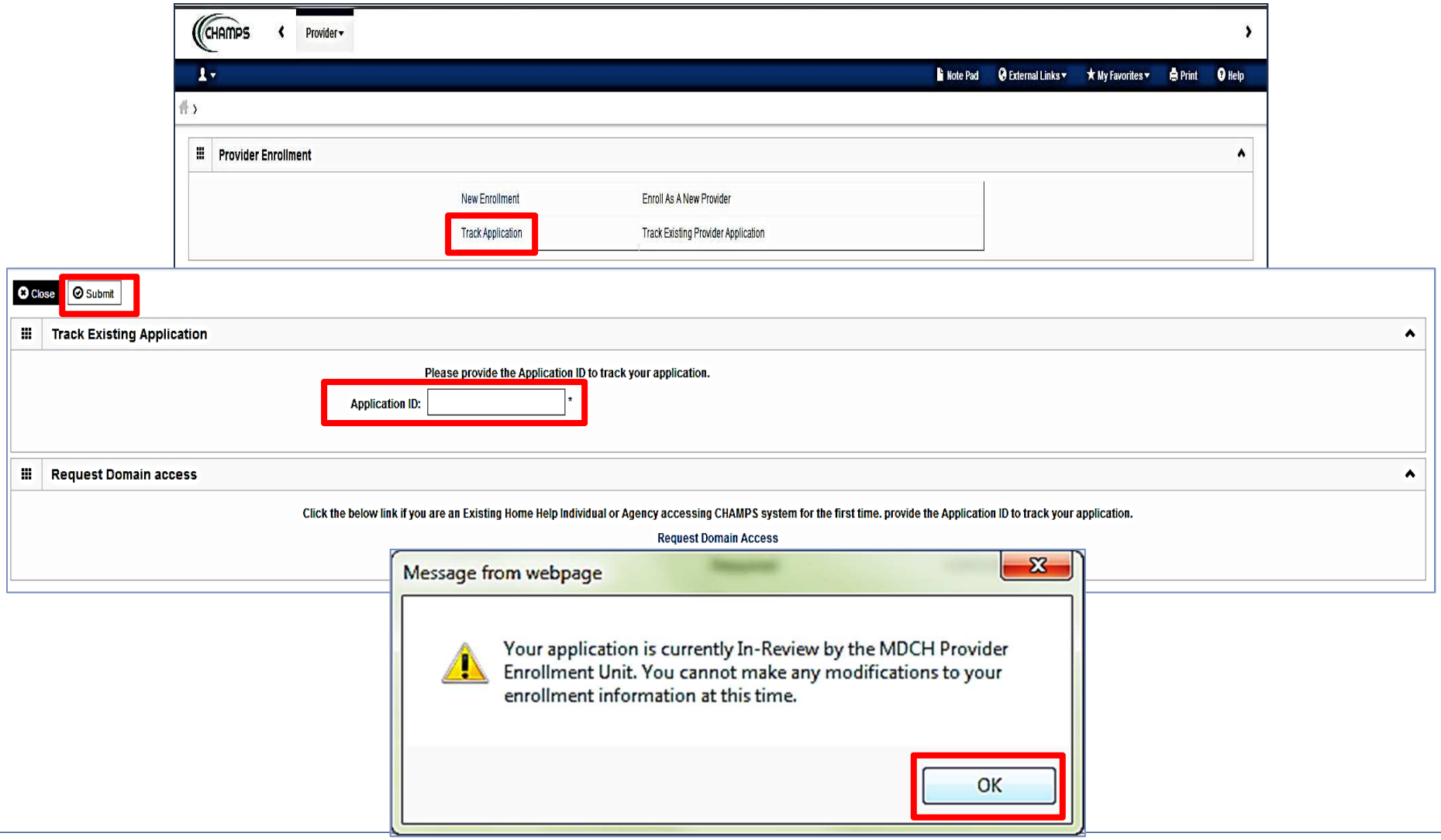
How to Verify the Status of Your Application

If you would like to check the status of your application, you can do so from the CHAMPS homepage:

On the home page, click the **Track Application** hyperlink (in blue)**.**

Enter your Application ID number. Click **Submit**.

A text box will pop up with a statement about the status of your application. Click **OK.**



Provider Resources

- Home Help Provider Support Hotline: 1-800-979-4662
- Home Help Provider Support Email: ProviderSupport@Michigan.gov
- Home Help Provider FAQ document: Go to Michigan.gov/homehelp and click on the Home Help Frequently Asked Questions (FAQs) link under the Additional Home Help Resources heading