



Michigan Department of Health & Human Services

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

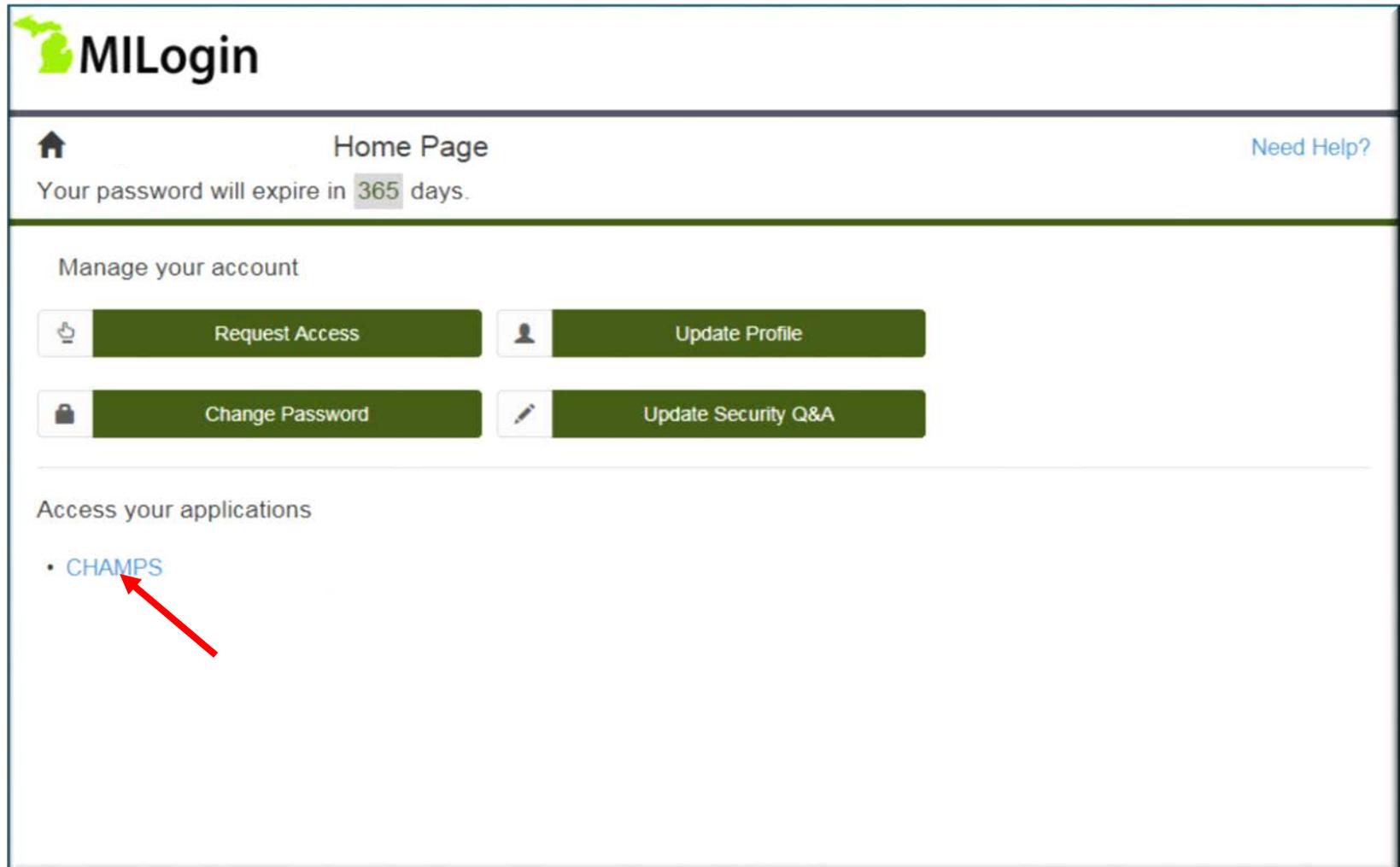
Call the Provider Support Helpline if you need assistance:

1-800-979-4662

Sign into MILogin by going to **https://milogintp.Michigan.gov** and entering your User ID and Password.
This will take you to the MILogin Application Portal.

The image shows a web browser window with the address bar containing the URL `https://milogintp.michigan.gov/eai/tplogin/authenticate?URL=/`. The browser's title bar reads "SOM - Login". The main content area displays the MILogin login portal. The portal header includes the Michigan state logo and the text "MILogin". Below the header, it says "Login to your account". A red asterisk indicates required fields. The login form contains two input fields: "*User ID" and "*Password", both of which are highlighted with a red box. Below these fields is a green "Login" button, also highlighted with a red box. Underneath the login button are three links: "Forgot your User ID?", "Forgot your password?", and "Need Help?". At the bottom of the form, there is a link "Don't have an account?" and a green "Create New Account" button. The footer of the page includes links for "MILogin Home", "Michigan.gov Home", "Policies", and "Contact Us", along with the copyright notice "Copyright 2015 State of Michigan".

You will be directed back to your MILogin home page.
From here, you can go into CHAMPS.



The screenshot displays the MILogin home page. At the top left is the MILogin logo, which includes a green outline of the state of Michigan. Below the logo, the page title "Home Page" is centered, and a "Need Help?" link is on the right. A notification states "Your password will expire in 365 days." Below this, a section titled "Manage your account" contains four buttons: "Request Access" (with a key icon), "Update Profile" (with a person icon), "Change Password" (with a lock icon), and "Update Security Q&A" (with a pencil icon). A horizontal line separates this from the "Access your applications" section, which features a single link for "CHAMPS" with a red arrow pointing to it.

MILogin

Home Page [Need Help?](#)

Your password will expire in 365 days.

Manage your account

 Request Access  Update Profile

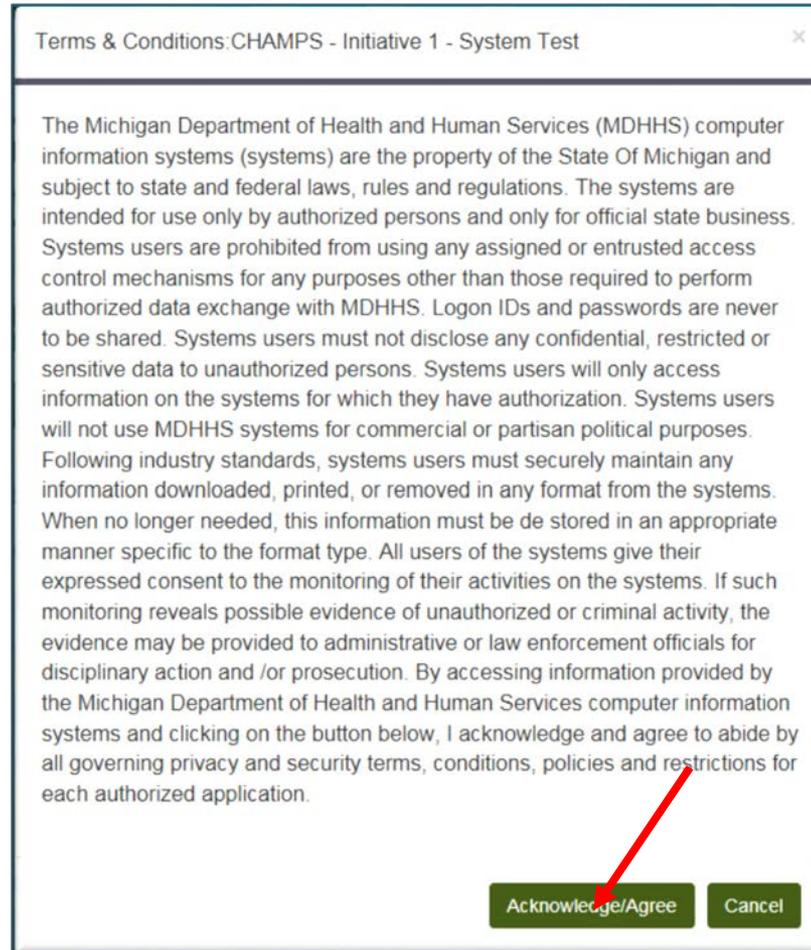
 Change Password  Update Security Q&A

Access your applications

- [CHAMPS](#)

You will need to click Acknowledge/Agree to accept the Terms & Conditions to get into CHAMPS.

From there, you can access the Electronic Service Verification (See *ESV Instructions* or *ESV Quick Reference Guide*).



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

The screenshot shows the CHAMPS homepage for a brand new provider. The page layout includes a top navigation bar with the CHAMPS logo, a 'Provider' dropdown menu, and utility links such as 'Note Pad', 'External Links', 'My Favorites', 'Print', and 'Help'. Below the navigation bar is a 'Provider Enrollment' section with a table of options. The 'New Enrollment' link is highlighted with a red box.

Provider Enrollment	
New Enrollment	Enroll As A New Provider
Track Application	Track Existing Provider Application

Choose **Atypical (noon-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.)**

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

Welcome to MMSIS - Windows Internet Explorer

Print Help

Basic Information(Home Help)

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

Entity Business Name: * (Doing Business As)

EIN/TIN: *

Contact Email Address:

Email-1

Email-2

Email-3

NPI:

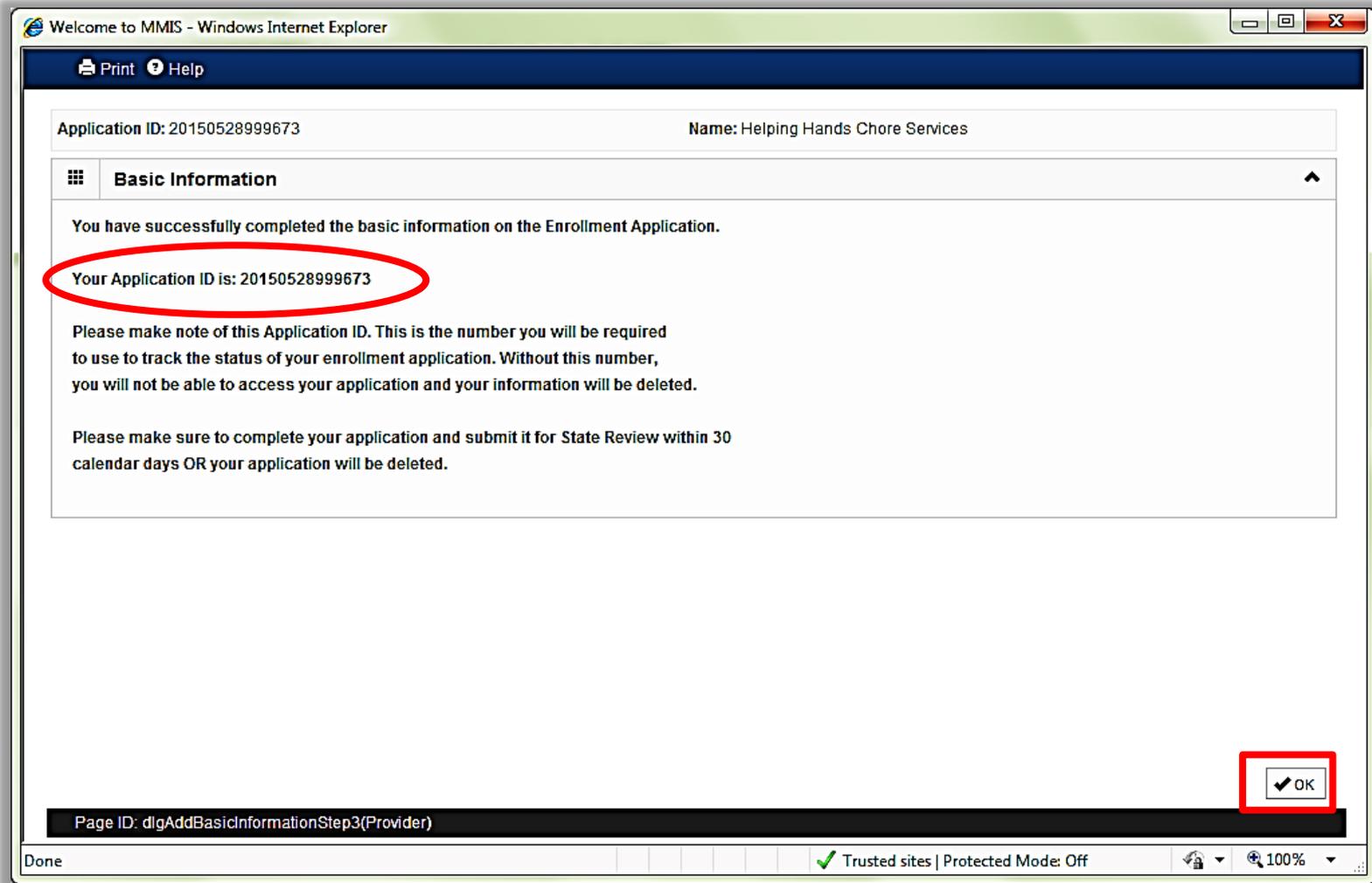
Please note that all providers are subject to a criminal background screening that could affect your ability to be paid through the Home Help program.

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: 20141203023112 Name: Doe, Jane

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

Locations List

Filter By

<input type="checkbox"/>	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 be *Primary Practice Location*.

***NOTE: Entering the **Zip Code** will automatically update **State, City/Town, and County**

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:

State/Province: MICHIGAN * **City/Town:** LANSING * **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 (E) (For Multiple Selection, use Ctrl Key)
Arabic
Chinese

OK **Cancel**

Page ID: dlGenrAddLocation(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: CHAMP's Notice

Handicap Accessible: Accept 835 (reported at EIN/TIN level):

Language(s) Spoken: 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)

Fiscal Year End Date: *
(mm/dd)

Licensed Medicare Bed(s):

Ventilator Dependent Unit(s):

Acute Care Bed(s):

Temporarily Non Available:

Distinct Part Unit: *
None
Psych
Skilled Nursing

Page ID: dlqEnrAddLocation(Provider)

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

Application ID: 20141203023112

Name: Doe, Jane

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

Locations List

Filter By 

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

 View Page:  Page Count  Viewing Page: 1    

Application ID: 20141203023112

Name: Doe, Jane

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

Location Details

Doing Business As:
Phone Number: (999) 999-9999 * Extn:
Web Page:
Handicap Accessible:
Accept 835(reported at EIN/TIN level):
End Date: 

Location Code: 01 Location Type: Primary Practice Location
Fax Number: Email Address:
Office Hours: Communication Preference:

Language(s) Spoken:
(For Multiple Selection, use Ctrl Key)



Address List

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

 View Page:  Page Count  Viewing Page: 1    

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**.

This screenshot shows the 'Add Provider Location Address' form. At the top, it displays 'Application ID: 20141203023112' and 'Name: Doe, Jane'. The form title is 'Add Provider Location Address'. A dropdown menu for 'Type of Address' is open, showing options: '--SELECT--', '--SELECT--', 'Correspondence', 'Pay To', and 'Remittance Advice'. The 'Correspondence' option is highlighted. Below the dropdown, there are instructions: '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)' and 'If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)'. There are input fields for 'Address Line 1' and 'Address Line 2'. A 'Print' button is visible at the bottom of the form.

Page ID: dlGEnrILocationAddress(Provider)

This screenshot shows the 'Add Provider Location Address' form after the 'Type of Address' has been set to 'Correspondence'. The 'Location Address' field now has a button labeled 'Copy This Location Address' next to it, which is highlighted with a red box. The form also shows 'Address Line 1' with the text '320 S WALNUT ST' and 'Address Line 2' which is empty. There is a 'City/Town' dropdown menu with 'LANSING' selected. At the bottom right, there are 'OK' and 'Cancel' buttons, with the 'OK' button highlighted by a red box.

Page ID: dlGEnrILocationAddress(Provider)

Notice the Correspondence and Location 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.

The screenshot displays the CHAMPS Provider Enrollment interface. At the top, the user is logged in as Scott, Sarah. The navigation bar shows 'My Inbox' and 'Provider'. The main content area is titled 'Application ID: 20150709666544' and 'Name: Helping Hands Chore Services'. Below this, there are several form fields: 'Accept 835 (reported at EIN/TIN level): No', 'End Date: 12/31/2999', and 'Language(s) Spoken: English'. A red box highlights the 'Close' and 'Save' buttons in the top left corner of the application details section. Below the application details is the 'Facility Details' section, which contains various input fields for 'State Facility ID', 'Fiscal Year End Date', 'Licensed Medicare Bed(s)', 'Licensed Medicaid/Medicare Bed(s)', 'Swing Bed(s)', 'Temporarily Non Available', 'Licensed Medicaid Bed(s)', 'Ventilator Dependent Unit(s)', 'Acute Care Bed(s)', and 'Distinct Part Unit'. The 'Address List' section at the bottom shows a table with columns for 'Address Type', 'Address', and 'End Date'. Two rows are visible: 'Correspondence' and 'Location', both with the address '320 S WALNUT ST, LANSING, MICHIGAN 48933' and an end date of '12/31/2999'. A red oval highlights the 'Correspondence' and 'Location' rows. The bottom of the page shows the page ID 'pgEnrollmentLocationGeneral(Provider)', the environment 'UAT (Server: wtw301.85 - Build: R8_5.4.1)', and the server time '07/09/2015 02:40:11 EDT'.

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	

Application ID: 20141203023112

Name: Doe, Jane

View Page

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 Individual**.

Click **OK**.

Print Help

Application ID: 20150528999673 Name: Helping Hands Chore Services

Add Specialty/Subspecialty

Location: 01- *

Provider Type: HOME HELP FAO *

Specialty: HOME HELP FAO *

End Date:

Add Subspecialty

Available Subspecialties

Associated Subspecialties *

No Subspecialty

»

«

✓ OK Cancel

Page ID: dlgEnrAddSpecialties(Provider)

Click **Close**.

Notice Steps 1-3 are complete. **Step 4** is optional.

Click **Step 5: Add Mode of Claim Submission** hyperlink.

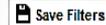
Application ID: 20141203023112

Name: Doe, Jane

 Close  Add

Specialty/Subspecialty List

Filter By  Go

 Save Filters  My Filters

Specialty/Subspecialty

Provider Type

End Date

HOME HELP INDIVIDUAL/No Subspe

Application ID: 20150709666544

Name: Helping Hands Chore Services

 Delete View Page:

 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:  Go Page Count: 1  Save To XLS

Viewing Page: 1

 First  Prev  Next  Last

The box next to **Online Direct Data Entry (DDE)** should already be selected for you.
Click **OK**.

The screenshot shows a web application window with a dark blue header containing 'Print' and 'Help' icons. Below the header, there is a white bar with 'Application ID: 20141203023112' on the left and 'Name: Doe, Jane' on the right. A section titled 'Mode of Claim Submission Details' is expanded, showing instructions: 'You may check multiple Modes of Claim Submission. Identify Claim Submission Details.' Below this, there are six checkboxes for different submission modes: 'Electronic Batch', 'CORE', 'Billing Agent', 'Online Direct Data Entry (DDE)', 'Paper', and 'Not Applicable'. The 'Online Direct Data Entry (DDE)' checkbox is checked and highlighted with a red box. At the bottom right, there are 'OK' and 'Cancel' buttons, with the 'OK' button also highlighted by a red box. The footer of the application shows 'Page ID: dlgBillingDetails(Provider)'.

Application ID: 20141203023112 Name: Doe, Jane

Mode of Claim Submission Details

You may check multiple Modes of Claim Submission.
Identify Claim Submission Details.

Mode of Claim Submission: Electronic Batch CORE Billing Agent
 Online Direct Data Entry (DDE) Paper Not Applicable

Page ID: dlgBillingDetails(Provider)

Step 6 is optional, so complete it only if you will have a **Billing Agent**.

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

Application ID: 20150709666544

Name: Helping Hands Chore Services

Close

Enroll Provider - Atypical Agency

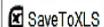
Business Process Wizard - Provider Enrollment (Atypical Agency). Click on the Step # under the Step Column.

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			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



Page Count: 1



Viewing Page: 1

« First

◀ Prev

Next ▶

» Last

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

Application ID: 20141203023112

Name: Doe, Jane

Close

Owners List

Add

Filter By

Go

Save Filters

My Filters

Owner SSN/EIN/TIN ▲▼	Owner Information ▲▼	Owner Type ▲▼	Start Date ▲▼	End Date ▲▼
<input type="checkbox"/> 222222222	Doe, Jane	Individual	12/03/2014	12/31/2999

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

Add Other Owned Entity List Ownership Interest in other Entities reimbursable 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**.

Application ID: 20141203023112 Name: Doe, Jane

Provider Controlling Interest/Ownership

Owner Type: <input type="text" value="---SELECT---"/> *	Percentage Owned: <input type="text" value=""/> *
SSN: <input type="text" value="---SELECT---"/>	EIN/TIN: <input type="text"/>
Legal Entity Name: <input type="text" value="Agent"/> <input type="text" value="Board of Directors/Officers/Principles"/> <input type="text" value="Corporate - Charitable 501(c)3"/> <input type="text" value="Corporate - Non Charitable"/> <input type="text" value="Foreign, Nonresident Alien"/>	Entity Business Name: <input type="text"/>
First Name: <input type="text" value="Government"/> <input type="text" value="Holding Company"/>	Last Name: <input type="text"/>
Suffix: <input type="text" value="Individual"/> <input type="text" value="Limited liability Company"/>	DOB: <input type="text"/>
Phone Number: <input type="text" value="Managing Employee"/>	Email: <input type="text"/>
Start Date: <input type="text" value="Sub-contractor"/>	End Date: <input type="text"/>

Address Line 1: <input type="text"/> *	Address Line 2: <input type="text"/>
(Enter Street Address or PO Box Only)	
Address Line 3: <input type="text"/>	City/Town: <input type="text" value="OTHER"/> *
State/Province: <input type="text" value="OTHER"/> *	<input type="text"/>
Country: <input type="text" value="UNITED STATES"/> *	County: <input type="text" value="OTHER"/> *
<input type="text"/>	<input type="text"/>
Zip Code: <input type="text"/>	<input type="text"/>

Page ID: dlgEnrlmntAddOwner(Provider)

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

Application ID: 20141203023112 Name: Doe, Jane

[Close](#)

Owners List

[Add](#)

Filter By [Go](#) [Save Filters](#) [My Filters](#)

Owner SSN/EIN/TIN ▲▼	Owner Information ▲▼	Owner Type ▲▼	Start Date ▲▼	End Date ▲▼
<input type="checkbox"/> 222222222	Doe, Jane	Individual	12/03/2014	12/31/2999

[Delete](#) View Page: [Go](#) [Page Count](#) [SaveToXLS](#) Viewing Page: 1 [First](#) [Prev](#) [Next](#) [Last](#)

Other Owned Entity

[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**

Application ID: 20141203023112 Name: Doe, Jane

Provider Controlling Interest/Ownership

Owner Type: <input type="text" value="---SELECT---"/> *	Percentage Owned: <input type="text" value=""/> *
SSN: <input type="text" value=""/>	EIN/TIN: <input type="text" value=""/>
Legal Entity Name: <input type="text" value="Board of Directors/Officers/Principles"/>	Entity Business Name: <input type="text" value=""/>
First Name: <input type="text" value=""/>	Last Name: <input type="text" value=""/>
Suffix: <input type="text" value=""/>	DOB: <input type="text" value=""/>
Phone Number: <input type="text" value=""/>	Email: <input type="text" value=""/>
Start Date: <input type="text" value=""/>	End Date: <input type="text" value=""/>

Address Line 1: <input type="text" value=""/> *	Address Line 2: <input type="text" value=""/>
<small>(Enter Street Address or PO Box Only)</small>	
Address Line 3: <input type="text" value=""/>	City/Town: <input type="text" value="OTHER"/> *
State/Province: <input type="text" value="OTHER"/> *	County: <input type="text" value="OTHER"/> *
Country: <input type="text" value="UNITED STATES"/> *	Zip Code: <input type="text" value=""/>

Page ID: dlgEnrlmntAddOwner(Provider)

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

Application ID: 20141203023112 Name: Doe, Jane

Owners List

Filter By

Owner SSN/EIN/TIN ▲▼	Owner Information ▲▼	Owner Type ▲▼	Start Date ▲▼	End Date ▲▼
<input type="checkbox"/> 222222222	Doe, Jane	Individual	12/03/2014	12/31/2999

View Page: Viewing Page: 1

Add Other Owned Entity

List Ownership Interest in other Entities reimbursible by Medicaid and/or Medicare.

Filter By

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**

Application ID: 20141203023112 Name: Doe, Jane

Provider Controlling Interest/Ownership

Owner Type: *
Percentage Owned: *

SSN: **EIN/TIN:**

Legal Entity Name: *

Entity Business Name:
(Doing Business As)

First Name: **Last Name:**

Suffix: *

DOB:

Phone Number: *

Email:

Start Date: *

End Date:

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County: *

Country: *

Zip Code:

Page ID: dlgenrImntAddOwner(Provider)

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

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**.

Application ID: 20150528999673

Name: Helping Hands Chore Services

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)

Address Line 3:

City/Town:

LANSING *

Inactivate

Page ID: pgEnrlmntMan

Application ID: 20150528999673

Name: Helping Hands Chore Services

Modify Owner Relationship

Owner Name:

PrestonBill

Relationship:

None

Page ID: dlgOwnerRelationship(Provider)

02/2015 10:26:29 EDT

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.

Application ID: 2015052899673 Name: Helping Hands Chore Services

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County: *

Country: *

Zip Code: -

Inactivate

Relationship

Filter By:

<input type="checkbox"/>	Owner Name	Modified Date	Operational Status
<input type="checkbox"/>	Bill Preston	05/28/2015 16:37:09	Active

View Page: 1 Viewing Page: 1

Final Adverse Legal Actions/Convictions Disclosure

Question	Answer	Final Adverse Legal Action Imposed	Comments
Click the link "Final Adverse Legal Actions/Convictions Disclosure" to read and answer the disclosure.	Not Completed		

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: 20141203023112

Name: Doe, Jane

Provider ID: 4002642

Name: Brown, Brittany

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

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

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**.

Application ID: 20150528999673

Name: Helping Hands Chore Services

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)

Address Line 3:

City/Town:

LANSING *

Inactivate

Page ID: pgEnrlmntMan

Application ID: 20150528999673

Name: Helping Hands Chore Services

Modify Owner Relationship

Owner Name:

PrestonBill

Relationship:

None

Page ID: dlgOwnerRelationship(Provider)

02/2015 10:26:29 EDT

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.

Application ID: 2015052899673 Name: Helping Hands Chore Services

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County: *

Country: *

Zip Code: -

Inactivate

Relationship

Filter By:

Owner Name	Modified Date	Operational Status
<input type="checkbox"/> Bill Preston	05/28/2015 16:37:09	Active

View Page: Viewing Page: 1

Final Adverse Legal Actions/Convictions Disclosure

Question	Answer	Final Adverse Legal Action Imposed	Comments
Click the link "Final Adverse Legal Actions/Convictions Disclosure" to read and answer the disclosure.	Not Completed		

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**.

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

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

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**.

Application ID: 20150528999673

Name: Helping Hands Chore Services

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 *

(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town:

LANSING *

Inactivate

Page ID: pgEnrlmntMan

Application ID: 20150528999673

Name: Helping Hands Chore Services

Modify Owner Relationship

Owner Name:

PrestonBill

Relationship:

None

Page ID: dlgOwnerRelationship(Provider)

02/2015 10:26:29 EDT

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.

Application ID: 20150528999673 Name: Helping Hands Chore Services

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County: *

Country: *

Zip Code: -

Inactivate

Relationship

Filter By

<input type="checkbox"/>	Owner Name	Modified Date	Operational Status
<input type="checkbox"/>	Bill Preston	05/28/2015 16:37:09	Active

View Page: Viewing Page: 1

Final Adverse Legal Actions/Convictions Disclosure

Question	Answer	Final Adverse Legal Action Imposed	Comments
Click the link "Final Adverse Legal Actions/Convictions Disclosure" to read and answer the disclosure.	Not Completed		

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

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

Application ID: 20150528999673

Name: Helping Hands Chore Services

Close

Save

View Screening Result

SSN: 123456789

EIN/TIN:

Legal Entity Name:

Entity Business Name:

(As shown on the Income Tax Return)

(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

Delete

View Page: 1

Go

Page Count

SaveToXLS

Viewing Page: 1

First

Prev

Next

Last

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.

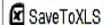
Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	07/09/2015	07/09/2015	Complete	
Step 2: Add Locations	Required	07/09/2015	07/09/2015	Complete	
Step 3: Add Specialties	Required	07/09/2015	07/09/2015	Complete	
Step 4: Add License/Certification/Other	Optional			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	

View Page:

1



Page Count: 1



Viewing Page: 1

First

Prev

Next

Last

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.)	<input type="text" value="Yes"/>	<input type="text"/>
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?	<input type="text" value="No"/>	<input type="text"/>
Do you want your name removed from our Provider Registry?	<input type="text" value="Not Completed"/>	<input type="text"/>
Do you want your name removed from our Provider Registry?	<input type="text" value="Yes"/>	<input type="text"/>
Do you want your name removed from our Provider Registry?	<input type="text" value="No"/>	<input type="text"/>
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.	<input type="text" value="No"/>	<input type="text"/>
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.	<input type="text" value="No"/>	<input type="text"/>
Have you ever had any criminal convictions? If yes, please tell us what for?	<input type="text" value="No"/>	<input type="text"/>
Are you providing services as a Business? If yes, what is the name of the business.	<input type="text" value="No"/>	<input type="text"/>
Do you perform services as an agency with 2 or more employees?	<input type="text" value="No"/>	<input type="text"/>
What county do you plan to work in?	<input type="text" value="Yes"/>	<input type="text"/>
What is the name of the Adult Services Worker you are working with?	<input type="text" value="No"/>	<input type="text"/>
Are you a Medicare certified home health agency?	<input type="text" value="No"/>	<input type="text"/>
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.	<input type="text" value="Yes"/>	<input type="text"/>
I also acknowledge that I am required to update any changes in the enrollment within 10 days of that change.	<input type="text" value="Yes"/>	<input type="text"/>

View Page: [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 Instructions

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: 20141203023112

Name: Doe, Jane

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.

Message from webpage

 Your Application Number 20141203023112 has been successfully submitted for State review. Return to CHAMPS with this application number to track the status of your application.

OK

Name: Helping Hands Chore Services

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	07/09/2015	07/09/2015	Complete	

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

CHAMPS Provider

Note Pad External Links My Favorites Print Help

Provider Enrollment

New Enrollment	Enroll As A New Provider
Track Application	Track Existing Provider Application

Tracking Your Application

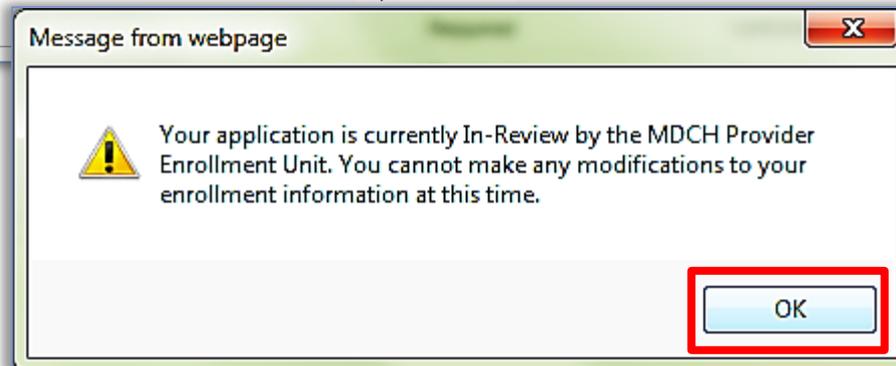
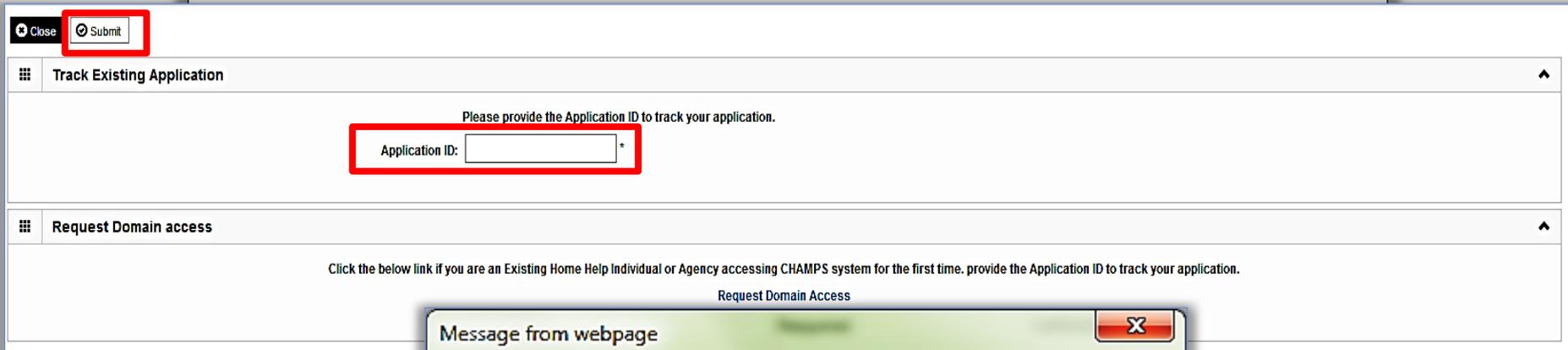
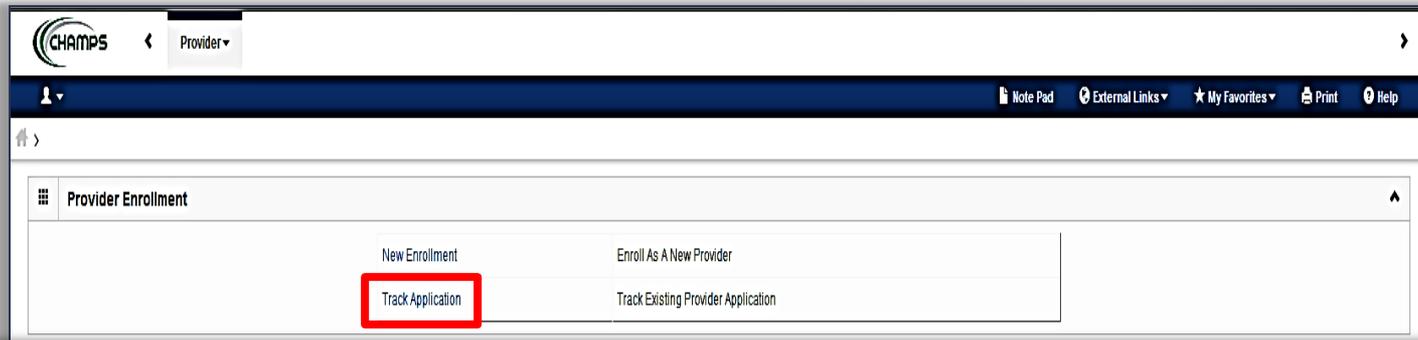
How to Verify the Status of Your Application

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