



Michigan Department of Health & Human Services

RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

New Individual 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 Individual Provider Enrollment Instructions

- Anyone becoming a *new* Home Help provider
- Create a MILogin user ID and password
- Gain access to CHAMPS
- Fill out the Provider Enrollment Application
- Track Your Application

***Have paper and a writing utensil nearby

*****You must complete the application within 30 days of starting it**

Call the Provider Support Helpline if you need assistance:

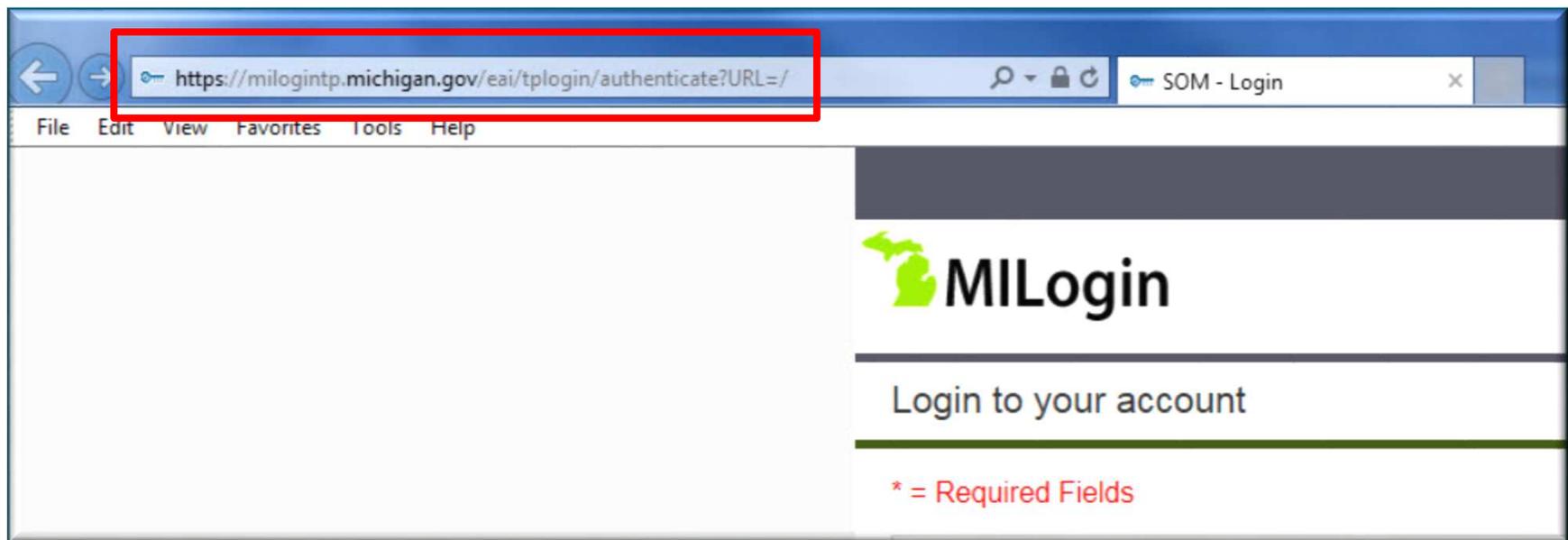
1-800-979-4662

Register for MILogin and CHAMPS

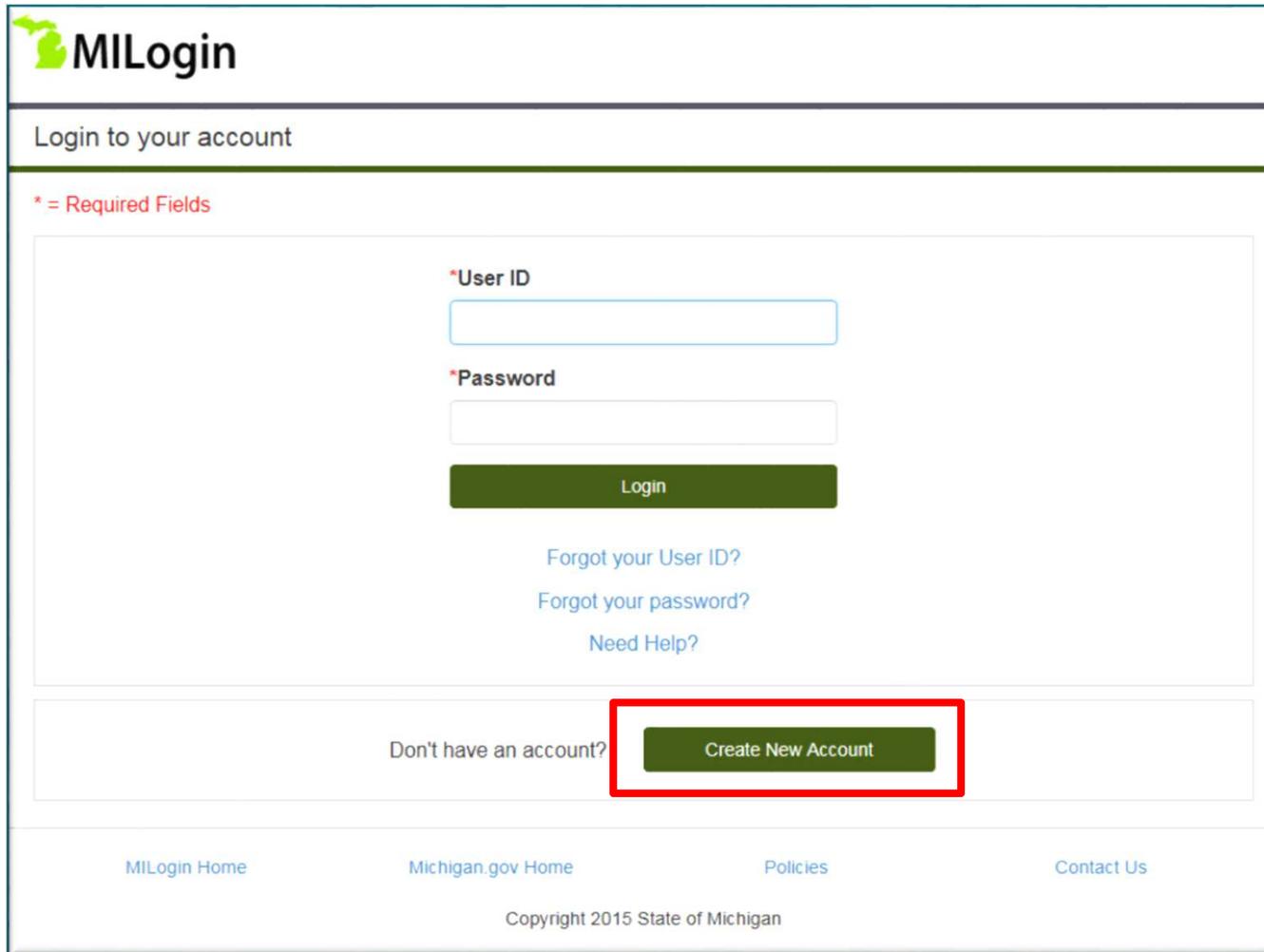
MILogin is a website that allows a user to enter one name and password in order to access multiple applications.

CHAMPS is the Community Health Automated Medicaid Processing System. Providers will enroll, update enrollment information, and report services performed in this system.

Open your web browser (e.g. Internet Explorer, Google Chrome, Mozilla Firefox, etc.) and type **https://milogintp.Michigan.gov** into the search bar.



Providers must register a MILogin User ID before gaining access to the site. Select the **Create New Account** button from the MILogin page.



 **MILogin**

Login to your account

* = Required Fields

*User ID

*Password

Login

[Forgot your User ID?](#)
[Forgot your password?](#)
[Need Help?](#)

Don't have an account? [Create New Account](#)

[MILogin Home](#) [Michigan.gov Home](#) [Policies](#) [Contact Us](#)

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Fill in the required information, indicated by the star (*): *First Name, Last Name, Email Address, Work Phone Number, and Answer Verification Question.*

Click **I agree to the terms & conditions** box.

Click **Next**.

MILogin

Create your account - Step 1 of 3

* = Required Fields

*First Name ← Middle Initial *Last Name ← Suffix

*Email Address ← *Confirm Email Address ←

*Work Phone Number ← Mobile Number

*Verification Question: "doctoring" has how many letters? ←

I agree to the [terms & conditions](#).

Next ← Clear

[MILogin Home](#) [Michigan.gov Home](#) [Policies](#) [Contact Us](#)

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Enter a User ID and Password. (make sure to follow the guidelines in the green box)

Select 4 Secret Questions and Answer them.

Click Create Account.

MILogin

Create your account - Step 2 of 3

* = Required Fields

***User ID**
Enter a User ID

***Password**
Enter password

***Confirm Password**
Confirm password

User ID guideline: Enter your last name, first initial, and any 4 numbers with no space between them. For Example: John Smith and using 9999 as an example for the four digit number, you would enter smithj9999.

Password guidelines:

- Must be at least 8 characters in length
- Must include characters from 3 of the following categories:
 - Upper case letters (A-Z)
 - Lower case letter (a-z)
 - Numbers (0-9)
 - Special characters (!\$#,%@~^&* _+=><)
- Should not be based on your User ID

Select four unique security questions. These questions will be used to restore access to your account in case you forget the password.

***Secret Question #1**
--Select Question--

***Secret Answer #1**
Enter security answer #1

***Secret Question #2**
--Select Question--

***Secret Answer #2**
Enter security Answer #2

***Secret Question #3**
--Select Question--

***Secret Answer #3**
Enter security Answer #3

***Secret Question #4**
--Select Question--

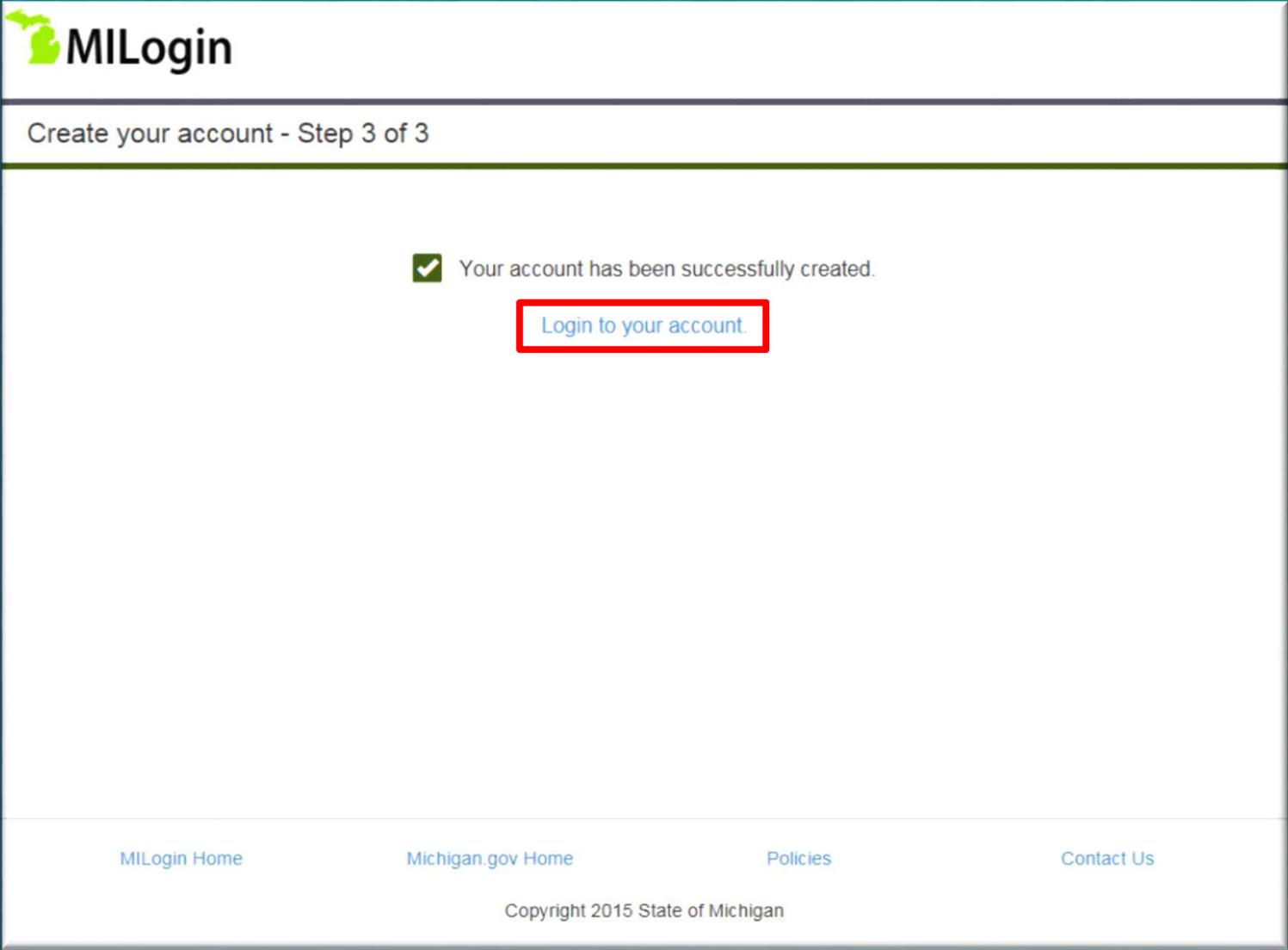
***Secret Answer #4**
Enter security Answer #4

Create Account **Back**

- Select Question--
- What was your favorite place to visit as a child?
 - What was the last name of your third grade teacher?
 - What was the make of your first car?
 - In what city were you born in?
 - What was the name of the company of your first job?
 - In what city did you and your spouse first meet?
 - What was your high school mascot?
 - What is your mothers maiden name?
 - What is your favorite team?
 - Where was the first concert you attended?

You will receive a confirmation that your account has been successfully created.

Click Login to your account



The screenshot shows the MILogin interface. At the top left is the MILogin logo, which consists of a green outline of the state of Michigan followed by the text "MILogin". Below the logo is a horizontal bar with the text "Create your account - Step 3 of 3". The main content area features a green checkmark icon followed by the text "Your account has been successfully created." Below this message is a blue button with the text "Login to your account.", which is highlighted with a red rectangular border. At the bottom of the page, there is a footer with four links: "MILogin Home", "Michigan.gov Home", "Policies", and "Contact Us". Below these links is the copyright notice "Copyright 2015 State of Michigan".

Enter the User ID and Password you just created.
Click Login.

MILogin

Login to your account

* = Required Fields

*User ID

*Password

Login

[Forgot your User ID?](#)
[Forgot your password?](#)
[Need Help?](#)

Don't have an account? [Create New Account](#)

[MILogin Home](#) [Michigan.gov Home](#) [Policies](#) [Contact Us](#)

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Your Home Page will not show any applications.
Click Request Access.

The screenshot shows the MILogin Home Page. At the top right, there are links for Home, Help, Logout, and MI.gov. The MILogin logo is on the left. Below the logo, there is a home icon and the text 'Home Page' and 'Need Help?'. A notification states 'Your password will expire in 365 days.' Under the heading 'Manage your account', there are four buttons: 'Request Access' (highlighted with a red box), 'Update Profile', 'Change Password', and 'Update Security Q&A'. Below this, the section 'Access your applications' contains the text: 'You do not have access to any application. You can request access by clicking on 'Request Access' button above.' The footer includes links for 'MILogin Home', 'Michigan.gov Home', 'Policies', and 'Contact Us', along with the copyright notice 'Copyright 2015 State of Michigan'.

Type CHAMPS in the Step 1: Search for an application box and click the search button.

MILogin

Request Access

Request access guidelines:

1. Search for an application with a keyword **or** select an agency to view its applications
2. Choose an application
3. Confirm your application and click 'Request Access' to proceed

Step 1: Search for an application

CHAMPS

OR

Step 1: Select an agency to view its applications

-  DTMB, Center for Shared Solutions
-  Michigan Department of Natural Resources
-  Center for Educational Performance and Information
-  Michigan State Police
-  Michigan Gaming Control Board
-  All Departments

Step 2: Choose an application - Showing search results for 'Champs'

| | |
|---------------------|---|
| CHAMPS ← | ↑ |
| CHAMPS - HealthBeat | |
| CHAMPS - Siebel CRM | |
| CHAMPS B2B | ↓ |

Step 3: Click on 'Request Access' button to proceed

No application selected yet.

[Request Access](#)

[Return to home page](#)

[MILogin Home](#)

[Michigan.gov Home](#)

[Policies](#)

[Contact Us](#)

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- Click on CHAMPS In 'Step 2: Choose an application box'.

Step 2: Choose an application - Showing search results for 'CHAMPS'

| | |
|---------------------|---|
| CHAMPS | ↑ |
| CHAMPS - HealthBeat | |
| CHAMPS - Siebel CRM | |
| CHAMPS B2B | ↓ |

Step 3: Application ready to be requested - Click on Request Access button to proceed

CHAMPS

(Community Health Automated Medicaid Processing System) is the Michigan Medicaid Management Information System (MMIS). It supports Medicaid provider enrollment and maintenance, beneficiary healthcare eligibility and enrollment, prior authorization, Home Help Electronic Service Verification (ESV), fee-for-service payments and managed care enrollments, payments, and encounters.

Request Access



[Return to home page](#)

- Confirm 'Step 3: Application ready to be requested' says CHAMPS.
- Click 'Request Access' button.



Request Access

* = Required Fields

Please confirm the name of the application to be requested before proceeding. By clicking on 'I Accept' you agree to the Terms & Conditions of this application.

App Name: **CHAMPS**

Terms & Conditions

The Michigan Department of Health and Human Services (MDHHS) computer information systems (systems) are the property of the State Of Michigan and subject to state and federal laws, rules and regulations. The systems are intended for use only by authorized persons and only for official state business. Systems users are prohibited from using any assigned or entrusted access control mechanisms for any purposes other than those required to perform authorized data exchange with MDHHS. Logon IDs and passwords are never to be shared. Systems users must not disclose any confidential, restricted or sensitive data to unauthorized persons. Systems users will only access information on the systems for which they have authorization. Systems users will not use MDHHS systems for commercial or partisan political purposes. Following industry standards, systems users must securely maintain any information downloaded, printed, or removed in any format from the systems. When no longer needed, this information must be destroyed in an appropriate manner specific to the format type. All users of the systems give their expressed consent to the monitoring of their activities on the systems. If such monitoring reveals possible evidence of unauthorized or criminal activity, the evidence may be provided to administrative or law enforcement officials for disciplinary action and/or prosecution. By accessing information provided by the Michigan Department of Health and Human Services computer information systems and clicking on the button below, I acknowledge and agree to abide by all governing privacy and security terms, conditions, policies and restrictions for each authorized application.

I Accept

Cancel

Note: Click 'Cancel' to go back to your homepage.

[Return to home page](#)

[MILogin Home](#)

[Michigan.gov Home](#)

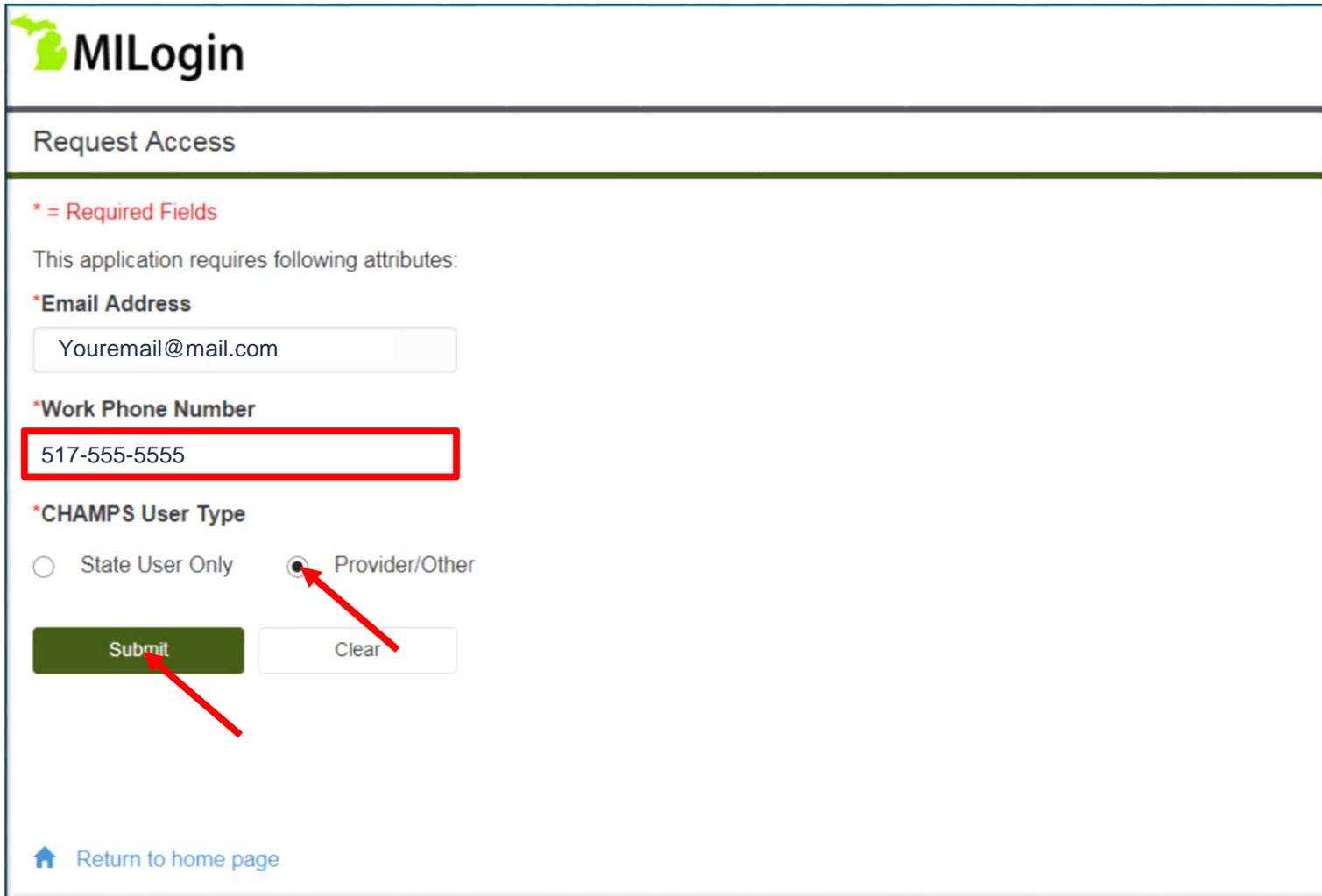
[Policies](#)

[Contact Us](#)

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- Confirm the 'App Name': says CHAMPS.
- Read the Terms & Conditions.
- Click 'I Accept' button.

Confirm your phone number.
Click the Provider/Other button.
Click Submit.



 **MILogin**

Request Access

* = Required Fields

This application requires following attributes:

***Email Address**

***Work Phone Number**

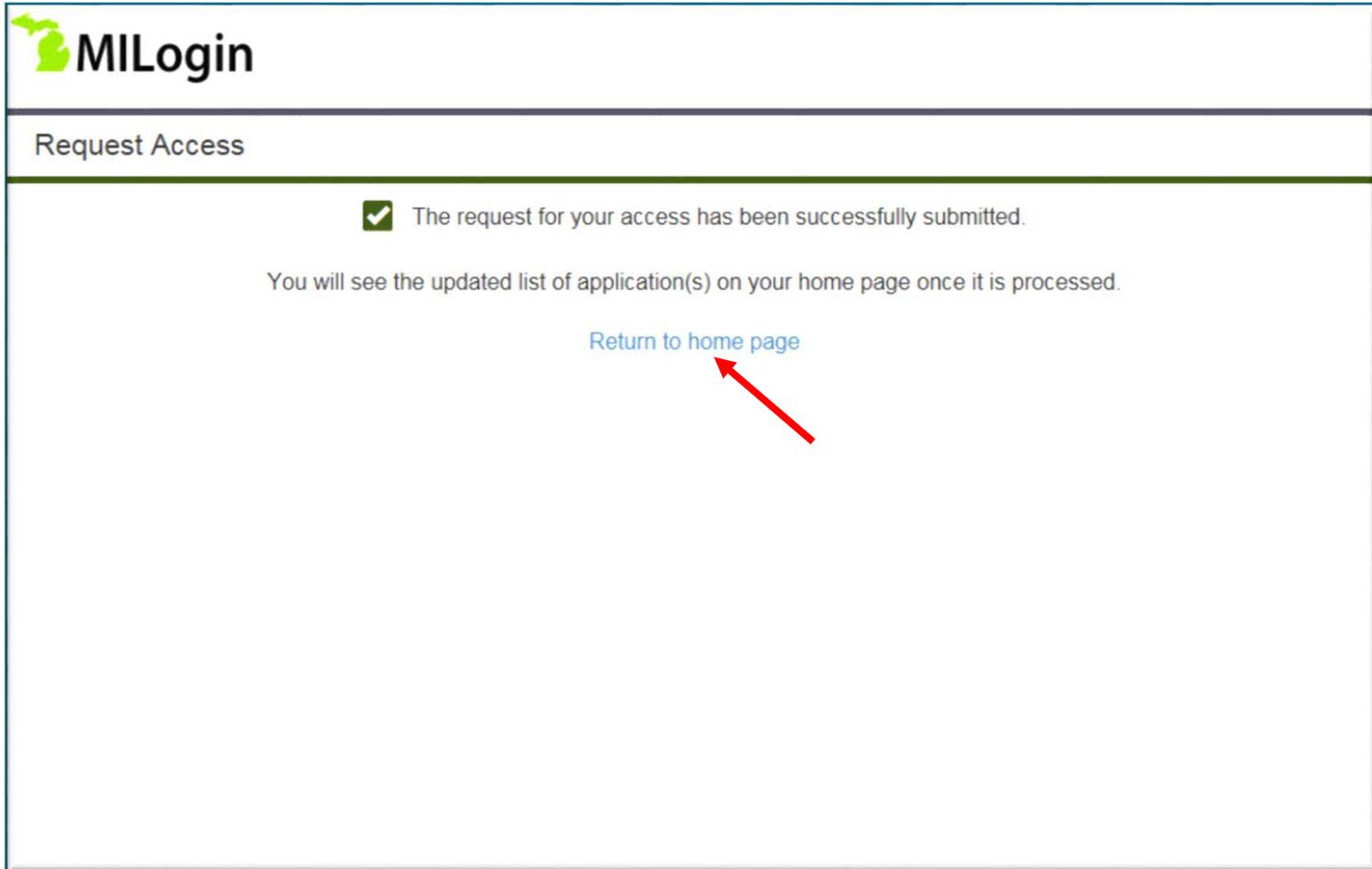
***CHAMPS User Type**

State User Only Provider/Other

[Return to home page](#)

Detailed description: The image shows a web form titled 'MILogin' with a sub-header 'Request Access'. It contains several required fields: 'Email Address' with the placeholder 'Youremail@mail.com', 'Work Phone Number' with the value '517-555-5555', and 'CHAMPS User Type' with radio buttons for 'State User Only' and 'Provider/Other'. The 'Provider/Other' radio button is selected. At the bottom, there are 'Submit' and 'Clear' buttons, and a link to 'Return to home page'. Red arrows point to the 'Submit' button and the 'Provider/Other' radio button. A red box highlights the 'Work Phone Number' field.

Your request to CHAMPS has been successfully submitted.
Click Return to home page.



 MILogin

Request Access

The request for your access has been successfully submitted.

You will see the updated list of application(s) on your home page once it is processed.

[Return to home page](#)



Applying as a New Individual Provider

Follow these steps to complete the application to become a new provider.

Be sure to contact your client's Adult Services Worker once the application is complete.

You will receive a notification approving or denying your application as a home help provider. This notice will have your Provider ID number on it- be sure to tell that number to your client's Adult Services Worker.

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 screenshot displays a web browser window with the address bar containing the URL <https://milogintp.michigan.gov/eai/tplogin/authenticate?URL=/>. The browser's menu bar includes File, Edit, View, Favorites, Tools, and Help. The page content shows the MILogin login interface. At the top left is the MILogin logo. Below it is the heading "Login to your account". A red asterisk indicates required fields. The form contains two input fields: "*User ID" and "*Password", both highlighted with red boxes. 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 area, there is a link "Don't have an account?" and a green "Create New Account" button. The footer of the page includes links for "MI Login Home", "Michigan.gov Home", "Policies", and "Contact Us", along with the text "Copyright 2015 State of Michigan".

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

The screenshot shows 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 is a navigation bar with a home icon, the text "Home Page", and a "Need Help?" link. A notification states "Your password will expire in 365 days." Below this is a section titled "Manage your account" containing four buttons: "Request Access" (with a magnifying glass icon), "Update Profile" (with a person icon), "Change Password" (with a padlock icon), and "Update Security Q&A" (with a pencil icon). A horizontal line separates this from the "Access your applications" section, which contains a single link for "CHAMPS". A red arrow points to the "CHAMPS" link.

MILogin

Home Page [Need Help?](#)

Your password will expire in 365 days.

Manage your account

Request Access Update Profile

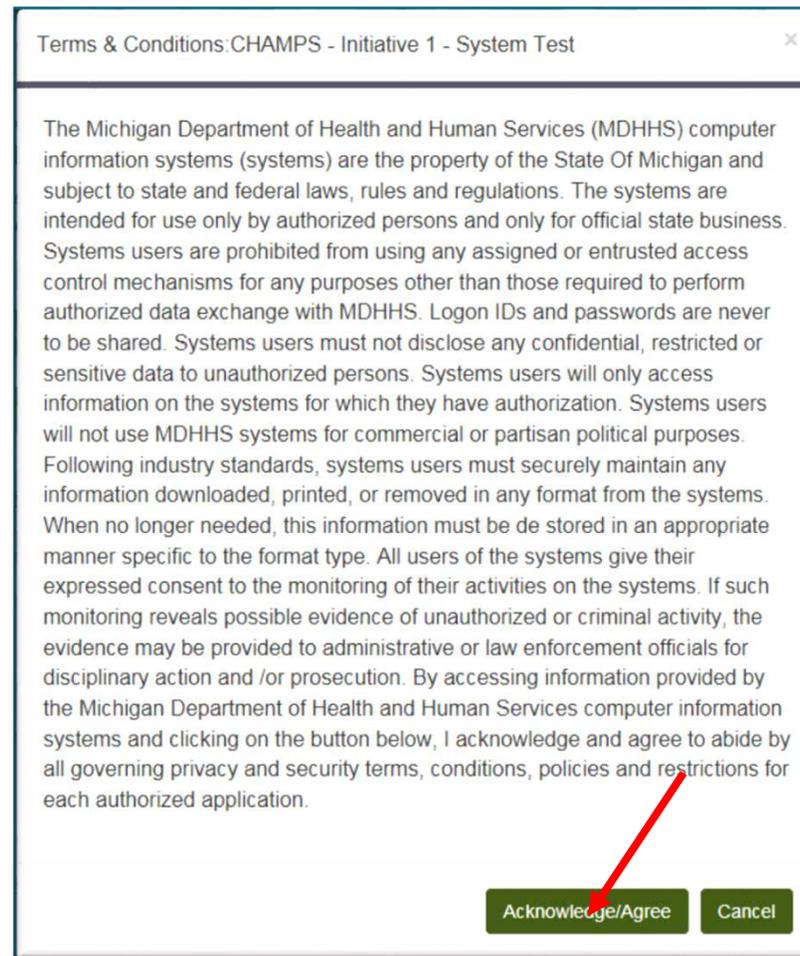
Change Password Update Security Q&A

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' option is highlighted with a red box.

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

Choose **Atypical (non-medical) provider**
Choose **Individual (Driver, Home Help/Personal Care, Carpenter, etc.)**.
Click the **Submit** button.

Jane Doe Quick Find Note Pad External Links My Favorites Print Help

MyInbox > 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: *First Name, Last Name, SSN, Date of Birth, Email, Address, and Zip Code.*

Click the **Validate Address** button.

Choose **Atypical Individual/Sole Proprietor** for **Applicant Type**.

Click **Finish**.

Print Help

Basic Information: Enter required fields and click Confirm button.

Basic Information

First Name: *
Last Name: *
Suffix: *
SSN: *
Date of Birth: *

Middle Initial:
Gender:

Applicant Type: Atypical Individual/Sole Proprietor *

Please check this box if you are an individual business: Business

EIN/TIN:
NPI:

Legal Entity Name:
Contact Email Address:
Email-1: *
Email-2:
Email-3:
Email-4:
Email-5:
Email-6:

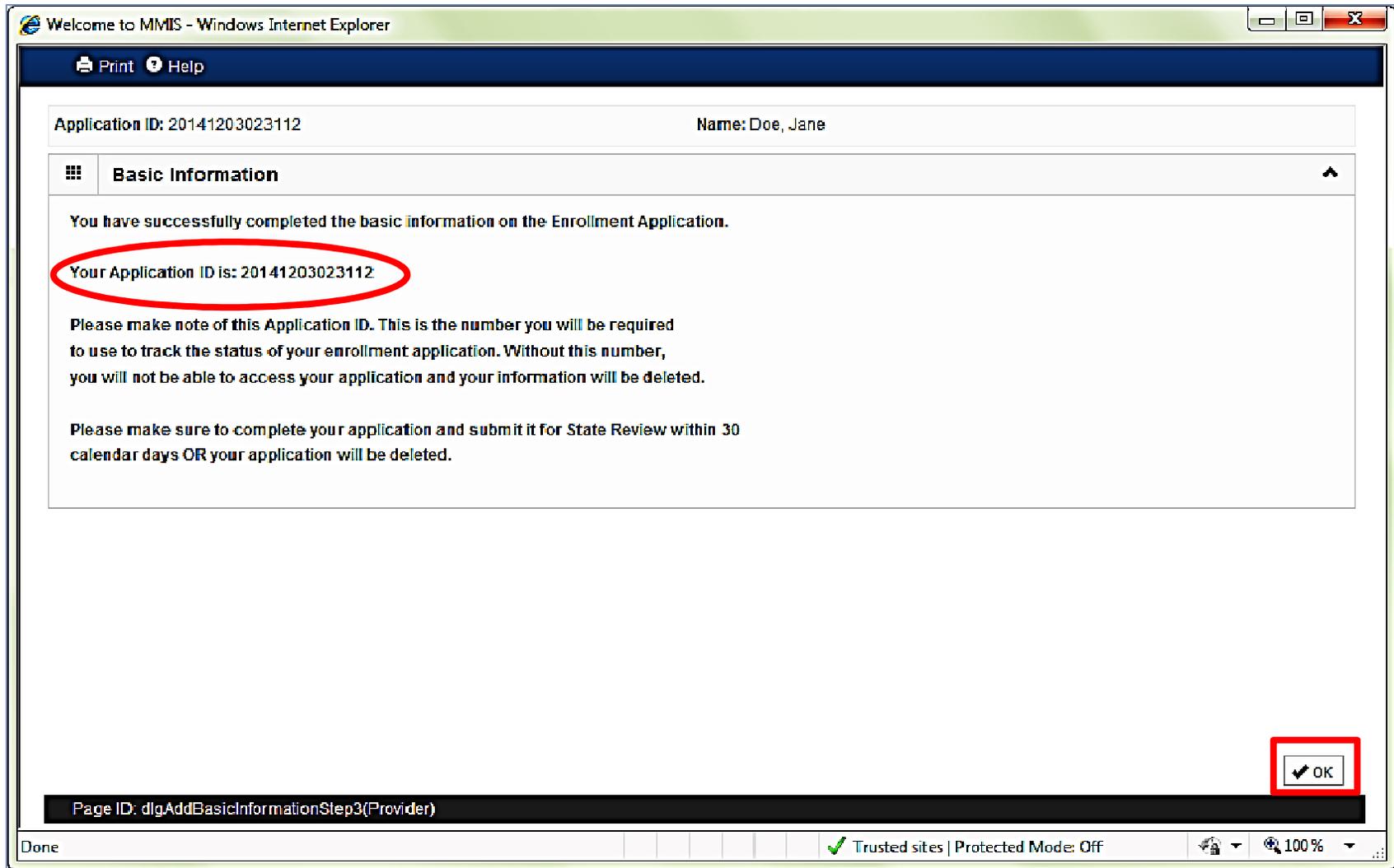
Home Address

Address Line 1: *
(Enter Street Address or PO Box Only)
Address Line 2:
Address Line 3:
State/Province: OTHER *
Country: UNITED STATES *

City/Town: OTHER *
County: OTHER *
Zip Code: - *

Page ID: dlgAddBasicInformationStep1(Provider)

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



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



Provider ▾

Scott, Sarah ▾

Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20150709507689

Name: Scott, Sarah

Close

Enroll Provider - Atypical Individual

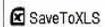
Business Process Wizard - Provider Enrollment (Atypical Individual). Click on the Step # under the Step Column.

| 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: Associate Billing Provider | Optional | | | Incomplete | |
| Step 5: Add License/Certification/Other | Optional | | | Complete | |
| Step 6: Add Mode of Claim Submission/EDI Exchange | Optional | | | Incomplete | |
| Step 7: Associate Billing Agent | Optional | | | Incomplete | |
| Step 8: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 9: Add Taxonomy Details | Optional | | | Incomplete | |
| Step 10: Associate MCO Plan | Optional | | | Incomplete | |
| Step 11: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 12: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 13: Submit Enrollment Application for Approval | Required | | | Incomplete | |

View Page: 1



Page Count: 1



Viewing Page: 1

First

Prev

Next

Last

Click **Add**.

Enter the required information, indicated by an star (*): *Address, Zip Code, and Phone Number.*

Click **Validate Address** (you *cannot* go any further without clicking this).

Click **OK**.

***NOTE: **Location Type** will always be *Primary Practice Location*.

***NOTE: Use your **personal residential address** for *Primary Practice Location*.

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

The screenshot shows a web application interface for adding a provider location. On the left, a sidebar contains a 'Locations List' section with a table and a '+ Add' button highlighted in a red box. The main content area is titled 'Add Provider Location' and contains a form with the following fields and instructions:

- Application ID: 20141203023112, Name: Doe, Jane
- Instructions: "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"
- Location Type: Primary Practice Location (dropdown menu)
- Doing Business As: (text input)
- End Date: (calendar icon)
- Instructions: "If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWER 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: (text input, highlighted in red, with an asterisk) (Enter Street Address or PO Box Only)
- Address Line 2: (text input)
- Address Line 3: (text input)
- City/Town: OTHER (dropdown menu)
- County: OTHER (dropdown menu)
- State/Province: OTHER (dropdown menu)
- Country: UNITED STATES (dropdown menu)
- Zip Code: (text input, highlighted in red)
- Validate Address: (button, highlighted in red)
- Phone Number: (text input, highlighted in red, with an asterisk)
- Phone Number Extension: (text input)
- Fax Number: (text input)
- Email Address: (text input)
- Web Page: (text input)
- Office Hours: (dropdown menu)
- Communication Preference: CHAMPS Notice (dropdown menu)
- OK: (button, highlighted in red)
- Cancel: (button)

Page ID: digEnrAddLocation(Provider)

Click on the **Primary Practice Location** link (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 |
|--------------------------|---|--|------------|
| <input type="checkbox"/> | Primary Practice Location | 320 S WALNUT ST, LANSING, MICHIGAN 48933 | 12/31/2999 |

View Page:

Important Note:
Make sure Accept 835 (reported at EIN/TIN level) is "NO".

Application ID: 20141203023112

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:

Office Hours: Location Type: Primary Practice Location
Email Address:
Communication Preference:

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

Address List

| Address Type | Address | End Date |
|--------------------------|--|------------|
| <input type="checkbox"/> | Location 320 S WALNUT ST, LANSING, MICHIGAN 48933 | 12/31/2999 |

View Page: Viewing Page: 1

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

***All mail from the Home Help program will be sent to the address entered here; therefore, enter the address where you regularly receive 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**.

The image displays two screenshots of a web application interface for adding a provider location address. The top screenshot shows the 'Add Provider Location Address' form with the 'Type of Address' dropdown menu open, highlighting 'Correspondence'. The bottom screenshot shows the same form with the 'Copy This Location Address' button highlighted. The form includes fields for 'Type of Address', 'Location Address', 'End Date', 'Address Line 1', 'Address Line 2', 'Address Line 3', and 'City/Town'. The application ID is 20141203023112 and the name is Doe, Jane.

Application ID: 20141203023112 Name: Doe, Jane

Add Provider Location Address

Type of Address: --SELECT-- *
Location Address: --SELECT-- Correspondence *
Pay To
Remittance Advice

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 Line 1: * Address Line 2: *

Address Line 3: *

Page ID: dlGEnrL_LocationAddress(Provider)

Application ID: 20141203023112 Name: Doe, Jane

Add Provider Location Address

Type of Address: Correspondence * End Date: *
Location Address: Copy This Location Address *

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 Line 1: 320 S WALNUT ST * Address Line 2: *
(Enter Street Address or PO Box Only)

Address Line 3: * City/Town: LANSING *

OK Cancel

Page ID: dlGEnrL_LocationAddress(Provider)

Notice the Correspondence and Location now have addresses.
Click **Add Address** one more time to designate a **Pay To** address.
In the **Type of Address** drop down menu, select **Pay To**.
Select **Copy This Location Address** next to **Location Address**.
Click **OK**.

Application ID: 20141203023112

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 Type: Primary Practice Location
Email Address:
Communication Preference: CHAMPS Notice

Add Address

Address List

| 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 |

Viewing Page: 1

Application ID: 20141203023112 Name: Doe, Jane

Add Provider Location Address

Type of Address: Pay To
Location Address: Copy This Location Address
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 Line 1: 320 S WALNUT ST *
(Enter Street Address or PO Box Only)
Address Line 2:
Address Line 3:
City/Town: LANSING

Page ID: dlgEnrlLocationAddress(Provider)

Important Note:
Make sure Accept 835(reported at EIN/TIN level) is "NO".

Add Address

Correspondence
320 S WALNUT ST, LANSING, MICHIGAN 48933
12/31/2999

Location
320 S WALNUT ST, LANSING, MICHIGAN 48933
12/31/2999

Type of Address: Pay To
Location Address: Copy This Location Address

Notice the Correspondence, Location, and Pay To columns all 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.

Application ID: 20141203023112 Name: Doe, Jane

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

01 Location Type: Primary Practice Location

Email Address:

Communication Preference: CHAMPS Notice

Language(s) Spoken: English Arabic Chinese

(For Multiple Selection, use Ctrl Key)

Add Address

Address List

| Address Type | Address | End Date |
|---|--|------------|
| <input type="checkbox"/> Correspondence | 320 S WALNUT ST, LANSING, MICHIGAN 48933 | 12/31/2999 |
| <input type="checkbox"/> Location | 320 S WALNUT ST, LANSING, MICHIGAN 48933 | 12/31/2999 |
| <input type="checkbox"/> Pay To | 320 S WALNUT ST, LANSING, MICHIGAN 48933 | 12/31/2999 |

Delete View Page: 1 Page Count Save To XLS Viewing Page: 1

« First < Prev > Next » Last

Important Note:
Make sure Accept 835(reported at EIN/TIN level) is "NO".



Click on the **Step 3: Add Specialties** link
Click **Add**.



Provider ▾

Scott, Sarah ▾

Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20150709507689

Name: Scott, Sarah

Close

Enroll Provider - Atypical Individual

Business Process Wizard - Provider Enrollment (Atypical Individual). 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: Associate Billing Provider | Optional | | | Incomplete | |
| Step 5: Add License/Certification/Other | Optional | | | Complete | |
| Step 6: Add Mode of Claim Submission/EDI Exchange | Optional | | | Incomplete | |
| Step 7: Associate Billing Agent | Optional | | | Incomplete | |
| Step 8: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 9: Add Taxonomy Details | Optional | | | Incomplete | |
| Step 10: Associate MCO Plan | Optional | | | Incomplete | |
| Step 11: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 12: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 13: Submit Enrollment Application for Approval | Required | | | Incomplete | |

View Pa Application ID: 20141203023112

Name: Doe, Jane

Close

Add

Specialty/Subspecialty List

Filter By



Go

Save Filters

My Filters ▾

| Specialty/Subspecialty | Provider Type | End Date |
|------------------------|---------------|----------|
| ▲ ▾ | ▲ ▾ | ▲ ▾ |

No Records Found!

For both **Provider Type** and **Specialty**, choose **Home Help Individual**.
Click **OK**.

Print Help

Application ID: 20141203023112 Name: Doe, Jane

Add Specialty/Subspecialty

Location: 01-*

Provider Type: --SELECT--*

Specialty: HOME HELP INDIVIDUAL

End Date:

Add Subspecialty

Available Subspecialties

Associated Subspecialties *

Page ID: dlgEnrAddSpecialties(Provider)

Print Help

Application ID: 20141203023112 Name: Doe, Jane

Add Specialty/Subspecialty

Location: 01-*

Provider Type: HOME HELP INDIVIDUAL*

Specialty: --SELECT--*

End Date: HOME HELP INDIVIDUAL

Add Subspecialty

Available Subspecialties

Associated Subspecialties *

>>

<<

OK Cancel

Page ID: dlgEnrAddSpecialties(Provider)

Click **Close**.

Steps 4-7 are optional. As an individual home help provider not associated with an agency, you do not need to complete these steps.

Application ID: 20141203023112 Name: Doe, Jane

Close **Add**

Specialty/Subspecialty List

CHAMPS ← Provider ▾

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

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20150709507689 Name: Scott, Sarah

Close

Enroll Provider - Atypical Individual

Business Process Wizard - Provider Enrollment (Atypical Individual). 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: Associate Billing Provider | Optional | | | Incomplete | |
| Step 5: Add License/Certification/Other | Optional | | | Complete | |
| Step 6: Add Mode of Claim Submission/EDI Exchange | Optional | | | Incomplete | |
| Step 7: Associate Billing Agent | Optional | | | Incomplete | |
| Step 8: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 9: Add Taxonomy Details | Optional | | | Incomplete | |
| Step 10: Associate MCO Plan | Optional | | | Incomplete | |
| Step 11: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 12: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 13: Submit Enrollment Application for Approval | Required | | | Incomplete | |

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

Click on the **Step 8: Add Provider Controlling Interest/Ownership Details** link.
Click on the **Add** button.



Provider

Scott, Sarah

Quick Find | Note Pad | External Links | My Favorites | Print | Help

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20150709507689

Name: Scott, Sarah

Close

Enroll Provider - Atypical Individual

Business Process Wizard - Provider Enrollment (Atypical Individual). 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: Associate Billing Provider | Optional | | | Incomplete | |
| Step 5: Add License/Certification/Other | Optional | | | Complete | |
| Step 6: Add Mode of Claim Submission/EDI Exchange | Optional | | | Incomplete | |
| Step 7: Associate Billing Agent | Optional | | | Incomplete | |
| Step 8: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 9: Add Taxonomy Details | Optional | | | Incomplete | |

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 |
|-------------------|-------------------|------------|------------|------------|
| 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 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 star(*): *SSN, Address, Percentage Owned, Start Date, and Zip Code.*
Click **Validate Address** button (you *cannot* go any further without this).
Click **OK**.

***NOTE: Type the number zero (0) in the **Percentage Owned** box.

***NOTE: Start Date is always the date you are filling out the application.

***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: *
SSN: *

Legal Entity Name: Agent
Board of Directors/Officers/Principles
Corporate - Charitable 501(c)3
Corporate - Non Charitable
Foreign, Nonresident Alien
Government
Holding Company
Individual
Suffix: Limited liability Company
Phone Number: *
Start Date: *

Percentage Owned: *

EIN/TIN:

Entity Business Name:
(Doing Business As)

Last Name:

DOB:

Email:

End Date:

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

Address Line 2:

Address Line 3:

City/Town: OTHER *

County: OTHER

State/Province: OTHER *

Country: UNITED STATES *

Zip Code:

Page ID: dlgEnrlmntAddOwner(Provider)

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

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 |
|--------------------------|-------------------|-------------------|------------|------------|
| 22222222 | Doe, Jane | Managing Employee | 12/03/2014 | 12/31/2999 |
| //////// | Doe, Jane | Individual | 12/03/2014 | 12/31/2999 |

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

Add Other Owned Entry

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! | | |

Click **Add**.

Select your name under the **Owner Name** drop down menu.

Select **Self** in the **Relationship** drop down menu.

Click **OK**.

Application ID: 20141203023112 Name: Doe, Jane

Modify Provider Controlling Interest/Ownership

Owner Type: Managing Employee Percentage Owned: *

SSN: *

EIN/TIN:

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

Entity Business Name: (Doing Business As)

First Name: *

Last Name: *

Suffix:

DOB: *

Phone Number: * Extn:

Email:

Start Date: *

End Date: *

Address Type: Home Address

Address Line 1: * Address Line 2:

(Enter Street Address or PO Box Only)

Address Line 3:

City/Town: *

State/Province: *

County: *

Country: *

Zip Code: -

Inactivate

Relationship

Filter By:

Owner Name

Print Help

Application ID: 20141203023112 Name: Doe, Jane

Add Owner Relationship

Owner Name: *

Relationship: *

Page ID: dlgOwnerRelationship(Provider)

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

The screenshot displays the CHAMPS Provider Portal interface. At the top, the user is logged in as Pung,Chelsey. The breadcrumb trail shows: Provider Portal > Track Application > HIPAA-Exempt Individual Enrollment > General. The application ID is 20141203023112 and the name is Doe, Jane.

The main section is titled "Modify Provider Controlling Interest/Ownership". It contains a form with the following fields:

- Owner Type: Managing Employee
- SSN: 222222222
- Legal Entity Name: (As shown on the Income Tax Return)
- First Name: Jane
- Suffix: [Dropdown]
- Phone Number: (999) 999-9999
- Start Date: 12/03/2014
- Percentage Owned: 0
- EIN/TIN: [Field]
- Entity Business Name: (Doing Business As)
- Last Name: Doe
- DOB: 01/01/1960
- Email: [Field]
- End Date: 12/31/2999
- Address Type: Home Address
- Address Line 1: 320 S WALNUT ST
- Address Line 2: [Field]
- Address Line 3: [Field]
- City/Town: LANSING
- State/Province: MICHIGAN
- County: INGHAM
- Country: UNITED STATES
- Zip Code: 48933 - 2014
- Validate Address: [Button]

Below the form is a table with the following columns: Owner Name, Modified Date, and Operational Status. The table contains one entry: Doe, Jane. A red circle highlights the "Doe, Jane" entry in the "Owner Name" column. A red arrow points from this circle to a red-bordered box containing the text: "Click the link 'Final Adverse Legal Actions/Convictions Disclosure' to read and answer the disclosure."

At the bottom of the page, there is a section titled "Final Adverse Legal Actions/Convictions Disclosure" with a table structure:

| 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 | | |

A red arrow points from the red-bordered box to the "Final Adverse Legal Actions/Convictions Disclosure" text in the table header.

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: 20141203023112
Provider ID: 4002642

Name: Doe, Jane
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

Repeat the previous steps for the **Individual** Owner Type:
Click on the **Individual** Owner Type SSN link (in blue).

Application ID: 20141203023112 Name: Doe, Jane

Close

Owners List

Add

Filter By **Go** **Save Filters** **My Filters**

| Owner SSM/EIN/TIN | Owner Information | Owner Type | Start Date | End Date |
|------------------------------------|-------------------|-------------------|------------|------------|
| <input type="checkbox"/> 222222222 | Doe, Jane | Managing Employee | 12/03/2014 | 12/31/2999 |
| <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 ! | | |

Click **Add**.

Select your name under the **Owner Name** drop down menu.

Select **Self** in the **Relationship** drop down menu.

Click **OK**.

Application ID: 20141203023112 Name: Doe, Jane

Close Save

Modify Provider Controlling Interest/Ownership

Owner Type: Individual Percentage Owned: 100

SSN: 222222222 * EIN/TIN:

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

First Name: Jane * Last Name: Doe *

Suffix: Phone Number: (999) 999-9999 * Extn: DOB: 01/01/1960 * Email: Start Date: 12/03/2014 * 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 * State/Province: MICHIGAN * County: INGHAM * Zip Code: 48933 - 2014 Validate Address Country: UNITED STATES *

Add Inactivate

Relationship

Filter By Go Save Filters My Filters

Print Help

Application ID: 20141203023112 Name: Doe, Jane

Add Owner Relationship

Owner Name: Doe, Jane Relationship: Self

OK Cancel

Page ID: dlqOwnerRelationship(Provider)

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

The screenshot shows the CHAMPS Provider Portal interface. At the top, there are navigation tabs for 'My Inbox', 'Provider', and 'TPL'. The user is logged in as 'Pung,Chelsey'. The breadcrumb trail is 'Provider Portal > Track Application > HIPAA-Exempt Individual Enrollment > General'. The application ID is 20141203023112 and the name is Doe, Jane.

The main section is titled 'Modify Provider Controlling Interest/Ownership'. It contains several form fields for personal and business information:

- Owner Type:** individual
- SSN:** 222222222
- Legal Entity Name:** (As shown on the Income Tax Return)
- First Name:** Jane
- Suffix:** (dropdown)
- Phone Number:** (999) 999-9999
- Start Date:** 12/03/2014
- Percentage Owned:** 100
- EIN/TIN:** (text field)
- Entity Business Name:** (Doing Business As)
- Last Name:** Doe
- DOB:** 01/01/1960
- Email:** (text field)
- End Date:** 12/31/2999

Below this is the address section:

- Address Type:** Home Address
- Address Line 1:** 320 S WALNUT ST
- Address Line 2:** (text field)
- Address Line 3:** (text field)
- State/Province:** MICHIGAN
- City/Town:** LANSING
- County:** INGHAM
- Country:** UNITED STATES
- Zip Code:** 48933 - 2014

At the bottom, there is a table with columns: Owner Name, Relationship, Modified Date, Operational Status, and Comments. The first row shows 'Doe, Jane' in the Owner Name column. A red circle highlights this entry, and a red arrow points to it from a larger red box that contains the text 'Final Adverse Legal Actions/Convictions Disclosure'. Below the table, there is a section titled 'Final Adverse Legal Actions/Convictions Disclosure' with a red box around the text: 'Click the link "Final Adverse Legal Actions/Convictions Disclosure" to read and answer the disclosure.'

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**.
Click **Close** to go to the Enroll Provider page (Not shown).

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

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):

Page ID: dlqOwnerCheckList(Provider)

Click on the Step 12: Complete Enrollment Checklist link.



Provider ▾

Scott, Sarah ▾

Quick Find

Note Pad

External Links ▾

My Favorites ▾

Print

Help

MyInbox > New Enrollment > Atypical Individual Enrollment

Application ID: 20150709507689

Name: Scott, Sarah

Close

Enroll Provider - Atypical Individual

Business Process Wizard - Provider Enrollment (Atypical Individual). 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: Associate Billing Provider | Optional | | | Incomplete | |
| Step 5: Add License/Certification/Other | Optional | | | Complete | |
| Step 6: Add Mode of Claim Submission/EDI Exchange | Optional | | | Incomplete | |
| Step 7: Associate Billing Agent | Optional | | | Incomplete | |
| Step 8: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 9: Add Taxonomy Details | Optional | | | Incomplete | |
| Step 10: Associate MCO Plan | Optional | | | Incomplete | |
| Step 11: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 12: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 13: 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: 20141203023112

Name: Doe, Jane

Close Save

Provider Checklist

Question

Are you interested in working for other Home Help clients? (If you say no this will not affect your current work.)

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?

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.

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.

Have you ever had any criminal convictions? If yes, please tell us what for?

Are you a registered Limited Liability Corporation (LLC)? If yes, what is the name of the LLC?

Are you a Medicare certified home health agency?

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.

I also acknowledge that I am required to update any changes in the enrollment within 10 days of that change.

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Viewing Page: 1

| Answer | Comments |
|---------------|----------|
| Not Completed | |

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Click on the **Step 13: Submit Enrollment Application for Approval** link. By clicking the **Next** button, you “agree that the information submitted as a part of the application is correct (Private and Confidential)”.

Application ID: 20150709507689 Name: Scott, Sarah

Close

Enroll Provider - Atypical Individual

Business Process Wizard - Provider Enrollment (Atypical Individual). 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: Associate Billing Provider | Optional | | | Incomplete | |
| Step 5: Add License/Certification/Other | Optional | | | Complete | |
| Step 6: Add Mode of Claim Submission/EDI Exchange | Optional | | | Incomplete | |
| Step 7: Associate Billing Agent | Optional | | | Incomplete | |
| Step 8: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 9: Add Taxonomy Details | Optional | | | Incomplete | |
| Step 10: Associate MCO Plan | Optional | | | Incomplete | |
| Step 11: 835/ERA Enrollment Form | Optional | | | Incomplete | |
| Step 12: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 13: Submit Enrollment Application for Approval | Required | | | Incomplete | |

View Page: 1 Page Count: 1 SaveToXLS Viewing Page: 1

Application ID: 20141203023112 Name: Doe, Jane

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



Submit Application

After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.



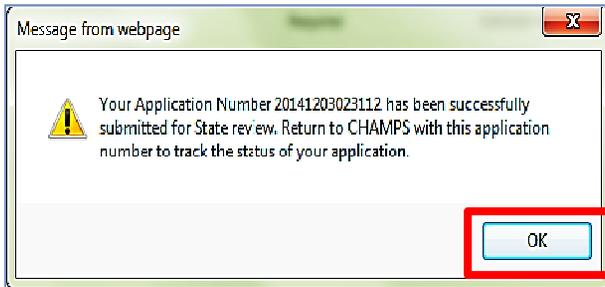
Terms and Conditions (Enrollment Process)



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 application main page.
Click **Close**.
This will return you to the CHAMPS home page.



| 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: Associate Billing Provider | Optional | | | Incomplete | |
| Step 5: Add License/Certification/Other | Optional | | | Complete | |
| Step 6: Add Mode of Claim Submission/EDI Exchange | Optional | | | Incomplete | |
| Step 7: Associate Billing Agent | Optional | | | Incomplete | |
| Step 8: Add Provider Controlling Interest/Ownership | | | | | |
| Step 9: Add Taxonomy Details | | | | | |
| Step 10: Associate MCO Plan | | | | | |
| Step 11: 835/ERA Enrollment Form | | | | | |
| Step 12: Complete Enrollment Checklist | | | | | |
| Step 13: Submit Enrollment Application for Approval | | | | | |

Tracking Your Application

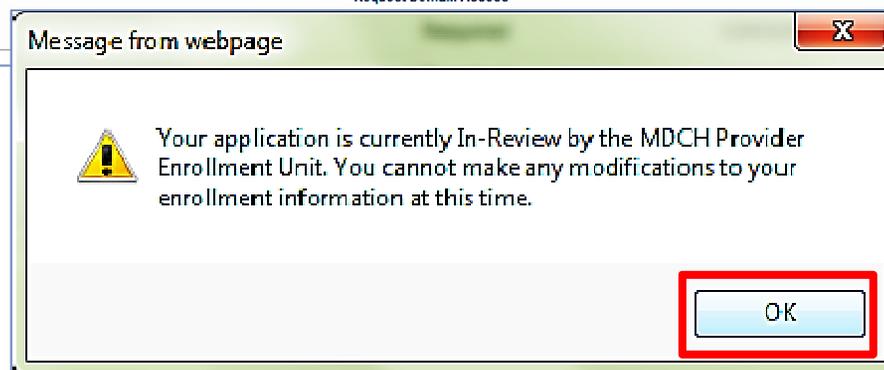
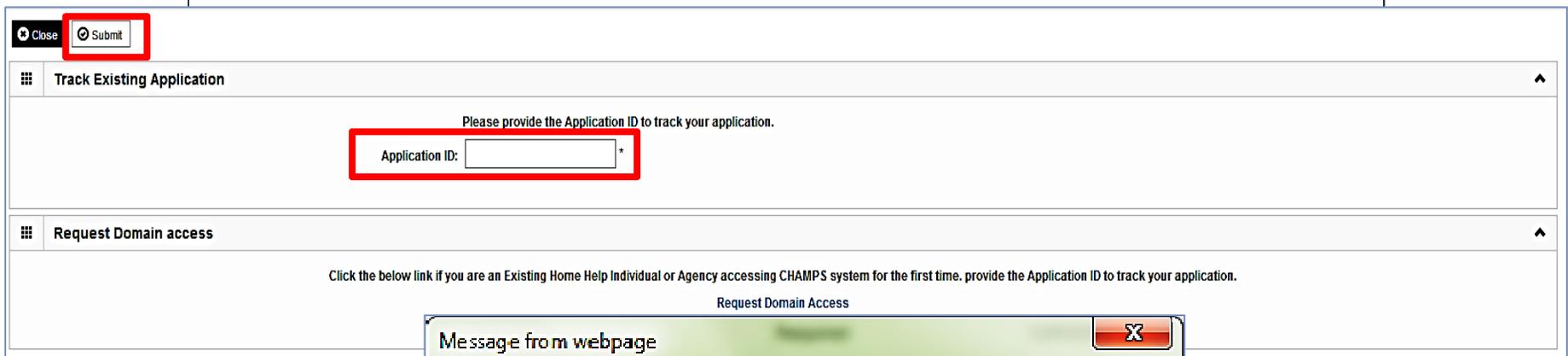
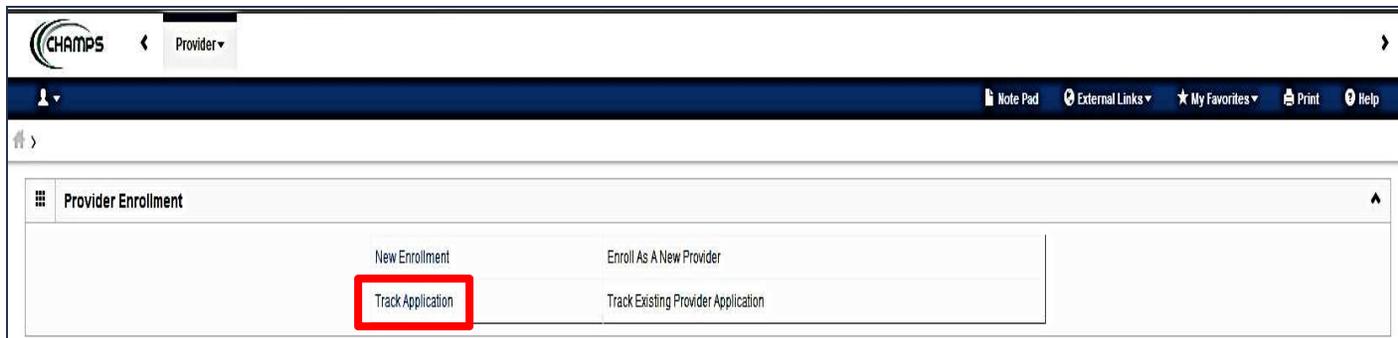
How to Track the Status of Your Application

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** link (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**.



When Your Application Is Approved

Once you have received your approval letter, you will be able to enter CHAMPS to access and submit your electronic service log. To learn how to record your services, see the ESV directions on the Home Help website: www.Michigan.gov/homehelp.

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