### Individual Home Help Provider

### New 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

### Checklist

\*\*\*You must complete the application within 30 days of starting it\*\*\*
 For anyone who wants to become a new Home Help Provider:
 Have paper and a writing utensil nearby
 Create a MiLogin user ID and password
 Gain access to CHAMPS
 Fill out the Provider Enrollment Application
 Track your Application

Application Approved

Contact the Provider Support Helpline if you need assistance:

1-800-979-4662



MiLogin is the State of Michigan Identity, Credential, and Access Management (MICAM) solution. All users who need access to the information within CHAMPS must obtain a MiLogin User ID and Password.

CHAMPS (Community Health Automated Medicaid Processing System) is the MDHS application where providers enroll, update provider enrollment information, and report services performed.

As of October 28, 2023, MiLogin Third Party has been rebranded to MiLogin for Business.



- Open your web browser (e.g., Internet Explorer, Google Chrome, Mozilla Firefox, etc.).
- Enter <u>https://milogintp.Michigan.g</u> <u>ov</u> into the search bar.
- Click create an account.

MiLogin for Business

#### Michigan's one-stop login solution for business

MiLogin connects you to all State of Michigan business services through one single user ID. Whether you want to renew your business license or request an inspection, you can use your MiLogin for Business user ID to log in to Michigan government services.

 $\rightarrow$ 

Copyright 2023 State of Michigan

User ID Password Eorgot your password

Log In

Create an Account

Welcome to

Help

Contact Us

Policies



- Enter an email address.
- Check the 'I'm not a robot' checkmark.
- Click Next Step.

**Don't have an email address?** There are several email providers who offer an email address and services at no cost. A few popular email providers are listed below.

- Gmail: <u>https://www.google.com/gmail/</u> <u>about/#</u>
- Yahoo Mail: <u>https://login.yahoo.com/account/</u> <u>create</u>
- Microsoft Live Hotmail: <u>https://outlook.live.com/owa/</u>

These commercial provider organizations are **not affiliated with the State of Michigan**. Your email messages will not be stored on the State of Michigan systems.





- Enter the Passcode that was sent to the email address.
- Click Next Step.
- If the passcode was not sent select the Resend Passcode link.





- Enter the Work Phone number.
- Click Next Step.





- Enter the User's First, optional Middle Initial, and Last name.
- Review the terms and conditions and click the 'I agree' checkbox.
- Click Next Step.





- A phone call will be made to the work phone number.
- Enter the Passcode.
- Click Confirm Passcode.
- If the call was missed, click the Resend Passcode to receive another phone call.

MiLogin for Busi	ness		He	lp Contact Us
< Previous S Step 5 of 10 Pass verif 0 0 0	code ication ○ ● ○ ○ ○ ○ ○ ○	$\rightarrow$	Enter your passcode We have sent you a passcode via a voice call to your work phone ending with Passcode 1230 - Confirm Passcode Resend Passcode	
Copyright 2023 State of Michigan				Policies



- Enter the mobile phone number.
  - This is an optional step and can be completed later by clicking the 'Skip this for now' link.
- Click Next Step.





 Select either the Text Message or Voice Call verification method.





- Enter the Passcode sent to the mobile phone number on file.
- Click Confirm Passcode.



![](_page_11_Picture_4.jpeg)

- Enter the User ID following the guidelines provided.
- Click Next Step.

![](_page_12_Picture_3.jpeg)

![](_page_12_Picture_4.jpeg)

- Create a Password following the guidelines.
- Enter the same password in the Confirm Password field.
- Click Create Account.

![](_page_13_Picture_4.jpeg)

![](_page_13_Picture_5.jpeg)

- Your MiLogin account has now been created successfully.
- Your MiLogin Welcome Page will not display any online services.
- Click Request Access.

\*Additional MiLogin resources are available by clicking the Help link at the top of the page.

![](_page_14_Picture_5.jpeg)

![](_page_14_Picture_6.jpeg)

 Filter by Departments and select for Michigan
 Department of Health and Human Services

#### OR

- Enter CHAMPS in the search for services box and click Search.
- Click on CHAMPS.

![](_page_15_Picture_5.jpeg)

![](_page_15_Picture_6.jpeg)

- Select the CHAMPS user type as 'Provider/Other' option.
- Click Next Step.

![](_page_16_Picture_3.jpeg)

![](_page_16_Picture_4.jpeg)

- You will be given confirmation that your request has been submitted successfully and is being processed.
- Click the continue to return to the MiLogin Welcome Page.

![](_page_17_Picture_3.jpeg)

![](_page_17_Picture_4.jpeg)

- You will be directed back to your MiLogin Welcome Page.
- Click the CHAMPS hyperlink.

![](_page_18_Picture_3.jpeg)

![](_page_18_Picture_4.jpeg)

- Review the terms and conditions and check the 'I agree to the Terms & Conditions'.
- Click Launch service.

![](_page_19_Picture_3.jpeg)

Home Discover Online Services Help Contact Us 🗸

#### MOHHS

#### CHAMPS

Back to Home

(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.

Please accept the Terms and Conditions to continue:

#### **Terms & Conditions**

The Michigan Department of Health & Human Services (MDHHS) computer information system (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 must not use MDHHS systems for commercial or partisan political purposes. Following industry standards, systems users must securely maintain any

![](_page_19_Figure_11.jpeg)

Copyright 2023 State of Michigan

![](_page_19_Picture_13.jpeg)

![](_page_19_Picture_15.jpeg)

- Your Name and Provider ID number will show in the top section
- In the 'Select Profile' dropdown menu, select Atypical Access
- Click go

![](_page_20_Picture_4.jpeg)

![](_page_20_Picture_5.jpeg)

# New Provider Enrollment

Steps on how to complete a new CHAMPS enrollment for an Individual Home Help Provider Type

![](_page_21_Picture_2.jpeg)

#### New Enrollment

• Click on **New Enrollment** 

CHAMPS	<	Provider 🕶							>
1					🕒 Note Pad	🔇 External Links 🕶	★ My Favorites →	🖨 Print	Help
III Provider E	Enrollment								^
			New Enrollment	Enroll As A New Provider					
			Track Application	Track Existing Provider Application					

![](_page_22_Picture_3.jpeg)

#### New Enrollment

- Click Atypical (non-medical)
   provider
- Individual will automatically be chosen
- Click **Submit**

						💾 Note Pad	🚱 External Links <del>-</del>	★ My Favorites 🗸	🚔 Print	9
> New Enrollment										
Enrollment Type										
				Select the Applicable	Enrollment Type					
Individual/Sole Proprietor										
C Regular Individual/Sole Proprietor or	r Rendering/Servicin	g Provider								
Group Practice (Corporation, Partnership,	, LLC, etc.)									
Billing Agent										
> Facility/Agency/Organization (FAO-Hospit	tal, Nursing Facility, '	Various Entities)	•							
Atypical (non-medical) provider (Choose t	this option if you do	not have a NPI)								
Individual (Driver, Home Help/Persor	nal Care, Carpenter, (	CTS, etc.)								

![](_page_23_Picture_5.jpeg)

#### New Provider Enrollment

- Enter the required information: First Name, Last Name, SSN, Date of Birth, Email, Address, and Zip Code
- Click Validate Address
- Confirm Atypical Individual/Sole Proprietor is listed for Applicant Type
- Click Finish

	First Name: *	Middle Initial:	
	Last Name: *	Gender:	
	Suffix:	Vendor ID:	
	SSN: *		
	Date of Birth:	Applicant Type: Atypical Individual/Sole Proprietor 👻 *	
Please check this box if y	ou are an individual business: Business		
	EIN/TIN:	Legal Entity Name:	
		Contact Email Address:	
	NPI:	Email-1: * Email-2:	
		Email-3: Email-4:	
		Email-5: Email-6:	
Home Address			
	Please ensure you are providing the he	me address of this provider. Failure to do so may result in this application/modification being denied.	
	Address Line 1: *	Address Line 2:	
	Address Line 3:	City/Town: OTHER 🗸 *	
	State/Province: OTHER V *	County: OTHER v	

![](_page_24_Picture_6.jpeg)

#### New Provider Enrollment

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

🚔 Print 🛛 Help		
Application ID:	Name:	
III Basic Information		^
You have successfully completed the basic information on the Enrollment Application.		
Your Application ID is:		
Please make note of this Application ID. This is the number you will be required to use to track the status of your enrollment application. Without this number, you will not be able to access your application and your information will be deleted.		
Please make sure to complete your application and submit it for State Review within 30 calendar days OR your application will be deleted.		

![](_page_25_Picture_4.jpeg)

✓ Ok

• Click Step 2: Add Locations

			🎦 Note i	Pad 🛛 😔 External Links <del>-</del>	★ My Favorites 🗸	🚔 Print	-
New Enrollment > Atypical Individual Enrollment							
pplication ID:	Name:						
Close							
Enroll Provider - Atypical Individual							
		Business Process W	/izard - Provider Enrollment (A	typical Individual). Click	on the Step # unde	er the Step	С
Step	Required	Start Date	End Date	Status	Step Remark		
Step 1: Provider Basic Information	Required	01/04/2023	01/04/2023	Complete			
Step 2: Add Locations	Required			Incomplete			
Step 3: Add Specialties	Required			Incomplete			
Step 4: Associate Billing Provider/Other Associations	Optional			Incomplete			
Step 5: Add License/Certification/Other	Optional			Incomplete			
Step 6: Add Mode of Claim Submission/EDI Exchange	Required			Incomplete			
Step 7: Associate Billing Agent	Optional			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: Upload Documents	Optional			Incomplete			
	Required			Incomplete			
Step 12: Complete Enrollment Checklist							

![](_page_26_Picture_3.jpeg)

Click Add

![](_page_27_Picture_2.jpeg)

![](_page_27_Picture_3.jpeg)

Enter the required information, indicated by an asterisk (\*): Address, Zip Code, Phone Number, and Office Hours 

- Click Validate Address
- For Office Hours use the drop-down arrow to choose the correct times. open or choose "Closed"
- Click OK
  - Please Note: Location Type will always be Primary Practice Location.
  - Use your personal residential address for Primary Practice
  - When the Zip Code is added, and Validate Address is selected, the State, City/Town, and County will automatically fill in.

				341							
ication ID:				Name	:						
all locations, Correspondence address is requir	red. For Primary P	ractice Location, Pr	ay-To address is requi	red. Enter Remittance A	dvice address only to	receive a paper Remitta	ance Advice.				
Add Provider Location											
	Location 1 Doing Busines: If a dep If an att	Type: Primary Pra s As: partment or drawer ttention line is requi	number is required en ired, please enter the i	* ter the information in lin	ne TWO. (For example: EE. (For example: ATT)	DEPT 222 or DEPARTN	IENT 222, DRAWR	End Date: 1111 or DRAWER 1111)		)	
	Address Lin	ne 1:	*	(v)				Address Line 2:			
	Address Lin	ne 3:						City/Town:	OTHER	*	
	State/Provi	ince: OTHER	*					County:	OTHER	~	
	Cour	ntry: UNITED ST.	ATES 🗸 *					Zip Code:	· · ·	Validate Address	
	Phone Num	nber:	* intri					Fax Number:			
	Email Add	iress:						Web Page:	[		
_							Con	munication Preference:		~	_
		Pleas	e enter the hours your	office is open for each	day. If you are closed	on a given day select "(	Closed" in the "Op	en At" drop down.			
	Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM	
	Sunday:	*	AM * PM *	*	AM * PM *	Thursday:	*	AM * *	*	AM * PM *	
	Monday:	*	AM*	*	AM 🌲 *	Friday:	*	AM 🜲 *	*	AM *	
	Tuesday:	*	AM _ *	*	AM +	Saturday:	*	AM 🌲 *	*	AM*	
	Wednesday:	v *	AM *	<b>v</b> *	AM *						

![](_page_28_Picture_9.jpeg)

- Click Primary Practice Location
  - Please Note: You are still in Step 2: Add Locations.

1			Note Pad	🔇 External Links 🕶	★ My Favorites <del>-</del>	🖨 Print
> New Enrollment > Atypical Individual Enro	liment					
pplication ID:		Name:				
Close Add To add/modify Pay To	, Correspondence and Remittance Advice addresses, click on	Location Type hyperlink				
Locations List						
Filter By	© Go				Save Filt	ers 🔻 My
II     Locations List       Filter By     V       Doing Business As	C Go	Location Details			End Date	ers 🔻 My
Image: Control of the second secon	Location Type	Location Details			End Date	ers 🖣 My
	C Go Location Type	Location Details			End Date	ers 🖣 My

![](_page_29_Picture_4.jpeg)

Click Add Address

										Note Pad	External Links •	★ My Favor	ites 🕶 🚔 Print	
New Enrollment > Atypical Individual Enrollment > General														_
lication ID:				Name:										
Save To add additional addresses, click "A	dd Address" butto	on.												
Location Details														
Doing Business As:					Lo	cation Code: 1					Location Type:	Primary Practice L	Location	
Phone Number:		* Extn:				Fax Number:					Email Address:			
Web Page:										Communi	cation Preference:		·	
Г		Open At:	Please enter the hours	your office is open for each	h day. If you are clos	ed on a given day sel	ect "Clos	open At:	" drop down.	Close At-	AM/D	M	-	
	Day:	Open At.	AM	Close AL.	AM	-	Day:	Open At.	AM/PM	Close AL	*			
	Sunday:	Close V +	PM - *		PM - *	Thur	sday:	08.00 •	PM -	10.00 🗸	PM	*		
	Monday:	Close 🗸 *	AM + PM - *	*	AM ↓ PM ↓	F	riday:	Close v *	AM ÷ *	~	* AM PM	*		
	Tuesday:	Close 🗸 *	AM * *	*	AM *	Satu	urday:	Close v *	AM * *	~	* AM	÷ *		
	Wednesday:	Close 🗸 *	AM * *	*	AM _ *									
Handicap Accessible:	No v													
Accept 835(reported at EIN/TIN level):	No v				Languag	e(s) Spoken; Engli	ish 🔺							
					(For Multiple Selection	Arab on, use Ctrl Key) Chin	ic ese 🔻							
End Date:	12/31/2999	<b></b>												
Address List														
Add Address														
Address Type	Addre	:55									End	Date		
Location	**										12/3	1/2999		
Delete View Page: 1 O Go B Page	Count G Save to	Evcel				Viewing Page: 1						« First 《	Prev > Next	T B
Location	Count 🗹 Save to	Excel				Viewing Page: 1					12/3	1/2999 K First	Prev Next	

![](_page_30_Picture_3.jpeg)

- In the Type of Address dropdown menu, select
   Correspondence
  - Please note: Fill in the address where you would like to receive your Home Help mail.
- If the address is the same as the one entered previously, select Copy This Location Address next to Location Address

Click OK

🚔 Print 🛛 Help				
Application ID:	Name:			
III Add Provider Location Address				~
Type of Address:	SELECT V	End Date:	<b>i</b>	
Location Address:	OCopy This Location Address			
If a department or drawer numl required, please enter the infor	er is required enter the information in line TWO.(For example: DEPT 222 or DEF mation in Line THREE. (For example: ATTN: Billing Dept.)	ARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is		
Address Line 1:	(Enter Street Address or PO Bay Only)	Address Line 2:		
Address Line 3:		City/Town:	OTHER V*	
State/Province:	OTHER v *	County:	OTHER V	
Country:	UNITED STATES ¥	Zip Code:	* - Validate Address	
				✓ OK Scancel

![](_page_31_Picture_6.jpeg)

- Notice the Correspondence and Location now have addresses
- Click Add Address one more time to add a Pay To address

									Note Pad	😧 External Links 🕶	* My Favorites •	🖨 Print	
v Enrollment > Atypical Individual Enrollment > General													
ation ID:				Name:									
Save To add additional addresses, click "A	dd Address" butto	on.											
Location Details													
Doing Business As:					Location Code:	1				Location Type: P	rimary Practice Locat	ion	
Phone Number:		* Extn:			Fax Number:					Email Address:			
Web Page:									Communi	cation Preference:	~		
			Please enter the hours	your office is open for eac	h day. If you are closed on a given	day select "Clo	osed" in the "Open At	" drop down.					
Γ	Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM			
	Sunday:	Close 🗸 *	AM *	*	AM *	Thursday:	08:00 🗸 *	AM +	10:00 🗸	* AM A	*		
	Monday:	Close v *	AM ^	*	AM *	Friday:	Close v *	AM ^ *	~	* AM -			
	monday		PM -		PM -	, nady.		PM -		PM -			
	Tuesday:	Close 🗸 *	PM +	*	PM +	Saturday:	Close v *	PM +	~	* AM • PM •	*		
	Wednesday:	Close 🗸 *	AM _ *	*	AM _ *								
Handicap Accessible:	No 🗸												
Accept 925/reported at EIN/TIN Javaliy	Nov				Languago(c) Spokony	English							
Accept 855(reported at EIN/TIN level):					(For Multiple Selection, use Ctrl Key)	Arabic Chinese							
End Date:	12/31/2999				(								
End Date:	12/31/2999												
ddress List													
Address													
Iress Type		åddress								End	Date		
		A.¥								AT.			
respondence										12/31	1/2999		
ation										12/31	/2999		
elete View Page: 1 O Go Page	Count G Save to	Eveal			Viewing Page:	1					Il First & Draw	> Nevt	

![](_page_32_Picture_4.jpeg)

- From the Type of Address drop-down menu, select Pay To
- If the address is the same as the one entered previously, select Copy This Location Address next to the Location Address
- Click OK

🚔 Print 🛛 Help			
Application ID:	Name:		
III Add Provider Location Address			*
Type of Address:	SELECT V	End Date:	
Location Address:	Copy This Location Address		
If a department or drawer num	ber is required enter the information in line TWO.(For example: DEPT 222 or DEPART	IMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is	
required, please enter the info	mation in Line THREE. (For example: ATTN: Billing Dept.)		
Address Line 1:	*	Address Line 2:	
	(Enter Street Address or PO Box Only)		
Address Line 3:		City/Town:	
State/Province:	OTHER V*	County:	OTHER V
Country:	UNITED STATES V	Zip Code:	* - Validate Address
			Cancel

![](_page_33_Picture_5.jpeg)

- Notice the Correspondence, Location, and Pay To address types all have addresses
- Click Save
- Click Close on the next two screens to go back to the list of steps (not shown)

New Enrollment > Atypical Individual Enrollment > General									Note Pad	External Links •	★ My Fav	rorites 🛪 🚔	Print
oplication ID:				Name:									
Close Bave to add additional addresses, click "A	dd Address" butto	n.											
Location Details													
Doing Business As:	[				Location Code	: 1				Location Type: F	Primary Practic	e Location	
Phone Number:		* Extn:			Fax Number	:				Email Address:			
Web Page:									Communi	cation Preference:		~	
			Please enter the hours	your office is open for eac	ch day. If you are closed on a giver	n day select "Clo	sed" in the "Open At	" drop down.					
	Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PN	4		
	Sunday:	Close 🗸 *	AM *	~ *	AM *	Thursday:	08:00 🗸 *	AM + *	10:00 🗸	* AM	*		
	Monday:	Close v *	AM - *	*	AM ·	Friday	Close v *	AM -	~	* AM -			
	monday		PM -		PM -	( null)		PM -		PM -			
	Tuesday:	Close 🗸 *	PM +	*	PM +	Saturday:	Close v *	AM ↑ PM ↓	~	* AM · PM ·	*		
	Wednesday:	Close 🗸 *	AM *	*	AM *								
L			(100.20)		(* M* 15)								
Handicap Accessible:	No 🗸												
Accept 835(reported at EIN/TIN level):	No 🗸				Language(s) Spoken	: English Arabic							
					(For Multiple Selection, use Ctrl Key	) Chinese 🔽							
End Date:	12/31/2999												
Address List													
Add Address													
Address Type		Address								End	Date		
		¥.A.								A.A.			
Correspondence										12/3	1/2999		
Pay To										12/3	1/2999		
										12.0			

![](_page_34_Picture_5.jpeg)

• Click Step 3: Add Specialties

				Note Pad	🚱 External Links 🕶	★ My Favorites -	🖨 Print
New Enrollment > Atypical Individual Enrollment							
pplication ID:	Name:						
Close							
Enroll Provider - Atypical Individual							
		Business	Process Wizard - Provider E	Enrollment (Atypic	al Individual). Click	on the Step # unde	ar the Step
tep	Require	d Start Date	End Date	Status		Step Remark	
tep 1: Provider Basic Information	Required	01/04/2023	01/04/2023	Comple	te		
tep 2: Add Locations	Required	01/04/2023	01/04/2023	Comple	te		
tep 3: Add Specialties	Required	1		Incomp	lete		
tep 4: Associate Billing Provider/Other Associations	Optional			Incomp	lete		
tep 5: Add License/Certification/Other	Optional			Incomp	lete		
tep 6: Add Mode of Claim Submission/EDI Exchange	Required	1		Incomp	lete		
tep 7: Associate Billing Agent	Optional			Incomp	lete		
tep 8: Add Taxonomy Details	Optional			Incomp	lete		
tep 9: Associate MCO Plan	Optional			Incomp	lete		
tep 10: 835/ERA Enrollment Form	Optional			Incomp	lete		
tep 11: Upload Documents	Optional			Incomp	lete		
tep 12: Complete Enrollment Checklist	Required	1		Incomp	lete		
tep 13: Submit Enrollment Application for Approval	Required	1		Incomp	ete		

![](_page_35_Picture_3.jpeg)

Click Add

		🖺 Note Pad 🛛 😧 External Links 👻 🛧 My Favorites 👻 🚔 Print
New Enrollment > Atypical Individual Enrollment		
application ID:	Name:	
Close Add		
Specialty/Subspecialty List		
Filter By	O Go	🖺 Save Filters 🔻
Specialty/Subspecialty	Provider Type	End Date
_ △♥	47	۸Ÿ
	No Records Found !	

![](_page_36_Picture_3.jpeg)

- In the Provider Type dropdown menu, select Atypical Individual
- In the Specialty drop-down menu, select Home Help Individual
- Click **OK**

pplication ID:	Name:	
III Add Cassisty/Cubassisty		
and specialty/subspecialty		
	Location: 01- V *	
	Provider Type: ATYPICAL INDIVIDUAL V *	
	specialty: HOME HELP INDIVIDUAL 🗸 *	
	End Date:	
Add Subspecialty		
Add outspecially		
	Available Subspecialties Associated Subspecialties *	
	No Subspecialty	
	»	
	v v	

![](_page_37_Picture_5.jpeg)

Click Close

		🖺 Note Pad 🛛 🥥 External Links 👻 🛧 My Favorites 👻 🚔 Print
New Enrollment > Alypical Individual Enrollment		
Alication ID:	Name:	
Nose Add		
Specialty/Subspecialty List		
Specialty/Subspecialty List		Save Filters V M
Specialty/Subspecialty List	Provider Type	End Date
Specialty/Subspecialty List Filter By Specialty/Subspecialty Specialty/Subspecialty	Provider Type	End Date

![](_page_38_Picture_3.jpeg)

#### Step 12: Complete Enrollment Checklist

 Click Step 12: Complete Enrollment Checklist

					Note Pad	External Links •	★ My Favorites ▼	🖨 Print
> New Enrollment > Atypical Individual Enrollment								
pplication ID:	Name:							
Close								
Enroll Provider - Atypical Individual								
			Business Process	Wizard - Provider Enrollm	ent (Atypica	al Individual). Click o	on the Step # und	ier the Ster
Step	Re	quired Sta	art Date	End Date	Status		Step Remark	
Step 1: Provider Basic Information	Re	quired 01	/04/2023	01/04/2023	Complete	3		
Step 2: Add Locations	Re	quired 01	/04/2023	01/04/2023	Complete	3		
Step 3: Add Specialties	Re	quired 01	/04/2023	01/04/2023	Complete	•		
Step 4: Associate Billing Provider/Other Associations	Op	tional			Incomplet	te		
Step 5: Add License/Certification/Other	Op	tional			Complete	•		
Step 6: Add Mode of Claim Submission/EDI Exchange	Op	tional			Incomplet	te		
Step 7: Associate Billing Agent	Op	tional			Incomplet	te		
Step 8: Add Taxonomy Details	Op	tional			Incomplet	te		
Step 9: Associate MCO Plan	Op	tional			Incomplet	te		
Step 10: 835/ERA Enrollment Form	Op	tional			Incomple	te		
Step 11: Upload Documents	Op	tional			Incomple	te		
Step 12: Complete Enrollment Checklist	Re	quired			Incomple	te		

![](_page_39_Picture_3.jpeg)

#### Step 12: Complete Enrollment Checklist

- Answer all the Provider Checklist questions by choosing Yes or No from each drop-down menu in the Answer column. If an answer is required, choose Yes and put the answer in the Comments.
- Click Save.
- Click Close.
  - Please Note: The County Name, Worker Name, and Clients Name will need to be included in the comments box on the appropriate question

CHAMPS < Provider -						>
	e Pad 🛛 🤤	🕽 External Links 🕶	★ My Favo	rites <del>-</del>	🖨 Print	Help
A > New Enrollment > Atypical Individual Enrollment > Provider Check List						
Application ID: Name:						
O Clove Bave						
III Provider Checklist						^
Question		Answer		Cinme	ents	
47		A.A.		<b>A</b>		
Are you interested in working for other Home Help clients? (If you say no this will not affect your current work.)		Not Comp	leted	•		
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?		Not Comp	leted	•		
Do you want your name removed from our Provider Registry?		Not Comp	leted	•		
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.		Not Comp	leted	•		
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.		Not Comp	leted	•		
Have you ever had any criminal convictions? If yes, please tell us what for?		Not Comp	leted	•		
Are you providing services as a Business? If yes, what is the name of the business.		Not Comp	leted	•		
What county do you plan to work in?		Not Comp	leted	•		
What is the name of the Adult Services Worker (Clients Caseworker) you are working with? Please include their first and last name.		Not Comp	leted	~		
Are you a Medicare certified home health agency?		Not Comp	leted	~		
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 wi and MDHS staff, as well as any potential client.	th necessary I	MDC Not Comp	leted	•		
I also acknowledge that I am required to update any changes in the enrollment within 10 days of that change.		Not Comp	leted	~		
All providers are considered for the Beneficiary Monitoring Program. Do you object to this participation?		Not Comp	leted	~		
Do you have a client you plan to work for? If yes, what is your clients name?		Not Comp	leted	•		
View Page: 1 O Go Page Count Save to Excel			<b>«</b> First	Prev	Next 3	>> Last

![](_page_40_Picture_6.jpeg)

 Click Step 13: Submit Enrollment Application for Approval

				Note Pad	External Links •	★ My Favorites -	🖨 Print
New Enrollment > Atypical Individual Enrollment							
plication ID:	Name:						
Close							
Enroll Provider - Atypical Individual							
		Business	Process Wizard - Provider	Enrollment (Atypic	al Individual). Click	on the Step # unde	ar the Step
tep	Required	Start Date	End Date	Status		Step Remark	
lep 1: Provider Basic Information	Required	01/04/2023	01/04/2023	Comple	te		
lep 2: Add Locations	Required	01/04/2023	01/04/2023	Comple	te		
lep 3: Add Specialties	Required	01/04/2023	01/04/2023	Comple	te		
tep 4: Associate Billing Provider/Other Associations	Optional			Incomp	lete		
lep 5: Add License/Certification/Other	Optional			Comple	te		
tep 6: Add Mode of Claim Submission/EDI Exchange	Optional			Incomp	lete		
tep 7: Associate Billing Agent	Optional			Incomp	lete		
tep 8: Add Taxonomy Details	Optional			Incomp	lete		
tep 9: Associate MCO Plan	Optional			Incomp	lete		
ep 10: 835/ERA Enrollment Form	Optional			Incomp	lete		
ep 11: Upload Documents	Optional			Incomp	lete		
lep 12: Complete Enrollment Checklist	Required	01/04/2023	01/04/2023	Comple	te		
ing 42. Submit Equalment Application for Approximat	Required			Incomp	lata		

![](_page_41_Picture_3.jpeg)

 Click Next. By clicking the Next button, you "agree that the information submitted as part of the application is correct (Private and Confidential)"

CHAMPS < Provider -								
1				Note Pad	External Links •	★ My Favorites ▼	🖨 Print	🕑 He
> New Enrollment > Atypical Individual Enrollment								
pplication ID:		Name:						
Close > Next								
Final Submission								
	Application ID:		EnrollmentType	e: Atypical Indi	vidual Provider			
		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		Spacial Instructions			Required			
		apecial instructions	Source					
∆▼		Special first ductions ▲▼	source		<b>▲</b> ▼			
∆₹		AT No Records Found !			A7			
۵ <b>۲</b>		No Records Found !	Source ▲▼		۸Ÿ			
۵7		No Records Found !	Source ▲▼		AT			
۵۷		No Records Found !	¥. A.A.		۸Ţ			
۵۷		No Records Found !	Source ▲▼		۸Ÿ			
Δ¥		AV No Records Found !	Source ▲♥		٨٧			
Δ¥		AT No Records Found !	Source ▲♥		۸Ÿ			
Δ¥		No Records Found !	Source ▲▼		۸Ÿ			
Δ¥		No Records Found !	Source 4 ¥		47			
Δ¥		No Records Found !	Source AY		47			
Δ¥		No Records Found !	Source 47		47			
Δ¥		AV No Records Found !	Source		47			
ΔΨ		AV No Records Found !	Source AY		47			
ΔΨ		No Records Found !	Source		47			
ΔΥ		No Records Found !	Source		47			
Δ¥		No Records Found !	Source		47			

![](_page_42_Picture_3.jpeg)

- Read the Terms and Conditions Atypical Enrollment statement
- Check the box at the bottom of the page indicating you have read and agree to the terms
- Click Submit Application

CHAMPS	۲	rovider -	
1		🔓 Note Pad 🛛 external Links 🔹 🖈 My Favorites 🔹 🊔 Print 😜 Help	
# > New Enrollment	> Atypical I	Kual Enrolment	
Application ID:		Name:	
O Close O Subm	it Application	ter reading the Terms and Conditions be sure to check the agreement box located at the end of the document.	
III Terms an	d Condit <u>i</u>	s Atvoical Enrollment	
		(CHAMPS < Provider-	>
	1. As a	) Note Pad Qi External Links * ★ My Favorites * ≜ Print	8 Help
	2. As a	> New Enrollment > Atypical Individual Enrollment	
	3.1 ag	Annii-stion IP	
	4. Und issu		
	5.1 ag		
	6. l un	11. To properly identify and announce their presence at the entrance of the building at the specified pick-up location if a curbside pick-up is not appearent, or with attending facility staff.	1
	7. in 0	12. To assist the passengers in the process of being sealed, including the fastening of the seat belt, when necessitated by the rider's condition.	
	9. Upc	13. To confirm, prior to allowing any vehicle to proceed, that all passengers are properly secured in their seat belts, car seats, and, when applicable, that wheelchairs and passengers who use wheelchairs are properly secured (Exception: Only a passenger who has a letter, carried on his/her person and signed by the	
	10. l un	passenger's physician, staling that the passenger's medical condition prevents the rider from using a seat beit, may be transported without a fastened seat beit and then only as allowed by state law).	
	11. l ag	14. To provide an appropriate even of assistance to passengers, when requested, or when recessinged by a passengers of vinuous.	irs
	<b>12.</b> I ag	16. To act in a professional manner at all times while providence services.	
	13.1 ag	17. To be clean and maintain a neat appearance at all times.	
	14. I ag	18. To be polite and courteous to riders; riders shall be treated with respect and in a culturally appropriate manner when receiving transportation services. The Manager should notify the volunteer driver of any known cultural issues significant to providing transportation services.	
		19. To limit review of any confidential rider information to the minimum information necessary to provide the service.	
		20. To only use or record confidential rider information as necessary to provide the Department information necessary for the administration of the program (i.e. mileage reimbursement, if applicable).	
	Def	21. To not to relain any original or copy of any document rider shares with you for purposes of transport.	
	Cor	22. To not to relain any original or copy of any document that may be provided by a health care provider to driver. Driver agrees to ensure that such documentation leaves with rider.	
	Driv	23. To report any breach of the terms of this user agreement to the Department. This includes, but is not limited to, accidental relention of medical record or other confidential rider information.	
	Rid	24. To return to the Department, as soon as possible, but in no event later than 3 business days after discovery, any confidential rider information retained left with driver after completing transport of the rider.	
	Ser	25. To never discuss, write, or share in any other format any information specific to a rider, except as necessary to communicate with the Department or with a health care provider or other staff at a facility rider is being transported to.	
		26. Not input or include any confidential rider information in any computer system of any kind, except as approved by the Department. This includes personal email accounts, file transfer systems, note applications, and any other electronic system of recording data not expressly approved for use by the Department.	
		27. Comply with any other agreements driver has entered into with respect to this program.	
		28. Respect the rider's privacy by not asking for more information about the individual's condition, reason for visit, or other personal information, while providing transport services. If the rider chooses to voluntarily share this information, it is subject to the same protections described above regarding protecting rider information, while providing transport services. If the rider chooses to voluntarily share this information, it is subject to the same protections described above regarding protecting rider information, while providing transport services. If the rider chooses to voluntarily share this information, it is subject to the same protections described above regarding protecting rider information.	rmation.
		By checking this, I acknowledge that I have read the terms and agreement and I agree to fully comply with all program requirements.	
			•

![](_page_43_Picture_5.jpeg)

- If you have not taken note of your Application Number, please do so for tracking purposes
- Click Close and close out of the application

				Note Pad	External Links -	★ My Favorites ▼	🚔 Print
New Enrollment > Atypical Individual Enrollment							
lication ID:	Name:						
r Application Number has been successfully sub	mitted for State review. Return with this application number to track the status of your	application. ×					
Foroll Provider - Atypical Individual							
		Business	Process Wizard - Provider E	nrollment (Atypic	al Individual). Click	on the Step # unde	r the Step
p	Required	Start Date	End Date	Status		Step Remark	
p 1: Provider Basic Information	Required	01/04/2023	01/04/2023	Comple	te		
ep 2: Add Locations	Required	01/04/2023	01/04/2023	Comple	te		
p 3: Add Specialties	Required	01/04/2023	01/04/2023	Comple	te		
p 4: Associate Billing Provider/Other Associations	Optional			Incompl	ete		
p 5: Add License/Certification/Other	Optional			Comple	te		
p 6: Add Mode of Claim Submission/EDI Exchange	Optional			Incompl	ete		
p 7: Associate Billing Agent	Optional			Incompl	ete		
ep 8: Add Taxonomy Details	Optional			Incompl	ete		
p 9: Associate MCO Plan	Optional			Incompl	ete		
p 10: 835/ERA Enrollment Form	Optional			Incompl	ete		
	Optional			Incompl	ete		
p 11: Upload Documents				0	te.		
p 11: Upload Documents p 12: Complete Enrollment Checklist	Required	01/04/2023	01/04/2023	Comple	10		

![](_page_44_Picture_4.jpeg)

# How to track the status of your application

![](_page_45_Picture_2.jpeg)

- Open your web browser (e.g. Internet Explorer, Google Chrome, Mozilla Firefox, etc.)
- Enter
   <u>https://milogintp.Michigan.g</u>
   <u>ov</u> into the search bar
- Enter your User ID and Password and click **Login**

![](_page_46_Figure_4.jpeg)

![](_page_46_Picture_5.jpeg)

- You will be directed to the MILogin Home Page
- Click the CHAMPS hyperlink

BMich	Michigan.gov Help c											
MILog	MILogin for Third Party											
A HOME	🗄 REQUEST ACCESS	UPDATE PROFILE		CHANGE PASSWORD	► LOGOUT							
Your passy Access your app MDDHHS M CHAMPS	Hom word will expire in 43 day dications by clicking on the app ichigan Department	e Page s lication links below of Health & Human	Services (MDHHS)									

![](_page_47_Picture_4.jpeg)

 Click the 'Acknowledge/Agree' button to accept the Terms & Conditions to get into CHAMPS

	Terms & Conditions	
MILogin for Third	CHAMPS	
HOME & REQUEST ACCESS HOR X Your password will expire in 42 d Access your applications by dlicking on the a Michigan Department	Terms & Conditions The Michigan Department of Health & Human Services (MDHHS) computer information system (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 & Human Services computer information systems and clicking on the button below, I acknowledge and agree to abide by all governing privacy and security terms,	
CHAMPS	CANCEL * Acknowledge/Agree	

![](_page_48_Picture_3.jpeg)

- The Provider ID and Name will show in the top dropdown menu
- In the Select Profile dropdown menu, select Atypical Access
- Click Go

![](_page_49_Picture_4.jpeg)

![](_page_49_Picture_5.jpeg)

 To check the status of your application, from the CHAMPS Homepage click the Track Application hyperlink

CHAMPS < Provider -							>
<b>1</b>			Note Pad	External Links <del>-</del>	★ My Favorites -	🖨 Print	Help
III Provider Enrollment							^
	New Enrollment	Enroll As A New Provider					
	Track Application	Track Existing Provider Application					

![](_page_50_Picture_3.jpeg)

- Enter your Application ID
- Click Next

![](_page_51_Picture_3.jpeg)

![](_page_51_Picture_4.jpeg)

- Enter your Social Security
   Number, Date of Birth and
   Home Zip Code
- Click **Submit**

CHAMPS < Provider -						
		🖺 Note Pad	External Links •	★ My Favorites ▼	🖨 Print	<b>9</b> H
Track Application						
lose Submit						
Verify Application Details						
	For Additional security please enter following information					
	SSN: ***********************************					
	Home Zip Code:					

![](_page_52_Picture_4.jpeg)

 A text box at the top will confirm the status of your application. If you do not see this statement, you have not completed and submitted the application to the state for review. Please complete all required steps to submit.

1					🕒 Note Pad 🛛 🚷	External Links -	★ My Favorites -	🚔 Print	9
Track Application > Atypi	ical Individual Enrollment								
pplication ID:		Name:							
Your application is co	urrently In-Review by the Provider Enrollment Unit, You cannot n	nake any modifications to your enrollment information at this time.							
	,								
Close									
Enroll Provider	- Atypical Individual								
			Business P	rocess Wizard - Provider Fru	rollment (Atypical I	ndividual) Clic	k on the Step # un	der the Ste	en (
tep		Required	Start Date	End Date	Status		Step Remark		
tep 1: Provider Basic Inform	nation	Required	01/04/2023	01/04/2023	Complete				
tep 2: Add Locations		Required	01/04/2023	01/04/2023	Complete				
tep 3: Add Specialties		Required	01/04/2023	01/04/2023	Complete				
tep 4: Associate Billing Prov	vider/Other Associations	Optional			Incomplete				
tep 5: Add License/Certifica	ation/Other	Optional			Complete				
	Submission/EDI Exchange	Optional			Incomplete	1			
tep 6: Add Mode of Claim S	ent	Optional			Incomplete				
tep 6: Add Mode of Claim S tep 7: Associate Billing Age		Optional			Incomplete				
tep 6: Add Mode of Claim S tep 7: Associate Billing Age tep 8: Add Taxonomy Detail	is				Incomplete				
Itep 6: Add Mode of Claim S Itep 7: Associate Billing Age Itep 8: Add Taxonomy Detail	15	Optional			Incomplete				
itep 6: Add Mode of Claim S itep 7: Associate Billing Age itep 8: Add Taxonomy Detail itep 9: Associate MCO Plan itep 10: 835/ERA Enrollmen	rs I It Form	Optional Optional							
itep 6: Add Mode of Claim S itep 7: Associate Billing Age itep 8: Add Taxonomy Detail itep 9: Associate MCO Plan itep 10: 835/ERA Enrollmen itep 11: Upload Documents	is ) It Form	Optional Optional Optional			Incomplete	•			
Itep 6: Add Mode of Claim S Itep 7: Associate Billing Age Itep 8: Add Taxonomy Detail Itep 9: Associate MCO Plan Itep 10: 835/ERA Enrollmen Itep 11: Upload Documents Itep 12: Complete Enrollmen	s t Form nt Checklist	Optional Optional Optional Required	01/04/2023	01/04/2023	Incomplete	•			

![](_page_53_Picture_3.jpeg)

Application Approved

#### Once the Application is Approved:

- Providers will receive an approval letter. The approval letter will go to the Correspondence Address you provided.
- You will be able to access CHAMPS to submit your Electronic Service Verification (ESV) Log.
- To learn how to record your services, see the Electronic Service Verification (ESV) Log Instructions at: <u>https://www.michigan.gov/mdhhs/-</u> /media/Project/Websites/mdhhs/Folder1/Folder2/F older1/ESV\_Instructions\_04012022.pdf

![](_page_54_Picture_5.jpeg)

![](_page_55_Picture_0.jpeg)

MDHHS Home Help Provider website: www.Michigan.gov/HomeHelp

### Provider Resources

![](_page_55_Picture_3.jpeg)

### **Provider Support:**

ProviderSupport@Michigan.gov

1-800-979-4662

![](_page_55_Picture_7.jpeg)

Thank you for participating in the Michigan Medicaid Program

![](_page_55_Picture_9.jpeg)