



Michigan Department of Health & Human Services

# New Individual Home Help Provider Associating to an Agency 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 associated with an Agency:
  - 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

\*\*\*An approved direct care worker that provides personal care services to an MDHHS Home Help Client is called an Agency Caregiver.\*\*\*

Call the Provider Support Helpline if you need assistance:  
**1-800-979-4662**

# Register for MILogin and CHAMPS

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

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

# MILogin for Third Party

User ID

Password

LOGIN

Don't have an account?

 SIGN UP

Forgot your User ID?

Forgot your password?

Need Help?

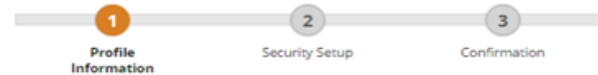
Copyright 2015-2019 State of Michigan

- Open your web browser (e.g. Internet Explorer, Google Chrome, Mozilla Firefox, etc.)
- Enter <https://milogintp.Michigan.gov> into the search bar
- Click **Sign Up**

# MILogin for Third Party

[HOME](#)

## Create Your Account



### Profile Information

Enter your profile information

\* Required

\* First Name

Middle Initial

\* Last Name

Suffix

\* Email Address

\* Confirm Email Address

\* Work Phone Number

Mobile Number

\* Verification Question: Bee, chin, ankle, leg and dog: how many body parts in the list?

I agree to the terms & conditions.

NEXT

RESET

- Complete all required fields
- Check the 'I agree' box
- Click **Next**

# MI Login for Third Party

[HOME](#)

## Create Your Account



### Security Setup

Provide user id and password information to complete your profile

\* Required

\* User ID

\* Password

\* Confirm New Password

### \* Security Options

To choose your preferred password recovery method(s), please click on the buttons below. Multiple options can be selected.



**i 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 (IS#,%@~^&\* \_-+=><)
- Should not be one of the last 3 used passwords
- Should not be based on your User ID

- Create the user ID and password following the listed guidelines
- Select the preferred password recovery method(s)
- Click **Create Account**

# MILogin for Third Party

[HOME](#)

## Create your account



## Confirmation

✓ Success

Your account has been successfully created.

**LOGIN**

- Your MILogin account has now been created successfully
- Click the **Login** button to return to the login screen

# MILogin for Third Party

User ID

Password

**LOGIN**

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

**SIGN UP**

[Forgot your User ID?](#)

[Forgot your password?](#)

[Need Help?](#)

Copyright 2015-2019 State of Michigan


- Enter your User ID and Password you just created
- Click **Login**



# MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

## Home Page

 Your password will expire in **364** days

Access your applications by clicking on the application links below

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You do not have access to any application. You can request access by clicking on [Request Access](#) link.

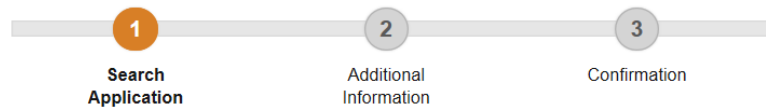
- Your Home Page will not show any applications
- Click **Request Access**

*\*MILogin resource links are listed at the bottom of the page*

# MIlogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

## Request Access



## Search Application

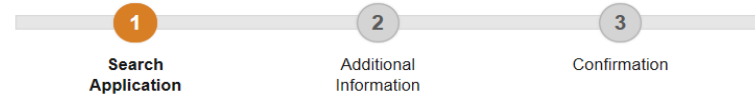
Search for an application with a keyword or select an agency to view its applications

- Type CHAMPS in the search box
- Click the search/magnifying button

# MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

## Request Access



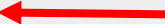
## Search Application

Search for an application with a keyword or select an agency to view its applications



Michigan Department of Health & Human Services (MDHHS)

CHAMPS



- Click on **CHAMPS**

**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.

General 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

I agree to the terms & conditions

I do not agree

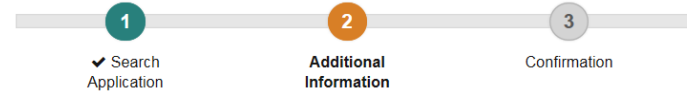
**CANCEL** **REQUEST ACCESS**

- Select the 'I agree to the terms & conditions' radio button
- Click **Request Access**

# MI Login for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

## Request Access



## Additional Information

Provide following information to submit your access request

\* Required

\* Email Address

\* Work Phone Number

\* CHAMPS User Type

- Provider/Other
- State User Only

**SUBMIT**

RESET



- Verify all information is correct
- Click **Submit**

# MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

## Request Access

1

✓ Search  
Application

2

✓ Additional  
Information

3

Confirmation

## Confirmation

### ✓ Success

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.

[HOME](#)

- You will be given confirmation that your request has been submitted successfully
- Click the **Home** button to return to the MILogin Home Page

# MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

## Home Page

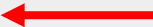
⌚ Your password will expire in **48** days

Access your applications by clicking on the application links below



Michigan Department of Health & Human Services (MDHHS)

CHAMPS



- You will be directed back to your MILogin Home Page. You will need to log out completely and log back in for CHAMPS to appear.
- Click the **CHAMPS** hyperlink.

Michigan.gov

HELP CONTACT US

## Terms & Conditions

### CHAMPS

**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,

**CANCEL** ✕ **Acknowledge/Agree**

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



## Provider Enrollment

[New Enrollment](#)

Enroll As A New Provider

[Track Application](#)

Track Existing Provider Application

- Click on **New Enrollment**.



Provider ▾



Note Pad

External Links ▾

My Favorites ▾

Print

Help

Home > New Enrollment

### Enrollment Type

Select the Applicable Enrollment Type

- Individual/Sole Proprietor
  - Regular Individual/Sole Proprietor or Rendering/Service Provider
- Group Practice (Corporation, Partnership, LLC, etc.)
- Billing Agent
- Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)
- 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, Local Education Agency etc.)

Submit

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

Basic Information: Enter required fields and click Confirm button.

**Basic Information**

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

Middle Initial:   
 Gender:    
 Vendor ID:

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**

Please ensure you are providing the home address of this provider. Failure to do so may result in this application/modification being denied.

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:  -

- 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.**

Application ID: [redacted]

Name: Test,Test

Basic Information

You have successfully completed the basic information on the Enrollment Application.

Your Application ID is: [redacted]

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.

✓ Ok

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

Application ID: Name:

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
<a href="#">Step 1: Provider Basic Information</a>	Required	04/25/2018	04/25/2018	Complete	
<b><a href="#">Step 2: Add Locations</a></b>	Required	04/25/2018		Incomplete	Please add/validate Location.
Step 3: Add Specialties	Required			Incomplete	
Step 4: Associate Billing Provider	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 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: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1 Go Page Count SaveToXLS

Viewing Page: 1

First Prev Next Last

- Click **Step 2: Add Locations**.

Application ID:  Name:   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"/> ▲▼	▲▼	▲▼	▲▼
No Records Found !			

- Click **Add**.

Application ID: \_\_\_\_\_ Name: \_\_\_\_\_

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

**Add Provider Location**

Location Type: Primary Practice Location \*

Doing Business As: \_\_\_\_\_ End Date: \_\_\_\_\_

If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, 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: \_\_\_\_\_ \*  
(Enter Street Address or PO Box Only)

Address Line 2: \_\_\_\_\_

Address Line 3: \_\_\_\_\_

City/Town: OTHER \*  
\_\_\_\_\_

State/Province: OTHER \*  
\_\_\_\_\_

County: OTHER \*  
\_\_\_\_\_

Country: UNITED STATES \*

Zip Code: \_\_\_\_\_ - \_\_\_\_\_ \* Validate Address

Phone Number: \_\_\_\_\_ \* Extn: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Web Page: \_\_\_\_\_

Communication Preference: \_\_\_\_\_

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open 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/PM *	_____ *	AM/PM *
Monday:	_____ *	AM/PM *	_____ *	AM/PM *	Friday:	_____ *	AM/PM *	_____ *	AM/PM *
Tuesday:	_____ *	AM/PM *	_____ *	AM/PM *	Saturday:	_____ *	AM/PM *	_____ *	AM/PM *
Wednesday:	_____ *	AM/PM *	_____ *	AM/PM *					

Handicap Accessible: No

Accept 835 (reported at EIN/TIN level): No

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

OK Cancel

- Enter the required information, indicated by an asterik (\*): Address, Zip Code, Phone Number and Office Hours.
- Click **Validate Address**.
- For **Office Hours**-use the drop-down arrow to chose the correct times. Make sure to select the hours you are open or choose "Closed".
- Click **OK**.

Please Note: **Location Type** will always be *Primary Practice Location*.

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

When the **Zip Code** is added, and **Validate Address** is selected, the **State, City/Town, and County** will automatically fill in.

Application ID:  Name:   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"/> ▲▼	▲▼	▲▼	▲▼
<input type="checkbox"/>	<a href="#">Primary Practice Location</a>	<input type="text"/>	12/31/2999

View Page:     Viewing Page: 1

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



Application ID: [redacted]

Name: [redacted]

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

## Location Details

Doing Business As: [redacted]

Location Code: 1

Location Type: Primary Practice Location

Phone Number: [redacted] \* Extn: [redacted]

Fax Number: [redacted]

Email Address: [redacted]

Web Page: [redacted]

Communication Preference: [dropdown]

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Close	AM PM	[dropdown]	AM PM	Thursday:	Close	AM PM	[dropdown]	AM PM
Monday:	Close	AM PM	[dropdown]	AM PM	Friday:	01:00	AM PM	02:00	AM PM
Tuesday:	Close	AM PM	[dropdown]	AM PM	Saturday:	Close	AM PM	[dropdown]	AM PM
Wednesday:	Close	AM PM	[dropdown]	AM PM					

Handicap Accessible: No

Accept 835 (reported at EIN/TIN level): No

Language(s) Spoken: English  
Arabic  
Chinese

End Date: 12/31/2999

## Address List

Address Type	Address	End Date
[dropdown]	[redacted]	12/31/2999

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

- Click **Add Address**.

Application ID: Name: 

## Add Provider Location Address

Type of Address: --SELECT--

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:  \*

(Enter Street Address or PO Box Only)

Address Line 3: State/Province: OTHER  \*Country: UNITED STATES  \*Address Line 2: City/Town: OTHER  \*County: OTHER Zip Code:  \* -   

- In the **Type of Address** drop-down 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**.

Application ID: [redacted]

Name: [redacted]

[Close](#) [Save](#) To add additional addresses, click "Add Address" button.

Preference:

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Close	AM PM		AM PM	Thursday:	Close	AM PM		AM PM
Monday:	Close	AM PM		AM PM	Friday:	08:00	AM PM	09:00	AM PM
Tuesday:	Close	AM PM		AM PM	Saturday:	Close	AM PM		AM PM
Wednesday:	Close	AM PM		AM PM					

Handicap Accessible: No

Accept 835(reported at EIN/TIN level): No

Language(s) Spoken: English

(For Multiple Selection, use Ctrl Key)

End Date: 12/31/2999

## Address List

[Add Address](#)

Address Type	Address	End Date
<input type="checkbox"/> Correspondence	[redacted]	12/31/2999
<input type="checkbox"/> Location	[redacted]	12/31/2999

Viewing Page: 1

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

Application ID: Name: 

## Add Provider Location Address

Type of Address: --SELECT--

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:  \*

(Enter Street Address or PO Box Only)

Address Line 3: State/Province: OTHER  \*Country: UNITED STATES  \*Address Line 2: City/Town: OTHER  \*County: OTHER Zip Code:  \* -   

- 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**.

Application ID: \_\_\_\_\_ Name: \_\_\_\_\_

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

**Location Details**

Doing Business As: \_\_\_\_\_

Location Code: 1

Location Type: Primary Practice Location

Phone Number: \_\_\_\_\_ \* Extn: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Web Page: \_\_\_\_\_

Communication Preference: \_\_\_\_\_

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

Day:	Open At:	AM/PM	Close At:	AM/PM	Day:	Open At:	AM/PM	Close At:	AM/PM
Sunday:	Close *	AM PM *	Close *	AM PM *	Thursday:	Close *	AM PM *	Close *	AM PM *
Monday:	Close *	AM PM *	Close *	AM PM *	Friday:	01:00 *	AM PM *	02:00 *	AM PM *
Tuesday:	Close *	AM PM *	Close *	AM PM *	Saturday:	Close *	AM PM *	Close *	AM PM *
Wednesday:	Close *	AM PM *	Close *	AM PM *					

Handicap Accessible: No

Accept 835(reported at EIN/TIN level): No

Language(s) Spoken: English

(For Multiple Selection, use Ctrl Key)

End Date: 12/31/2999

**Address List**


Address Type	Address	End Date
<input type="checkbox"/> Correspondence	_____	12/31/2999
<input type="checkbox"/> Location	_____	12/31/2999
<input type="checkbox"/> Pay To	_____	12/31/2999

 View Page: 1   

Viewing Page: 1

- 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).

Application ID: [Redacted]

Name: [Redacted]

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
<a href="#">Step 1: Provider Basic Information</a>	Required	05/01/2018	05/01/2018	Complete	
<a href="#">Step 2: Add Locations</a>	Required	05/01/2018	05/01/2018	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	05/01/2018		Incomplete	Please add required specialties.
Step 4: Associate Billing Provider	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 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: Upload Documents	Optional			Incomplete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	
Step 14: Submit Enrollment Application for Approval	Required			Incomplete	

View Page: 1   

Viewing Page: 1

- Click **Step 3: Add Specialties**.

Application ID: Name: 

Close

Add

## Specialty/Subspecialty List

Filter By



Go

Save Filters

My Filters ▾

Specialty/Subspecialty

Provider Type

End Date



No Records Found !

- Click **Add**.


Application ID:  Name:

Add Specialty/Subspecialty

Location: 01-  \*

Provider Type: ATYPICAL INDIVIDUAL  \*

Specialty: HOME HELP INDIVIDUAL  \*

End Date:  

Add Subspecialty

Available Subspecialties

Associated Subspecialties \*

»

«

No Subspecialty

OK Cancel

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



Application ID: Name: 

## Specialty/Subspecialty List

Filter By



Specialty/Subspecialty

Provider Type

End Date



▲▼

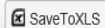
▲▼

▲▼

 HOME HELP INDIVIDUAL/No Subspecialty

ATYPICAL INDIVIDUAL

12/31/2999

View Page: 

Viewing Page: 1

- Click **Close**.

Provider ID:  Name:

View/Update Provider Data - Atypical Individual

Business Process Wizard - Provider Data Modification (Atypical Individual)

<input type="checkbox"/> Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	12/15/2015	12/15/2015	Complete		
<input type="checkbox"/> Step 2: Locations	Required	05/30/2018	06/05/2018	Complete		
<input type="checkbox"/> Step 3: Specialties	Required	12/15/2015	12/15/2015	Complete		
<input type="checkbox"/> Step 4: Associate Billing Provider/Other Associations	Optional	06/22/2018	06/22/2018	Complete		
<input type="checkbox"/> Step 5: License/Certification/Other	Optional	12/15/2015	12/15/2015	Complete		
<input type="checkbox"/> Step 6: Mode of Claim Submission/EDI Exchange	Optional	12/15/2015	12/15/2015	Complete		
<input type="checkbox"/> Step 7: Associate Billing Agent	Optional	12/15/2015	12/15/2015	Complete		
<input type="checkbox"/> Step 8: Provider Controlling Interest/Ownership Details	Required	06/22/2018	12/15/2015	Complete		
<input type="checkbox"/> Step 9: Taxonomy Details	Optional	12/15/2015	12/15/2015	Complete		
<input type="checkbox"/> Step 10: View Servicing Provider Details	Optional	12/15/2015	12/15/2015	Complete		
<input type="checkbox"/> Step 11: Associate MCO Plan	Optional	12/15/2015	12/15/2015	Complete		
<input type="checkbox"/> Step 12: 835/ERA Enrollment Form	Optional	12/15/2015	12/15/2015	Incomplete		
<input type="checkbox"/> Step 13: Upload Documents	Optional	12/23/2017	12/23/2017	Complete		
<input type="checkbox"/> Step 14: Complete Modification Checklist	Required	06/22/2018	06/22/2018	Incomplete		
<input type="checkbox"/> Step 15: Submit Modification Request for Review	Required	06/22/2018	06/22/2018	Complete		

View Page:

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- Click **Step 4: Associate Billing Provider/Other Associations**.

Provider ID:  Name:

☰ Billing Provider/Other Associations List ▲

Filter By ▾   And Filter By ▾   And Operational Status Active ▾

NPI/Provider ID ▲▼	Provider Name ▲▼	Start Date ▲▼	End Date ▲▼	Status ▲▼	Operational Status ▲▼	Inactivation Date ▲▼
--------------------	------------------	---------------	-------------	-----------	-----------------------	----------------------

No Records Found !

- Click **Add**.

Provider ID:  Name:

Associate Billing Provider/Other Associations

Enter NPI/Provider ID of Billing Provider/Other Associations and click "Confirm Provider."

Type:   \*

ID:  \*

Start Date:   \*

Provider Name:

End Date:

- In the **Type** drop-down menu, click **Provider ID**.
- Enter **Provider ID of Agency**.
- **Start date** would be the current date.
- Click **Confirm Provider**.
- Click **OK**.
- Click **Close** (not shown).

Application ID: Name: 

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
<a href="#">Step 1: Provider Basic Information</a>	Required	05/01/2018	05/01/2018	Complete	
<a href="#">Step 2: Add Locations</a>	Required	05/01/2018	05/01/2018	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	05/01/2018	05/01/2018	Complete	
<a href="#">Step 4: Associate Billing Provider</a>	Optional	05/01/2018	05/01/2018	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Optional			Incomplete	
<a href="#">Step 6: Add Mode of Claim Submission/EDI Exchange</a>	Optional			Incomplete	
<a href="#">Step 7: Associate Billing Agent</a>	Optional			Incomplete	
<a href="#">Step 8: Add Provider Controlling Interest/Ownership Details</a>	Required			Incomplete	
<a href="#">Step 9: Add Taxonomy Details</a>	Optional			Incomplete	
<a href="#">Step 10: Associate MCO Plan</a>	Optional			Incomplete	
<a href="#">Step 11: 835/ERA Enrollment Form</a>	Optional			Incomplete	
<a href="#">Step 12: Upload Documents</a>	Optional			Incomplete	
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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Last

- Click **Step 8: Add Provider Controlling Interest/Ownership Details**.  
Please Note: Step 5-7 are optional and are not required for Home Help Providers.

Application ID:

Name: Individual, Test

Close

Actions

Add Owner

Import Owner

Owners Adverse Action

Filter By

And

Go

Save Filters

My Filters

Owner	Owners Relationships	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/>	Individual, Test	Individual	320 S Walnut St	11/21/2018	12/31/2999	Completed	Not Completed	100	

Delete

View Page: 1

Go

Page Count

SaveToXLS

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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 !

- In the **Actions** drop-down menu, select **Add Owner**.

Print Help

Application ID: \_\_\_\_\_ Name: \_\_\_\_\_

**Provider Controlling Interest/Ownership**

Type:  \* ⓘ

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:

Please ensure you are providing the home address of this provider. Failure to do so may result in this application/modification being denied.

Address Type: Home Address

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

Address Line 2:

Address Line 3:

City/Town:  \*

State/Province:  \*

County:  \*

Country:  \*

Zip Code:  -  \*

- In the **Type** drop-down menu, select **Managing Employee**. The **Managing Employee** can be the same as the **Owner**.
- Enter the required information: *SSN, Percentage Owned, First Name, Last Name, DOB, Phone Number, Start Date, Address, Zip Code*.
- Click **Validate Address**.
- Click **OK**.

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

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

When the **Zip Code** is added, and **Validate Address** is selected, the **State, City/Town, and County** will automatically fill in.

Application ID: [redacted] Name: Individual, Test

Close + Actions

Add Owner

Import Owner

Owners Relationships

Filter By [ ] And [ ] Go Save Filters My Filters

Owner	Owners Adverse Action	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/>		Individual, Test	Individual	320 S Walnut St	11/21/2018	12/31/2999	Not Completed	Not Completed	100
<input type="checkbox"/>		Two, Individual	Managing Employee	100 N Capital Ave	11/21/2018	12/31/2999	Not Completed	Not Completed	0

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
<input type="checkbox"/>		

No Records Found !

Please Note: Managing Employee will now be listed

- In the **Actions** drop-down menu, select **Owners Relationships**.



Application ID: [ ] Name: Individual, Test

**Add Relationship**

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?  Yes  No (Click Save to update)

**Owner List**

Show Owners: All [v] [Go] Save Filters My Filters [v]

Selected Owner: Individual, Test SSN/EIN/TIN: [ ] Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Individual, Test	Relation to Assoc. Owner
Sample, Example	[ ]	Managing Employee	[v]	[v]
Individual, Test	[ ]	Individual	[v]	None [v]

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Selected Owner: Sample, Example SSN/EIN/TIN: [ ] Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- Answer question (at the top)
- If no relationships exist select **No**, click Save, read the pop-up message, click Ok, and Close.
  - Skip to [slide 47](#)
- If relationships exist select **Yes**, and continue

CHAMPS Provider

Application ID: [Redacted] Name: Individual, Test

**Add Relationship**

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?  Yes  No (Click Save to update)

**Owner List**

Show Owners All [Go] Save Filters My Filters

Selected Owner: Individual, Test SSN/EIN/TIN: [Redacted] Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Individual, Test	Relation to Assoc. Owner
Sample, Example	[Redacted]	Managing Employee	[Dropdown]	[Dropdown]
Individual, Test	[Redacted]	Individual	[Dropdown]	None [Dropdown]

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

Selected Owner: Sample, Example SSN/EIN/TIN: [Redacted] Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- If Yes, select the relationship between the Assoc. Owner to the Selected Owner (e.g., the relationship to the individual enrolling, Test Individual, from the Assoc. Owner, Sample, Example or Individual Test) [Assoc. Owner → Selected Owner]
- To add the relationship click the dropdown menu

CHAMPS Provider

https://milogintpmichigan.gov/ - Welcome to MMIS - Internet Explorer

Print Help

Application ID [redacted] Name: Individual, Test

**Add Relationship**

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?  Yes  No (Click Save to update)

**Owner List**

Show Owners All [dropdown] Go [button] Save Filters My Filters [dropdown]

**Selected Owner: Individual, Test** SSN/EIN/TIN: [redacted] Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Individual, Test	Relation to Assoc. Owner
Sample, Example	[redacted]	Managing Employee	[dropdown menu]	[dropdown]
Individual, Test	[redacted]	Individual	[dropdown]	None [dropdown]

View Page: 1 Go Page Count SaveToXLS

Selected Owner: Sample, Example SSN/EIN/TIN: [redacted] Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- Step 1: Select the relationship between the **Assoc. Owner** (example: Sample, Example) to the **Selected Owner** (example: Individual, Test) [Assoc. Owner → Selected Owner]

CHAMPS Provider

https://milogintpa.michigan.gov/ - Welcome to MMIS - Internet Explorer

Application ID: [Redacted] Name: Individual, Test

**Add Relationship**

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?  Yes  No (Click Save to update)

**Owner List**

Show Owners All [Go] Save Filters My Filters

Selected Owner: Individual, Test SSN/EIN/TIN: [Redacted] Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Individual, Test	Relation to Assoc. Owner
Sample, Example	[Redacted]	Managing Employee	Spouse	[Dropdown Menu]
Individual, Test	[Redacted]	Individual	[Dropdown Menu]	

View Page: 1 [Go] Page Count SaveToXLS Viewing Page: 1

Selected Owner: Sample, Example SSN/EIN/TIN: [Redacted] Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- Step 2: Select the relationship between the **Selected Owner** (example: Individual, Test) to the **Assoc. Owner** (example: Sample, Example) [Selected Owner → Assoc. Owner]
  - In this example the relationship of Selected Owner and Assoc. Owner are spouses

CHAMPS Provider

Application ID: [Redacted] Name: Individual, Test

**Add Relationship**

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?  Yes  No (Click Save to update)

**Owner List**

Show Owners All [Go] Save Filters My Filters

Selected Owner: Individual, Test SSN/EIN/TIN: [Redacted] Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Individual, Test	Relation to Assoc. Owner
Sample, Example	[Redacted]	Managing Employee	Spouse	Spouse
Individual, Test	[Redacted]	Individual	[Redacted]	[Redacted]

View Page: 1 [Go] Page Count SaveToXLS Viewing Page: 1

Selected Owner: Sample, Example SSN/EIN/TIN: [Redacted] Status: Not Completed

Save Close

Page ID: dlgAddModifyOwnerRelationship(Provider)

- Select the relationship between the **Selected Owner** (example: Individual, Test) to the **Assoc. Owner** (example: Individual, Test) [Selected Owner → Assoc. Owner]
  - In this example the relationship of Selected Owner to Assoc. Owner is self

Application ID: [redacted] Name: Individual, Test

## Add Relationship

 Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?  Yes  No (Click Save to update)

## Owner List

Show Owners All ▾ Go

Save Filters My Filters ▾

Selected Owner: Individual, Test SSN/EIN/TIN: [redacted] Status: Not Completed

Assoc. Owner	SSN/EIN/TIN	Type	Relation to Individual, Test	Relation to Assoc. Owner
Sample, Example	[redacted]	Managing Employee	Spouse ▾	Spouse ▾
Individual, Test	[redacted]	Individual	▾	Self ▾

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Selected Owner: Sample, Example SSN/EIN/TIN: [redacted] Status: Not Completed

Save Close

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

Application ID:

Name: Individual, Test

Close

Actions

 Add Owner  
 Import Owner  
 Owners Relationships

Owners Adverse Action

Owner	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/>	individual, Test	Individual	320 S Walnut St	11/21/2018	12/31/2999	Completed	Not Completed	100
<input type="checkbox"/>	Two, Individual	Managing Employee	100 N Capitol Ave	11/21/2018	12/31/2999	Completed	Not Completed	0

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

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

Please Note: The **Relationship Status** shows completed for each Owner.

- In the **Actions** drop-down menu, select **Owners Adverse Action**.

CHAMPS Provider

Application ID: [Redacted] Name: Individual, Test

### 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 reevaluation 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 or recipients. Offenses include, but are not limited to: 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 misdemeanor or felonies that may result in a mandatory or permissive exclusion under State or Federal law.
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.

#### FINAL ADVERSE LEGAL ACTION/CONVICTION ACTION HISTORY

Do any of the owners, under any current or former name or business identity, ever had a final adverse legal action listed above imposed against them? Please answer in the 'Owners with Adverse Action' section below for each owner.

Owner Name	Response	Comments
Two, Individual	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>
Individual, Test	<input type="radio"/> Yes <input type="radio"/> No	<input type="text"/>

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Page ID: pgEnrImntAdverseAction(Provider)

OK Cancel

- Read the **Final Adverse Legal Actions/Convictions** statement.
- Answer the questions at the bottom by choosing **Yes** or **No** and comment if necessary.
- Click **OK**.



Application ID:

Name: Individual, Test

Close

Actions



## Owners List

Filter By





And



Go

Save Filters

My Filters

Owner SSN/EIN/TIN	Owner Information	Owner Type	Address	Start Date	End Date	Relationship Status	Adverse Action	Percentage owned
<input type="checkbox"/> ▲▼	individual, Test	Individual	320 S Walnut St	11/21/2018	12/31/2999	Completed	No	100
<input type="checkbox"/> ▲▼	Two, Individual	Managing Employee	100 N Capitol Ave	11/21/2018	12/31/2999	Completed	No	0



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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 !

- The Adverse Action column will show Yes or No indicating it's complete.
- Click **Close**.

Application ID :  Name 

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
<a href="#">Step 1: Provider Basic Information</a>	Required	05/04/2018	05/04/2018	Complete	
<a href="#">Step 2: Add Locations</a>	Required	05/04/2018	05/04/2018	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	05/04/2018	05/04/2018	Complete	
<a href="#">Step 4: Associate Billing Provider</a>	Optional	05/04/2018	05/04/2018	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Optional			Incomplete	
<a href="#">Step 6: Add Mode of Claim Submission/EDI Exchange</a>	Optional			Incomplete	
<a href="#">Step 7: Associate Billing Agent</a>	Optional			Incomplete	
<a href="#">Step 8: Add Provider Controlling Interest/Ownership Details</a>	Required	05/04/2018	05/04/2018	Complete	
<a href="#">Step 9: Add Taxonomy Details</a>	Optional			Incomplete	
<a href="#">Step 10: Associate MCO Plan</a>	Optional			Incomplete	
<a href="#">Step 11: 835/ERA Enrollment Form</a>	Optional			Incomplete	
<a href="#">Step 12: Upload Documents</a>	Optional			Incomplete	
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required			Incomplete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

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- Click **Step 13: Complete Enrollment Checklist**.

CHAMPS Provider

Application ID: \_\_\_\_\_ Name: \_\_\_\_\_

Close Save

### Provider Checklist

Question	Answer	Comments
Are you interested in working for other Home Help clients? (If you say no this will not affect your current work.)	Not Completed	
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 Completed	
Do you want your name removed from our Provider Registry?	Not Completed	
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 Completed	
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 Completed	
Have you ever had any criminal convictions? If yes, please tell us what for?	Not Completed	
Are you providing services as a Business? If yes, what is the name of the business.	Not Completed	
What county do you plan to work in?	Not Completed	
What is the name of the Adult Services Worker you are working with?	Not Completed	
Are you a Medicare certified home health agency?	Not Completed	
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.	Not Completed	
I also acknowledge that I am required to update any changes in the enrollment within 10 days of that change.	Not Completed	
All providers are considered for the Beneficiary Monitoring Program. Do you object to this participation?	Not Completed	
Do you have a client you plan to work for? If yes, what is your clients name?	Not Completed	

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- Answer all of 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 **Comments**.
- Click **Save**.
- Click **Close**.

Please Note: The *County Name*, *Worker Name* and *Clients Name* will need to be included in the *comments box* when appropriate.

Application ID: Name:

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
<a href="#">Step 1: Provider Basic Information</a>	Required	05/04/2018	05/04/2018	Complete	
<a href="#">Step 2: Add Locations</a>	Required	05/04/2018	05/04/2018	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	05/04/2018	05/04/2018	Complete	
<a href="#">Step 4: Associate Billing Provider</a>	Optional	05/04/2018	05/04/2018	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Optional			Complete	
<a href="#">Step 6: Add Mode of Claim Submission/EDI Exchange</a>	Optional			Incomplete	
<a href="#">Step 7: Associate Billing Agent</a>	Optional			Incomplete	
<a href="#">Step 8: Add Provider Controlling Interest/Ownership Details</a>	Required	05/04/2018	05/04/2018	Complete	
<a href="#">Step 9: Add Taxonomy Details</a>	Optional			Incomplete	
<a href="#">Step 10: Associate MCO Plan</a>	Optional			Incomplete	
<a href="#">Step 11: 835/ERA Enrollment Form</a>	Optional			Incomplete	
<a href="#">Step 12: Upload Documents</a>	Optional			Incomplete	
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required	05/04/2018	05/04/2018	Complete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required			Incomplete	

View Page: 1 Go Page Count SaveToXLS

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- Click **Step 14: Submit Enrollment Application for Approval.**

Application ID: [redacted] Name: [redacted]

Close Next

## Final Submission

Application ID: [redacted]

EnrollmentType: Atypical Individual 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	Special Instructions	Source	Required
Δ▽	▲▽	▲▽	▲▽

No Records Found !

- 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

Last Login:

New Enrollment > Atypical Individual Enrollment

Application ID: [redacted]

Close Submit Application After reading the Terms and Conditions be sure to check

### Terms and Conditions Atypical Enrollment

- As an individual provider of Home Help services, I agree that the Med...
- As a Home Help provider agency, I agree that the agency contract is v...
- I agree that personal care services will be provided for a Michigan Me...
- Under Section 3504 of the Internal Revenue Code, I agree to accept t...
- I agree to return any payments received for Home Help services not p...
- I understand that the Home Help program is funded by Medicaid and r...
- In order to receive payment, I agree to keep and submit to MDHHS, D...
- Upon request, I agree to provide MDHHS, DHS or their designee, any...
- Upon request, I agree to provide MDHHS, DHS or their designee, any...
- I understand I will be subject to a criminal history screening and may r...
- I agree to cooperate with MDHHS, DHS or their designee, regarding a...
- I agree to report any changes relative to the beneficiary including but...
- I agree to comply with the privacy, security and confidentiality provis...
- I agree to comply with the provisions of 42 CFR 431.107 and Act No. 2...

**Definitions:**

**Confidential Rider Information:** Includes, but is not limited to, the ri...

**Department** means the Michigan Department of Health and Human S...

**Driver** means an individual providing Non-Emergency Medical Transp...

**Rider** means the individual being transported by driver.

**Service** means the provision by driver of Non-Emergency Medical Tra...

CHAMPS < Provider

Last Login:

New Enrollment > Atypical Individual Enrollment

Application ID: [redacted] Name: [redacted]

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

- To never solicit or accept controlled substances, alcohol, or medication from rider.
- To never solicit or accept money from riders.
- To never use alcohol, narcotics, or controlled substances, or be under their influence, while providing services to riders. Prescribed medications can be used by a driver as long as his or her duties can still be performed in a safe manner and driver has written documentation from a treating physician that the medication does not impact the ability to drive.
- To never eat or consume any beverage while operating the vehicle or while involved in rider assistance.
- To never smoke in the vehicle when rider is present. For purposes of this agreement, "smoke" includes electronic cigarettes and any other product or device which emits vapor, smoke, or any similar gaseous matter of any kind.
- To never wear any type of headphone while providing the service.
- To be responsible for rider's personal items.
- To provide, as appropriate to the needs of the rider, assistance with exiting the vehicle, to open and close vehicle doors when passengers enter or exit the vehicle, and to provide assistance as necessary to or from the main door of the place of destination.
- To properly identify and announce their presence at the entrance of the building at the specified pick-up location if a outside pick-up is not apparent, or with attending facility staff.
- To assist the passengers in the process of being seated, including the fastening of the seat belt, when necessitated by the rider's condition.
- 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 passenger's physician, stating that the passenger's medical condition prevents the rider from using a seat belt, may be transported without a fastened seat belt and then only as allowed by state law).
- To provide an appropriate level of assistance to passengers, when requested, or when necessitated by a passenger's condition.
- To provide support and direction to passengers. Such assistance shall also apply to the movement of wheelchairs and mobility-limited persons as they enter or exit the vehicle using the wheelchair lift/ramp, as applicable. Such assistance shall also include storage by the driver of mobility aids and folding wheelchairs.
- To act in a professional manner at all times while providing services.
- To be clean and maintain a neat appearance at all times.
- 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.
- To limit review of any confidential rider information to the minimum information necessary to provide the service.
- 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).
- To not retain any original or copy of any document rider shares with you for purposes of transport.
- To not retain 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.
- To report any breach of the terms of this user agreement to the Department. This includes, but is not limited to, accidental retention of medical record or other confidential rider information.
- 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.
- 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.
- 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.
- Comply with any other agreements driver has entered into with respect to this program.
- 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.

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

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

Application ID:

Name:

Your Application Number **123456789** has been successfully submitted for State review. Return with this application number to track the status of your application. ✕

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
<a href="#">Step 1: Provider Basic Information</a>	Required	06/06/2018	06/06/2018	Complete	
<a href="#">Step 2: Add Locations</a>	Required	06/06/2018	06/06/2018	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	06/06/2018	06/06/2018	Complete	
<a href="#">Step 4: Associate Billing Provider/Other Associations</a>	Optional	06/06/2018	06/06/2018	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Optional			Complete	
<a href="#">Step 6: Add Mode of Claim Submission/EDI Exchange</a>	Optional			Incomplete	
<a href="#">Step 7: Associate Billing Agent</a>	Optional			Incomplete	
<a href="#">Step 8: Add Provider Controlling Interest/Ownership Details</a>	Required	06/06/2018	06/06/2018	Complete	
<a href="#">Step 9: Add Taxonomy Details</a>	Optional			Incomplete	
<a href="#">Step 10: Associate MCO Plan</a>	Optional			Incomplete	
<a href="#">Step 11: 835/ERA Enrollment Form</a>	Optional			Incomplete	
<a href="#">Step 12: Upload Documents</a>	Optional			Incomplete	
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required	06/06/2018	06/06/2018	Complete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required	06/06/2018	06/06/2018	Complete	

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

# Tracking Your Application

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How to Track the Status of Your Application



# MILogin for Third Party

Login to your account

User ID

Password

**LOGIN**

**SIGN UP**

[Forgot your User ID?](#)

[Forgot your password?](#)

[Need Help?](#)

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- Enter your User ID and Password you just created
- Click **Login**

# MILogin for Third Party

[HOME](#)[REQUEST ACCESS](#)[UPDATE PROFILE](#)[SECURITY OPTIONS](#)[CHANGE PASSWORD](#)[LOGOUT](#)

## Home Page

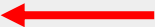
⌚ Your password will expire in **48** days

Access your applications by clicking on the application links below



Michigan Department of Health & Human Services (MDHHS)

CHAMPS



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

Michigan.gov

HELP CONTACT US

## Terms & Conditions

### CHAMPS

**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,

**CANCEL** ✕ **Acknowledge/Agree**

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

CHAMPS < Provider ▾

Note Pad External Links ▾ My Favorites ▾ Print Help

Provider Enrollment

<a href="#">New Enrollment</a>	Enroll As A New Provider
<a href="#">Track Application</a>	Track Existing Provider Application

- If you would like to check the status of your application, you can do so from the CHAMPS homepage:
- On the homepage, click the Track Application hyperlink.

Close

Next

## Track Existing Application

Please provide the Application ID to track your application.

Application ID

## Request Access to Home Help Provider Info

Click the below link if you are an Existing Home Help Individual or Agency accessing CHAMPS system for the first time. provide the Application ID to track your application.

[Home Help Providers requesting access to their Information.](#)

- Enter your **Application ID**.
- Click **Next**.

Close

Submit

## Verify Application Details

For Additional security, please enter following information:

SSN:  \*

Date Of Birth:  \*

Home Zip Code:  \*

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

Application ID: \_\_\_\_\_ Name: \_\_\_\_\_

Your application is currently In-Review by the Provider Enrollment Unit. You cannot make any modifications to your enrollment information at this time.



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
<a href="#">Step 1: Provider Basic Information</a>	Required	05/04/2018	05/04/2018	Complete	
<a href="#">Step 2: Add Locations</a>	Required	05/04/2018	05/04/2018	Complete	
<a href="#">Step 3: Add Specialties</a>	Required	05/04/2018	05/04/2018	Complete	
<a href="#">Step 4: Associate Billing Provider</a>	Optional	05/04/2018	05/04/2018	Complete	
<a href="#">Step 5: Add License/Certification/Other</a>	Optional			Complete	
<a href="#">Step 6: Add Mode of Claim Submission/EDI Exchange</a>	Optional			Incomplete	
<a href="#">Step 7: Associate Billing Agent</a>	Optional			Incomplete	
<a href="#">Step 8: Add Provider Controlling Interest/Ownership Details</a>	Required	05/04/2018	05/04/2018	Complete	
<a href="#">Step 9: Add Taxonomy Details</a>	Optional			Incomplete	
<a href="#">Step 10: Associate MCO Plan</a>	Optional			Incomplete	
<a href="#">Step 11: 835/ERA Enrollment Form</a>	Optional			Incomplete	
<a href="#">Step 12: Upload Documents</a>	Optional			Incomplete	
<a href="#">Step 13: Complete Enrollment Checklist</a>	Required	05/04/2018	05/04/2018	Complete	
<a href="#">Step 14: Submit Enrollment Application for Approval</a>	Required	05/04/2018	05/04/2018	Complete	

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First Prev Next Last

- 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.

# Application Approved

- Once the Application is Approved:
  - Providers will receive an approval letter. The approval letter will go to the Correspondence Address you provided.



# Provider Resources

- Home Help Provider Support Hotline  
1-800-979-4662
- Home Help Provider Support Email:  
[ProviderSupport@Michigan.gov](mailto:ProviderSupport@Michigan.gov)
- Home Help Website  
[www.Michigan.gov/HomeHelp](http://www.Michigan.gov/HomeHelp)