

**Michigan Department of Community Health
Division of Chronic Disease and Injury Control
Diabetes and Other Chronic Diseases Section
Washington Square Bldg., 7th Floor
109 W. Michigan Avenue
Lansing MI 48913**

**DIABETES SELF-MANAGEMENT TRAINING PROGRAM
APPLICATION FOR CERTIFICATION/RECERTIFICATION
GROUP ENTITY**

HEALTH SYSTEM NAME _____
NAME OF PROGRAM COORDINATOR _____
ADDRESS _____

PHONE _____
FAX _____
E-MAIL ADDRESS _____

MEDICAL PROVIDER TYPE: (PLEASE CIRCLE ONE #)

1=Provider Type 40 (Hospital Outpatient Department)

2=Provider Type 77 (Local Public Health Department)

ADA Recognized Date of Expiration _____

AADE Recognized Date of Expiration _____

Organizational NPI# _____

Specify program charges for:

Individual Instruction/per 1/2 hour _____

Group Instruction/per 1/2 hour _____

Total number of hours that comprise a comprehensive education program _____

Components 1) _____
2) _____
3) _____
4) _____

Application continued on tab 2 (Pages 2-3) below.

List affiliated hospitals. List all specific educational components that are included in the program i.e. (gestational pediatrics, adult continuous subcutaneous insulin infusion) and program charges. **Does not imply Medicaid certified for reimbursement.**

Hospital Name _____
Contact Person _____
Address _____
Phone _____
Fax _____
E-Mail _____

Medicaid Provider Number _____

Specify program charges for:

Individual Instruction/per 1/2 hour _____

Group Instruction/per 1/2 hour _____

Total number of hours that comprise a comprehensive education program _____

Components 1) _____
2) _____
3) _____
4) _____

Hospital Name _____
Contact Person _____
Address _____
Phone _____
Fax _____
E-Mail _____ Date of Expiration _____

AADE Recognized _____ Date of Expiration _____

Specify program charges for:

Medicaid Individual Instruction/per 1/2 hour _____

Group Instruction/per 1/2 hour _____

Total number of hours that comprise a comprehensive education program _____

Components 1) _____
2) _____
3) _____
4) _____

Hospital Name _____
Contact Person _____
Address _____
Phone _____
Fax _____
E-Mail _____

Medicaid Provider Number _____

Specify program charges for:

Individual Instruction/per 1/2 hour _____

Group Instruction/per 1/2 hour _____

Total number of hours that comprise a comprehensive education program _____

Components 1) _____
2) _____
3) _____
4) _____

We have Diabetes Self-Management Training Programs that meet the Michigan Diabetes Self-Management Training Certification Policy. Program documentation to confirm this statement is on file and available for review at any time.

We herein submit an official request for certification/recertification (circle one) of our diabetes training programs by the Michigan Department of Community Health, Diabetes and Other Chronic Diseases Section (MDCH, DOCDS). For Provider types 40 & 77, this certification will be used for the purpose of applying for Medicaid reimbursement for Medicaid eligible clients participating in our program. We understand that the MDCH, DOCDS will notify the Medical Services Administration, Michigan Department of Community Health, provided we are an eligible agency, of our certified status so that we may initiate Medicaid billing.

We understand that we must maintain policy requirements in order to keep our certification and that the MDCH, DOCDS reserves the right to review any or all of our program documentation and make a site visit at any time.

We agree to submit the following program data to the MDCH/DOCDS:

- 1) An annual report.
- 2) A statistical report regarding the patients educated by the state fiscal year (October 1 through September 30) by **November 30** of each year.
- 3) Significant program changes within 30 days of the change.
Site/location change
Addition of satellite site/s
Change in Coordinator
Change in sponsoring organizations status such as merger, agreements, etc.
Addition of specialized educational components and /or any other significant changes

Revised 1/15/2014

Provide signatures below to attest to the truth and accuracy of the contents of this application and to verify that the sponsoring organization is currently Medicare/Medicaid certified and licensed by the State of Michigan.

Program Coordinator

Name (Print) _____ Title _____

Signature _____ Date _____

Health System Administrator (or designee)

Name (Print) _____ Title _____

Signature _____ Date _____

The undersigned administrators of each individual hospital DSMT Program site operating under this health system application have on-site supervisory responsibility for the DSMT Program and are in agreement with the terms and provisions of the group health system application.

Name (Print) _____ Title _____

Signature _____ Date _____

Name (Print) _____ Title _____

Signature _____ Date _____

Name (Print) _____ Title _____

Signature _____ Date _____

Name (Print) _____ Title _____

Signature _____ Date _____