

# Provider Application Form and Declaration of Intent

MI Opioid Treatment Access Loan Repayment Program  
Michigan Department of Health and Human Services

Today's Date

1. Personal Information			
a. Last Name	b. First Name	c. Middle Name	d. Male Female
e. Home Address:		f. City:	g. State:
h. Zip Code:			
i. Home Phone:	j. Cell Phone:	k. Direct Work Phone:	
l. Personal Email:	m. Work Email:	n. Additional Email:	
o. Date of Birth (mm/dd/yyyy):		p. SIGMA Customer/Vendor ID Number:	
2. Educational and Professional Information			
a. Professional Designation: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Nurse Practitioner/Specialist (Masters) <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Other (Specify):			
b. Specialty: <input type="checkbox"/> Family Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Obstetrics/Gynecology <input type="checkbox"/> Pediatrics <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Other (Specify):			
c. License Number:	d. State of Licensure:	e. NPI Number:	
3. Opioid Treatment Practice Information			
a. Opioid Treatment Certification: <input type="checkbox"/>		b. Certificate Number:	
c. Current OTP Capacity:		d. Current OTP Caseload:	
e. Type of Opioid Treatment Provided: <input type="checkbox"/> SUD <input type="checkbox"/> MAT		f. Methadone Treatment Offered: <input type="checkbox"/> Yes <input type="checkbox"/> No	

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4. Eligibility: MIOTA LRP Agreement and Practice Site Information		
a. Practice/Facility Name:	b. # Hours/Week:	
c. Address:	d. City/State:	e. Zip Code:
i. Is this your primary practice site? <input type="checkbox"/> Yes <input type="checkbox"/> No		
ii. Do you practice at other locations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide any additional Practice Sites Information:		
2 <sup>nd</sup> Facility Name (if applicable):	# Hours/Week:	
Address 2:	City/State:	Zip Code:
3 <sup>rd</sup> Facility Name (if applicable):	# Hours/Week:	
Address 3:	City/State:	Zip Code:
f. In what county/ies is your practice located:		
g. Are you currently providing opioid treatment at a practice site    Yes    No If yes, which:		

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**5. Loan Information**

a. Current Loans			
#	Account or ID #	Name of the Loan Program	Lender
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
<b>Total Eligible Debt</b>			

**b. Do any of the above loans entail a service obligation requirement? Yes No \*If yes, please circle those loans\***

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## 6. Certification Statement and Declaration of Intent

### Certification Statement:

I certify that I will comply with all the policies and procedures described in the Fiscal Year 2019 MIOTA LRP Application & Program Guidance and that all information in this application is accurate and complete.

### Declaration of Intent:

I affirm my intention to:

- 1) begin offering opioid treatment in Michigan by obtaining a Drug Enforcement Agency (DEA) registration certificate that clearly reflects the possession of a DATA 2000 Waiver, or
- 2) be providing opioid treatment to patients in Michigan by having obtained a DEA registration certificate that clearly reflects the possession of a DATA 2000 Waiver, and in the case of physicians, will apply for a patient limit increase, or
- 3) be a Substance Use Disorder Counselor that practices full time in an Opioid Treatment Program (OTP) or an Office-Based Opioid Treatment (OBOT) Practice.

I affirm that I have one of the following professional titles and an appropriate unencumbered license in the State of Michigan:

- 1) Physician (MD or DO)
- 2) Nurse Practitioner (NP)
- 3) Physician Assistant (PA)
- 4) Substance Use Disorder (SUD) Counselor

I understand that I may not be dually enrolled in this loan repayment program and any other loan repayment program with a service obligation (for example, the Michigan State Loan Repayment Program or the National Health Service Corps). As part of my obligation as a participant in the Michigan Opioid Treatment Access (MIOTA) Loan Repayment Program (LRP) I will remain employed on a full-time basis at the approved eligible practice site.

If I am a physician (MD or DO) and accepted into this program, I understand I must do one of the following:

- Apply for and receive a DEA registration certificate that clearly reflects the possession of a DATA 2000 Waiver by January 1, 2020, or
- Apply for and receive approval to increase the patient limit of the current DATA 2000 Waiver in the first year of the Service Obligation Period

I understand that if I am physician (MD or DO) and accepted into this program, I understand I must do all of the following in the first six months of the Service Obligation Period:

- Submit a plan to provide for SUD counseling for SUD patients. This plan should detail the provider's plan for making referrals to SUD counseling services and providing information on available community group or self-help resources or any other supportive resources.
- Participate in provider-to-provider support specific to substance abuse, as available in my community. More information is available through MDHHS.
- Obtain state licensure for the SUD program if an individual, or individuals in a group practice, is offering psychological or medical services and providing buprenorphine or naltrexone treatment to more than 100 individuals at any one time at a specific property.

If I am a Nurse Practitioner or Physician's Assistant and accepted into this program, I understand I must do both of the following by January 1, 2020:

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- Complete the required 24 hours of required training to obtain a DATA 2000 waiver, and
- Apply for and receive a DEA registration certificate that clearly reflects the possession of a DATA 2000 Waiver

If I am a Nurse Practitioner or Physician's Assistant and accepted into this program, I understand I must also:

- Participate in provider-to-provider support specific to substance abuse, as available in my community. More information is available through MDHHS.
- Obtain state licensure for SUD program if an individual, or individuals in a group practice, is offering psychological or medical services and providing buprenorphine or naltrexone treatment to more than 100 individuals at any one time at a specific property.

If I am a Substance Use Disorder Counselor I understand I must have a valid substance use disorder certification and a valid professional license and must provide full-time SUD counseling in an OTP setting or OBOT setting for the duration of the Service Obligation Period.

If I am a Substance Use Disorder Counselor, I understand I must also:

- Participate in provider-to-provider support specific to substance abuse, as available in my community. More information is available through MDHHS.
- Obtain state licensure for SUD program if an individual, or individuals in a group practice, is offering psychological or medical services and providing buprenorphine or naltrexone treatment to more than 100 individuals at any one time at a specific property.

Every six months during the service obligation period, I will provide data regarding my actual caseload size in order to receive payment. I understand that review of this data is critical to my continued participation with the MIOTA LRP and that if I do not provide this information, I will not receive my allotted loan repayment funds.

I understand that if I am awarded a MIOTA agreement, I enter into a service obligation. MIOTA service obligations are legal responsibilities that should be taken seriously. I will carefully read the MIOTA agreement before signing and I understand that if a breach of the agreement occurs, I will face a default penalty.

Signature:

Date: