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| **1.a. Sponsoring Agency – AGENCY INFORMATION** | | | | | **TODAY’S DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **a. Name of Sponsoring Agency:** | | | | | | | | **b. County:** | |
| Click or tap here to enter text. | | | | | | | | Enter here. | |
| **c. Address:** | | | **d. City:** | | | | **e. State:** | | **f. Zip:** |
| Click or tap here to enter text. | | | Enter here. | | | | Enter here. | | Enter here. |
| **g. Agency Tax Classification:** | | **h. Agency Setting Type:** | | | | **i. Federal ID #:** | | | |
| For Profit Non-Profit | | Choose an item. | | | | Enter here. | | | |
| **j. Does the agency have a contractual affiliation, partnership or membership with one of the following?** | | | | | | | | | |
| Choose an item. | | | | | | | | | |
| **1.b. Sponsoring Agency – ADMINISTRATOR INFORMATION** | | | | | | | | | |
| **K. EXECUTIVE ADMINISTRATOR *(CEO, President, Executive Director, Superintendent, Principal, Agency Owner, etc.)* \***  Responsible for completing application materials *(such as this form)* and employment verification for the employee. | | | | | | | | | |
| ***k. Full Name:*** | | | | ***l. Professional Title:*** | | | | | |
| Click or tap here to enter text. | | | | Click or tap here to enter text. | | | | | |
| ***m.* *Email Address:*** | | | | ***n. Direct Phone Number:*** | | | | | |
| Click or tap here to enter text. | | | | Click or tap here to enter text. | | | | | |
| **O. LEGAL ADMINISTRATOR *(CEO, President, Business Director, Contracts Manager, Superintendent, Principal, etc.)* \***  Responsible for reviewing, signing, and managing legal agreement(s) between the Agency and MDHHS. | | | | | | | | | |
| ***o. Full Name:*** | | | | ***p. Professional Title:*** | | | | | |
| Click or tap here to enter text. | | | | Click or tap here to enter text. | | | | | |
| ***q.* *Email Address:*** | | | | ***r. Direct Phone Number:*** | | | | | |
| Click or tap here to enter text. | | | | Click or tap here to enter text. | | | | | |
| **S. POINT OF CONTACT *(Department Head, Human Resources Manager, Recruiter, Executive Assistant, etc.)* \***  Responsible for notifying BHLRP Program Staff of employment status, absences, leave and work status of the employee. | | | | | | | | | |
| ***s. Full Name:*** | | | | ***t. Professional Title:*** | | | | | |
| Click or tap here to enter text. | | | | Click or tap here to enter text. | | | | | |
| ***u.* *Email Address:*** | | | | ***v. Direct Phone Number:*** | | | | | |
| Click or tap here to enter text. | | | | Click or tap here to enter text. | | | | | |
| \***PLEASE**  **NOTE**: | The Executive Administrator, the Legal Administrator, the Point of Contact, and the Direct Supervisor  (of the employee) CANNOT be the same staff member for each role. While a single staff member may  hold several roles at the agency, a single staff member cannot be listed for more than TWO of the  above roles. *For Example: the Executive Administrator and Legal Administrator can be listed as the*  *same staff member above, but CANNOT be listed as the Point of Contact and Direct Supervisor.* | | | | | | | | |

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| **2. Provider (Employee) Information** | | | | | |
| **a. Provider (Employee) Last Name:** | | **b. Provider (Employee) First Name:** | | | **c. Middle Name:** |
| Click or tap here to enter text. | | Click or tap here to enter text. | | | Enter here. |
| **d. Provider Employment Start Date:** | **e. Provider Employment Status:** | | | **f. Provider Email:** | |
| Click or tap here to enter text. | Full TimePart Time | | | Click or tap here to enter text. | |
| **g. This BHLRP agreement will be used for:\_** | | | Provider Recruitment  Provider Retention | | |

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| **h. Provider Professional Designation:**  *Indicates professional licensure or certification provider holds.* | | **i. Provider Patient Demographic:**  *Patient group that provider services.* | |
| Choose an item. | | Choose an item. | |
| j. Provider Job Title: | Click or tap here to enter text. | | |
| *Official job title or position that the provider holds; separate from their professional designation.*  *Examples of a "full” job or position title could include: Social Worker, Case Manager II, Clinic Manager, Team Lead, Counselor,*  *Administrative Assistant, Whole Child Systems Supervisor, 31N Student Mental Health Counselor, Program Specialist III, etc.* | | | |
| k. Please provide an estimate of the provider’s total weekly hours worked:  *Example: 40 hours, 37.5 hours, 35 hours, etc.* | | | Enter text here. |
| l. During an average week, please provide an estimate of how many hours the  provider spends providing direct, one-on-one behavioral health services  to patients or clients through your agency:  *Such as therapy, counseling, crisis intervention, or other direct clinical mental health services* | | | Enter text here. |
| m. During an average week, please provide an estimate of how many hours  the provider spends providing indirect behavioral health services to  patients, clients or their families through your agency:  *Such as case management, clinical assessment or intake, or care coordination & planning* | | | Enter text here. |
| n. During an average work week, please provide an estimate of how many  hours the provider spends conducting leadership, management, administrative,  or other non-behavioral health-related tasks at your agency: | | | Enter text here. |
| o. Please provide an estimate of the provider’s average weekly patient case load:  *The number of patients or clients seen for direct behavioral healthcare services each week.* | | | Enter text here. |
| p. Provider Priority Group:  *(Please see Page #10 of this application form for information regarding Priority Group Criteria and Eligibility Prioritization)* | | | |
| Child Provider in a Community Mental Health Authority (CMH) or Tribal Health Center Setting   Child Provider in a Public School-Based Setting   Child Provider in Any Non-Profit, Eligible Setting \_   Adult Provider in a Community Mental Health Authority (CMH) or Tribal Health Center Setting   Adult Provider in Any Non-Profit, Eligible Setting | | | |

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| **3. Provider Practice Site Information:** | |
| **INSTRUCTIONS:** On Pages #4 – #7 below, the Executive Administrator is required to list all worksites or locations  the provider physically works out of and reports to on a daily basis. There are four blank practice site templates included below. If the provider only works out of a single practice site, only Practice Site Template #1 (below) is required to be completed. If the provider regularly reports to five or more worksites, please indicate this below.  If the provider does not work out of the agency location listed on Page #1 of this form, please do not list it below. | |
| **a. Please provide an estimate of how many hours per week the provider spends working out**  **of varying community-based locations**. *(Such as public libraries, parks, coffee shops, etc.)* | Enter text here. |
| **b. Please provide an estimate of how many hours per week the provider offers home-based**  **services through patient homes or apartments.** *(excluding inpatient care centers)* | Enter text here. |
| **c. Please provide an estimate of how many hours per week the provider offers inpatient care**  **services through residential care facilities, inpatient hospitals, or inpatient clinics**. | Enter text here. |
| d. Please provide an estimate of how many hours per week the provider spends providing  TELE-HEALTH services (remotely)from THEIR HOME OR RESIDENCE. *(from home, not the office)* | Enter text here. |
| **e. Please provide an estimate of how many hours per week the provider spends providing**  **TELE-HEALTH services through their Practice Site(s) or Worksite(s) listed on Pages #4 - #7.** | Enter text here. |
| **f. Please provide an estimate of how many hours per week the provider spends providing**  **IN-PERSON services through the Practice Site(s) or Worksite(s) listed on Pages #4 - #7.** | Enter text here. |

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| **FOR SCHOOL–BASED PROVIDERS ONLY:** | | | | |
| **Please indicate the number of days per calendar year that the provider is expected to participate in district-granted school breaks. *If the provider is expected to work year-round, list “0” for each applicable line.*** | | | | |
|  | **f. Summer Break:** | **g. Winter Break:** | **h. Mid-Winter Break:** | **i. Spring Break:** | |
| **NUMBER**  **OF DAYS:** | Enter text here. | Enter text here. | Enter text here. | Enter text here. | |

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| **Please provide the name of each practice site or worksite that the provider regularly reports to below.** | |
| **j. Name of Practice Site or Worksite #1:** | Enter text here. |
| **k. Name of Practice Site or Worksite #2:** | Enter text here. |
| **l. Name of Practice Site or Worksite #3:** | Enter text here. |
| **m. Name of Practice Site or Worksite #4:** | Enter text here. |

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| **n. Does the provider report to more than four eligible practice sites or worksites?\_** | Yes  No |
| **o. Please list the total number of worksites the provider regularly reports to each week:** | Enter text here. |

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| **Practice Site #1 (REQUIRED)** | | | | | | |
| **Name of Practice Site:** | | | **Physical Address:** | | | |
| Enter text here. | | | Enter text here. | | | |
| **City:** | **County:** | | | **State:** | | **9-Digit Zip Code:** |
| Enter text here. | Enter text here. | | | Enter text here. | | Enter text here. |
| **Site Manager or Supervisor Name** | | **Site Manager or Supervisor Job Title** | | | | |
| Enter text here. | | Enter text here. | | | | |
| **Site Manager or Supervisor Email Address** | | **Manager or Supervisor Phone** | | | | |
| Enter text here. | | Enter text here. | | | | |
| **Number of Hours per Week that provider will work from this worksite or location:\_** | | | | | | Enter text here. |
| **Number of Weeks per Year that provider will from this worksite or location:\_** | | | | | | Enter text here. |
| **Is this practice site classified as a NON-PROFIT Agency?\_** | | | | | | Yes  No |
| ***If this practice site is under construction, what is the estimated opening date:\_*** | | | | | | Enter text here. |
| **Check ALL of the following that describe the Practice Site:** | | | | | | |
| Community Mental Health Authority (CMH)  Tribal Health Center  Public School or Public School-Based Setting  Community Health Center | | | Community Mental Health Clinic  Non-Profit Outpatient Clinic (Group Practice)  Non-Profit Outpatient Clinic (Solo Practice)  OtherNon-Profit, Outpatient Organization | | | |
| **Percentage of total Practice Site caseload that utilizes the Sliding Fee Scale within the last 12 months?** | | | **Percentage of total practice site caseload that is billed to Medicaid within the last 12 months?** | | | |
| Enter text here. | | | Enter text here. | | | |
| **Does the provider practice at more than one (1) eligible practice site?\*** | | | | | Yes  No | |
| ***\*If checked “No” above (only one practice site or worksite for the provider), please skip to Page #8 of this application.*** | | | | | | |

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| **Practice Site #2 (If Applicable)** | | | | | |
| **Name of Practice Site:** | | | **Physical Address:** | | |
| Enter text here. | | | Enter text here. | | |
| **City:** | **County:** | | | **State:** | **9-Digit Zip Code:** |
| Enter text here. | Enter text here. | | | Enter text here. | Enter text here. |
| **Site Manager or Supervisor Name** | | **Site Manager or Supervisor Job Title** | | | |
| Enter text here. | | Enter text here. | | | |
| **Site Manager or Supervisor Email Address** | | **Manager or Supervisor Phone** | | | |
| Enter text here. | | Enter text here. | | | |
| **Number of Hours per Week that provider will work from this worksite or location:\_** | | | | | Enter text here. |
| **Number of Weeks per Year that provider will from this worksite or location:\_** | | | | | Enter text here. |
| **Is this practice site classified as a NON-PROFIT Agency?\_** | | | | | Yes  No |
| ***If this practice site is under construction, what is the estimated opening date:\_*** | | | | | Enter text here. |
| **Check ALL of the following that describe the Practice Site:** | | | | | |
| Community Mental Health Authority (CMH)  Tribal Health Center  Public School or Public School-Based Setting  Community Health Center | | | Community Mental Health Clinic  Non-Profit Outpatient Clinic (Group Practice)  Non-Profit Outpatient Clinic (Solo Practice)  OtherNon-Profit, Outpatient Organization | | |
| **Percentage of total Practice Site caseload that utilizes the Sliding Fee Scale within the last 12 months?** | | | **Percentage of total practice site caseload that is billed to Medicaid within the last 12 months?** | | |
| Enter text here. | | | Enter text here. | | |

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| **Practice Site #3 (If Applicable)** | | | | | |
| **Name of Practice Site:** | | | **Physical Address:** | | |
| Enter text here. | | | Enter text here. | | |
| **City:** | **County:** | | | **State:** | **9-Digit Zip Code:** |
| Enter text here. | Enter text here. | | | Enter text here. | Enter text here. |
| **Site Manager or Supervisor Name** | | **Site Manager or Supervisor Job Title** | | | |
| Enter text here. | | Enter text here. | | | |
| **Site Manager or Supervisor Email Address** | | **Manager or Supervisor Phone** | | | |
| Enter text here. | | Enter text here. | | | |
| **Number of Hours per Week that provider will work from this worksite or location:\_** | | | | | Enter text here. |
| **Number of Weeks per Year that provider will from this worksite or location:\_** | | | | | Enter text here. |
| **Is this practice site classified as a NON-PROFIT Agency?\_** | | | | | Yes  No |
| ***If this practice site is under construction, what is the estimated opening date:\_*** | | | | | Enter text here. |
| **Check ALL of the following that describe the Practice Site:** | | | | | |
| Community Mental Health Authority (CMH)  Tribal Health Center  Public School or Public School-Based Setting  Community Health Center | | | Community Mental Health Clinic  Non-Profit Outpatient Clinic (Group Practice)  Non-Profit Outpatient Clinic (Solo Practice)  OtherNon-Profit, Outpatient Organization | | |
| **Percentage of total Practice Site caseload that utilizes the Sliding Fee Scale within the last 12 months?** | | | **Percentage of total practice site caseload that is billed to Medicaid within the last 12 months?** | | |
| Enter text here. | | | Enter text here. | | |

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| **Practice Site #4 (If Applicable)** | | | | | |
| **Name of Practice Site:** | | | **Physical Address:** | | |
| Enter text here. | | | Enter text here. | | |
| **City:** | **County:** | | | **State:** | **9-Digit Zip Code:** |
| Enter text here. | Enter text here. | | | Enter text here. | Enter text here. |
| **Site Manager or Supervisor Name** | | **Site Manager or Supervisor Job Title** | | | |
| Enter text here. | | Enter text here. | | | |
| **Site Manager or Supervisor Email Address** | | **Manager or Supervisor Phone** | | | |
| Enter text here. | | Enter text here. | | | |
| **Number of Hours per Week that provider will work from this worksite or location:\_** | | | | | Enter text here. |
| **Number of Weeks per Year that provider will from this worksite or location:\_** | | | | | Enter text here. |
| **Is this practice site classified as a NON-PROFIT Agency?\_** | | | | | Yes  No |
| ***If this practice site is under construction, what is the estimated opening date:\_*** | | | | | Enter text here. |
| **Check ALL of the following that describe the Practice Site:** | | | | | |
| Community Mental Health Authority (CMH)  Tribal Health Center  Public School or Public School-Based Setting  Community Health Center | | | Community Mental Health Clinic  Non-Profit Outpatient Clinic (Group Practice)  Non-Profit Outpatient Clinic (Solo Practice)  OtherNon-Profit, Outpatient Organization | | |
| **Percentage of total Practice Site caseload that utilizes the Sliding Fee Scale within the last 12 months?** | | | **Percentage of total practice site caseload that is billed to Medicaid within the last 12 months?** | | |
| Enter text here. | | | Enter text here. | | |

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| **Section 4: Certification of Compliance and Declaration of Intent:** | | | | |
| **Certification Statement:**  I certify that each of the Practice Site(s) identified in this application form meet all of the following  MDHHS Behavioral Health Loan Repayment Program (BHLRP) Requirements.  **Practice Site Regulations:**  The Practice Site(s) identified in this application:  • Are incorporated and licensed to do business in Michigan.  • Do not discriminate in the provision of services to an individual because the individual is unable to pay or because payment of those services would be made under Medicare, Medicaid, or the State Children’s Health Insurance Program (CHIP), or based upon the individual’s race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity.  • Use a schedule of fees or payments for the site’s services that is consistent with locally prevailing rates or charges and is designed to cover the site’s reasonable cost of operation.  • Have notices posted in a clearly visible location such as the front office or waiting room, and on the site’s website (if applicable). The notice explicitly states that no one will be denied access to services due to inability to pay; and there is a discounted/sliding fee schedule available. Sites do not have to post the details of the policy or the actual fee schedule. When applicable, this statement should be translated into the appropriate language/dialect.  • Apply the discounted/sliding fee schedule equally, consistently, and on a continuous basis to all recipients of services, **without regard to the particular clinician that treats them.**  **Employment Regulations:**  The Sponsoring agency or practice site will not reduce the salary or benefits of BHLRP providers because they receive BHLRP Payments.  For all medical providers, at least 32 hours per week must be spent providing eligible behavioral health care services. These services must be conducted during normally scheduled hours in the designated practice site.  The required full-time hours per week may be compressed in to not less than four (4) days per week, with no more than 12 hours of work performed in any 24-hour period. Time spent in “on-call” status will not count toward the full-time hourly requirement. Hours worked in excess of the provider’s full-time hours will not be applied to any other workweek.  Behavioral Health Loan Repayment Program providers can spend no more than seven (7) weeks or 35 workdays per agreement year away from the practice site for vacation, holidays, continuing professional education, illness, or any other reason\*. Absences greater than seven (7) weeks or 35 workdays will extend the service obligation end date. The practice site, or its sponsoring agency, must inform the Behavioral Health Loan Repayment Program office when a provider goes on extended leave or exceeds the seven (7) week or 35 workday limit.  \*Please note leave time does not apply to employer-mandated, extended break periods for school-based workers, such as breaks observed during the summer months or observed holidays.  The practice site will communicate with the Behavioral Health Loan Repayment Program Office about any changes in practices site or provider employment status, including the provider moving to another practice site, not approved in this application, for any or all of their workweek, termination, etc.  **(continued below)**  8  The practice site will maintain and make available for review by the Michigan Department of Health and Human Services all personnel or other administrative records associated with a Behavioral Health Loan Repayment Program provider including documentation which contains such information that the Department may need to determine if the provider or practice site have fully complied with the program requirements.  Neither the practice site, nor its sponsoring agency has been investigated for, or convicted of Medicaid or Medicare fraud. If this is not true, please provide a brief explanation of when this occurred and the nature and outcome of the investigation.  **Declaration of Intent:**  As the Executive Administrator for the Sponsoring Agency, I affirm our intention to employ the provider who has applied for the Behavioral Health Loan Repayment Program as identified in this application form throughout any loan agreement they may be awarded. The provider will be employed full time at the practice site(s) identified in this form. The provider will provide direct behavioral health care services to an ambulatory setting throughout the term of their Behavioral Health Loan Repayment Program service obligation. I understand that the provider must spend at least 32 hours of their work week providing eligible behavioral health care services.  If there are any changes in the provider’s clinical assignment, practice site locations or employment status, I agree to contact the Behavioral Health Loan Repayment Program Office within ten (10) working days to inform the office of any of these changes. **I understand that if the sponsoring agency fails to employ the provider throughout the loan repayment period without adequate justification, the sponsoring agency may jeopardize the opportunity to participate in this program in the future.**  In addition, I agree to read and comply with all policies and procedures described in the BHLRP Program Guidance document, available on the Behavioral Health Loan Repayment Program Website. | | | | |
| **This Certification of Compliance and Declaration of Intent requires the signature of the**  **Executive Administrator, identified in Section #1 of this application form.**  **The signature of the executive administrator below certifies that:**  1) The information provided in this application form are true and correct; and  2) Signifies that the practice site(s) identified comply with the requirements set forth in this application. | | | | |
|  | Enter administrator name here. |  | Enter administrator name here. |  |
|  | **Executive Administrator Name** |  | **Executive Administrator Title** |  |
|  |  |  | Enter today’s date here. |  |
|  | **Executive Administrator Signature** *(Digital or Manual Signature Required)* |  | **Today’s Date** |  |

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The below prioritization system will be utilized to rank applicants for the BHLRP:

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| **PRIORITY GROUP #1: Child Providers in a Community Mental Health Authority (CMH) Setting** |
| Providers within this Priority Group:   * Provide behavioral health services to children (0-18 years), or to children AND adults * Practice out of a Public Community Mental Health Authority (CMH) or Tribal Health Center * Practice Sites do not need to be located within a HPSA * No employer match or contribution |
|  |
| **PRIORITY GROUP #2: Child Providers in a Public School-Based Setting** |
| Providers within this Priority Group:   * Provide behavioral health services to children (0-18 years of age) * Practice out of a Public School(s) or Public School-Based Site(s) * Practice Site(s), including any School-Based Site(s), do not need to be located within a HPSA * No employer match or contribution |
|  |
| **PRIORITY GROUP #3: Child Providers in Any Non-Profit, Eligible Setting** |
| Providers within this Priority Group:   * Provide behavioral health services to children (0-18 years of age) * Practice out of a Public, Non-Profit Site (such as community agency, outpatient clinic, etc.) * Practice Site(s) MUST be located within a HPSA (see **below** for further information) * Employer Match / Contribution (see **below** for further information) |
|  |
| **PRIORITY GROUP #4: Adult Providers in a Community Mental Health Authority (CMH) Setting** |
| Providers within this Priority Group:   * Provide behavioral health services to adults (18+ years of age) * Practice out of a Public Community Mental Health Authority (CMH) or Tribal Health Center * Practice Sites do not need to be located within a HPSA * No employer match or contribution |
|  |
| **PRIORITY GROUP #5: Adult Providers in Any Non-Profit, Eligible Setting** |
| Providers within this Priority Group:   * Provide behavioral health services to adults (18+ years of age) * Practice out of a Public, Non-Profit Site (such as community agency, outpatient clinic, etc.) * Practice Site(s) MUST be located within a HPSA (see **below** for further information) * Employer Match / Contribution (see **below** for further information) |

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