Michigan Department of Health & Human Services
Division of Chronic Disease and Injury Control
Diabetes and Other Chronic Diseases Section
Washington Square Bldg. 7th Floor
109 W. Michigan Ave
Lansing MI 48913

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

SPONSORING ORGANIZATION NAME _____

NAME OF PROGRAM _____

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)

Organizational NPI# _____

ADA Recognized Date _____

Expiration Date _____

AADE Recognized Date _____

Expiration Date _____

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 _____

List all specific educational components that are included in the program (gestational, pediatrics, adult, continuous subcutaneous insulin infusion).

1) _____

2) _____

3) _____

4) _____

List all **additional** sites where program is taught. List all specific educational components that are included in the program at each site (gestational pediatrics, adult continuous subcutaneous insulin infusion).

Site Name _____

Contact Person _____

Address _____

Phone _____

Fax _____

E-Mail _____

Components 1) _____

2) _____

3) _____

4) _____

Site Name _____

Contact Person _____

Address _____

Phone _____

Fax _____

E-Mail _____

Components 1) _____

2) _____

3) _____

4) _____

We have a Diabetes Self-Management Training (DSMP) Program that meets the Michigan DSMT 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 education program by the Michigan Department of Health & Human Services, Diabetes and Other Chronic Diseases Section (MDHHS, 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 MDHHS, DOCDS will notify the Medical Services Administration, Michigan Department of Health & Human Services, provided we are an eligible agency, of our certified status so that we may initiate Medicaid billing.

We understand that we must maintain the requirements according to the DSMT policy in order to keep our certification and that the MDHHS, 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 MDHHS/DOCDS:

1) An annual report.
2) A statistical report regarding the patients educated during 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, using the "Change Form" eg.
    Site/location change
    Addition of satellite site/s
    Change in coordinator
    Changes in sponsoring organizations status such as merger, agreements, etc.
    Addition of specialized educational components and/or any other significant changes

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_____

Chief Executive Officer (or designee)

Name (Print) _____Title_____

Signature_____Date_____