Request for Applications for
First Episode Psychosis (FEP) Treatment
For Services to Begin FY 2020

RFA Issued:
October 4, 2019
This Request for Applications is organized in the following manner:

**Introduction:** Provides information about Network180, system principles, and RFA timeline.

**Section 1 – Service Summary for RFA:** Program Description.

**Section 2 – General Information about the RFA Process:** Provides bidders with a general overview to the procurement process.

**Section 3 – Instructions for Application Submission:** Describes the required format and content for applications submitted.

**Section 4 – Attachments:** Includes the required documents to be submitted with each response to the RFA.

**Section 5 – Administrative Requirements:** Outlines the administrative requirements and standards bidders must meet to be considered as a grantee of Network180 services.

**Section 6 – Program Narrative Requirements:** Describes the required elements

**Section 7 – Application Evaluation:** Describes the evaluative and scoring criteria to be used for each section.
Introduction

Authority and Background

This Request for Applications (RFA) is issued by Network180, a governmental authority, located at 3310 Eagle Park Dr. NE, Suite 100, Grand Rapids, Michigan, 49525. Network180 and the Michigan Department of Health and Human Services have established a contractual relationship where Network180 is a recipient of Michigan’s 10% set aside of Mental Health Block Grant Funds. Network180 seek to establish subawards to fulfill its responsibly under the grant award.

The federal funding used to pay for this grant is 100%; the Catalog of Federal Domestic Assistance (CFDA) number is 93.958 and the CFDA Title is Block Grants for Community Mental Health Services; the federal agency name is Department of Health and Human Services; the federal grant award number is 252513 (18) and the award phase is October 1, 2019 through September 30, 2020. The federal program title is Comprehensive Services for Behavioral Health- 2020/First Episode Psychosis.

Information about Network180

Kent County (Grand Rapids, MI) established a Community Mental Health Board in 1966. It was reorganized under the Michigan Mental Health Code in August 1975. In October 1979, the Kent County Community Mental Health (Kent CMH) Board applied for status as a “Contract Board” with the Michigan Department of Mental Health – the first Board in the state to acquire a contract with the State of Michigan for the provision of mental health services. Kent CMH opened the Cornerstone Access/Crisis Center in 1985. In 1999, Kent CMH took responsibility for the state contract for substance abuse treatment, becoming the Coordinating Agency for Substance Abuse Services for a four-county region. Kent CMH has been accredited by CARF since 1996. In 2000, Kent CMH became one of the first agencies in the nation to receive a three-year CARF Network Administration Accreditation. In April 2003, Kent CMH was granted authority status and changed its name to Kent County CMH Authority dba Community Mental Health and Substance Abuse Network of West Michigan (CMHSA). In 2005, CMHSA changed its name and is doing business as Network180.

Network180, operating as a Mental Health Authority, is responsible for the provision of mental health services for eligible adults with serious mental illness, children with emotional disturbance, and persons with intellectual/developmental disabilities in Kent County. Network180 is also responsible for substance abuse treatment and prevention services for eligible residents of Kent County. Network180 provides a full array of services to these populations through a coordinated system of contracts with provider organizations that provide the direct services to recipients. Network180 administers care through contractual relationships with more than 30 providers who are responsible for managing operations within the terms of negotiated contracts for services.

The Network180 website (www.network180.org) includes information about Network180 that can be accessed to assist the bidder in preparing applications, including:

1. Mission, Vision, and Values
2. Strategic Plan
3. Division Performance Reports and Population Plans
4. Network180 policies related to contract expectations
5. MDHHS contract- Boilerplate
6. MDHHS contract- First Episode Psychosis
7. MDHHS contract Attachment E- Federal Mental Health Block Grant Special Contract Provisions
8. Sample Network180 contract with First Episode Psychosis provider
9. First Episode Psychosis Work Plan
10. Quarterly Reporting format
11. Budget forms

Grantee Relationship Expectations

Network180 expects that grantees under this award will comply with subrecipient monitoring policies and procedures, as outlined in the policies and procedures, included as part of this release. Grantee will also provide quarterly update and reporting to the Network180 Grant Manager, as prescribed by MDHHS, and Network180. Please refer to sample Network180 contract with First Episode Psychosis provider for more information.

Grantee will be required to obtain, and submit the results to Network180, a single audit for any year in which the grantee organization realizes $750,000 or more in total for all federal grant expenditures.

Grantee Commitment

Grantee response to this RFA reflects a commitment to participate in the entire training, implementation, and service delivery process.

Contract Boilerplate

Existing contracts between grantee agencies and Network180 include a contract boilerplate which contains the principles and policies that are the foundation for the contractual relationship between Network180 and the grantee agencies. Network180 contract policies are available for review on the Network180 website. All bidders are expected to be familiar with these policies and requirements. The remainder of this RFA is intended to provide additional information and expectations for grantee contracts with Network180 and will become the basis for the contract service specifications once the contract has been awarded.

The Network180 fiscal year begins October 1. The contract term for this RFA is twelve months beginning October 1, 2019 and ending September 30, 2020. This contract is renewed on an annual basis, pending continued contract between MDHHS and Network180.
**Services included in this RFA**
First Episode Psychosis (FEP) Treatment as described in the Service Summary and the resource entitled “Recovery After an Initial Schizophrenia Episode (RAISE).”

It is the intent of Network180 to award multiple contracts under this RFA, however, Network180 reserves the right not to award contracts for FEP services.

Interested organizations must submit a complete response to this RFA no later than October 18, 2019 at 12:00pm (noon) Eastern Standard Time. Applicants must email their completed application and all supporting documentation to Procurement@network180.org. All application information must be contained in one email, with attachments easily identifiable.

**RFP Timelines:**

- **October 4, 2019**  
  Request for Applications issued
- **November 13, 2019**  
  Final day for questions to be submitted by bidders at 3:00 p.m. EST
- **November 15, 2019**  
  Deadline for release of responses to written questions
- **November 20, 2019**  
  **Applications due to Network180 by 12:00 p.m. (noon) EST**
- **November 25 - December 6, 2019**  
  Application evaluation period
- **December 9, 2019**  
  Bidder notification of awards
- **December 16, 2019**  
  Network180 Board approval of awards
- **December 18, 2019**  
  Appeal deadline at 4:00 p.m. EST
- **December 23, 2019**  
  Pending receipt of contract from MDHHS- Contracts sent to awarded grantees
- ***November 23, 2019***  
  Contract implementation date

*Implementation of the services in this contract will require full team training on the specified model of care, scheduled for a later date. Implementation of services will begin once training has occurred.*
Section 1
Service Summary- First Episode Psychosis Treatment

It is estimated that 10 per 100,000 individuals experience their first episode of psychosis annually. Early intervention in the course of an individual’s course of their experiences of psychosis can alter the course of the illness, enabling individuals to more fully function and participate in family and the community. In 2008 the National Institute of Mental Health began a research initiative, Recovery After an Initial Schizophrenia Episode (RAISE), to develop, test and implement Coordinated Specialty Care (CSC) for individuals who recently experienced their first episode of psychosis. Initial and subsequent outcomes of the initiative continue to support the efficacy of the model of care.

In 2014, following the conclusion of the RAISE research project, President Obama directed that the Substance Abuse and Mental Health Services Administration (SAMHSA) require that five (5) percent of their Mental Health Block Grant (MHBG) funding be allocated to support “evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders.” Funding was first allocated in the state of Michigan beginning July 1, 2014. Funding has continued to be renewed each fiscal year since that time. Additionally, effective in mid-fiscal year 2016, funding was increased to equate to ten (10) percent of the MHBG. SAMSHA has further directed that intervention be focused only on the models of care used in RAISE.

Coordinated Specialty Care programs (CSC) have been proven effective treatment for first episode psychosis (FEP) as early intervention services for psychosis can improve symptoms and restore functioning that is superior to the usual care. Coordinated Specialty Care is a team-based multi-aspect approach to treating FEP. Components of CSC include assertive case management, individual/group psychotherapy, supported employment and education services, family education and support, and psychopharmacologic treatment and monitoring. At its base, CSC is recovery-oriented and collaborative in nature.

NAVIGATE is a CSC treatment model developed by the RAISE Early Treatment Program research team. Contracted teams will be trained in the NAVIGATE model, and will then implement the program within their geographical area. A team of 4-6 clinicians fulfill key roles in implementation of this model. Roles include Project Director, Supported Employment/Education Specialist, Individual Resilience Therapist, Family Therapist, and Psychiatrist/Prescriber. Case Management functions may be necessary, though not part of the prescribed treatment model, and are typically performed by the Individual Resilience Therapist. The target population is individuals aged 15-30 who have experienced FEP within the previous 18 months. Implementation of the program will include education and development of referral sources; education, recruitment, and enrollment of program participants; delivery of services; ongoing consultation and training from NAVIGATE trainers; and work towards development of funding sources or structures independent of grant funding.

Network180 has received grant funding for implementation of FEP services for the state of Michigan, through contract with Michigan Department of Health and Human Services. Grant funding totaling $2,036,326 for fiscal year 2020 be utilized to continue existing program services, expand program services within the state, provide training, and work to develop means of
sustaining treatment through this model of care independent of grant funds. This grant period is to end September 30, 2020, however due to the 21st Century Cures Act, opportunity to continue this program is anticipated. This statement shall not be assumed as guarantee of continued funding. Federal Mental Health Block Grant constraints on use of these funds are applicable.

It is anticipated that most program participants will initially have commercial insurance benefits or no benefits. Most program components are generally not included as a part of commercial insurance benefits. CSC teams will ensure enrollment in benefits for which an individual may be eligible, and paneling of eligible disciplines for that insurer. Reimbursement by commercial insurances or other third-party payers for eligible services provided through this program must be sought and maximized by service grantees, in support of the state of Michigan’s focus on sustainability of the program.

**Network180 is seeking to expand service provision within the state of Michigan.** Current programs are established in Kent County (InterAct of Michigan), Lansing/East Lansing (ETCH, LLP), Oakland County (Easter Seals Michigan), and Kalamazoo County (InterAct of Michigan). Applications to initiate programs outside of these established service areas will be considered. Consideration will also be given to supplement established programs not currently funded through this grant, without supplanting current funding, with the goal of expansion of services. Full capacity for one team is a minimum of 30 individuals receiving services. Below is an outline of the expected staffing for a full team. The first six (6) months most staffing is lowered as program participants are recruited and enrollment is built. Note that the Project Director’s FTE begins at the expected ongoing level as the role of that individual includes outreach, education, and establishment of referral sources.

<table>
<thead>
<tr>
<th>Position</th>
<th>Months 1-6</th>
<th>Months 7-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Project Director</td>
<td>0.5 FTE</td>
<td>0.5 FTE</td>
</tr>
<tr>
<td>Supported Employment/</td>
<td>0.5 FTE</td>
<td>1.0 FTE</td>
</tr>
<tr>
<td>Education Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Resilience Therapist</td>
<td>0.5 FTE</td>
<td>1.0 FTE</td>
</tr>
<tr>
<td>*Family Therapist</td>
<td>0.25 FTE</td>
<td>0.5 FTE</td>
</tr>
<tr>
<td>Psychiatrist/Prescriber</td>
<td>0.125 FTE</td>
<td>0.25 FTE</td>
</tr>
<tr>
<td>Peer Services</td>
<td>0.25 FTE</td>
<td>0.5 FTE</td>
</tr>
</tbody>
</table>

*It is typical for the Project Director and Family Therapist positions to be filled by the same individual, i.e., one professional fulfilling both roles.

**Expected Outcomes**

It is anticipated that each full team will build capacity and enrollment to serve a minimum of 30 individuals. Work plans will be developed and quarterly reporting, per grant requirements, will be submitted. Outcomes will be measured using prescribed measurement tools.

**Additional Resources**

• Psychosis-Risk and Early Psychosis Program Network (PEPPNET) website https://med.stanford.edu/peppnet.html
• Michigan Minds Empowered website www.michiganminds.org
• NAVIGATE website http://navigateconsultants.org/
Section 2
General Information about the RFA Process

- All questions must be submitted in writing by email to Procurement@network180.org. Questions regarding the content and the intent of the RFP will not be addressed after November 13, 2019 at 3:00 p.m. (EST). Written questions and associated responses to all questions will be posted on the Network180 website – www.network180.org.

- Network180 reserves the right to not award a contract as a result of this process.

- Network180 reserves the right to consider modifications to the program at any time before the execution of a contract, if such action is in the best interest of Network180, Michigan Department of Health and Human Service, or SAMHSA.

- Network180 is not liable for any costs incurred by respondents to this RFA prior to the issuance of a contract.

- Any respondent to this RFA must disclose any personal or business relationship with employees of Network180 or members of the Network180 Board. Any decision to grant a contract to a respondent having such a relationship will be dependent on consultation regarding conflict of interest. Provide detailed information about this in the Administrative Requirements section.

- All information included in a bidder’s application is subject to disclosure under the Michigan Freedom of Information Act, 1976 PA 442, once the application process has been concluded.

- All applications must be accompanied by an Attestation Statement signed by an official authorized to bind the bidder to the provisions contained in its response (see Attestation Statement provided in Section 5 of this RFA).

- A limited appeal process will be in place for organizations objecting to the application process. This appeal will be limited to alleged violations of the application process and shall not address the qualitative review by the review teams. An organization protesting the application process must identify alleged violations and the basis for its objection in writing and submit to the Network180 Board Chairperson by December 18, 2019 at 4:00 p.m. (EST).
Section 3
Instructions for Application Submission

1. Bidders must submit a complete response to this RFP to Network180 by November 20, 2019 12:00 p.m. (noon) EST in order to be considered. Late submissions will not be accepted. There will be no exceptions to this requirement. Completed applications must be submitted to Network180:

   - Email the submission in PDF format to Procurement@network180.org
   - The application and all supporting documents must be attached to one email
   - All attachments must be clearly labeled as to their content
   - Attachments will be submitted as outlined in Section 4 of this RFA
   - Applications not following this format will not be read by the evaluators

2. A written response is required for each item unless otherwise indicated. Failure to answer any of the items will negatively impact the bidder’s score.

3. Font size must be 12 point, Times New Roman, throughout the narrative response.

4. Margins must be 1 inch from all sides of 8 ½ x 11 inch page with portrait orientation.

5. Font style, font size, page orientation and margin rules do not apply to the Proposed Organization Chart.

6. Scoring for each sub-section will be based solely on the information included within the stated page limits.

7. Failure to comply with instructions stated in this Request for Applications is grounds for sanctions which may include the reduction of points as appropriate or elimination of the application from the review process.
Section 4
Attachments

- There will be a total of 15 attachments as listed below
- Each attachment will be (1) PDF document containing all information
- Your e-mail should contain the attachments in the order in which listed below
- Answers to questions and information in each attachment must be in the order as presented in this RFA

Attachments:

1. Attestation Statement- completed and signed (available at the end of this RFA)
2. Section 6: Program Requirements Narrative- General Information
3. Section 6: Program Requirements Narrative- Service Provision
4. Section 6: Program Requirements Narrative- Staffing Requirements
5. Section 6: Program Requirements Narrative- Training Requirements
6. Section 6: Program Requirements Narrative- Proposed Budget
7. Section 5: Administrative Requirements- Quality Audit Results form(s)
8. Section 5: Administrative Requirements- Contract Termination
9. Section 5: Administrative Requirements- Organizational Chart
10. Section 5: Administrative Requirements- Criminal Background Checks
11. Section 5: Administrative Requirements- Office of Inspector General
12. Section 5: Administrative Requirements- Affiliations or Sub-Contractual Relationships
13. Section 5: Administrative Requirements- Conflict of Interest
14. Section 5: Administrative Requirements- Training and Credentials
15. Section 5: Administrative Requirements- Fiscal Viability
Section 5
Administrative Requirements

The following items are the Administrative Requirements and standards the bidder must meet as a Grantee of Network180 services. Failure to comply with instructions stated in this Request for Applications is grounds for sanctions which may include the reduction of points as appropriate or elimination of the application from the review process.

The Administrative Requirements section will be evaluated as follows:

<table>
<thead>
<tr>
<th>Scoring/Rating</th>
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<tbody>
<tr>
<td>Quality Audit Results form</td>
</tr>
<tr>
<td>Contract Termination</td>
</tr>
<tr>
<td>Organizational Chart</td>
</tr>
<tr>
<td>Criminal Background Checks</td>
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<td>Office of Inspector General</td>
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<tr>
<td>Affiliations or Sub-Contractual Relationships</td>
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<tr>
<td>Conflict of Interest</td>
</tr>
<tr>
<td>Training and Credentials</td>
</tr>
<tr>
<td>Fiscal Viability</td>
</tr>
</tbody>
</table>

**Quality Audit Results form**

Acceptable Response/Resolve Prior to Contract

Complete and sign a Quality Audit Results form for each entity that has conducted a quality review of your programs during the past three (3) years. Attach each form to your RFA submission, clearly labeling each.

**Contract Termination**

Acceptable Response/Resolve Prior to Contract

Provide a detailed listing of any service contracts in the past three (3) years that terminated prior to the natural expiration. Reference on contracts that relate to the delivery of programs/services to individuals. Explain circumstances, reason for termination of the contract and impact on individuals served. **(1 page limit)**

**Organizational Chart**

Acceptable Response/Resolve Prior to Contract

Provide a copy of your organizational chart, including the proposed First Episode Psychosis program.

**Criminal Background Checks**

Acceptable Response/Resolve Prior to Contract

Provide a copy of your policy and/or plan for conducting criminal background checks on all staff at the time of hire and at least once every two years after that.
Office of Inspector General

Provide your policy and/or process for ensuring on a monthly basis that your entity and individuals implementing the program are not excluded, debarred or suspended from participation in federal and/or state health care programs.

Affiliations or Sub-Contractual Relationships:

Complete the Disclosure of Ownership form and attach to your RFA submission, clearly labeling. Disclose information about any affiliations or sub-contractual relationships, common ownership, overlapping Boards, pending or planned mergers or acquisitions which may affect the terms of potential contract. Name the specific organization(s) and the specific nature of the organizational relationship. Network180 may request a meeting with the parties involved or request additional information to determine Grantee panel eligibility and appropriateness for contracting with Network180.

Conflict of Interest:

Complete the Conflict of Interest form and attach to your RFA submission, clearly labeling. Disclose any personal or business relationships with employees of Network180 or the board members of Network180, including the nature of the relationship and the name of the employee or board member.

Training and Credentials:

Describe your procedures for initial and on-going verification of state training credentials as applicable to this program. (1 page limit)

Financial Viability:

Provide documents demonstrating financial viability attaching to your RFA submission, clearly labeling. Submit a copy of the most recent financial audit or review and management letter issued by a CPA regarding internal controls. If an audit or review has not been conducted, submit other documents demonstrating financial viability.
Section 6
Program Narrative Requirements

Application will be evaluated according to the strength of the response, experience, and ability in all required areas. There is a page limit per sub-section. Information beyond the page limit for each sub-section will not be read. Scoring for each sub-section will be based solely on the information included within the stated page limits.

Respondents must include specific and detailed responses to the following:

**General Information:**

1. Name of Grantee
2. Contact Person
3. Email Address
4. Phone Number
5. Mailing Address

**Service Provision:**

6. Review the following:
   a. Resources listed in the Introduction and Section 1 of this Request for Application
   b. The Network180 First Episode Psychosis Treatment Program FY 2020 Request for Applications

Do you agree to provide the services outlined in this RFA, the RFA Resources, and per the NAVIGATE training and ongoing fidelity monitoring (provided as part of awarding this grant)?

7. Describe your organization’s experience providing the service components, or similar service components, as described in the resources in Section 1, to the target population, including the number of years. Please include any current or past contracts with other funders or organizations to provide this or a similar service. **(2 page limit)**

8. Describe how your organization will identify, develop and educate potential referral sources. Include how you will provide outreach to diverse and underserved populations. For programs seeking supplemental funding, identify your current or anticipated structure and process. **(1 page limit)**

9. Describe the geographic/catchment area in which you anticipate providing the FEP Treatment program. Please include detail around the components of the population that are
included in this area. An example might be, residents of a specific county or city. Identify unusual factors that add to or diminish a population size, such as presence of a major university, or seasonal residents. *One core requirement is the population size must be large enough in order to establish pool of potential participants to meet a team enrollment of at least 30 individuals meeting the criteria for the RAISE program. The identified geographic/catchment area should have a population size of approximately 650,000 or more individuals. (1 page limit)

10. Describe your organization’s experience in data and outcome reporting on SAMHSA grants or State of Michigan Department of Community Health Grants. (1 page limit)

11. Does your organization attest that it will meet all required data reporting and monitoring elements for the FEP Treatment program?

**Staffing Requirements:**

12. The associated FTE’s with this program are described in a previous section. Please describe in detail how you will staff this program, enabling an increase in staffing at or around the seventh month. If possible, please include the names of individuals targeted to provide this service, including their credentials and experience working with the targeted population in the identified role. (1 page limit)

13. Describe how your staffing of this program will fit into the structure of your organization. Include an organizational chart. (1 page limit)

**Training Requirements:**

14. Do all of your organization’s staff assigned to the FEP Treatment program agree to attend the ongoing training and consultation meetings (phone conferences)? Phone consultation for all roles, excluding the Prescriber will occur one hour, twice monthly. Phone consultation for the Prescriber will occur one hour monthly.

**Proposed Budget:**

15. Complete and attach a proposed budget utilizing the attached budget forms. Refer to the attached guidelines for expenses that are not reimbursable under Federal MHBG (labeled Attachment E).

16. As described earlier in this Request for Applications, one focus of the activities under this grant is development of sustainability through identification of alternative funding sources. Describe your organization’s experience in working with and billing third party payers such as commercial insurances. Identify the 2-3 largest commercial insurers in your proposed geographical area and indicate whether your organization is currently paneled as a provider with each organization. (1 page limit)
Section 7
Application Evaluation

The evaluation of applications received in response to the RFA will be conducted comprehensively, fairly, and impartially. Structural, quantitative scoring techniques will be utilized to maximize the objectivity of the evaluation.

A team of reviewers will evaluate all applications received. Each application will be evaluated according to the strength of the response, integration of Network180 System Principles, experience and ability in all required areas. Following this review, Network180 staff will make a recommendation to the Network180 Board for award of the contract.

Scores will be determined as follows, unless otherwise indicated in the Program Description/Requirements:

<table>
<thead>
<tr>
<th>Evaluation Categories</th>
<th>Possible Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 5: Administrative Requirements (all)</td>
<td>Acceptable Response/Resolve Prior to Contract</td>
</tr>
<tr>
<td>Service Provision</td>
<td>20</td>
</tr>
<tr>
<td>Staffing Requirements</td>
<td>10</td>
</tr>
<tr>
<td>Training Requirements</td>
<td>Acceptable Response/Resolve Prior to Contract</td>
</tr>
<tr>
<td>Proposed Budget</td>
<td>Acceptable Response/Resolve Prior to Contract</td>
</tr>
<tr>
<td>Question #15</td>
<td>5</td>
</tr>
<tr>
<td>Question #16</td>
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</tbody>
</table>

**Total Points = 35**

In the event there are no significant differences between the scores of applications, Network180 will make award recommendations based on the organization with the most positive results from internal and external quality reviews. Should the result continue to be such that there is no significant difference in applications, Network180 will make award recommendations based on the application with the highest number of points awarded for the Service Provision section.
Attestation Statement

I believe the information submitted in this application, including all attachments, is true to the best of my knowledge. I fully understand that any misleading statement or omission in this document discovered at any time may constitute cause for immediate termination from the application process and/or from future contracts.

I further understand that if selected to be part of this Network180 service, I have a continuing duty to update, as necessary, the information submitted in this application. Such updates will be made within ten (10) calendar days of their occurrence. Network180 reserves the right to review all updates and make decisions regarding continued participation on its Grantee panel.

Name ________________________________________________
Signature

Name _________________________________________________
Printed or typed

Business Name __________________________________________

Title __________________________________________________

Date ___________________________________________________

[Print this page, complete the requested information, and include with your response to this RFA]

Disclosure of Ownership, Controlling Interests and Management Form
Disclosure of Ownership, Controlling Interests and Management Form

The PrePaid Inpatient Health Plan ("PIHP") is required to collect disclosure of ownership, controlling interests, and management information from providers that are credentialed or otherwise enrolled to participate in the Medicaid program and/or the Prepaid Inpatient Health Plan (PIHP). This requirement is pursuant to a Medicaid and/or PIHP State Contract with the State Agency and the federal regulations set forth in 42 CFR Part §455. Required information includes: 1) the identity of all owners and others with a controlling interest of 5% or greater; 2) certain business transactions as described in 42 CFR §455.105; 3) the identity of managers and others in a position of influence or authority; and 4) criminal convictions, sanctions, exclusions, debarment or termination information for the provider, owners or managers. The information required includes, but is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN).

Completion and submission of this Statement is a condition of participating as a credentialed or enrolled provider in the PIHP managed care network for services to members under Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program. Failure to submit the requested information may result in a refusal of participation in PIHP or denial of a claim.

This statement should be submitted at any of the following times: upon the submission of an application; upon execution of an agreement; during re-credentialing or re-contracting (at least every two years); within 35 days after any change in ownership of the disclosing entity. A Statement must be provided to PIHP within 35 days of a request for this information by the U.S. Department of Health and Human Services (HHS) or the State Agency. PIHP maintains policies and practices that protect the confidentiality of personal information, including Social Security numbers, obtained from its providers and associates in the course of its regular business functions. PIHP is committed to protecting information about its providers and associates, especially the confidential nature of their personal information.

Detailed instructions and a glossary of terms can be found at the end of this form. If attachments are included, please indicate to which section those attachments refer.

Provider/Provider Entity Information

Please fill out the entire section. Every field must be complete. If fields are left blank, the form will be returned for corrections/completeness. *These fields cannot be left blank; check appropriate box or use 'N/A'.

<table>
<thead>
<tr>
<th>Please choose appropriate category:</th>
<th>Name of Provider/Provider Entity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Entity</td>
<td>Name of Person Completing this Form:</td>
</tr>
<tr>
<td>Licensed Independent Practitioner</td>
<td>Title:</td>
</tr>
<tr>
<td>Managing Employee</td>
<td>Phone Number:</td>
</tr>
<tr>
<td>HCBS Provider</td>
<td>Fax:</td>
</tr>
<tr>
<td>Other:</td>
<td>Email:</td>
</tr>
<tr>
<td>Group Affiliation? Yes No</td>
<td>In which state(s) do you participate in Medicaid?</td>
</tr>
<tr>
<td>If yes, do you have a private practice as well? Yes No</td>
<td></td>
</tr>
<tr>
<td>Additional Addresses (list all Practice Locations)</td>
<td>Attaching list? Yes No</td>
</tr>
<tr>
<td>*SSN (if Individual Provider): N/A</td>
<td>*Medicaid ID#:</td>
</tr>
<tr>
<td>*Federal Tax ID# (if Entity): N/A</td>
<td>*Applied for Medicaid ID</td>
</tr>
<tr>
<td></td>
<td>*Not applicable</td>
</tr>
<tr>
<td>*Applied for NPI #</td>
<td>*Not applicable</td>
</tr>
</tbody>
</table>
Section I: Individual Provider Ownership Information

1. Are there any individuals or organizations with a Direct or Indirect Ownership Interest of 5% or more in your entity/practice? □ Yes □ No - Skip to #2 □ N/A - Skip to #2

See instructions for more information and examples

If yes, list the name, primary address date of birth (DOB), and Social Security Number (SSN) for each person having an Ownership Interest in the disclosing entity of 5% or greater. List the name, Tax Identification Number (TIN), primary business address, every business location, and P.O. Box address of each organization, corporation, or entity having an Ownership Interest of 5% or greater. (42 CFR §455.104). Attach additional sheets as necessary

<table>
<thead>
<tr>
<th>Name of Owner</th>
<th>DOB (mm/dd/yyyy)</th>
<th>Complete Address (Street/City/State/Zip)</th>
<th>** SSN or TIN or both as applicable</th>
<th>% Interest</th>
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</table>

** SSN and TIN required under §455.104; See sect 4313 of the Balanced Budget Act of 1997 amended Sect 1124 and Federal Register Vol. 76 No 22

Section II: Ownership in Other Providers & Entities

2. Does the Owner identified in Section I have an Ownership or Controlling Interest in any other provider entity? □ Yes □ No - Skip to #3 □ N/A - Skip to #3

If yes, list the name and the SSN or TIN of the other provider or entity in which the Owner identified in Section I also has an Ownership or Controlling Interest (42 CFR §455.104(b)(3)). Attach additional sheets as necessary

<table>
<thead>
<tr>
<th>Name of Owner from Section I</th>
<th>Name of Other Provider or Entity</th>
<th>Other Provider or Entity's SSN (indiv.) or TIN (entity)</th>
</tr>
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Section III: Subcontractor Ownership

3. Do you, as the Provider Entity, have a Direct or Indirect Ownership Interest of 5% or more in any Subcontractor? □ Yes □ No - Skip to #4 □ N/A - Skip to #4

If yes, does another individual or organization also have an Ownership or Controlling Interest in the same Subcontractor? □ Yes □ No

If yes, list the following information for each person or entity with an Ownership or Controlling Interest in any Subcontractor in which you also have Direct or Indirect Ownership Interest of 5% or more (42 CFR §455.104). Attach additional sheets as necessary □ Yes □ No

Legal Name of Subcontractor:

Name of Subcontractors Other Owner: Other Owner’s:

Other Owner’s Address: City, State, Zip:

Other Owner’s TIN: Other Owner’s SSN: % Interest:
Section IV: Familial Relationships of All Owners

4. Are any of the individuals identified in Sections I, II, or III related to each other? □ Yes □ No- Skip to #5
□ N/A- Skip to #5
If yes, list the individuals identified and the relationship to each other (e.g. spouse, domestic partner, sibling, parent, child) (42 CFR §455.104(b)(2). Attach additional sheets as necessary □ Yes □ No

| Name of Owner 1 | Name of Owner 2 | Relationship |

Section V: Criminal Convictions, Sanctions, Exclusions, Debarment, or Terminations

5. Have you or any person who has Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Provider Entity ever been indicted or convicted of a crime related to that person’s involvement in any program under Medicaid, Medicare, CHIP, or Title XX programs? □ Yes □ No- Skip to #6 □ N/A – Skip to #6
If yes, list those persons and the required information below (42 CFR §455.106).
Attach additional sheets as necessary □ Yes □ No

| Name: | DOB: |
| Address: | SSN (indiv.) or TIN (entity): |
| City, State, Zip: | State and Date of Conviction: |
| Matter of the Offense | Date of Reinstatement: |

6. Have you or any person who has Ownership or Controlling Interest, or who is an Agent or Managing Employee of your Provider Entity ever been sanctioned, excluded, or debarred from Medicaid, Medicare, CHIP, or Title XX programs?
□ Yes □ No- Skip to #7 □ N/A – Skip to #7
If yes, list those persons and the required information below (42 CFR §455.436).
Attach additional sheets as necessary □ Yes □ No

| Name: | DOB: |
| Address: | SSN (indiv.) or TIN (entity): |
| City, State, Zip: | List all states where currently excluded: |
| Reason for Sanction, Exclusion, or Debarment: | Date of Reinstatement: |

| Date(s) of Sanctions, Exclusions, or Debarments: | |

7. Has the Provider Entity, or any person who has Ownership or Controlling Interest in the Provider Entity, or who is an Agent or Managing Employee of the Provider Entity ever been terminated from participation in Medicaid, Medicare, CHIP, or Title XX programs?
□ Yes □ No- Skip to #8 □ N/A – Skip to #8
If yes, list those persons and the required information below (42 CFR §455.416).
Attach additional sheets as necessary □ Yes □ No

| Name: | DOB: |
| Address: | SSN (indiv.) or TIN (entity): |
| City, State, Zip: | Terminated from Medicare? □ Yes □ No |
| Reason for Termination: | Date of Termination: |
| State that originated Termination: | Date of Reinstatement: |

*At any time during the Contract period, it is the responsibility of the Provider/Provider Entity to promptly provide notice upon learning of convictions, sanctions, exclusions, debarments and terminations (see Fed. Register, Vol. 44, No. 138)

Section VI: Business Transaction Information
8. **Business Transactions – Subcontractors:** Has the Provider Entity had any business transactions with a Subcontractor totaling more than $25,000 in the previous twelve (12) month period?  
- [ ] Yes  
- [ ] No - Skip to #9  
- [ ] N/A - Skip to #9  
  **If yes,** list the information for Subcontractors with whom the Provider Entity has had business transactions totaling more than $25,000 during the previous 12 month period ending on the date of this request (42 CFR §455.105(b)(1))  
  Attaching additional sheets as necessary  
- [ ] Yes  
- [ ] No

<table>
<thead>
<tr>
<th>Name of Subcontractor:</th>
<th>Subcontractor’s SSN or TIN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subcontractor Address:</td>
<td>City, State, Zip:</td>
</tr>
<tr>
<td>Subcontractors Owner (SO):</td>
<td>SO’s SSN or TIN:</td>
</tr>
<tr>
<td>SO’s Address:</td>
<td>City, State, Zip:</td>
</tr>
</tbody>
</table>

9. **Significant Business Transactions – Wholly Owned Suppliers:** Has the Provider Entity had any Significant Business Transactions with a Wholly Owned Supplier exceeding the lesser of $25,000 or 5% of operating expenses in the past five (5) year period?  
- [ ] Yes  
- [ ] No – Skip to #10  
- [ ] N/A – Skip to #10  
  **If yes,** list the information for any Wholly Owned Supplier with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period (43 CFR §455.105(b)(2)).  
  Attaching additional sheets as necessary  
- [ ] Yes  
- [ ] No  
  See Glossary for definition

<table>
<thead>
<tr>
<th>Name of Supplier:</th>
<th>Suppliers SSN or TIN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suppliers Address:</td>
<td>City, State, Zip:</td>
</tr>
</tbody>
</table>

10. **Significant Business Transactions – Subcontractors:** Has the Provider Entity had any Significant Business Transactions with a Subcontractor totaling more than $25,000 in the past five (5) year period?  
- [ ] Yes  
- [ ] No – Skip to #11  
- [ ] N/A - Skip to #11  
  **If yes,** list the information for Subcontractors with whom the Provider Entity had any Significant Business Transactions exceeding the $25,000 during the past 5-year period (42 CFR §455.105(b)(2)).  
  Attaching additional sheets as necessary  
- [ ] Yes  
- [ ] No

<table>
<thead>
<tr>
<th>Name of Subcontractor:</th>
<th>Subcontractor’s SSN or TIN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subcontractor Address:</td>
<td>City, State, Zip:</td>
</tr>
<tr>
<td>Subcontractors Owner (SO):</td>
<td>SO’s SSN or TIN:</td>
</tr>
<tr>
<td>SO’s Address:</td>
<td>City, State, Zip:</td>
</tr>
</tbody>
</table>

  **This information must be provided and/or updated within 35 days of a request.** Medicaid payments may be denied for services furnished during the period beginning on the day following the date the information was due until it is received (42 CFR §455.105)
Section VII: Management and Control

11. **Managing Employees**: Does the Provider Entity have any Managing Employees?
   - ☐ Yes  ☐ No  ☐ N/A  skip to #12
   - If yes, list all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operations of Provider Entity (general manager, business manager, administrator or director), including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104). Attach additional sheets as necessary  ☐ Yes  ☐ No

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Complete Address</th>
<th>SSN</th>
<th>Title</th>
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<td>mm/dd/yyyy</td>
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12. **Agents**: Does the Provider Entity have any Agents?  ☐ Yes  ☐ No  ☐ N/A
   - If yes, list all Agents that have been delegated the authority to obligate or act on behalf of Provider Entity, including the name, date of birth (DOB), address, Social Security Number (SSN), and title (42 CFR §455.104). Attach additional sheets as necessary  ☐ Yes  ☐ No

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Complete Address</th>
<th>SSN</th>
</tr>
</thead>
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<td>mm/dd/yyyy</td>
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</table>

Through signature below, I hereby certify that any employees or contractors providing services pursuant to a contract with Lakeshore Regional Entity are screened with the applicable background check including, but not limited to, verification against the OIG’s List of Excluded Individuals & Entities (https://oig.hhs.gov/exclusions/index.asp) and the System for Award Management (SAM) www.sam.gov and any applicable state, federal, or other governmental exclusion or sanction database and that the information provided herein is true, accurate, and complete. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of a claim and/or termination of the contract.

Signature: ________________________________  Title: ________________________________
Print Name: ________________________________  Date: ________________________________
Phone: ______________________ Fax: ______________________  Email: ______________________
Disclosure Instructions

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the section number that is being continued. For example: Section I Ownership Information, continued. Please see Glossary for definition of capitalized terms.

Section I: Provider Entity Ownership Information
Please list the required information for each individual or organization that has a Direct or Indirect Ownership of 5% or more or has a Controlling Interest in your entity. If the owner is a corporation: the primary business address must be listed and every business location and PO Box address. Provider members of a group practice who have ownership or a controlling interest in Provider Entity must submit a separate Statement.

Providing the SSN and TIN (as applicable) is required under 42 CFR 455.104; please see Section 4313 of the Balanced Budget Act of 1997, amended Section 1124, and the Federal Register Vol. 76 No. 22. Any form without the required SSN and TIN (as applicable) is incomplete and will not be processed.

Section II: Ownership in Other Providers & Entities
Please identify the other providers or entities that are owned or controlled at least 5% by the same individual or organization identified in Section I that has an Ownership or Controlling Interest in your entity. This information is to identify shared and interconnected ownership and controlling interests.

Section III: Subcontractor Ownership
If your entity has a Direct or Indirect Ownership of 5% or more in a Subcontractor and other individuals or entities also have a Direct or Indirect Ownership of that same Subcontractor, please identify the Subcontractor and provide the required information for the additional owners.

Section IV: Familial Relationships of All Owners
Report whether any of the persons listed in Sections I, II, and III are related to each other and identify the parties and their relationship. For the definition of domestic partner, refer to your state’s laws. Provider members of a group practice who are related to the Provider Entity’s owners or those with a controlling interest must submit a separate Statement.

Section V: Criminal Convictions, Sanctions, Exclusions, Debarment, and Terminations
List your own criminal convictions, sanctions, exclusions, debarments, and termination, and for any person who has an ownership or controlling interest, or is an agent or managing employee of your entity. List all offenses related to each person’s or entity’s involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services since the inception of these programs. Review all of the databases necessary to verify this information:

1. Exclusion status may be verified through the HHS-OIG List of Excluded Individuals/Entities (LEIE) at [https://oig.hhs.gov/exclusions/index.asp](https://oig.hhs.gov/exclusions/index.asp)
2. Sanction information is available in the GSA’s SAM (System for Award Management) database [www.sam.gov](http://www.sam.gov).
3. State specific exclusions/sanction databases may be accessed through the State Agency’s website.

Section VI: Business Transaction Information
1. List the Ownership of any Subcontractors that you have had business transactions totaling more than $25,000 within the last twelve (12) month period ending on the date of the request.
2. List any Significant Business Transactions between your entity and any Wholly Owned Supplier during the past 5 years.
3. List any Significant Business Transactions between your entity and any Subcontractor during the past 5 years.

Remember that a Significant Business Transaction is defined as any transaction or series of related transactions that exceeds the lesser of $25,000 or 5% of a provider’s operating expenses during any one fiscal year.

This information must be made available within 35 days of a request by the US Department of Health and Human Services (HHS), the State Medicaid Agency, and the Medicaid Managed Care Organization responding to an HHS or State request.

Section VII: Management & Control
1. List the required information for all employees that hold a position of Managing Employee within your entity.
2. List the required information for all Agents that have the authority to obligate or act on behalf of your entity.
3. List the required information for all individuals on the governing board or board of directors if your entity is organized as a corporation. CMS requires the identification of officers and directors of a Provider Entity that is organized as a corporation, without regard to the for-profit or not-for-profit status of that corporation.
Glossary

Agent: any person who has been delegated the authority to obligate or act on behalf of a Provider Entity.

CHIP: The Federal insurance program for children, Child Health Insurance Program, in Michigan this is known as MiChild.

Controlling Interest: defined as the operational direction or management of a disclosing entity which management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity; the ability or authority to nominate or name members of the Board of Directors or Trustees; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

Determination of ownership or control percentages:

a) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A’s interest equates to 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B’s interest equates to 4 percent indirect ownership interest in the disclosing entity and need not be reported.

b) Person with an ownership or controlling interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity’s assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider’s assets, A’s interest in the provider’s assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider’s assets, B’s interest in the provider’s assets equates to 4 percent and need not be reported.

Direct Ownership Interest: the possession of equity in the capital, the stock, or the profits of the disclosing entity.

HCBS Provider: a provider of Home and Community Based Services for Medicaid beneficiaries.
CONFLICT OF INTEREST COMPLIANCE CERTIFICATE

CMHSP intends to avoid Conflict(s) of interest or the appearance of Conflict(s) of Interest. A Conflict of Interest occurs when an individual puts his or her own personal interests in conflict with CMHSP’s interest or creates a situation where CMHSP is at a disadvantage with its funding agencies, regulators, accrediting bodies, customers, Provider, suppliers or competitors. Thus, CMHSP reserves the right to determine, at its sole discretion, whether any information received from any source indicates the existence of a Conflict of Interest.

Conflicts of Interest means:
1. A Provider, a sub-contractor, any management officials or affiliated business entities of a Provider or sub-contractor; or any employees and agents who will perform services under a proposed or existing contract with CMHSP has one or more personal, business or financial interests or relationships which would cause a reasonable individual with knowledge of the relevant facts to question the integrity or impartiality of those who are or will be acting under a proposed or existing CMHSP contract; or
2. A Provider, a sub-contractor, any management officials or affiliated business entities of a Provider or sub-contractor who will perform services under a proposed or existing contract with CMHSP is an adverse party to a lawsuit with CMHSP; or
3. Any other facts exist which CMHSP, in its sole discretion, determines may, through performance of a proposed or existing CMHSP contract, provide a Provider or sub-contractor with an unfair competitive advantage which favors the interests of the Provider or sub-contractor or any person with whom the Provider or sub-contractor has or is likely to have a personal or business relationship; or sub-contractor, any management officials or affiliated business entities of a Provider or subcontractor, or any employees and agents who will perform services under a proposed or existing contract with CMHSP refers any portion of the services to a family member.

Representations as to Conflicts of Interest:

Answers to the following questions are provided for the Provider or sub-contractor, its officers, directors, any management officials, any persons that own or control you or that you own or control; and any employees or agents who will perform services under the contract: You have a conflict of interest when you, any person that owns or controls you, or any entity you own or control answers “yes” to any of the following four (4) questions:

1. Have any such person(s) a personal, business or financial interest or relationships that relate to the services the Provider performs under this contract?

☐ YES ☐ NO

2. Has the Provider been removed from or prohibited from participating in any Federal, State or Local Programs?

☐ YES ☐ NO

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3. Are any such person(s) a party to litigation against CMHSP, or represents a party that is?

☐ YES      ☐ NO

4. Does the Provider make any referrals to family members when performing services under the contract?

☐ YES      ☐ NO

The Provider or sub-contractor agrees that if it is awarded a contract, throughout the life of the contract, immediate notification will be provided to the CMHSP Contract Manager if at any time a potential or actual conflict of interest becomes known.

The undersigned hereby affirms that: (check one)

☐ I have read the above statements and declare no conflict of interest exists that would jeopardize the ability of the Contractor or subcontractor to perform under a CMH contract.

☐ A suspected or potential conflict of interest does exist and additional information is attached along with a plan to address the potential conflict of interest.

Organization Name: _____________________________________________________________

Signature: _______________________________ Date: ______________________________

Name and Title

Printed Name of Authorized Representative: _________________________________________