MCCMH MCO Policy 3-020

*(was MCCMH Policy 5-05-035)*

Chapter: **PROVIDER NETWORK MANAGEMENT**
Title: **PROCUREMENT OF GOODS AND SERVICES**

Prior Approval Date: 10/12/06
Current Approval Date: 10/17/07

Approved by: Donald J. Dahlkemper 10/17/07
Executive Director Date

## I. Abstract

This policy establishes the standards and procedures of the Macomb County Community Mental Health Board (MCCMH) regarding the solicitation of goods and service provider capacity from public or private sector entities for the direct-operated and contract network providers of MCCMH services.

## II. Application

This policy shall apply to all current and prospective network providers of the MCCMH Board who wish to submit a proposal to provide goods and/or services for the MCCMH Board.

## III. Policy

It is the policy of the MCCMH Board that goods and contractual public or private services estimated to be valued at $5000.00 or more shall be acquired through a formal Procurement Process. The Procurement Process shall be through a Competitive Bidding Process, or, if warranted, through the Non-Competitive Negotiations Process contained in this policy.

## IV. Definitions

A. Network Provider
MCCMH directly-operated or contract providers of services to MCCMH consumers.

B. Competitive Bid
The formal process of soliciting proposals/quotations for the provision of goods or services for which the cost exceeds $5,000.00 through public advertisements pursuant to the issuance of a Request for Proposal (RFP), MCCMH #199 (Exhibit A) by the

MCCMH Board.

C. Request For Proposal, MCCMH #199 (Exhibit A)
The general specifications required for submission of a proposal/quotation for the procurement of goods and services as delineated by the MCCMH Board pursuant to applicable statute, rules, regulations, licensing requirements and the needs of the population to be served.

D. Non-Competitive Negotiation
Selection of a provider of goods or services and/or negotiation of a written contract which does not occur through a competitive bidding process. Documentation is required and must be filed with each purchase order indicating the specific reasons (see Standard B.) for the non-competitive negotiation and how the pricing was determined.

E. Emergency Purchases
Immediate procurement of goods or services when there exists a threat to public health, welfare, or safety and the urgency for obtaining the goods or service does not permit a delay incident to competitive solicitation.

F. Delegated Function
Any function covered by the provisions of the federal Balanced Budget Act that the MCCMH, as a PIHP/MCO, is required to provide under contract with the Michigan Department of Mental Health that is assigned to a third party via contract between the PIHP and the third party.

## V. Standards

A. Plans for programmatic development will be reviewed by the appropriate MCCMH consumer advisory councils. The process for behavioral health services shall include review by the MCCMH Citizens Advisory Council. The process for substance abuse services shall include review by the Substance Abuse Advisory Council.

B. Unless otherwise excepted by MCCMH Board approval, selection of a network provider to provide goods or services to MCCMH for which the cost exceeds $5,000.00 shall be accomplished through competitive bidding. Under certain circumstances, the MCCMH Board may select a provider of goods or services through non-competitive negotiation.

C. Non-competitive negotiation may be considered when:

1. The provision of goods or services is available only from a single source;

2. After solicitation of a number of sources competition is determined inadequate;

3. The goods or services sought are goods or professional services of limited quantity or duration;

4. The goods or services are unique and/or the selection of the provider has been granted to the consumer under a voucher or self-determination program;

5. Continuity of care is a paramount concern in adding residential or other services to already existing service contracts; extension/expansion of current contracts may occur under this provision; and/or

6. There is a public exigency or emergency, and the urgency for obtaining the goods or services does not permit a delay incident to competitive solicitation; extension/expansion of current contracts may occur under this provision.

   In each emergency as much competition as is practical under the circumstances shall be factored into the decision of award. Written documentation specifying the nature of the emergency must be included in the contract file.

D. The MCCMH Board reserves the right to reject or to waive any defect(s) in any or all proposals/quotations.

E. After the publication and release of a RFP is made, there will be no alteration, addition or deletion from the RFP packet without written notification of such to all bidders.

F. Decisions regarding final approval of any or all proposals/quotations submitted through the process of competitive bids and RFPs shall be made solely by the MCCMH Board.

## VI. Procedures

A. Proposals/Quotations Development

1. Upon determination of the need for goods or services, the MCCMH Business Management Director or designee shall place an advertisement in the Public Notice Section of the major newspapers serving Macomb and its surrounding Counties. The purpose of the advertisement shall be to notify interested entities of the impending goods or services to be obtained by MCCMH and to invite them to contact the MCCMH Business Management Director's Office to secure a RFP package within ten (10) business days from the date of the advertisement.

2. The MCCMH Business Management Director or designee shall prepare a list of all entities requesting RFP packages, whether solicited via advertisement or other means, with identification of those who have previously provided similar goods or services for MCCMH, other CMHSPs, or the Michigan Department of Community

Mental Health (MDCH). The MCCMH Business Management Director or designee shall forward a RFP package to all listed entities.

3. The RFP package(s) shall include, as applicable:

   a. Announcement of the date, time, and location of a bidders' meeting for providers interested in the submission of proposals/quotations to MCCMH for the provision of goods or services;

   b. A copy of this policy;

   c. A description of specific criteria to be met for the goods or services to be provided;

   d. Identification of the MCCMH consumer population to be served along with any special factors to be considered in the provision of services;

   e. Identification of specific performance standards to be included in the contract;

   f. Identification of PIHP/MCO delegated functions to be included in the contract;

   g. Specification of the requirements for budget/finance detail;

   h. Designation of the applicable statutes, rules, regulations, licensing requirements and other criteria to be satisfied;

   i. The deadline date for submission of proposals/quotations which shall not be less than ten (10) business days from the printed public announcement. Proposals received after the deadline date will not be considered;

   j. A Network Provider Qualification Statement, MCCMH #200 (Exhibit B);

   k. A description of the proposed Evaluation Criteria by category, including but not limited to Network Provider Capability, Technical Approach, and Financial Aspects. Each category will indicate maximum points available;

   l. The specific minimum requirements for the duration of all prices quoted by the bidder;

   m. A copy of the Draft/Proposed Contract with the MCCMH Board, if available; and

   n. A Provider Profile Application (Exhibit C).

4. Proposals/Quotations submitted for MCCMH Board consideration shall contain, at a minimum, the information listed below, with appropriate documentation. Proposals/ quotations not including the information shall be subject to rejection.

    1. Information pertaining to the goods or services to be provided as required in the RFP, with appropriate documentation.

    2. Information describing the bidder's compliance with local ordinances, statutes, rules, regulations, licensing requirements, as applicable, and MCCMH specific criteria related to the following:

        a. Estimated costs for the provision of services to MCCMH, including all related costs, e.g., taxes, necessary permits, fees, and insurance, etc.

        b. Proposed contractual terms including, but not limited to, length of the agreement, taxes, insurances, special conditions, etc.

    3. For services, the bidder's credit and financial statements, including business and personal references obtained from the Network Provider Qualification Statement, MCCMH #200 (Exhibit B).

    4. A completed Provider Profile Application (Exhibit C).

B. Proposal/Quotation Selection

1. Proposal Evaluation Team

    a. Proposal Evaluation Teams shall include appropriate staff and individual consumers and/or consumer interest groups that have an interest in receiving the proposed service.

    b. The Proposal Evaluation Team shall examine, evaluate and score all submitted proposals/quotations for potential selection utilizing the Evaluation Criteria as stated in the RFP and the Network Application/Profiling information submitted pursuant to the provisions of MCCMH MCO Policy 3-004, "Network Application / Profiling Process."

    c. Team members shall receive reimbursement**, based upon hardship or need,** for travel or other expenses directly related to procurement reviews with approval of the MCCMH Executive Director.

    d. The Team will submit a summary of the proposals/quotations, evaluation results

and selection recommendations to the MCCMH Executive Director.

e. MCCMH Executive Director or designee(s) shall submit a recommendation to the MCCMH Board for final approval, along with information relative to other submissions and the rationale upon which recommendations are made.

2. Evaluation of proposals/quotations for potential selection of a RFP bidder shall include, as applicable:

   a. Assessment of costs of the proposal/quotation relative to submissions by other providers and the availability of public funds.

   b. Prior history of the provider, from the Provider Qualification Statement (Exhibit B), as a satisfactory supplier of goods or services provided to MCCMH, other Community Mental Health Service Programs (CMHSPs), or the Michigan Department of Community Health (MDCH).

   c. Assessment of the soundness of the submitting provider as an organization or corporation to provide goods or services.

   d. Evaluation of prior contractual performance of the bidder under contract with MCCMH Board, if available.

   e. Satisfaction of the submission requirements and criteria contained in the RFP and this policy.

   f. Information contained on the Provider Profile Application.

   g. Satisfaction of the general specifications of the RFP.

3. If the proposal includes the procurement of any PIHP/MCO delegated functions, MCCMH will evaluate the prospective provider's ability to perform the activities to be delegated, based on the documentation submitted. MCCMH reserves the right to request further documentation to determine the prospective provider's ability to perform the specific function, prior to delegation.

C. Post-Approval Process

1. The MCCMH Business Management Director shall send written notice to those providers whose proposals/quotations were not approved for selection that their submissions were not selected, and the reason for the decision, i.e. their relative score is insufficient.

2. Following approval by the MCCMH Board, the MCCMH Director of the Business Management Division shall send written notice (a facsimile transmission is acceptable) to the provider which submitted the accepted proposal/quotation informing it of the selection and approval of its proposal/quotation for the provision of goods or contractual services for MCCMH.

3. The proposed Agreement with associated funding information shall be submitted to the MCCMH Board for review and approval.

4. All documents submitted to MCCMH relevant to the proposals, evaluation forms and recommendations will be maintained by MCCMH as back-up documentation of the RFP process. Substance Abuse documentation will be maintained by the Office of Substance Abuse. All relevant information shall be kept for no less than seven (7) years by the MCCMH Board.

D. Agreement Approval

1. All contracts require approval by the MCCMH Board.

E. Rescission of the Approved Proposal/Quotation

1. An approved proposal/quotation shall be subject to rescission if the MCCMH Board and the provider fail to agree upon acceptable contractual terms.

2. An approved proposal/quotation shall be subject to rescission if the provider fails to tailor the submission to MCCMH in accordance with the specifications contained in the RFP and within the agreed upon costs, pursuant to those approved by the MCCMH Board.

3. Any bidder may withdraw its submitted proposal at any time during the Procurement Process. The decision to withdraw a proposal must be submitted in writing to the MCCMH Board.

## VII. References / Legal Authority

A. MCL 330.1228; MSA 14.800(228)

B. MDCH/CMHSP Specialty Supports and Services Managed Care Contract

C. County of Macomb Policy and Procedures, as adopted May/1994 by the Macomb County Board of Commissioners

D. MCCMH MCO Policy 3-004, "Network Application / Profiling Process"

E. 42 CFR 438.230(b)

## VIII. Exhibits

A. Request for Proposal, MCCMH #199
B. Network Provider Qualification Statement, MCCMH #200
C. Provider Profile Application

Date (MONTH, DAY, YEAR)

# REQUEST FOR PROPOSAL

The Macomb County Community Mental Health Board is accepting proposals for the provision of _____. The services must meet the following requirements: _____

_____

Bidders may obtain a proposal packet by contacting the MCCMH Business Management Division at the Provider Network Unit by Calling (586) 469-6472.

Deadline for the proposal is 5:00 p.m. **DAY**, **DATE**.

Date (MONTH, DAY, YEAR)

Dear Prospective Bidder:

Macomb County Community Mental Health (MCCMH) is currently requesting a proposal for _____.

Enclosed are:

1. Service Features Guidelines;

2. MCCMH Policy on Procurement of Services;

3. Network Provider Qualification Statement.

All bids will be evaluated with reference to the following criteria:

1. The cost of the services to be provided;

2. The ability, capacity, and skill of the bidder to perform the contract, and to provide the services required;

3. The character, integrity, reputation, judgment, experience, and efficiency of the bidder, based upon objective verifiable information;

4. The bidder's history of compliance with applicable laws and ordinances relating to contract performance;

5. The number and scope of conditions attached to the bid; and

6. Whether the bidder is presently in default to the MCCMH Board for any reason.

**Prospective Network Providers shall be required to comply with MCCMH MCO Policy 3-004, "Network Application / Profiling Process."**

The MCCMH Board reserves the right to reject all bids, to waive or not to waive informalities or irregularities in bids or bidding procedures, to accept any bid, even though not the lowest.

Proposals are to be submitted to:

Provider Network
Attention: Area Manager
22550 Hall Road
Clinton Township, MI 48036

The deadline is **TIME**, **DAY, DATE.**

Sincerely,

John Kinch
MCCMH Business Management Director

**MACOMB COUNTY COMMUNITY MENTAL HEALTH**
**22550 Hall Road**
**Clinton Township, MI 48036**

# Service Feature Guidelines

All of the services provided to Macomb County Community Mental Health must meet specific guidelines and regulations. The following features reflect what is required to comply to those regulations and what we have found through past experience to be desirable.

## Features Required

1. Provide costs of the services to be provided including all related costs, e.g., taxes, necessary permits, fees, taxes, and insurance, etc.

2. Provide the proposed Service Agreement terms including, but not limited to, length of the contract, annual fees, taxes, insurances, special conditions, etc.

3. Provide credit and financial statements, including business and personal references, on the Network Provider Qualifications Statement (enclosed).

## Desirable Features

1. Provide

2. Provide

3. Provide

**MACOMB COUNTY COMMUNITY MENTAL HEALTH**
**PROCUREMENT OF SERVICES**

## NETWORK PROVIDER QUALIFICATION STATEMENT

License No.: _____ Years in Business: _____

Former business names operated under: _____

_____

If Corporation: Corporate ID No.: _____ Date Incorporated: _____

Names of President, Vice-President, Secretary, and Treasurer:

_____

_____

Names of all partners: _____

_____

_____

Limited or general: _____

If D.B.A., list name of primary license: _____

_____

List of major services your company has provided - location and references with telephone number:

_____

_____

_____

List training, education, etc. of key individuals in organization: _____

_____

_____

_____

List trade references: _____

_____

List bank references: _____

_____

Attach copy of personal or business financial statement (include name, telephone number, address of accountant, bookkeeper, etc.)

Name, address and telephone number of Bonding Company / Agent:

_____

_____

_____ _____

Signature Date Notary Public / Personal Signature Guarantee

**SECTION A**
**Macomb County Community Mental Health**
**Provider Profile Application**

| CORPORATE INFORMATION | | | |
|---|---|---|---|
| | Corporate/Legal Name: | | |
| | Organization/DBA Name: | | |
| | Organization Mailing Address: | | |
| | City: | State: | Zip code: |
| | Billing Address (if different than mailing) | | |
| | Tel.:( ) | Fax:( ) | E-Mail: |

| ADMINISTRATIVE INFORMATION | |
|---|---|
| | Chief Administrative Officer: |
| | Chief Financial Officer: |
| | Chief Medical Officer: |
| | Chief Clinical Manager: |
| | Recipient Rights Contact: |
| | Business Manager: |
| **PLEASE ATTACH A LISTING OF THE PROGRAM'S CURRENT BOARD OF DIRECTORS (specifying number of primary and secondary consumers on Board)** | |

***Important Note:*** *All programs listed in this application must correspond to the Tax Identification Number (TIN) and Payee listed below. If there is more than one TIN, an additional application must be completed.*

| TAX ID | | |
|---|---|---|
| | TIN: | Payee: |
| | Medicaid # (if applicable): | Agency NPI # (if applicable): |
| | Medicare # (if applicable): | |

| TYPE OF PROGRAM *(Please check ALL that apply)* | | |
|---|---|---|
| | ___ Assertive Community Treatment | ___ O.T. ___ P.T. ___ SP & L |
| | ___ Assistance w/Challenging Behavior | ___ Out of County Case Management Services |
| | ___ Children's Model Waiver | ___ Out of County Outpatient Services |
| | ___ Children's Residential | ___ Out of County Residential Services |
| | ___ Case Management Services | ___ Outpatient Clinic Mental Health Services |
| | ___ Community Living Supports ( ___ MI or ___ DD) | ___ Peer Delivered or Operated Services |
| | ___ Crisis Residential (Adult or Child) | ___ Psychiatric Hospital (Adult or Child) |
| | ___ Day Programs | ___ Psycho-Social Rehabilitation Programs |
| | ___ Emergency/Crisis Unit – hospital based | ___ Residential Group Home |
| | ___ Family Support Services ( ___ MI or ___ DD) | ___ Respite Care |
| | ___ General Hospital | ___ Skill Building Services ( ___ MI or ___ DD) |
| | ___ Hab Waiver Services | ___ Supported Indep. Program (SIP) |
| | ___ Home Based Services | ___ Wrap Around Services |
| | ___ Intensive Crisis Stabilization Services | ___ Other (specify): |

**TYPE OF ORGANIZATION** *(Please check one)*

| | | |
|---|---|---|
| ___ Federal | ___ City | ___ Other (specify): |
| ___ State | ___ Private Non-profit | |
| ___ County | ___ Privately Owned | |

| | | |
|---|---|---|
| Parent Corporation or Owner of Organization: | | |
| Street Address: | | |
| City: | State: | Zipcode: |
| Telephone: ( ) | Fax: ( ) | |
| Name and Title of Corporate Executive Officer: | | |

## LICENSOR/CERTIFICATION AND/OR ACCREDITATION

Is the organization state licensed/certified: _____ Yes *(If yes, complete the following license information and*
_____ No *attach a copy.)*

| | | |
|---|---|---|
| Type: | License #: | Exp. Date: |
| Type: | License #: | Exp. Date: |
| Type: | License #: | Exp. Date: |
| Type: | License #: | Exp. Date: |

| | | Yes | No | N/A | Exp. Date |
|---|---|---|---|---|---|
| ACCREDITATION/CERTIFICATION | Has the organization been reviewed and accredited by JCAHO? | | | | |
| | Has the organization been reviewed and accredited by CARF? | | | | |
| | Has the organization been certified by COA? | | | | |
| | Has the organization been reviewed and accredited by DCH? | | | | |
| | Has the organization been approved or certified by Medicaid? | | | | |
| | Has the organization been approved or certified by Medicare? | | | | |
| | Please indicate any other accreditation/certifications: | | | | |

***(Please attach a current copy of all Accreditation Award Letters or Certificates)***

| | | | |
|---|---|---|---|
| LIABILITY/INSURANCE INFORMATION | Company Name of Liability Carrier: | | |
| | Policy Number: | | |
| | LIMITS: | Per Occurrence: | Aggregate: |
| | DATES: | Effective Date: | Expiration Date: |
| | Company Name of Liability Carrier: | | |
| | Policy Number: | | |
| | LIMITS: | Per Occurrence: | Aggregate: |
| | DATES: | Effective Date: | Expiration Date: |

*(Please attach a current copy of the policy face sheet with limits and expiration dates listing coverage for organization sites.* ***ALL ADDRESSES*** *must be listed.)*

**ORGANIZATION PROFILE**

*(Please complete this section in its entirety. Your responses need to cover the past five (5) calendar years plus current year to the present. If a question does not apply to your organization, you may check "N/A" (Not Applicable.)*

| | Yes | No | N/A |
|---|---|---|---|
| Has the organization's state license/certification ever been revoked, suspended, or limited? | | | |
| Is there action pending to suspend, revoke, or limit the organization's license/certification? | | | |
| Has the organization ever had its JCAHO accreditation revoked, suspended, or limited? | | | |
| Is there action pending to revoke, suspend, or limit the organization's JCAHO accreditation? | | | |
| Has the organization ever had its CARF accreditation revoked, suspended, or limited? | | | |
| Is there action pending to revoke, suspend, or limit the organization's CARF accreditation? | | | |
| Has the organization ever had its COA certification revoked, suspended, or limited? | | | |
| Is there action pending to revoke, suspend, or limit the organization's COA certification? | | | |
| Has the organization ever had any other certification/accreditation revoked, suspended, or limited? | | | |
| Is there action pending to revoke, suspend, or limit the organization's other certification/accreditation? | | | |
| Has the organization ever had sanctions imposed by Medicare and/or Medicaid? | | | |
| Has the organization ever been denied professional liability insurance or has its insurance ever been canceled or denied renewal? | | | |
| Has the organization ever been a defendant in any lawsuit in regard to the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000 or more? | | | |
| Has the organization had any malpractice claims in regard to the practice of mental health or substance abuse treatment? | | | |
| * Note: If you have answered "yes" to any of the above questions, please provide the current status and details on a separate sheet of paper. Please include the following: description of incident, correspondence with state licensing boards, and/or a detailed description of any litigation, including settlements, court awards, etc. Please feel free to include a personal summary of the events; however, your application cannot be processed without the necessary official documentation. | | | |

**ADMITTING PRIVILEGES FOR PSYCHIATRIC HOSPITALIZATION** (if applicable)

*Please list all psychiatric providers who have admitting privileges at your organization.* _____N/A

| Provider Last Name | Provider First Name | Licensor |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**PROGRAM PROFILE**

*Your organization may provide more than one of the identified program types on page one of this application. If so, please photocopy this page (page four), plus pages five and six, and complete for <u>each</u> program service.*

| HOURS OF OPERATION (e.g., 8:30 am - 8:00 pm) | Mon. | Tue. | Wed. | Thur. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

**TREATMENT STAFF ROSTER**

*A separate sheet may be attached that includes the following requested information.*

| Name (last, first) | Degree(s) | Professional Credential(s) | Hire Date | Job Title |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**AGE GROUP AND GENDER**

*Please check (✓) the groups for which this program provides services.*

| Child/Adolescent (0 -17) | Adult (18 - 59) | Senior (60 and up) |
|---|---|---|
| ___ Female ___ Male | ___ Female ___ Male | ___ Female ___ Male |

| *Please respond to the following questions regarding the service address(es):* | Yes | No |
|---|---|---|
| Does this service address comply with ADA (Americans w/Disabilities Act) regulations? | | |
| Is this service address accessible by public transportation (within 0.5 mile)? | | |
| Do you accept Medicaid? | | |
| Do you accept Medicare? | | |
| Do you have a provider agreement with BC/BS for this address? | | |
| List all HMOs and other organizations with which you have a provider agreement: | | |
| | | |
| | | |

**PROGRAM AND SERVICE INFORMATION**

*Please provide a list of all services unique to the service site.*

| Component | Capacity |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| OUTCOME STUDIES | Does the program conduct Outcome Studies? ___ Yes ___ No<br>*(If yes, briefly describe and include examples.)* |
|---|---|
| | |
| | |
| | |

**LANGUAGE COMPETENCE**

| |
|---|
| *In addition to English, please identify the languages in which the program offers service (including American Sign Language):* |

**PROBLEM FOCUS OR SUPPORT SERVICES**

*(The following information is for internal Macomb CMH use only. Each consumer's benefit plan will determine if a problem area or service is reimbursable.) Check all that apply.*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Adjustment Disorders | | Elimination Disorders | | Mood Disorders | | Somatoform Disorders |
| | Anxiety Disorders | | Factitious Disorders | | Motor Skill Disorders | | Substance Related Disorders |
| | Attention Deficit & Disruptive Behavioral Disorders | | Forensic Evaluation | | Personality Disorders | | Tic Disorders |
| | Communication Disorders | | Impulse-Control Disorders NOS | | Schizophrenia & Other Psychotic Disorders | | Others (specify): |
| | Delirium, Dementia, and other Cognitive Disorders | | Learning Disorders | | Sexual & Gender Identity Disorders | | |
| | Dissociative Disorders | | Mental Disorders due to a General Medical Condition | | Physical/Sexual Abuse | | |
| | Eating Disorders | | Developmental Disabilities | | Sleep Disorders | | |

**SPECIAL POPULATIONS**

*Please indicate if you have any experience to service the following. Check all that apply.*

| |
|---|
| ___ Hearing impaired ___ Visually impaired ___ Speech impaired ___ Other (specify below): |

**AFTERCARE**

*Does the program offer aftercare? ___ Yes ___ No If yes, please complete this section.*

| Type of Program | Duration in Weeks | # Sessions per Week | Duration of Session |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**CERTIFICATION, RELEASE, AND SIGNATURE**

**I hereby certify that all information contained in this application, and all its attachments is accurate, complete, and true.**

**I understand that in making this application to Macomb County Community Mental Health (CMH), the organization agrees to the following:**

(a) any information contained in this application which subsequently is found to be false could result in denial of my application or termination of participation in the CMH Provider Network;
(b) it is the organization's responsibility to promptly advise CMH of any changes or additions to the information contained in this application;
(c) all the information contained in this application or its attachments is subject to CMH investigation and review; and
(d) this is an application only and that submission of this application does not automatically result in participation in the CMH Provider Network.

We hereby authorize the Macomb CMH to consult with administrators and members of the organization and/or institutions which the agency has been or is currently associated with, and others, including past and present malpractice carriers, who may have information bearing on professional competence, character, and ethical qualifications. We further consent to the inspection by representatives of Macomb CMH of all documents that may be material to an evaluation of the organization's professional competence, character, and ethical qualifications.

WE HEREBY RELEASE FROM LIABILITY ALL REPRESENTATIVES OF MACOMB CMH FOR THEIR ACTS PERFORMED IN GOOD FAITH AND WITHOUT MALICE IN CONNECTION WITH EVALUATING THIS APPLICATION, CREDENTIALS, AND QUALIFICATIONS, AND WE RELEASE FROM ANY LIABILITY ANY AND ALL INDIVIDUALS AND ORGANIZATIONS WHO PROVIDE INFORMATION TO MACOMB CMH IN GOOD FAITH AND WITHOUT MALICE CONCERNING PROFESSIONAL COMPETENCE, CHARACTER, AND ETHICS. WE HEREBY CONSENT TO THE RELEASE AND EXCHANGE OF INFORMATION RELATING TO ANY DISCIPLINARY ACTION, SUSPENSION, OR CURTAILMENT OF PROFESSIONAL PRIVILEGES AND/OR CLINICAL SERVICES TO THE MACOMB CMH PROVIDER NETWORK.

A. All applications for participation in the CMH Prover Network shall be reviewed by the CMH Network Management Division. Recommendations for CMH Provider Network participation will be forwarded to the CMH Board, or designee for approval.

   By signing this, the organization gives consent for verification of the information provided in this application.

B. In the event that the agency, organization, or institution is accepted for participation in the CMH Provider Network, we consent to CMH inspection of our patient records relating to consumers as necessary for its peer and utilization review process.

   We understand that if this application is rejected for reasons relating to professional conduct or competence, CMH may report the rejection to the appropriate State licensing board and/or the National Practitioner Data Bank.

   1. To abide by applicable bylaws, rules and regulations, policies and procedures of the CMH Provider Network as in force at the time of this application, and agree to be bound by the terms thereof in all matters related to the consideration of this application.

   2. Acknowledge the organization's obligation to provide continuous care and supervision to all for whom we have responsibility, and that the organization will seek clinical consultation as necessary to insure the highest quality of consumer care.

   3. That the organization, or designee will be willing to appear before any appropriate committee of CMH with regard to this application.

It is understood that failure to comply with the agreements specified above or providing inaccurate, incorrect, or withholding information on this application will automatically terminate appointment as a provider of behavioral health service in the CMH Provider Network.

_____ _____

Signature of Organization CEO or Designated Representative Date