



**NORTH COUNTRY COMMUNITY MENTAL HEALTH AUTHORITY**

1420 Plaza Drive  
Petoskey, MI 49770

phone: 231-347-7890 fax: 231-347-1241

website: [www.norccmh.org](http://www.norccmh.org)

**ACKNOWLEDGEMENT OF TRAINING MATERIAL &  
CONTRACT PROVIDER MANUAL**

As the authorized representative of contracted entity \_\_\_\_\_, I  
acknowledge that I have been trained or have received information on North Country  
Community Mental Health Authority's Plans, Policies, Procedures and Guidelines as  
follows, and understand my contractual responsibilities as it applies thereto.

*(Please Initial Each Item)*

\_\_\_\_\_ Receipt of Provider Manual contained online at [www.norccmh.org](http://www.norccmh.org)

\_\_\_\_\_ Bloodborne Pathogens

\_\_\_\_\_ Infection Control & Safety Manual

\_\_\_\_\_ Regulatory Compliance Plan and Whistleblowers Protection Act

\_\_\_\_\_ Cultural Competency Plan and Limited English Plan

\_\_\_\_\_ HIPAA

\_\_\_\_\_ Confidentiality of Patient Records and Substance Abuse Patient Records

\_\_\_\_\_ Preventing Sexual Harassment

\_\_\_\_\_ Medicaid False Claims and Regulatory Compliance

\_\_\_\_\_ Recipient Rights Policy, Summary of Abuse and Reporting Requirements, DCH  
Administrative Code Part 7, and Chapter 7 of the Michigan Mental Health Code

\_\_\_\_\_ Code of Ethics

\_\_\_\_\_ Risk Management Policy and Procedure

\_\_\_\_\_ Person Centered Planning Guidelines

\_\_\_\_\_ Grievance and Appeal Procedure

\_\_\_\_\_ Advanced Directives Policy

\_\_\_\_\_ Quality Improvement Plan

Name of Authorized Representative: \_\_\_\_\_

Title of Authorized Representative: \_\_\_\_\_

Signature of Authorized Representative: \_\_\_\_\_

Date Signed: \_\_\_\_\_