- Meal Preparation
- Laundry
- Routine household care and maintenance
- Activities of daily living (personal hygiene)
- Shopping
- Money Management
- Non-Medical Care
- Monitoring of Medication Administration
- Socialization and Relationship Building
- Participation in Regular Community Activities

These services also include transportation from the participant's residence to community activities, among activities, and back to the participant's residence.

Services are to be provided, documented, and reimbursed on a per unit bases. A unit is a 15-minute duration of time where face-to-face services are provided to the client as pre-authorized.

Summary

NCCMH is seeking a provider for a leased four-bed specialized residential home in Charlevoix County and Community Living Supports for Otsego and Emmet Counties. Services and quantities vary but to give potential respondents some idea of need there are four individuals in a specialized residential home in Charlevoix County requiring 24 hours a day of support (approximately 9.5 FTE) and 3 individuals in Otsego County living in a private resident home (PRH) needing Community Living Supports for 24 hours a day (approximately 4.5 FTE.) Community Living Support services are needed for a 4-5 bed multi-unit home in Emmet County, where occupancy has not yet been determined. **Respondents to this request may submit quotes to provide specialized residential services, Community Living Support services, or both.** Once established within the provider network, additional opportunities may be developed.

Qualifications:

All those submitting quotes must be able to provide these services in compliance with the Michigan Department of Health and Human Services (MDHHS,) Michigan Medicaid Provider Manual, HCBS final rule, all applicable provisions of the Michigan Mental Health Code, Public Act 258 of 1974, as amended MCL 330.1100 et seq, the Michigan Public Health Code, Public Act 368 of 1978, as amended, all applicable Administrative Rules, related Recipient Rights and policies of NCCMH, along with the ability to comply with HIPAA including the Standards of Privacy of Individually Identifiable Health Information (42 C.F.R., Part 2.)

Respondents to this request must be able to provide staffing who possess the necessary skills and experience to provide these services and must:

- Be at least 18 years of age.
- Be in good standing with the law with no exclusionary convictions.
- Be able to practice prevention techniques to reduce transmission of any communicable diseases from themselves to other in the environment where they are providing these services.
- Be able to communicate expressively and receptively to follow individual plan requirements and beneficiary specific emergency procedures and report on activities performed.

In addition to the above, staff for these services must also complete training in areas of Recipient Rights, Person Centered Planning, CPR/First Aid, Nonviolent Crisis Intervention, Gentle Teaching, Medication Administration/Vital Signs, and Nutrition and Food Services. (A complete list of all requirements, references, and resources can be found at our website, www.norcocmh.org, under the tab "Providers.")

Respondents to this request should also be able to demonstrate through established policies and procedures the ability to support staff, provide training (initial and on-going) maintain documentation supporting the delivery of service according to Medicaid rules, and appropriately bill for services consistent with NCCMH policies.

Respondents to the request should be able to meet all other NCCMH contract requirements. (A copy of the contract can be requested through the Provider Network Manager, Angela Balberde, abalberde@norcocmh.org.

Quotes for Specialized residential should be based on actual Medicaid approved cost associated with the provision of this service. Submission should be for facility projected costs for one year and an average per diem rate for an individual.

Quotes for Community Living Supports should be based on actual Medicaid approved cost associated with the provision of this service minus transportation. Transportation cost will be added to the rate based on actual mileage for clients served. Submission should be for Community Living Supports representing one unit of service (15-minutes), serving one individual. Services provided to multiple individuals at the same location, during the same time, by one staff member would result in a modification of the rate consistent with NCCMH practices representing an equal percentage of the cost.

A panel consisting of members of NCCMH Clinical Team along with those from the Finance and Administrative Teams will review all responses and select(s) based on quality, expertise, history

in providing high quality services, flexibility in meeting changing/future needs, and price. (NCCMH will not be obligated to choose based on the lowest bid.)

A meeting to answer potential Respondents questions will be held on January 16, 2023 via zoom. Please pre-register for this meeting by contacting Angela Balberde at abalberde@norcocmh.org. A link will then be sent.

Quote Sheet

Responses to this Request for Quote must be submitted in an envelope titled and addressed as follows: Provider Network Manager, NCCMH 1420 Plaza Dr., Petoskey, MI 49770, or electronically in PDF format to the following email address, abalberde@norcocmh.org.

Respondent	Contact Person
Name of Organization: Address: Ex. Director: Telephone: Fax: Website: Federal tax identification #:	Name: Address: Telephone: Email:

*Please complete and submit North County Community Mental Health Authority Quote for Specialized Residential (**Attachment A**), Quote for Community Living Supports (**Attachment B**), and Contract Provider Application (**Attached**). Provide responses and/or submit documentation addressing the following:

- Demonstrate proof of, or the ability to obtain, liability insurance in the amount of $1,000,000.00 per occurrence, and /or aggregate, combined single limit for Personal Injury, Bodily Injury, and Property Damage.
- Describe your organizations experience in providing Community Living Support or like services. (List any accreditations, certifications, licenses, or member affiliations.)
- Submit copies of your organization's policies/procedures regarding direct care staff qualifications.
- Describe how your organization ensures that services are delivered by staff trained and mentored consistent with the principles of Trauma Informed Care and in a Culture of Gentleness.
- Provide proof of the ability of, and policies on, performing appropriate background checks for all employees.

- Describe the training and experience of direct care staff that would be assigned to perform the services listed above.
- Describe how your organization arranges for emergency coverage for staff shortages.
- Provide any customer satisfaction data that has been collected in the last three years.
- Submit a short narrative detailing your organization.

The Respondent to this request certifies to the best of their knowledge and belief that all information in this response is true and correct and has been duly authorized by their governing body.

Authorized Representative

Signature:_____ **Date:**_____

Name and Title (Print):_____

Attachment A

Specialized Residential Quote

4 bed, 9.5 FTE

RESIDENTIAL (Yearly Budget)

FACILITY PROJECTED COSTS

Room and Board Costs
Lease $ 19,200
Utilities $
Maintenance $
Equipment $
Food $
Subtotal $

Less Revenue
SSI/SSA @ $1027.50 $
Room and Board Total $

Operations
Salary/Wages $
Transport $
Misc./Activity $
Medical Personal Supplies $
Sub Total $
Administration $
Insurance/Liability $
Sub Total Residential $

Revenue
Remaining SSI/SSA $

Total Residential $

Total Per Diem $

· Administration must not be more than 9.5% in all instances/scenarios.

Attachment B

Private Resident Home Quote

3 clients
Home help revenue: Approximately $43,838 yearly

PROJECTED COSTS (RESIDENTIAL LIVING SITE)

Based on a 12-month budget. 4.5 FTE's

Salaries and Wages $
Transportation $
Subtotal $
Administration $
Insurance/Liability $
TOTAL RESIDENTIAL BUDGET $

PROJECTED REVENUES $
TOTAL PROJECTED REVENUES $
YEARLY GRAND TOTAL PAYOR FUNDING $

· Administration must not be more than 9% in all instances/scenarios.

Service Description/Service Units	Quote Amount
Community Living Supports 15 Minute Unit Serving 1 Person (H2015) (Transportation Cost to be Added based on actual mileage.)	$_____/Per Unit

NORTH COUNTRY
COMMUNITY MENTAL HEALTH

NORTH COUNTRY COMMUNITY MENTAL HEALTH AUTHORITY

CONTRACT PROVIDER APPLICATION

1) PROVIDER IDENTIFICATION/INFORMATION

Contracted Provider Name:

D/B/A's (if none, write none):

Federal Tax ID/SSN:

Provider website/URL:

Provider Legal Entity Type - Check one of the following:

☐ Sole Proprietors and partnerships: Individual providers including practitioners who file taxes on the 1040 series of tax forms

☐ For-profit corporations: Those companies that typically file a tax form 1120 with the IRS.

☐ Governmental units: Includes transportation authorities, intermediate school districts, public universities and community colleges.

☐ Non-Profit organizations or corporations: Typically, those organizations that have 501(c)3 status and report on the IRS 990 form.

2) SERVICES PROVIDED

Check all general categories of services that you are qualified to provide, regardless of whether or not those services are included in your NCCMH contract:

☐ Licensed Residential
☐ Personal Residential Home
☐ Professional Services (Therapy, Doctor, etc.)
☐ Other:
☐ Respite/Respite Camp
☐ Day Programs
☐ InPatient Hospital

National Provider Identifier (NPI) #, if applicable:

Medicaid ID #, if applicable:

Are you registered in CHAMPS: ☐ YES ☐ NO **Are you accepting New Enrollees?** ☐ YES ☐ NO

Cultural Competency is required training for our staff: ☐ YES ☐ NO

Do you have Linguistic Capabilities: ☐ YES ☐ NO

Specify any secondary language capabilities:

ADA Compliance: Are all of your Office/Facility, Retail outlets, Exam Rooms, Equipment able to accommodate persons with disabilities? ☐ YES ☐ NO

Method of Personal Intervention: We ☐ DO ☐ DO NOT train on and solely use the CPI Method.

We (also or alternatively) use the following methods of personal intervention:

Note: If you do not SOLELY utilize the CPI form of intervention in facilities where NCCMH clients are placed, you are required to request written approval from NCCMH Behavior Treatment Committee on the use of other forms of Non-Violent Crisis Intervention other than CPI. Alternative methods must be approved by written contract addendum. Please contact the NCCMH Contract Manager at providerrelations@norcocmh.org for information.

3) CONTACT INFORMATION

Corporate/Legal Address:

Physical Address:

City: State: Zip:

Mailing Address:

City: State: Zip:

Authorized Person to sign & modify contracts:

Contract Signee:
Title:
Phone:
Cell:
Fax:
Email:

Primary Contact for Client Placement:

Business Name:
Primary Contact:
Address:
City:
Phone:
Fax:
Cell:
Email:

Primary Contact for Finance:

Business Name:
Primary Contact:
Address:
City:
Phone:
Fax:
Cell:
Email:

PLEASE ATTACH ADDITIONAL INFORMATION AS NEEDED FOR EACH SPECIFIC MAIN LOCATION/CONTACT.

PLEASE ATTACH LISTING OF HOMES, LICENSES AND CONTACT INFORMATION FOR EACH LICENSED/SPECIALIZED OR OTHER HOME TYPE.

4) ACCREDITATION, LICENSES

Are you licensed or accredited? ◯ YES ◯ NO If yes, list below:

Accreditation/License Entity Name: _____ Expiration: _____

Accreditation/License Entity Name: _____ Expiration: _____

Accreditation/License Entity Name: _____ Expiration: _____

If no, do you have plans to become accredited? ◯ YES ◯ NO

PLEASE ATTACH COPY OF ACCREDITATION OR LICENSES.

5) ATTESTATION

I fully understand that any misstatements in, or omissions from, this application may constitute cause for disqualification or termination of provider participation with North Country Community Mental Health Authority. All information submitted in this application is true to the best of my knowledge and belief.

I verify that all professional staff and other health services staff who deliver direct services to our consumers are current and in good-standing with their respective training, licensing and/or certifying board or agency. I also verify that those employees who do not yet have their required training, license and/or certification, have a plan and are working to obtain the appropriate license and/or certification. I also verify relevant legal background checks as well as educational credentials were verified or completed prior to hire and rechecked on any frequency required by Medicaid or by contract with North Country Community Mental Health Authority.

I understand that any contractual relationship with North Country Community Mental Health Authority may be subject to termination if I fail to comply with any of the regulations or policies specified in the contract or by Medicaid regulation.

DECLARING THAT THE STATEMENTS MADE IN THIS APPLICATION ARE TRUE, I HEREBY MAKE APPLICATION AND REQUEST TO BECOME OR REMAIN A PART OF THE NCCMH PROVIDER NETWORK:

Name of Contractor's Authorized Representative	Title
Signature	Date