



# NORTH COUNTRY COMMUNITY MENTAL HEALTH AUTHORITY

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## ACKNOWLEDGEMENT OF ACCESS TO NCCMH TRAINING HUB, TRAINING REQUIREMENTS, AND PROVIDER RESOURCES

As an authorized representative of \_\_\_\_\_,

I acknowledge that:

*(please initial each item)*

\_\_\_\_\_ I have the resources necessary to access and understand the NCCMH Training Hub and Training Requirement lists located online at <https://www.norcocmh.org/provider-training/>

\_\_\_\_\_ I have the resources necessary to access and understand the NCCMH Provider resources located online at <https://www.norcocmh.org/provider-administrative-resources/> where I can review:

1. Policies and Procedures
2. Provider Manual
3. Provider Time Study Instructions
4. Provider Forms

\_\_\_\_\_  
Name & Title of Authorized Representative:

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

\_\_\_\_\_  
Date