



**Inter-Tribal Council of Michigan
Anishnaabek Access to Recovery (ATR)**

**Individual
Tier 2 ATR Network Provider
Enrollment Application
Recovery Support**

**Inter-Tribal Council of Michigan
Anishnaabek Access to Recovery (ATR) Network
Tier 2 Individual Recovery Support Enrollment Application**

This "Individual Recovery Support Enrollment Application is intended for single individuals who wish to provide recovery support services to the ATR Network. To participate as an Anishnaabek Access to Recovery network provider, an individual must complete this application. This application is an abbreviated version of the "Tier 2, ATR Network Provider" enrollment application. A business or agency with more than one staff person should complete the "ATR Network Provider" application.

The following three (3) parts of the application must be complete for it to be processed:

Part 1 – General Applicant Information

- All applicable questions are answered. If an item is not applicable, write N/A
- Certification is signed and dated by the individual.
- Each individual person providing services has completed, signed, and dated the attestation statement.

Part 2 – Business Participation Agreement

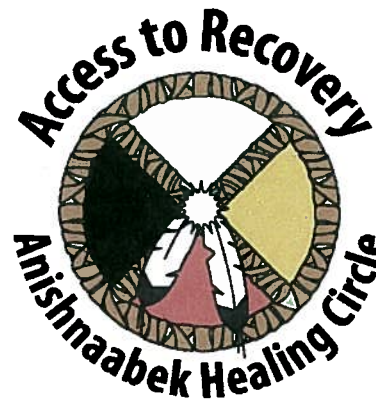
- The provider participation agreement is signed and dated by an authorized individual.

Part 3 – Support Documentation

- License for the individual or sole proprietor (business) (if applicable).
- W-9 – Request for Taxpayer Identification Number for the individual.
- Current license, certification, and/or registration for each person who will be providing services under this agreement (if applicable).
- Documentation of liability insurance.
- Background check documentation.

Once the application is complete, the application and support documents must be mailed to the Inter-Tribal Council of Michigan. Please submit the completed application forms and supporting documentation to:

Donelda Harper
ATR Treatment Coordinator/Provider Liaison
Inter-Tribal Council of Michigan
Behavioral Health Services
2956 Ashmun Street, Suite A
Sault Ste. Marie, MI 49783
906-632-6896 extension 127
FAX 906-635-4212
dharper@itcmi.org



Instructions

1. **Name** – Provide the name of the individual applying as a recovery support provider.
2. **Physical Address** – Provide the street, city, state, and ZIP where recovery support services are provided.
3. **Mailing Address** – If different than the physical address, provide the street or post office box, city, state, and ZIP code where mail is received.
4. **TIN/SS#** – Provide the tax identification number (TIN) for the individual..
6. **Telephone Number** – Provide the area code and telephone number where the individual can be reached.
7. **Facsimile Number** – Provide the area code and fax number where the individual can be reached.
8. **Email** – Provide the e-mail address where the individual can be reached.

This individual is seeking approval as an ATR:
___ Recovery Support Provider

Part 1 - General Application Information

Administration Information

1. Applicant Name _____
2. Applicant Title/Position: _____
3. Physical Address (Street, City, State, ZIP Code)(Location where services are provided)

4. Mailing Address (If Different: Street/P.O. Box, City, State, ZIP Code)

5. Tax Id Number/SS# _____
6. Telephone Number _____
7. Fax Number _____
8. Email _____

Client Services Hours of Operation

Main location: Hours of Operation for Client Services:						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Other location(s) (list addresses for other locations):						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Instructions – Services

Check all boxes that apply for the (1) levels of care, (2) service populations, (3) services

Recovery Support Services

Identify the Level(s) of Care that You Provide (Check all that apply)

Recovery Support __ adult __ adolescent (age range _____)

1. Identify the Gender of Clients that You Serve:

Gender: __ Male __ Female

Business License:

Provide Licensing Information (if applicable, many Recovery Support providers are not licensed)

Business	Licensing Agency Name	Licensing Type	Licensing Number	Effective Dates mm/dd/yy – mm/dd/yy

Include credential information for each individual who will provide services. A copy of the individual's credential, certification, or registration must be provided with the application (**only if applicable: many recovery support providers do not have formal credentials**).

Please Describe Any Specialty Services that you provide:

Comments _____

**Services that you are qualified to provide.
Check all that apply:**

Recovery Support Services

- Family Services (Marriage Education, parenting and child development services.)
- Child Care Services

- Employment Services
- Pre-Employment Services/ Job Readiness
- Employment Coaching
- Individual Services Coordination (Case Management)
- Recovery Support Planning
- Transportation Services
- HIV/AIDS Services
- Transitional Drug Free Housing Services (Limits Apply)
- Continuing Care
- Relapse Prevention
- Recovery Coaching
- Pastoral Guidance
- Traditional Healing Services
- Spiritual Support Services
- Group/Peer Support Services/Self Help Support Groups
- Individual/Peer Support Service

- Traditional Healing
- Sweat Lodge
- Substance Abuse Education
- HIV/AIDS Education
- Daily Living Skills/Group
- Indigenous Language Recovery/Expression
- Storytelling/Cultural Teaching
- Talking Circle
- Tribal Song and Dance
- Tribal Arts and Crafts
- GED Preparation
- Educational Tutoring
- Other Education Services
- Peer Coaching/Mentoring
- Alcohol- and Drug-Free Social Activities
- Physical Fitness and Well-Being Activities
- Stress Management
- Nutritional Management
- Information and Referral
- Other Peer to Peer Recovery Support Services
- Other _____

- Acupuncture
- Auricular Acupuncture
- Alternative Therapies (specify) _____

Certification

1. I understand that I/we have a right to appeal any decision regarding the disposition of this application. Appeals will be decided by a three member panel with the tribal network and Inter-Tribal Council jointly selecting panel members.

2. I declare that the statements on this application are correct to the best of my knowledge.

Signature _____

Title _____

(Stamped signature is not acceptable)

Date _____



Individual Attestation Questions

**Must be completed, signed, and dated by each individual providing
RECOVERY SUPPORT SERVICES.**

Each person is required to complete, sign, and date this form. An application will not be considered complete unless a completed attestation question form is submitted for each person who is identified to provide services in the provider application.

Please answer "YES" or "NO" to the questions below. If you answer "YES" to questions A through C, please provide a full explanation on a separate sheet of paper referencing the section number.

A. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes No If yes, give particulars on a separate sheet of paper.

B. Do you presently use any drugs illegally?

Yes No

C. Have you had a criminal background check within the last 12 months? Is it on file with your organization or agency and/or available for audit?

Yes No

I hereby affirm that the information submitted in this Section (Individual Provider Attestation Questions) and any attached addendums is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that omissions and misrepresentations may result in denial of my application or termination of my privileges as a provider under ATR.

Print Name

Signature

Date

Provide a copy of credential information or license for each person, if applicable.

Part 2 – Business Participation Agreement

Must be signed and dated by the individual providing services. The individual agrees to:

1. Not charge ATR for services paid for by other funding sources. (Examples of such funding sources are private insurance, Medicaid, Medicare, or State Block Grant funds administered by the Regional Coordinating Agency that your organization has a contract with). ATR Funds are the payer of last resort with the exception of Indian Health Services and Tribal Resources. (CFR 42 136.61) Tribal resources pooled with Indian Health Services resources are covered by the rules established for Indian Health Services funds. **ATR must supplement, not supplant, other funding sources.**

Do not charge a client for the following:

- Services for which the provider is entitled to payment from ATR;
 - Services for which the provider could have been entitled to payment from ATR had the provider complied with certain procedural requirements;
 - Services not necessary and appropriate for the clinical management of the presenting problem(s);
 - Services for which the provider could have been entitled to payment from ATR had the provider not been charged with a reduction or denial in payment as a result of quality review; and
 - Services rendered during a period in which the provider was not authorized to provide services.
2. Comply with the applicable provisions related to ATR policy.
 3. Accept the ATR allowable payment combined with any cost share or other health insurance amounts payable by, or on behalf of, the client, as full payment for authorized services.
 4. Collect from the client those amounts that the client has a liability to pay for.
 5. Allow ATR to review the clinical records of clients in accordance with applicable tribal, state and/or federal law.
 6. Cooperate fully with utilization and clinical quality management reviews conducted by ATR.
 7. Cooperate fully with GPRA data collection conducted by ATR.
 8. Obtain authorization via a voucher from ATR before rendering services.
 9. Maintain records related to clients for whom payment was made for services rendered by the provider or otherwise under arrangement, for a period of 7 years from the date of service.
 10. Maintain records that substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment, and outcome at completion or discontinuation of treatment.
 11. Notify ATR within five (5) business days when a client's eligibility status has changed.
 12. Notify ATR immediately of suspected fraud and abuse and notify ATR immediately if either the provider or the provider's employees becomes excluded from participation in federal programs.
 13. Notify ATR immediately when an employee who serves as a provider is no longer employed by the organization or their eligibility status changes.

14. Do not use ATR program funds for clinical research involving human subjects, or enroll clients in clinical research involving human subjects.
15. Maintain professional liability insurance up to \$1,000,000 per incident/ \$3,000,000 aggregate.
16. Provide quality services within the appropriate standards of care for each provider's profession.
17. Meet all ATR reporting requirements.
18. Agree to participate in core competency trainings related to ATR.
19. The individual agrees and understands that agents of the ATR will conduct random audits and may inspect the premises, review personnel and client records, observe program operations, and interview employees and clients associated with the program(s).
20. Meet future requirements established by ATR. (Any change in ATR requirements will be made in the form of a written amendment to this agreement).
21. Align current billing & accounting practices with electronic voucher system: orient accounting staff to voucher payment protocols.
22. Align current data submission practices with ATR Voucher system submission requirements to fax hardcopy to ITC, or scan document and send as a PDF file.

I understand that I/we have a right to appeal any decision regarding the implementation of this agreement. Appeals will be decided by a three member panel with the tribal network and Inter-Tribal Council jointly selecting panel members.



The ATR program agrees to make this agreement effective until terminated by either party. The effective date shall be the date on the application acceptance letter.

Signer's Name (Print)

Signer's Title (Print)

Signer's Name (Signature)
(Stamped signature is not acceptable)

Date

Part 4 – CHECKLIST FOR ATR TIER 2 NETWORK PROVIDER APPLICATION	
Completed Application/Completed Checklist: INDIVIDUAL RECOVERY SUPPORT	
	In addition to the documentation below, please submit this completed checklist and the provider application. Please indicate that you have included the documentation by placing an "X" in the box below the number. If you will not be submitting one of the documents, place an "NA" in the box below the number. Do not leave any items on the checklist or questions on the application blank. Only completed applications will be reviewed.
1.	Accreditation, License(s) for Business (RECOVERY SUPPORT)
	Copy of state, tribal license(s) to provide the level(s) of services offered (only if applicable, for many Recovery Support providers, this does not apply).
2.	Professional Licensure for Individuals (RECOVERY SUPPORT)
	For Recovery Support individuals, provide a copy of each individual's license, certification, or registration. (only if applicable, for many Recovery Support providers, this does not apply).
3.	Criminal Background Check
	Certification that each individual who has client contact has a recent (within 12 months) background check on file and available for audit. Anyone having client contact must have no prior convictions for child abuse or felony firearms charges. Information Only, Michigan Law Enforcement Information Network (LEIN), Michigan State Department of Human Services Central Registry Clearance are 2 sources for background checks.
4.	Professional, Business Liability or Malpractice Insurance
	Provide a copy of the individual or agency's professional, business or malpractice insurance. A minimum of \$1,000,000 per incident/ \$3,000,000 aggregate is required.
5.	IRS Form W9
	Completed and signed W9 form containing TIN or SS# for an individual or sole proprietor.
	<p>INCLUDE ALL REQUESTED DOCUMENTS</p> <div style="display: flex; justify-content: space-around; align-items: center;">   </div>

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