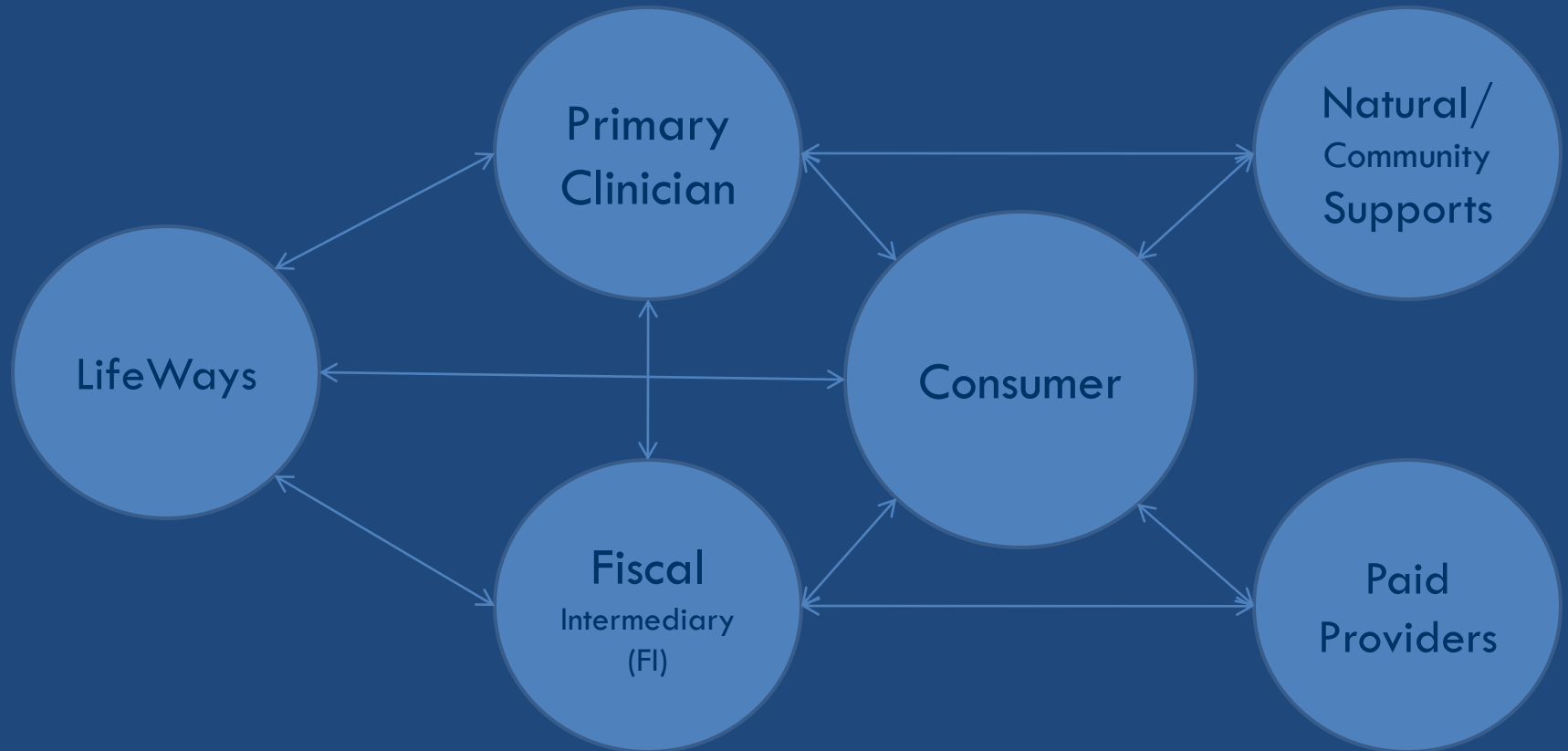


SELF-DETERMINATION



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Self-Determination is . . .

- A philosophy that people with disabilities have the right to control their own lives. Under a Self-Determination arrangement, you can hire your own workers and manage your services within a set budget.
- Four main principles:
 1. Freedom: to live the life you want and to have choice (of qualified providers and eligible services)
 2. Authority: to control the way you receive your authorized services and supports within a budget (based on Individual Plan of Service)
 3. Support: is provided to foster success
 4. Responsibility: to follow State and Federal laws, to control a *set amount* of money to purchase support services based on your Individual Plan of Service, and to use public funds wisely



Definitions

- ❑ Budget: dollars that can be used for services. The budget amount is calculated based on the Individual Plan of Service which is developed through a Person-Centered Planning process
- ❑ Fiscal Intermediary (FI): a company that, for a fee, helps the consumer-employer develop a budget based on authorized services, handles payroll responsibilities and prepares a monthly budget status report.
- ❑ Individual Plan of Service (IPOS): A document that describes what goal(s) the consumer wants to work on, what supports are needed, and the responsibilities of everyone participating in the plan. Also called “Treatment Plan” or “Person-Centered Plan”.
- ❑ Medical Necessity: the scope (what kind), amount (how much and how often), and duration (for how long) of services a person needs based on their current mental health condition. There must be written proof that without the requested service(s), the consumer’s condition would worsen.
- ❑ Payer of Last Resort: Medicaid is the “payer of last resort”. That means all other natural & community supports must be used before Medicaid will pay for a service. Examples of other supports may include: Department of Human Services’ chore provider or home help services, Community Action Agency literacy services, and Michigan Rehabilitation Services’ supported employment.
- ❑ Person-Centered Planning (PCP): A process by which the IPOS is developed. The consumer says what their goals for treatment are, and those goals are built into an IPOS.
- ❑ Primary Clinician: A case manager or supports coordinator who helps the consumer access needed services and resources and coordinates care with other providers.
- ❑ Specialty Services: paid for by Medicaid, including Skill Building, Community Living Supports, etc.
- ❑ Utilization Management (UM): A department of LifeWays that reviews and approves or denies requests for service authorization.

Funding and Supports

□ Public Dollars

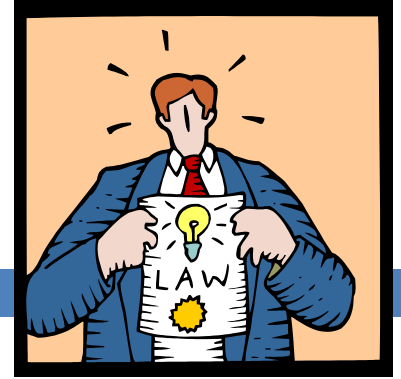
- SSI/SSDI/Social Security/Medicaid rules still apply
 - Must use resources within published guidelines
 - CMS (Centers for Medicaid Services)
 - DHS (Department of Human Services)
 - SSA (Social Security Administration)
 - DCH (Department of Community Health)
 - LifeWays

□ Private Dollars

- From employment
- Family contributions



Medicaid Basics



- ❑ Medicaid pays for services that are medically necessary:
 - ❑ To screen and assess the presence of mental illness, developmental disability or substance abuse
 - ❑ To assist with attaining or maintaining sufficient functioning level to achieve goals
 - ❑ Encourages community inclusion and participation
 - ❑ Based upon personal and clinical information
 - ❑ Provided by trained professionals (or staff supervised by trained professionals as appropriate)
 - ❑ Based upon person-centered planning
 - ❑ Provided within standards of timeliness
 - ❑ Sufficient in amount, scope and duration to achieve identified purpose (goals)



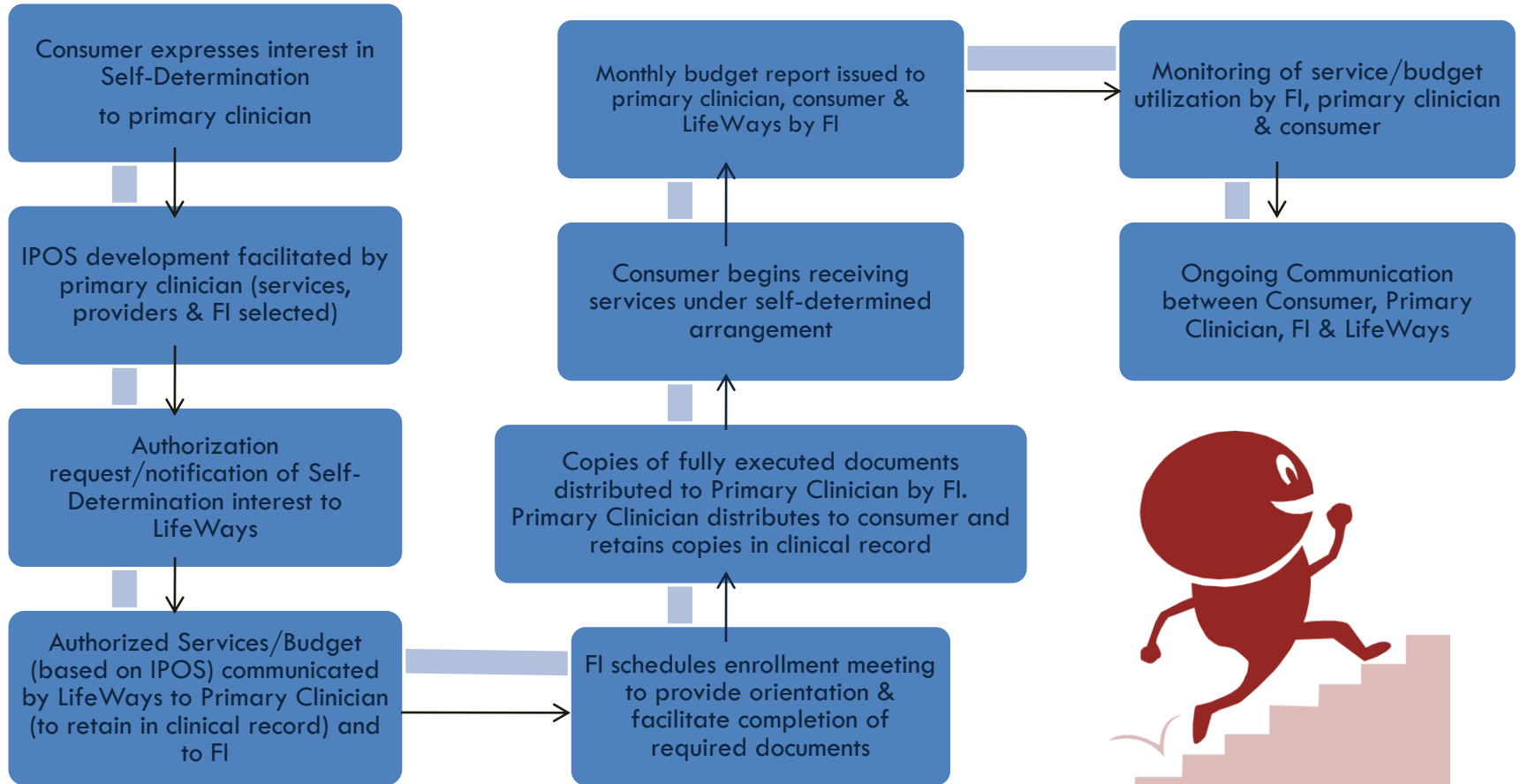
Medicaid Basics



- ❑ Medicaid is the “payer of last resort”. That means all other natural and community supports must be used before Medicaid will pay for a service.
- ❑ Services are defined in Section 3 of the Mental Health/Substance Abuse chapter of the [Medicaid Provider Manual](#).
- ❑ Specialty services and supports cannot supplant (be used instead of) State plan services.
 - ❑ For example: Home Help (State Plan) must be used before Community Living Supports (Specialty Service)
- ❑ The Individual Plan of Service (IPOS) that results from person-centered planning specifies consumer goals and the amount (how much and how often), scope (what kind) and duration (for how long) of each service needed to support the achievement of those goals.



Process



Roles & Responsibilities: Consumer/Guardian

- Participate in Person-Centered Planning process
- Hire qualified employees
- Verify services provided (sign timesheets)
- Monitor utilization of services
- Monitor budget



Roles & Responsibilities: Primary Clinician

- IPOS facilitation
- Request Service Authorization
- Notify LifeWays of changes in consumer needs
- Support consumer in monitoring service & budget utilization



Roles & Responsibilities:

Employee

- ❑ Provide services according to IPOS
- ❑ Document services provided in a timely and accurate manner
- ❑ Provide documentation and consumer progress updates to primary clinician
- ❑ Submit accurate time sheets (signed by consumer/guardian) to Fiscal Intermediary
- ❑ Complete Employment Agreement or Staffing Agency Agreement (with consumer/guardian)
- ❑ Complete Medicaid provider agreement



Roles & Responsibilities: Fiscal Intermediary

- ❑ Complete Criminal Background Checks (before employee begins working)
- ❑ Facilitate completion of required documents
- ❑ Process timesheets and pay consumers' employees
- ❑ Manage payroll (Workers' Compensation, employment taxes)
- ❑ Compile & distribute monthly budget reports
- ❑ Communicate with primary clinician regarding budget concerns
- ❑ Provide customer support related to FI functions



Roles & Responsibilities:

LifeWays

- Educate consumers & providers regarding Self-Determination
- Authorize services/budget based on medical necessity
- Manage fiscal intermediary contract
- Pay fiscal intermediary for authorized services



Authorizations

Budget Determination Summary (should be reviewed with consumer/guardian by primary clinician):

- Consumer name & case number
- Diagnosis
- IPOS end date
- Primary Clinician
- Fiscal Intermediary
- Services authorized, LifeWays authorized rate, effective/end dates and authorization number
- Authorized budget amount per service type
- Total authorized budget for treatment period. Note: non-service related costs such as employment costs (like training and workers' compensation) & Fiscal Intermediary costs are not part of the calculated budget.



Self-Determination Budget

- ❑ Developed by Fiscal Intermediary based on services authorized by LifeWays
- ❑ Sent to consumer (or guardian), primary clinician and LifeWays
- ❑ Must be retained in consumer's clinical record by primary clinician



Sample Budget Report

Sent each month to:

- Consumer or guardian
- Case Manager or Supports Coordinator
- LifeWays



Individual Report For

CONSUMER NAME

For Month of:

Your Budget is OK

Authorization Period:

Item	Units Budgeted	Actual Units	Difference	Budgeted Cost	Month Cost	Difference
CLS (Hrs)	18	20	(2)	\$368	\$267	\$101
Fiscal Intermediary Fee				\$125	\$125	\$0
Skill Building (Hrs)	18	16	2	\$368	\$213	\$154

Authorization to Date

Item	Units Budgeted	Actual Units	Difference	Budgeted Cost	YTD Cost	Difference
CLS (Hrs)	61	36	25	\$1,269	\$480	\$788
Fiscal Intermediary Fee				\$500	\$500	\$0
Skill Building (Hrs)	61	28	33	\$1,269	\$373	\$895
Workers Comp				\$387	\$387	\$0
<i>Difference</i>						\$1,684

Remaining Until:

Item	Starting Units	Actual Units	Remaining	Total Budget	Spent To Date	Remaining
CLS (Hrs)	88	36	52	\$1,838	\$480	\$1,358
Fiscal Intermediary Fee				\$637	\$500	\$137
Skill Building (Hrs)	88	28	60	\$1,838	\$373	\$1,464
Workers Comp				\$387	\$387	\$0

Remaining Units: 114

Remaining Dollars: \$2,959

Your Supports Coordinator/Case Manager is:

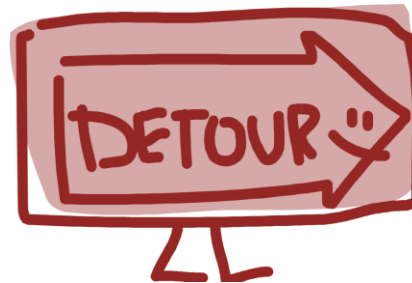
Phone

This report was sent to the following people:



Amendments to IPOS

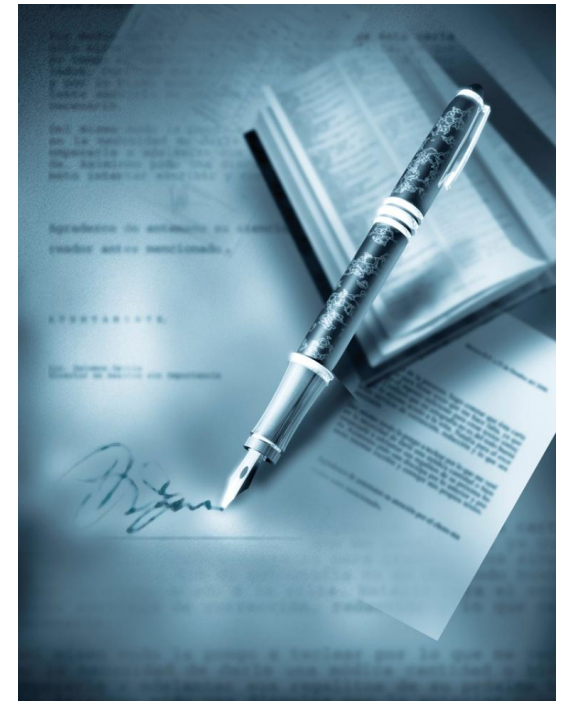
- If your needs change during the treatment plan year, you have the right to have a planning meeting – at any time – to make changes to your IPOS.
- Primary Clinician (Case Manager or Supports Coordinator) communicates change to LifeWays Utilization Management
 - Completes IPOS amendment.
 - If approved, a new Budget Determination Summary is completed.



Required Agreements

Should all be in place BEFORE consumer begins receiving services through Self-Determination

- ❑ Self-Determination Agreement (a.k.a. Choice Voucher Agreement)
 - ❑ Between LifeWays & Consumer
 - ❑ Outlines purpose of Self-Determination & defines responsibilities of parties
- ❑ Employment Agreement or Staffing Agency Agreement
 - ❑ Between consumer and chosen provider/employee
 - ❑ Outlines services to be provided, rate of reimbursement, employee/employer responsibilities (must be updated when there are changes)
- ❑ Job Description
 - ❑ Signed by employee
 - ❑ Describes services to be provided, standard requirements of employment & essential job functions
- ❑ Medicaid Provider Agreement
 - ❑ Between LifeWays and provider/employee
 - ❑ Outlines provider responsibilities per Medicaid regulations & LifeWays standards
- ❑ Ethical Standards for Self-Determination Providers
 - ❑ Attestation of agreement with LifeWays defined ethical standards



Service Documentation Requirements

All documentation is subject to review by auditing bodies and must be made available, upon request, to LifeWays, the State Medicaid agency, the U.S. Department of Health and Human Services, or the State Medicaid fraud control unit.

Basic service documentation forms:

- IPOS
- Progress Note
- PC/CLS Chart & Individual Consumer Log



Documentation: IPOS

- The IPOS is developed through a person-centered planning process.
- It is the basis for all services being provided.

INDIVIDUALIZED PLAN OF SERVICE			
Consumer Name (First, MI, Last)			Consumer No.
Date of Psychosocial Assessment:	Date of Pre-Planning:	Date of PCP Meeting:	<input type="checkbox"/> INITIAL Start Date: <input type="checkbox"/> ANNUAL End Date:
Integrated Treatment and Care Coordination			
Others involved in the consumer's treatment:		Method of Communication:	Frequency of Communication:
<input type="checkbox"/> LifeWays Physician's Unit, Physician Name:		<input type="checkbox"/> Fax <input type="checkbox"/> Letter <input type="checkbox"/> Telephone Call	
<input type="checkbox"/> Primary Care Physician, Physician Name:		<input type="checkbox"/> Fax <input type="checkbox"/> Letter <input type="checkbox"/> Telephone Call	
<input type="checkbox"/> Other Service Providers, Please list Name and Service:		<input type="checkbox"/> Fax <input type="checkbox"/> Letter <input type="checkbox"/> Telephone Call	
<input type="checkbox"/> Other, Please list:			
Comments:			
Preferences and Accommodations			
<input type="checkbox"/> Not applicable to consumer			
Preferences as indicated in assessment and/or the person centered planning process (include non-verbal needs):			
Accommodations made to meet preferences (include non-verbal accommodations):			
Health and Safety			
<input type="checkbox"/> Not applicable to consumer			
Summary of health and safety risks as indicated in assessment and/or the person centered planning process:			
Supports to address health and safety needs:			
Transportation safeguards:			
Formal Review of Effectiveness of Treatment Plan			
Consumer/guardian/family will provide ongoing feedback regarding their treatment plan using the following method:		<input type="checkbox"/> Consumer self report as needed <input type="checkbox"/> Scheduled face to face contacts <input type="checkbox"/> Telephone calls	
Staff will document consumer's satisfaction and progress towards outcomes using the following method:		<input type="checkbox"/> Progress Notes <input type="checkbox"/> Formal Review of Treatment	
Staff will conduct formal reviews of the treatment plan at this frequency:		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/> Other:	
Consumer has Crisis Plan on file: <input type="checkbox"/> Yes <input type="checkbox"/> No			



Documentation: Progress Note

- ❑ The Individual Progress Note is used to document the provision of services when staff are *teaching and training* (regardless of location) and there is an expectation of progress.
- ❑ It must minimally include:
 - Consumer name & case number
 - Date of service
 - Start/Stop time of service
 - Place of service
 - Type of service (note: “self-determination” is not a service). Examples of services are: CLS, skill building, respite
 - Goal & Objective being worked on
 - Interventions provided (what staff did) & consumer’s response (what consumer did)
 - Statement of progress toward goal/objective (whether or not there was progress, how progress or lack thereof was observed)
 - Staff signature/date
- ❑ Additional notes may be written on the back of the form or on an attached piece of paper that includes the consumer’s name & case number

INDIVIDUAL PROGRESS NOTE	
Consumer Name (First, MI, Last)	Consumer No.
Start Time: _____ End Time: _____ Total Units Used (optional): _____	Date of Contact
Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Community <input type="checkbox"/> Office <input type="checkbox"/> Other: _____	
Type of Service <input type="checkbox"/> Individual Counseling <input type="checkbox"/> Case Management/Supports Coordination <input type="checkbox"/> IDDT <input type="checkbox"/> Other: _____ <input type="checkbox"/> Family Counseling <input type="checkbox"/> ACT <input type="checkbox"/> Homebased	
Non-Billable Service (complete if applicable) <input type="checkbox"/> Telephone Call <input type="checkbox"/> Consumer Cancelled <input type="checkbox"/> Appointment Was: <input type="checkbox"/> Consumer No-Show/DNKA <input type="checkbox"/> Staff Cancelled <input type="checkbox"/> Scheduled/Routine <input type="checkbox"/> Unable to Locate <input type="checkbox"/> Other: _____ <input type="checkbox"/> Follow-Up/Routine <input type="checkbox"/> Other: _____ <input type="checkbox"/> Crisis Intervention <input type="checkbox"/> Unforeseen Need Requested by Consumer	
Comments:	
<input type="checkbox"/> Not a face-to-face contact (skip section)	
Consumer Presentation	
Orientation	<input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time
Affect	<input type="checkbox"/> Appropriate <input type="checkbox"/> Restricted <input type="checkbox"/> Flat <input type="checkbox"/> Labile <input type="checkbox"/> Other: _____
Mood	<input type="checkbox"/> Dysthymic <input type="checkbox"/> Euthymic <input type="checkbox"/> Elated <input type="checkbox"/> Anger <input type="checkbox"/> Anxious <input type="checkbox"/> Manic <input type="checkbox"/> Other: _____
Thought Content	<input type="checkbox"/> Hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/> Grandiose <input type="checkbox"/> Illusions <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____
Risk	<input type="checkbox"/> Suicidal Ideations <input type="checkbox"/> Homicidal Ideations <input type="checkbox"/> Acute Psychosis <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____
If Risk involved, please check as appropriate: <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Attempt <input type="checkbox"/> Other: _____	
Comments:	
New Health/Welfare/Safety concerns reported by the consumer or observed since the last contact? <input type="checkbox"/> No <input type="checkbox"/> Yes, Action taken: _____	
Goal/Objective addressed from Individualized Plan of Service (IPOS):	
Stressors and/or new issues presented today:	
Interventions provided and consumer's response: (i.e. motivational enhancing interventions, stage wise treatment)	
Natural/community support in achieving goal since last contact: (Indicate if present during contact, how staff is working to engage supports) <input type="checkbox"/> No support <input type="checkbox"/> Some support <input type="checkbox"/> Great support	
Comments:	
Progress towards goal/objective: <input type="checkbox"/> Not Rated <input type="checkbox"/> No Progress <input type="checkbox"/> Some Progress <input type="checkbox"/> Good Progress	
Comments:	
Satisfaction reported by consumer:	
Consumer's Rating of Their Progress: <input type="checkbox"/> I am happy with my progress <input type="checkbox"/> I am not happy with my progress	
Comments:	
Consumer Signature (optional)	Date
Staff Signature/Credentials	Date
Supervisor Signature/Credentials (if applicable)	Date



Documentation: PC/CLS Chart

- Used to document services provided in the home
- Completed in addition to Individual Consumer Log

NAME: _____ CASE# _____ MONTH/YR: _____

PC CLS	#Units		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
PC		Eat/Feed																																
CLS		Meal Prep																																
PC		Toileting																																
CLS																																		
PC		Bathing																																
CLS																																		
PC		Grooming																																
CLS																																		
PC		Dressing																																
CLS																																		
PC		Transfers																																
CLS																																		
PC		Ambulate																																
CLS																																		
PC		Housekeep																																
CLS		Laundry																																
CLS		Individual goals																																
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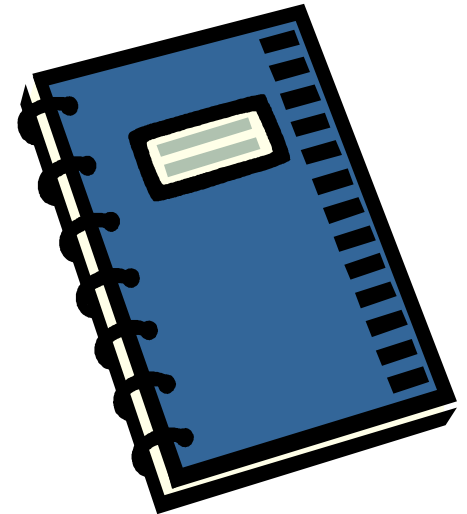
Circle PC or CLS being provided Enter # Units provided per day in each category Staff initial in box corresponding with the day of the month provided.
Staff Providing Care enter initials and signature below. If additional staff, add on back of the sheet.

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____



Documentation: Individual Consumer Log

- Individual Consumer Log
 - Used to document services provided in the home
 - Completed in addition to the PC/CLS Chart
 - Maintain separate log for each consumer
 - Make available for primary clinician review
 - Document the following:
 - Consumer Name
 - Date
 - Notes from each shift for that date, including:
 - Time period (ex. 8:00 a.m. – 12:00 noon)
 - Consumer response and progress toward goal
 - Anything staff did that is not recorded in PC/CLS Chart
 - Any behaviors/interventions*
 - Any medical issues/interventions*
 - Staff signature



*May require an incident report (explained in Recipient Rights training provided by LifeWays)



Documentation: Time Sheets

- Time sheets for directly employed staff
 - Must be signed by consumer/guardian
 - Must indicate service provided (ex., Community Living Supports, Skill Building)
 - Must include date and time OR date and number of hours provided (depending on type of service)
 - In-Home CLS (per diem service – include date and number of hours)
 - Out of home CLS & Skill Building – include date and time (ex. 9:00 a.m. – 11:00 a.m.)
 - When multiple consumers are served during the same timeframe, time must be divided among those served to reflect active treatment provided for each consumer. (ex. if served two consumers from 10:00 a.m. – noon, do not bill for two hours for each consumer)
 - Must be accompanied by progress notes that provide evidence of service delivery when submitted to the Fiscal Intermediary



Employee Eligibility

- ❑ Proof of appropriate licensure/degree (and/or supervision)
- ❑ Completion of training required by LifeWays (see Job Description or Staffing Agency Agreement and [Required Training & Resources Chart](#))
- ❑ At least 18 years of age at time of hire
- ❑ Not excluded from program participation (Medicaid, Medicare, LifeWays)
- ❑ Able to prevent transmission of communicable diseases
- ❑ Able to perform basic first aid procedures
- ❑ Felony Convictions:
 - ❑ The Medicaid Provider Manual allows past felony convictions for employees of adults, BUT that person must “not be a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing”. So, a person with a past felony conviction could be hired to work for with an adult IF they meet this additional criteria AND if the consumer/guardian employer signs the Criminal Background Check Waiver Letter available from the FI prior to hire.
 - ❑ Any felony conviction excludes a potential employee from working with a child.
- ❑ Able to communicate expressively and receptively in order to follow IPOS requirements and beneficiary-specific emergency procedures, and report on activities performed
- ❑ Refer to Job Description or Staffing Agency Agreement for requirements specific to services to be provided



Required Training & Resources

- ❑ [Click here to view Required & Resources Training Chart](#)
- ❑ Other training (depending on the type of service being provided and the consumer-employer's needs – see job description or staffing agency agreement)
- ❑ Employee must provide written proof of training to the consumer-employer and/or Fiscal Intermediary.
- ❑ Costs for training come from the consumer's self-determination budget.



Monitoring

Service Utilization

- Monitored by Primary Clinician & Consumer/Guardian
- Over/Under (medical necessity)
- Should be in alignment with IPOS
- Some fluctuations are expected, but dramatic fluctuations or changes in usage that are expected to continue require communication to Utilization Management



Budget

- Monitored by FI, Primary Clinician and Consumer/Guardian
- FI provides monthly reports
- Rates paid for services must agree with Employment Agreement or Staffing Agency Agreement AND cannot exceed LifeWays authorized rate (included in Budget Determination Summary)
- Important to consider employment costs (training, fiscal intermediary fees, worker's compensation) which are not included in budget calculations when determining rates of payment



Services Provided under Self-Determination

- Are defined in Section 3 of the Mental Health/Substance Abuse chapter of the Medicaid Provider Manual
- Brief summaries follow this slide for services commonly received in self-determined arrangements
- Medicaid Law applies (see slides on “Medicaid Basics”)
- Must be provided according to the IPOS



What are Community Living Supports?

- ❑ Service Code: H2015 (in the community) H0043 (in the home)
- ❑ Service Description (see Medicaid Provider Manual for complete description):
 - ❑ Assisting, reminding, observing, guiding and/or training in: meal preparation; laundry; routine, seasonal, and heavy household care & maintenance; activities of daily living (e.g., bathing, eating, dressing, personal hygiene); and shopping for food or other necessities of daily living
 - ❑ Staff assistance, support and/or training with: money management, non-medical care (not requiring nurse or physician intervention), socialization & relationship building, and transportation to & from the consumer's residence & community activities & among community activities (excluding to/from medical appointments), participation in regular community activities & recreation opportunities (attending classes, movies, concerns, events in a park, volunteering, voting); attendance at medical appointments; acquiring or procuring goods, other than those listed under shopping, and non-medical services
 - ❑ Reminding, observing and/or monitoring of medication administration
 - ❑ Staff assistance with preserving the health & safety of the consumer in order that he/she may reside or be supported in the most integrated, independent community setting.



What is Skill Building?



- Service Code: H2014
- Service Description (see Medicaid Provider Manual for complete description):
 - Activities identified in the IPOS that assist a beneficiary to increase his/her economic self-sufficiency and/or to engage in meaningful activities such as school, work and/or volunteering.
 - The services provide knowledge & specialized skill development and/or support.
 - The service may be provided in the beneficiary's home or in the community.



What is Case Management?

- Service Code: T1017
- Service Description (see Medicaid Provider Manual for complete description):
 - Assists consumers to design and implement strategies for obtaining services and supports that are goal-oriented and individualized.
 - Services include: assessment, planning, linkage, advocacy, coordination and monitoring to assist consumers in gaining access to needed health & dental services, financial assistance, housing employment, education, social services, and other services and natural supports developed through the person-centered planning process.



What is Supports Coordination?

- Service Code: T1016
- Service Description (see Medicaid Provider Manual for complete description):
 - Assessing the need for support and service coordination, and assurance of the following:
 - Planning and/or facilitating planning using person-centered principles
 - Developing an IPOS using the person-centered process
 - Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of services and supports
 - Brokering of providers of services/supports
 - Assistance with access to entitlements and/or legal representation
 - Coordination with the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers



Medicaid Fraud & Abuse

- As a person receiving services that are paid for by Medicaid, you have a responsibility to protect against fraud/abuse. The following are examples of Medicaid fraud/abuse:
 - Signing a timesheet you know is wrong
 - Billing for services that were not provided
 - Poor or no documentation to support services delivered
 - Forging a signature
 - Purchasing an asset (like a vehicle) or making repairs/maintenance to an asset with Medicaid dollars



Medicaid Fraud & Abuse continued

- ❑ Consequences
 - ❑ Repayment of funds
 - ❑ No future Medicaid reimbursement
 - ❑ Criminal charges
- ❑ Reporting fraud & abuse
 - ❑ LifeWays Corporate Compliance
Hotline: 1-866-630-3690



Conflict of Interest

- ⊘ A parent cannot be reimbursed by Medicaid to provide Community Living Supports for their child.
- ⊘ Employees cannot approve their own time sheet.
- ⊘ Dual/exploitative relationships with consumers/guardians must be avoided.



Code of Ethics

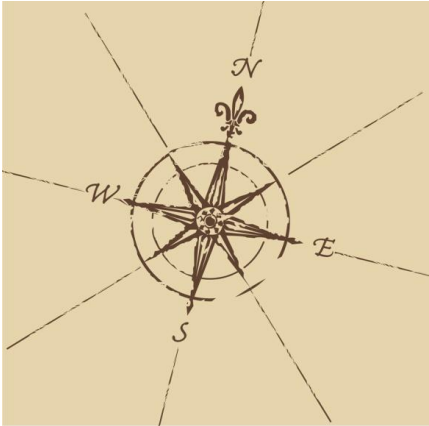


Providers who accept a contract or employment with a LifeWays consumer/guardian under self-determination, imply agreement with:

- ❑ LifeWays defined Ethical Standards. Signature attesting to understanding and acceptance of the defined ethical standards is required *prior to employment* under a self-determination arrangement. ([Click here to print and sign attestation](#))
- ❑ LifeWays Standards and Best Practice Guidelines which are linked to the Ethical Standards attestation above and can also be found on the LifeWays website at www.lifewayscmh.org.



Resources



STATE:

- ❑ Medicaid Provider Manual:
<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>
- ❑ Center for Self-Determination: www.self-determination.com
- ❑ Michigan Department of Community Health: <http://www.michigan.gov/mdch>
- ❑ Social Security Administration: www.ssa.gov
- ❑ Department of Human Services: www.michigan.gov/fia
- ❑ Centers for Medicare and Medicaid Services: www.cms.hhs.gov

LOCAL:

- ❑ LifeWays: (517) 780-3332 or (866) 630-3690
www.lifewayscmh.org
 - Shannan Clevenger, Self-Determination Coordinator
(517) 796-4574
 - Annette Friday, Self-Determination Contract Manager
(517) 780-3353
- ❑ ARE: Jackson (517) 788-9147; Hillsdale (517) 439-5210
www.dropincenters.org
 - Certified Peer Support Specialists
 - Independent Facilitation



Provider Training Confirmation

By my signature below, I acknowledge that I have completed the LifeWays *SELF-DETERMINATION SELF-STUDY TRAINING*. I understand that I will be accountable for the information contained in this training. If I have questions I may contact LifeWays or my employer for clarification.

I also understand that this signed training acknowledgement must be provided to my employer *PRIOR* to my providing any services and that it will be maintained as evidence of my completion of Self-Determination Training.

Name (please print): _____

My signature below indicates that I:

- ✓ Completed the Self-Determination Training on ____/____/_____.
- ✓ Understand that if I have any questions regarding the training subject matter I may contact LifeWays or my employer for clarification.
- ✓ Have achieved functional competency in the training subject matter.

Provider/Employee Signature: _____ Date: _____

