

**Michigan Department of Health & Human Services  
Division of Chronic Disease and Injury Control  
Diabetes and Other Chronic Diseases Section  
Washington Square Bldg. 7th Floor  
109 W. Michigan Ave  
Lansing MI 48913**

**DIABETES SELF-MANAGEMENT TRAINING PROGRAM  
APPLICATION FOR CERTIFICATION/RECERTIFICATION  
INDIVIDUAL ENTITY**

SPONSORING ORGANIZATION NAME \_\_\_\_\_

NAME OF PROGRAM \_\_\_\_\_

NAME OF PROGRAM COORDINATOR \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PHONE \_\_\_\_\_

FAX \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

MEDICAL PROVIDER TYPE: (PLEASE CIRCLE ONE #)

1=Provider Type 40 (Hospital Outpatient Department)

2=Provider Type 77 (Local Public Health Department)

Organizational NPI# \_\_\_\_\_

ADA Recognized Date \_\_\_\_\_

Expiration Date \_\_\_\_\_

AADE Recognized Date \_\_\_\_\_

Expiration Date \_\_\_\_\_

Specify program charges for:

Individual Instruction per 1/2 hour \_\_\_\_\_

Group Instruction per 1/2 hour \_\_\_\_\_

Total number of hours that comprise a comprehensive education program \_\_\_\_\_

List all specific educational components that are included in the program (gestational, pediatrics, adult, continuous subcutaneous insulin infusion).

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

**Application continued on tab 2 (Pages 2-3) below.**

List all **additional** sites where program is taught. List all specific educational components that are included in the program at each site (gestational pediatrics, adult continuous subcutaneous insulin infusion).

Site Name \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
E-Mail \_\_\_\_\_  
Components 1) \_\_\_\_\_  
2) \_\_\_\_\_  
3) \_\_\_\_\_  
4) \_\_\_\_\_

Site Name \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
E-Mail \_\_\_\_\_  
Components 1) \_\_\_\_\_  
2) \_\_\_\_\_  
3) \_\_\_\_\_  
4) \_\_\_\_\_

Site Name \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
E-Mail \_\_\_\_\_  
Components 1) \_\_\_\_\_  
2) \_\_\_\_\_  
3) \_\_\_\_\_  
4) \_\_\_\_\_

We have a Diabetes Self-Management Training (DSMP) Program that meets the Michigan DSMT Certification Policy. Program documentation to confirm this statement is on file and available for review at any time.

We herein submit an official request for certification/recertification (circle one) of our diabetes education program by the Michigan Department of Health & Human Services, Diabetes and Other Chronic Diseases Section (MDHHS, DOCDS). For Provider types 40 & 77, this certification will be used for the purpose of applying for Medicaid reimbursement for Medicaid eligible clients participating in our program. We understand that the MDHHS, DOCDS will notify the Medical Services Administration, Michigan Department of Health & Human Services, provided we are an eligible agency, of our certified status so that we may initiate Medicaid billing.

We understand that we must maintain the requirements according to the DSMT policy in order to keep our certification and that the MDHHS, DOCDS reserves the right to review any or all of our program documentation and make a site visit at any time.

We agree to submit the following program data to the MDHHS/DOCDS:

- 1) An annual report.
- 2) A statistical report regarding the patients educated during the state fiscal year (October 1 through September 30) by **November 30** of each year.
- 3) Significant program changes within 30 days of the change, using the "Change Form" eg.
  - Site/location change
  - Addition of satellite site/s
  - Change in coordinator
  - Changes in sponsoring organizations status such as merger, agreements, etc.
  - Addition of specialized educational components and/or any other significant changes

Provide signatures below to attest to the truth and accuracy of the contents of this application and to verify that the sponsoring organization is currently Medicare/Medicaid certified and licensed by the

**Program Coordinator**

Name (Print) \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Chief Executive Officer (or designee)**

Name (Print) \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_