*INSTRUCTIONS: Eligible Region 5 Providers must complete this application form. Enter the form fields and provide the requested information (or check appropriate boxes). See the* [*MSHN Regional Guidance*](https://nam11.safelinks.protection.outlook.com/?url=https%3A%2F%2Fmidstatehealthnetwork.org%2Fdownload_file%2F2805%2F0&data=04%7C01%7C%7C100fce7e6d21469ea17708d9fc567a6d%7C843a070b9fc1420ea2dee05952409d46%7C0%7C0%7C637818270625515375%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=pCUwpu7TFjpUR3lz9crL%2FmMASL9T%2F5q7cMle3IdB9vY%3D&reserved=0) *for eligibility criteria, exclusions, and other details. Region 5 Funding Entities may request more information in order to make a funding determination. Attach additional pages as necessary. Submit completed applications to the Region 5 Funding Entity with which the provider is contracted. If more than one, submit to the Region 5 Funding Entity which represents the largest amount of contract revenue to the provider.*

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| --- | --- | --- | --- | --- |
| Provider Name  Site Name (if applicable)  Address of Site  City, State, Zip of Site  Contact Name:  Contact Phone: | Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text. | | Region 5 Funding Entities with which the Provider has current contracts  (CHECK ALL THAT APPLY) | Provider Application submitted to:  (CHECK ONE) |
| **Eligibility Attestation:**  Applicant Provider is contracted to a Region 5 Funding Entity  -----  Site(s) to be supported are within geographic boundaries of Region 5  -----  Applicant Provider Delivers Medicaid Manual Supports and Services | Yes  No  Uncertain  -----  Yes  No  Uncertain  -----  Yes  No  Uncertain | Please identify and describe here any current year provider stabilization funding received *for the same purposes* from a Region 5 funding entity:  Click or tap here to enter text. | Bay-Arenac Behavioral Health  Clinton-Eaton-Ingham CMH  CMH For Central Michigan  Gratiot Integrated Health  Huron Behavioral Health  The Right Door  LifeWays  Montcalm Care Center  Newaygo CMH  Saginaw CMH  Shiawassee Health & Wellness  Tuscola Behavioral Health Sys  Mid-State Health Network |  |

**Funding Request:** Below, please check the box for each category of support requested. Provide the amount of funding requested. Then provide any pertinent formulas for how the provider arrived at the funding amount requested.  *For example: Retention bonus of $XXX for ### of FTEs, $XXX paid at onset of program; $XXX paid at end of successful continuation of employment (not to exceed 09/30/2023) = Total Funding Request.*  Finally, provide a brief narrative for each category of funding requested. Attach additional documents as needed to provide sufficient details to justify request, as needed. The fields on this form automatically expand to permit room for pertinent details.

| **WORKFORCE APPLICANT INCENTIVES** |  | **EXISTING WORKFORCE RETENTION INCENTIVES** |  |
| --- | --- | --- | --- |
| **Attraction/“Signing” Incentives –**  **Requested $:** Click or tap here to enter text.  **Formula Used:** Click or tap here to enter text.  **Brief Narrative:** Click or tap here to enter text.  **Referral Incentives –**  **Requested $:** Click or tap here to enter text.  **Formula Used:** Click or tap here to enter text.  **Brief Narrative:** Click or tap here to enter text.  **Temporary Compensation Adjustments –**  **Requested $:** Click or tap here to enter text.  **Formula Used:** Click or tap here to enter text.  **Brief Narrative:** Click or tap here to enter text.  **Onboarding Costs –**  **Requested $:** Click or tap here to enter text.  **Formula Used:** Click or tap here to enter text.  **Brief Narrative:** Click or tap here to enter text.  **Recruitment Costs –**  **Requested $:** Click or tap here to enter text.  **Formula Used:** Click or tap here to enter text.  **Brief Narrative:** Click or tap here to enter text.  **Other – Must be detailed and attached separately. –**  **Requested $:** Click or tap here to enter text.  **Formula Used:** Click or tap here to enter text.  **Brief Narrative:** Click or tap here to enter text. |  | **Retention Incentives –**  **Requested $:** Click or tap here to enter text.  **Formula Used:** Click or tap here to enter text.  **Brief Narrative:** Click or tap here to enter text.  **Temporary/Short Term Compensation Adjustment –**  **Requested $:** Click or tap here to enter text.  **Formula Used:** Click or tap here to enter text.  **Brief Narrative:** Click or tap here to enter text.  **Onboarding Costs –**  **Requested $:** Click or tap here to enter text.  **Formula Used:** Click or tap here to enter text.  **Brief Narrative:** Click or tap here to enter text.  **Shift Differentials –**  **Requested $:** Click or tap here to enter text.  **Formula Used:** Click or tap here to enter text.  **Brief Narrative:** Click or tap here to enter text.  **Overtime or other premiums –**  **Requested $:** Click or tap here to enter text.  **Formula Used:** Click or tap here to enter text.  **Brief Narrative:** Click or tap here to enter text.  **Temporary staffing arrangements –**  **Requested $:** Click or tap here to enter text.  **Formula Used:** Click or tap here to enter text.  **Brief Narrative:** Click or tap here to enter text.  **Other – Must be detailed and attached separately. –**  **Requested $:** Click or tap here to enter text.  **Formula Used:** Click or tap here to enter text.  **Brief Narrative:** Click or tap here to enter text. |  |

**TOTAL FUNDING REQUESTED** (Add all requested amounts and enter the total here): Click or tap here to enter text.

By submitting this application, the applicant/provider attests that it has reviewed and is qualified for the MSHN regional provider stabilization support requested, that the applicant/provider governing body has authorized (or will authorize, prior to the expenditure of funds) the program proposed by the applicant/provider, that the applicant/provider will use all funds provided for the stated purpose(s), will provide all documentation required by the funding entity, and will comply with federal, state and local regulations pertinent to the requested provider staffing stabilization funding. The applicant further acknowledges that the funding entity will not commit to any proposed cost that extend beyond 09/30/2023.

The Region 5 Funding Entity may require additional information from the applicant organization in order to formulate a funding decision, justify or support the expenditure of public funds, or for other reasons supportive of the fiduciary responsibilities of the organization providing requested funding.

**Provider Representative:** Click or tap here to enter text.

**Provider Representative Title:** Click or tap here to enter text.

**Date:** Click or tap here to enter text.

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| MSHN/CMHSP Use Only:  Approved Amount: $Click or tap here to enter text.  Denied Denial Reasons: Click or tap here to enter text.  MSHN/CMHSP Authorized Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |