

NORTHPOINTE BEHAVIORAL HEALTHCARE SYSTEMS

SELF-DETERMINATION PROVIDER INFORMATION

PROVIDER NAME: _____

ADDRESS: _____

PHONE #: _____

EMAIL ADDRESS: _____

_____ has received special training from parent/guardian
(Provider Name)
and is qualified to provide care for _____ .
(recipient's name)

To qualify as a Self-Determination Provider, Northpointe needs evidence of the following:

- Be a responsible adult at least 18 years of age;
- Must be able to practice prevention techniques to reduce the transmission of communicable disease from themselves to others in the environment where they are providing support;
- Able to read and follow written plans of service/supports as well as beneficiary specific emergency procedures
- Able to write legible progress and/or status notes
- Be in “good standing” with the law (i.e.: not a fugitive from justice, a convicted felon or illegal alien) and successfully complete a criminal background check
- Complete First Aid Training every 2 years
- Must complete Recipient Rights Training annually
- Must have Universal Precautions training annually and a signed acknowledgement
- Complete Employee Health form annually

I understand that Northpointe Behavioral Healthcare Systems is not responsible for the actions of the worker or the child/adult while care is being provided.

Signature of Provider **Date**

Signature of Parent/Guardian **Date**

This information on the SD Provider is to be completed and signed by Parent/Guardian and the SD Provider and returned to Northpointe Behavioral Healthcare Systems, 715 Pyle Drive, Kingsford, MI 49802, Attention: Self Determination Coordinator, prior to family receiving reimbursement.

My assigned Northpointe Care Manager is: _____