

Provider demographics

As a plan participating in the Michigan Coordinated Health (MICH) Highly Integrated Dual Special Needs Plan (HIDE SNP), we must provide our members with access to medical programs and services. We are required to reasonably accommodate members and ensure programs and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities. Accordingly, we will inform members in the provider directory of a provider’s ability to accommodate special needs. Please visit our website at www.amerhealthcaritasvipcare.com/mi and verify that your provider demographics are correct in our online provider directory.

All questions must be completed

| | | | | | | | | | | | | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Practice name and tax ID number: | | | | | | | | | | | | | | | | | |
| 2. I have confirmed that all provider information (including group name, provider name, address, and phone numbers) in the online provider directory (accessible at www.amerhealthcaritasvipcare.com/mi) is correct for all providers associated with this tax ID number. | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> All information is correct. <input type="checkbox"/> Information is incorrect or information is missing. Please identify incorrect or missing information: | | | | | | | | | | | | | | | | | |
| 3. Practice fax number: | | | | | | | | | | | | | | | | | |
| 4. Practice web address: | | | | | | | | | | | | | | | | | |
| 5. Individual completing the survey: | | | | | | | | | | | | | | | | | |
| 6. Email address where the office would like to receive electronic communications: | | | | | | | | | | | | | | | | | |
| 7. Please confirm the practice hours of operation. (Check the opening and closing time for each day.) | | | | | | | | | | | | | | | | | |
| | 24/7 | Closed | 6 a.m. | 7 a.m. | 8 a.m. | 9 a.m. | 10 a.m. | 11 a.m. | 12 a.m. | 1 p.m. | 2 p.m. | 3 p.m. | 4 p.m. | 5 p.m. | 6 p.m. | 7 p.m. | 8 p.m. |
| Sunday | <input type="checkbox"/> |
| Monday | <input type="checkbox"/> |
| Tuesday | <input type="checkbox"/> |
| Wednesday | <input type="checkbox"/> |
| Thursday | <input type="checkbox"/> |
| Friday | <input type="checkbox"/> |
| Saturday | <input type="checkbox"/> |



8. Do/can you provide alternative appointment scheduling for those who need extra time, extended hours, or home visits? (Please check all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> Alternative appointment scheduling | <input type="checkbox"/> Home visits |
| <input type="checkbox"/> Extended hours | <input type="checkbox"/> Not applicable |

9. Please list the specific languages other than English spoken by the providers and/or staff.

- | | |
|---|--|
| <input type="checkbox"/> American Sign Language (ASL) | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> French | <input type="checkbox"/> Russian |
| <input type="checkbox"/> French Creole | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> German | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Greek | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> Italian | |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Not applicable |

Provider or staff names:

10. Do any of the providers in your office have special experience, skill, expertise, or training in treating persons with trauma, substance use disorders, physical disabilities, chronic illness, HIV/AIDS, serious mental illness, homelessness, deafness or hearing impairment, blindness or visual impairment, co-occurring disorders, or other areas of specialty? Select all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Substance use | <input type="checkbox"/> Deafness or hearing impairment |
| <input type="checkbox"/> Physical disability | <input type="checkbox"/> Blindness or visual impairment |
| <input type="checkbox"/> Chronic illness | <input type="checkbox"/> Co-occurring disorders |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other (please specify): |
| <input type="checkbox"/> Serious mental illness | |
| | <input type="checkbox"/> Not applicable |

Provider or staff names:

11. Is your practice location accessible by public transportation?

- | | | | |
|------------------------------|--------------------------------|-------------------------------|---|
| <input type="checkbox"/> Bus | <input type="checkbox"/> Train | <input type="checkbox"/> Rail | <input type="checkbox"/> Not applicable |
|------------------------------|--------------------------------|-------------------------------|---|

12. Have providers and/or staff completed disability and cultural competency training? Yes No

13. Does the provider's location offer any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Wide entry | <input type="checkbox"/> Accessible scales |
| <input type="checkbox"/> Wheelchair access | <input type="checkbox"/> Accessible bathrooms including stalls and grab bars |
| <input type="checkbox"/> Accessible exam rooms | <input type="checkbox"/> Other accessible equipment |
| <input type="checkbox"/> Accessible tables | <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> Accessible lifts | |



| | |
|---|--|
| 14. Do you accommodate services, teaching materials, and documents for individuals with learning, intellectual, and/or cognitive disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 15. Are printed materials available in alternative formats? | |
| <input type="checkbox"/> Large print (16- to 18-point font) | <input type="checkbox"/> Digital versions of commonly used written materials |
| <input type="checkbox"/> Braille | <input type="checkbox"/> Optical recognition software |
| <input type="checkbox"/> Taped text | <input type="checkbox"/> Not applicable |
| 16. Do you provide any of the following accommodations to ensure effective communication with hearing-impaired individuals? | |
| <input type="checkbox"/> Qualified sign language interpreters | <input type="checkbox"/> Assisted listening devices or systems |
| <input type="checkbox"/> Written notes between the provider and patient | <input type="checkbox"/> Closed caption decoders |
| <input type="checkbox"/> Computer-aided real-time transcription (CART) | <input type="checkbox"/> Access to a TTY/TDD line |
| <input type="checkbox"/> Video relay service (VRS) | <input type="checkbox"/> Not applicable |
| 17. Do you have electronic prescribing capabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Please submit completed survey by email to michiganprovidernetwork@amerihealthcaritas.com. Thank you for providing this valuable information.

