**Region 4 Behavioral Health System**

**MINIMUM STANDARDS FOR**

**NETWORK PROVIDER ENROLLMENT**

Providers will be enrolled into a network based on the successful completion of the provider enrollment process outlined in this document, the provider’s demonstration of its ability to comply with *Nebraska Administrative Code 206: Behavioral Health Services* (NAC 206)including the service definition(s) specific to the service(s) the applicant desires to provide in the network, and the availability of funding to purchase services identified as core and necessary to meet the behavioral health needs of individuals and families who meet clinical and financial eligibility criteria.

Regional Behavioral Health Authorities are a component of the Nebraska Behavioral Health System (NBHS) which is overseen by the Department of Health and Human Services, Division of Behavioral Health (DBH), and as such, DBH retains the right, based on quality and/or safety issues, to deny approval of new practitioners, providers, and sites in the Behavioral Health Network, and to terminate or suspend individual practitioners or providers.

Note: NAC 206: Behavioral Health Services including service definitions of all services included in the NBHS service array may be accessed via the internet at: http://dhhs.ne.gov/Pages/reg\_bhregs.aspx and click on [Title 206 -- Behavioral Health Services](http://dhhs.ne.gov/Pages/reg_t206.aspx)

DESIRED OUTCOMES

The minimum standards for behavioral health provider enrollment in the Behavioral Health Network are designed to answer the following questions:

1. Does the provider have the capability to provide mental health and/or substance use disorder services?
2. Is the Network interested in purchasing the services the provider has to offer?
3. Are there any health and safety related issues?
4. Is the provider achieving the outcomes the Network is interested in purchasing?

SUMMARY OUTLINE OF ENROLLMENT PROCESS

1. Initial Enrollment of Providers
	1. Demonstration of Capacity
	2. National Accreditation
	3. On-Site Visit
	4. Primary Source Verification
2. Retention of Providers
	1. Demonstration of Capacity
	2. National Accreditation
	3. On-Site Visit
	4. Primary Source Verification
3. Enrollment
4. Capacity
	1. Capacity of Provider
	2. Capacity Network Will Purchase

**BEHAVIORAL HEALTH PROVIDER ENROLLMENT STANDARDS, RESPONSIBILITIES, AND SELECTION CRITERIA**

1. INITIAL ENROLLMENT OF PROVIDERS

The decision to enroll a behavioral health provider in the Regional Network is based on the collection of the following information: (A) Demonstration of Capacity, (B) National Accreditation, (C) On-Site Visit, and (D) Primary Source Verification.

1. Demonstration of Capacity
	1. Facility Licenses, Fire Inspections, and Food Permits, as required.
	2. Professional Licenses, as required.
	3. Insurance as listed below:
		1. Workers’ compensation,
		2. Motor vehicle liability,
		3. Professional liability (minimum of $1,000,000 per occurrence and $3,000,000 in aggregate per year),
		4. Directors/officers liability,
		5. General liability coverage in an amount not less than $1,000,000.
	4. Fiscal Viability – demonstrated as “an ongoing concern” by an audited balance sheet.
	5. Providers must be enrollee as a Medicaid provider (MC 19 and MC 20 form) if the service provider is eligible for Medicaid funding.
	6. A Program Plan for each service provided in the Network.
		1. Entry (admission) and exit (discharge) criteria
		2. Description of the assessment procedures
		3. Description of how consumer input into the program is completed.
		4. Staffing
		5. Quality improvement
2. National Accreditation

Provider organizations must be accredited by the national accrediting body that is appropriate to the organization's mission. National accrediting bodies include: The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or other nationally recognized accreditation organization(s) approved by the Region and DBH. Documentation of accreditation must include:

a. A complete copy of the most recent official accreditation report;

b. Documentation of the most recent official award of accreditation; and

c. A complete copy of the plan of correction submitted in response to the official

 accreditation report, if applicable.

C. On-Site Visit

1. The on-site visit for providers is conducted by Network Management prior to the provider’s enrollment in the Network and prior to providing service to person registered or authorized for service. The on-site visit is completed at the provider’s location to verify the information provided under Section 1.A.
2. The on-site visit will evaluate the site where services are provided including where the provider’s organized programmatic, clinical, and financial record keeping functions are performed.
3. The on-site visit will verify that the provider’s clinical record keeping practices conform with the program plan submitted and minimum standards. This is a systematic review of the clinical records for conformity and the type of information included in treatment or rehabilitation plans, but will not make judgment on the appropriateness of treatment.
4. The on-site visit will include a data audit to verify the information reported to the Region and DBH and compliance with the NBHS Centralized Data System.
5. If an individual practitioner does not have National Accreditation, an on-site quality assurance review, using the standards set in NAC 206, will be completed. Organizations and group practices will be required to have National Accreditation.

D. Primary source Verification

 All information used to meet the criteria under Section I.A. and I.B. (credentialing and facilities, malpractice insurance coverage, national accreditation, and related documents) is compiled. This is completed by Network Management, which verifies key information such as licenses, insurance coverage, national accreditation, and related documents.

II. RETENTION OF PROVIDERS

The decision to retain a behavioral health provider is based on an actual performance and

retention review. The Retention Review is completed by Network Management and

consists of the following parts. (NOTE: Providers already enrolled will go through the

Retention Review Process at the end to the Provisional 12-month-time period.)

* 1. Continue to Meet the Requirements for Initial Enrollment in Section 1.A.
	2. Performance Review

An Actual Performance Review is completed to determine if the provider has

demonstrated a commitment to providing quality services. The Actual Performance

Review consists of four parts: (1) Contract compliance, (2) Results Produced, (3) Consumer Satisfaction, and (4) Error Free Reporting.

* + 1. Contract Compliance – the provider has complied with all requirements listed in the provider’s contract with the Region. If there were compliance issues, the provider submitted a corrective action plan and fulfilled all requirements in such plan.
		2. Results Produced – The behavioral health provider has data demonstrating the operation of the behavioral health service. The data reported includes:
			1. Utilization Data – process orientated information
			2. Outcome Data – demonstrates results based on actual clinical (Increased Functioning, Increased Health Status, Decreased Symptoms, Employment Outcomes, Improved Housing, Improved Legal Status, and/or other related outcomes.
			3. Record of Accepting NBHS referrals.
		3. Consumer Satisfaction

 This is based on the attention paid to customer service and includes:

a. Consumer Satisfaction Survey

b. Tracking consumer complaints regarding the provider

c. Malpractice suits (is anything pending in the area, or recently adjudicated?)

d. Does the provider or service create unnecessary dependence (service demonstrates promotion of growth and independence and does not foster dependence)?

4. Error Free Reporting

a. Information reported is “without mistakes” in the billing, utilization of the Centralized Data System, consumer service data, and other reporting.

* 1. When there are errors, it is costly to correct the problem. The measure here is the “error rate” in reporting – the lower the error rate the better.
	2. On-Site Visit
		1. The on-site visit reconfirms the information in Section I.A. and is conducted before the Retention Review is completed.
		2. The site visit report must include information on how well the record keeping system conforms to the standards sets. There will be specific requirements for corrective actions with deadlines when standards are not met.
	3. Primary Source Verification

Information used to meet the criteria in Section I.A. and I.B. must be verified and

documented by Network Management to complete the Retention Review.

1. ENROLLMENT

To receive funds from the Region for the delivery of behavioral health services, providers must submit the following:

* + 1. Completed Provider Enrollment Application (Provider Enrollment Attachment 1);
		2. Current copy of the required licenses issued by the Department of Health and Human Services or the applicable local licensing authorities of competent jurisdiction which apply to the program;
		3. Documentation on the type of organization seeking approval (such as governmental, private non-profit) to operate the program(s); and
		4. Accreditation appropriate to the organization's mission by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), or other nationally recognized accreditation organization(s) approved by the Director. Documentation of accreditation must include:

 a. A complete copy of the most recent official accreditation report;

 b. Documentation of the most recent official award of accreditation; and

 c. A complete copy of the plan of correction submitted.

Exceptions to required national accreditation include: (1) Substance use disorder prevention organizations, and (2) when a nationally recognized accreditation organization appropriate to the organization’s mission cannot be identified.

Organizations that do not have documentation of official award of accreditation by TJC, CARF, COA, or other nationally recognized accreditation organization(s) approved by the Region and the Division must submit an Accreditation Development Plan for progressively bringing the organization into accreditation status during a two-year period. During the time an organization is working towards accreditation under an Accreditation Development Plan, the organization must meet the standards for behavioral health services in NAC 206, Chapter 6. The Accreditation Development Plan must demonstrate a systematic approach toward achieving accreditation and must comply with all requirements contained in NAC 206, Chapter 5.

1. CAPACITY

The capacity will indicate the behavioral health services the provider desires to deliver in the Regional Network and how much service the provider is capable of offering.

V. ADDITIONAL PROVIDER RESPONSIBILITIES

In addition to the above stated requirements, each provider must meet the following criteria to be an approved behavioral health provider to be included in the Regional Behavioral Health Network.

1. If services of a provider are eligible for Medicaid funding, the provider must be enrolled as a Medicaid provider.
2. Providers will continue to be enrolled only as long as licensure is maintained. Providers will be immediately terminated as an approved provider upon written notification by the Region whenever licensure is denied or revoked, or in the event of the imminent jeopardy of the health and safety of the consumers.
3. Failure to maintain compliance with the criteria set forth in the Provider Responsibilities and Provider Selection Criteria stated throughout this document will jeopardize the provider’s inclusion in the Regional Behavioral Health Network. The Region will notify the provider in writing of the failure to maintain compliance, at which time, the provider shall be allowed thirty (30) days to meet requirements or file a “Plan of Compliance” within twenty (20) days with the Region. If the provider fails to meet compliance within thirty (30) days or file a “Plan of Compliance” within twenty (20) days with the Region, the provider shall be dis-enrolled from the Regional Behavioral Health Network.
4. Providers of Federal Block Grant set-aside services (substance use disorder prevention services and services for pregnant women and women with dependent children and/or mental children’s services and services for persons disabled by serious mental illness) must have the demonstrated ability to provide these services per federal block requirements.
5. Providers must have the capacity to provide an evaluation and assessment of the behavioral health needs of any person seeking authorization and payment for the service(s) they provide.
6. To be enrolled as a network provider, all providers must agree to comply with all reporting and billing requirements of the Region.
7. Providers must agree to routine verification of the services delivered. Verification will be completed by the Regional Network Management and/or DBH.
8. To be enrolled as a Regional Behavioral Health Network provider, all providers must agree to comply with the clinical eligibility, levels of care entry and exit criteria, and assessment and service definition guidelines as contained in NAC Title 206, Service Definitions. A provider, that does not comply, will not be eligible for continued membership in the Regional Network.
9. Providers must agree to serve all clinically and financially appropriate referrals registered and authorized through the NBHS Centralized Data System.
10. Providers must agree to register all persons in the NBHS Centralized Data System for Non Fee for Service (NFFS), which do not require prior authorization, within 48 hours of admission to a service.
11. Providers shall comply with all reporting requirements for person placed in their services pursuant to the Mental Health Commitment Act.
12. To be enrolled as a network provider, all providers must agree to comply with the financial eligibility criteria, the fee schedule, and to accept the rate schedules established by the Region and/or DBH. A provider that does not comply will not be eligible for continued membership in the Regional Network.
13. Providers must agree to ensure continuity of care to link the consumer to others services and providers so behavioral health care is not interrupted. This shall include coordinating consumer care through other providers and the Region.
14. Providers shall comply with federal and state required standards of confidentiality and shall collaborate as a member of the Regional Behavioral Health Network and comply with confidentiality protocols to ensure continuity of care within the Network. Such protocols include at a minimum, a release of information for each consumer to sign, which allows the Region and DBH to receive confidential information and make a determination if care shall be authorized.
15. Providers must agree to attend at least 80% of Region 4 Network meetings on an annual basis.

**PROVIDER ENROLLMENT ATTACHMENT B-1**

**PROVIDER ENROLLMENT APPLICATION**

To be considered for enrollment in the Region 4 Behavioral Health Network the following application must be completed in its entirety and signed. Completed applications are to be mailed to Region 4 Behavioral Health System, 206 Monroe Ave., Norfolk, NE 68701, or emailed to knygren@region4bhs.org.

PART I. IDENTIFYING INFORMATION

DATE OF REPORT: \_\_\_\_/\_\_\_\_/\_\_\_\_

Check One: \_\_\_\_ INITIAL ENROLLMENT \_\_\_\_RETENTION

1. Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Medicaid #:
3. Federal Tax ID #:
4. Social Security #:
5. It is preferred that organizations hold membership in a national organization dedicated to

behavioral healthcare which ascribes to a professional and business code of ethics and

standards. It is also preferred that members of a group practice or individual practitioners hold membership in a state or national professional association which ascribes to a professional code of ethics (i.e., American Psychiatric Association, American Psychological Association, National Association of Social Workers, American Nursing Association, Employee Assistance Professionals Association, Nebraska Counseling Association).

\*Please list memberships in national and state professional association(s):

1. Is the Applicant: (check one)

 \_\_ Organization/Facility \_\_\_ Group Practice \_\_ Individual/Professional Practice

1. Name of Director/CEO of Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person, if other than Director/CEO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Phone Number: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAX Number: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Physical location where service will be provided:

(Street): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (State): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Zip Code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Mailing address of provider:

(Street): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (State): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Zip Code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is Provider part of a larger organization? No \_\_\_\_ Yes\_\_\_\_

If yes, provide name/address/phone of the larger organization:

(Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (State): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Zip Code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Phone): (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Federal Tax Identification Number: (Organization/Group) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: (Individual) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Identify foreign language(s) or sign language provider has capacity to speak fluently in

treating clients:

\_\_\_ Sign Language (SL) \_\_\_ Hebrew (HE) \_\_\_ Portuguese (PO) \_\_\_ German (GE)

\_\_\_ Arabic (AR) \_\_\_ Hindi (HI) \_\_\_ Russian (RU) \_\_\_ Laotian (LA)

\_\_\_ Chinese (CH) \_\_\_ Italian (IT) \_\_\_ Spanish (SP) \_\_\_ Vietnamese (VI)

\_\_\_ Farsi (FA) \_\_\_ Japanese (JA) \_\_\_ Tagalog (TA) \_\_\_ French (FR)

\_\_\_ Korean (KO) \_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Identify any special population(s) provider has capacity to serve:

(i.e., Hispanic, Pregnant Women, Women with Children, Native American)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Identify the Legal Status of the Organization or Individual: (check one)

\_\_\_For-Profit \_\_\_Non-Profit \_\_\_Quasi-Governmental \_\_\_Other (specify) \_\_\_\_\_\_\_\_\_

1. NATIONAL ACCREDITATION:

Type of National Accreditation: (check all which apply)

\_\_\_\_ 1. The Joint Commission

\_\_\_\_ 2. The Commission on Accreditation of Rehabilitation Facilities (CARF)

\_\_\_\_ 3. Council on Accreditation (COA)

\_\_\_\_ 4. American Osteopathic Association (AOA) for hospital psychiatric services only

.

Date of Last Accreditation \_\_\_\_/\_\_\_\_/\_\_\_\_

Date when Accreditation Expires \_\_\_\_/\_\_\_\_/\_\_\_\_

PART II. CAPACITY

|  |  |
| --- | --- |
| **SERVICE** | **PROVIDER’S FULL CAPACITY IN THIS SERVICE** |
|  |  |
|  |  |
|  |  |
|  |  |

PART III. PEER RECOMMENDATIONS

1. Individual Practitioners

For providers seeking enrollment in the Region 4 Behavioral Network for the first time, the provider must attach three (3) letters of recommendation from professionals with similar licensure and certification.

1. Organizations/Agencies/Group Practices

For organizations and group practices seeking enrollment in the Region 4 Behavioral Health Network for the first time, the organization must provide one (1) letter of recommendation from each of the following sources:

1. Referral Entity
2. Organization Providing Similar Services
3. Behavioral Health Professional

PART IV. PROVIDER REQUIRED INFORMATION

Please attach copies of each of the following:

1. Organizational Chart
2. List of Board of Directors
3. A Professional Staff List including name, title, program, education level, institution(s), and residency/internship/training for any clinical expertise or other specialties
4. Professional Licenses and/or #s and/or Certificates (as applicable)
5. Medicaid Provider Enrollment Letters and # (as applicable)
6. Documentation of Drug-Free Workplace Training and Participants
7. Most recent Accreditation Certificate and Report
8. Facility State Licenses
9. Fire Inspections
10. Food Permits (as required)
11. Insurance Certificates for each of the following:
	1. Directors & Officers Insurance or Official’s Bond for All Members of the Board
	2. General Liability Insurance in amount not less than $1,000,000
	3. Professional Liability Insurance (minimum of $1,000,000 per occurrence and $3,000,000 in aggregate per year). If provider qualifies as a health care provider under the Nebraska Provider Medical Liability Act (Nebraska Act) they may maintain the lesser levels of professional liability insurance required by the Nebraska Act as long as the provider remains continuously covered under the Nebraska Act.
	4. Worker’s Compensation Insurance
	5. Motor Vehicle Liability Insurance
12. Outcome Measurement and Reporting documentation for the following:
	1. Perception of Care
	2. Consumer Satisfaction Survey
	3. Life Functioning
13. Program Plans for all Region funded services
14. A copy of Policies & Procedures addressing the following:
	1. Internal disaster plan that includes protecting the life and safety of participants
	2. Any youth who have not attained the age of 18 years shall be prohibited from using tobacco products on agency premises
	3. Americans with Disabilities Act
	4. Chronic Infectious Diseases
	5. Client Rights & Responsibilities
	6. Code of Ethics
	7. Compliance with Voter Registration Bill (LB76) passed in 1994
	8. Confidentiality of Case Records
	9. Criminal Background/Central Registry Check Policy to include a check of the following registries:
		1. Sex Offender Registry
		2. Nebraska Child Abuse and Neglect Registry
		3. Nebraska Adult Abuse and Neglect Registry
		4. Criminal Records Check by the NE State Patrol
		5. Department of Motor Vehicles (as applicable)
		6. Out-of-state background checks on newly hired employees, interns, and volunteers who have resided in Nebraska less than 2 years
	10. Annual verification of all applicable employee’s required license(s) to ensure such license(s) have not been revoked or suspended
	11. Cultural Diversity/Competence
	12. Drug-Free Workplace Policy
	13. EOE/Affirmative Action
	14. Grievance procedures in regards to employees and participants. (Must include how participant’s rights will be protected when report is received.)
	15. Continuing Education/Training for Employees
	16. Processing of Complaints
	17. Record Management/Retention (to include Timeline of Client Record Retention Following Discharge, Methods for Disposal of Client Records, Listing of Documents included in Personnel Files, and How Information Regarding Personnel is Accessed)
	18. Workplace Harassment
	19. Sexual Harassment
	20. Cultural Sensitivity Survey

By signing this application, the undersigned certifies that the information is true, accurate and complete:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title