GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES
DEVELOPMENTAL DISABILITIES ADMINISTRATION

HOME and COMMUNITY BASED WAIVER SERVICES MEDICAID PROVIDER ENROLLMENT APPLICATION

APPLICATION PROCESS – The Department on Disability Services, Developmental Disabilities Administration (DDS/DDA) and the Department of Health Care Finance (DHCF) has a three step application review process.

Step One
Prospective providers must send a letter of interest to DDA to enroll as a Medicaid provider of Waiver services. All letters of interest are to be sent to the following email address: letterofintent.potentialproviders@dc.gov
All prospective providers must first attend the Prospective Providers Meeting prior to submitting this application. The DDS/DDA Provider Relations Specialist or designated staff reviews the application to determine whether an applicant submitted the required documentation as outlined in the Medicaid Provider Application and General Provisions of the HCBS waiver regulations. Applicants that fail to submit the required documentation will receive a letter from the DDS/DDA Provider Relations Specialist, requesting the information be sent to DDS/DDA within three (3) business days. Failure to provide the information within the allotted timeframe will result in a denial of the application, with the restriction that the application cannot be resubmitted within a year of the denial date. Applicants that submit all of the required will proceed to the second step in the approval process.

Step Two
The DDS/DDA Provider Relations Specialist will schedule a date and time to conduct the face to face interview with the owner(s) and Key Personnel within ten (10) business days. The review panel, consists of representatives from various business units in DDS/DDA, will assess the provider's knowledge, and ability to provide the service(s) identified in the application. Applicants will be asked a series of questions that will assist DDS/DDA Review Committee in assessing their knowledge of DDS/DDA mission and vision, policies and procedures and, has an understanding of best practices in the IDD field. The Applicants who are unable to satisfactorily present knowledge and expectation for service delivery will receive a denial letter from DDA Provider Relations Specialist with the restriction that the applicant cannot resubmit the application within one year of the date of denial. Applicants that are determined to have knowledge, ability and systems in place to provide service(s) will receive notification from DDS that the application has been delivered to DHCF for final approval or denial.

Step Three
Once DDS/DDA has completed their review, the application and recommendations to approve is forwarded to DHCF for their review and approval process. Within Thirty (30) days of receipt, to ensure service(s) are provided according to Federal and District of Columbia rules and regulations. The Applicant will receive an approval or denial letter from DHCF.

Summary
Submission of an application does not constitute automatic acceptance into the program. Anticipated processing time for applications in Step One is approximately fifteen (15) business days
"In State" DDS/DDA Waiver Providers are defined as entities located inside the geographic boundaries of the District of Columbia
"Out of State" DDS/DDA Waiver Providers are defined as entities located outside the geographic boundaries of the District of Columbia

Electronic copies of the DDS/DDA Waiver Provider Enrollment Package can be found on the DDS website at dds.dc.gov

Direct questions to:
Department on Disability Services
Developmental Disabilities Administration
Provider Relations Specialist
Tel (202) 730-1781

Mail completed application package to:
Department on Disability Services
Developmental Disabilities Administration
Provider Relations Specialist
1125 15th Street, NW
2nd Floor Mailroom
Washington, DC 20005

APPLICATION INSTRUCTION

Application packages MUST be assembled according to the following instructions:

1. **Submit all required information in a three (3) ring binder as indicated in the Provider Application Checklist along with this application**:
    a. Place the required documents in a three (3) ring binder
    b. Each section shall be labeled each according to the order the items are listed on the checklist along with the required documents

SECTION A:

All information is required must this be filled out completely.

- National Provider Identifier (NPI) is mandatory, and shall be in the name of the provider only.
- Medicaid Provider Number (If applicable).
- Type of Business: Check one box only. If other is checked, write in type of entity
- Partnerships must attach a legible copy of the partnership agreement.
- If other is checked, write in type of entity.

Attach requested documents and must be legible. All signatures must be entered using blue ink.

SECTION B:

1a) Company Name

Individual Practitioners

Individual practitioners/clinicians should provide full name.

Company/Group

Give company name or corporate group name as registered with the Internal Revenue Service (IRS) and under which business is conducted.

1b) Out of State Applicant/Provider ONLY

Attach a copy of your District of Columbia Certificate of Authority (Obtained through the DC Department of Consumer and Regulatory Affairs)

Provide information regarding your District of Columbia registered agent.

All applicant must indicate National Provider Identifier and must copy of NPI Letter
All applicants should attach a Medicaid Provider Number if applicable.

1c) Company Information

Insurance Information

Attach copies of **all** requested documents.

- Minimum liability insurance coverage is $1,000,000.00
- Minimum aggregate limit of $3,000,000.00
- Attach copy of Certificates of Insurance for the business address listed on the application.

Criminal Background Checks

- Attach copies of current (within the past 90 days) Criminal Background Checks for each "unlicensed" professional or administrator.
- Indicate the number of Background Checks that are included.

Medicaid Billing Information *(Only one Remittance Address is allowed per provider number.)*

- Where do you want payments sent? A Post Office Box is acceptable.
- Where do you want Remittance Advices sent? A Post Office Box is acceptable.
- Check whether you will use electronic or paper billing.

DDS/DDA/DHCF Correspondence Information *(Only one Correspondence Address is allowed per provider number.)*

- Provide the mailing address to which correspondence (manual updates, memoranda, etc.) can be sent. A Post Office Box address is acceptable.
- Independent Clinician /Professionals must provide copies to prove ownership or leasing of a private office

Sanctions

- If questions are answered "YES" please provide explanation and additional information. If the space allotted is not sufficient please attached additional documentation to substantiate your answer.

SECTION C

Home and Community Based Services

Included in this section are definitions of DDS/DDA Waiver Service categories and the important provider requirements for each. Each Waiver Service is governed by the General Provisions and rule found in parenthesis next to the Service name and provider enrolling for these services is required to have working knowledge of the services, how they are to implemented, who can provide the services, documentation requirements and timelines. A copy of the rule can be downloaded from dds.dc.gov and reviewed to identify all requirements necessary to perform the service. Check off services in which you/your agency is enrolling for.

SECTION D

Please read and review all instructions and complete forms in its entirety:

- **Disclosure of Ownership and Control Interest Statement and Criminal Information**
- **IRS Form W-9 Request for Taxpayer Identification Number and Certification**
- **Medicaid Provider Agreement**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES
DEVELOPMENTAL DISABILITIES ADMINISTRATION

MEDICAID WAIVER PROVIDER ENROLLMENT APPLICATION PACKAGE

Important:

- Read all instructions before completing the application.
- Type or print clearly, in blue ink.
- If you must make corrections, please line through, date, and initial in blue ink.
- Do not use staples on this application or on any attachments.
- Do not leave any questions, boxes or lines blank. Enter N/A if not applicable.
- Signatures must be entered using blue ink

SECTION A

I. National Provider Identifier (NPI): _____
(*This information is mandatory, and shall be in the name of the provider only. Attach legible copy of NPI letter)*

II. Medicaid Provider Number (if applicable):_____

III. Type of Business (Check One)
[ ] Sole proprietor
[ ] Partnership (attach legible copy of agreement)
[ ] Government Entity
[ ] Corporation
[ ] Limited Liability Company (LLC)
[ ] Nonprofit Corporation
[ ] Other (Please Specify)_____

IV. Will or does the applicant/provider delivers direct support services? Yes___ No___ N/A___
If yes, attach a copy of the Quality Improvement Plan

V. Does applicant/provider own, have an investment in, manage, own stock in, participate in a joint venture, or act as a partner contract consultant or medical/dental advisor in any medical/dental enterprise or medical/dental supplier outside of the business identified in this application where you would financially benefit directly or indirectly?
Yes __ No __ N/A___ If Yes please provide the following information
Name of Organization_____
Type of Organization _____
Mailing Address_____
Telephone Number_____ Tax ID Number_____
Percent of Business Owned/Invested by You _____
Nature of Business Investment (Owner, Partner, Investor, etc.)

SECTION B

NOTE: Attach legible copies of all that apply: BUSINESS LICENSE/CERTIFICATE OF OCCUPANCY/ PERMITS/ CERTIFICATES/ CERTIFICATE OF NEED/JACO CERTIFICATION/HUMAN CARE AGREEMENT-Please see the Provider Application Checklist to determine which documents are to be submitted.

1a) COMPANY NAME (as listed with the IRS) _____

Name of Owner(s) _____

1b) OUT OF STATE APPLICANTS "ONLY" (Attach copy of D.C. Certificate of Authority)

Registered Agent Name_____
(Last Name) (First Name) (Middle Name)

_____
(Street Address or PO Box Number) City/State Zip Code

_____
Telephone Number Fax Number

Email_____

Medicaid Provider Number in the state of your service location _____
(Attach copy of Medicaid enrollment in your State)

Medicare Provider Number_____
(Attach copy of CMS Supplier Letter)

1c) COMPANY INFORMATION (Attach documents as directed)

This information must be included in the applicants file upon submission.

INSURANCE INFORMATION

1. Name of Insurance Company_____

_____

Insurance Policy Number Date Policy issued (mm/dd/yyyy) Expiration Date of Policy (mm/dd/yyyy)

_____

Insurance Agent's Name (Last, First, MI)

_____

Telephone Number Fax Number Email Address

2. Name of Insurance Company_____

_____

Insurance Policy Number Date Policy issued (mm/dd/yyyy) Expiration Date of Policy (mm/dd/yyyy)

_____

Insurance Agent's Name (Last, First, MI)

_____

Telephone Number Fax Number Email Address

CRIMINAL BACKGROUND CHECKS

- Attach copies of current (within the past 90 days) criminal background checks for all **unlicensed** professionals.
- How many background checks have you included: _____
- Have any officer and/or employee of the business ever been convicted of a felony? Yes __No ___NA__

IF ANSWERED "YES" "PLEASE PROVIDE AN EXPLANATION OR ADDITIONAL INFORMATION". Attach additional documents if answer requires additional room

_____

_____

_____

MEDICAID BILLING INFORMATION

Medicaid Payment Address

_____

(Street Address or PO Box Number) City/State Zip Code

Medicaid Remittance Address *(if different from Medicaid Payment Address)*

_____

(Street Address or PO Box Number) City/State Zip Code

How are you billing? ___ Electronic___ Paper

DDS/DDA/DHCF CORRESPONDENCE INFORMATION

PLEASE LIST THE FOLLOWING:

Primary Address

_____

(Street Address or PO Box Number) City/State Zip Code

Correspondence Address *(If different from Primary Address)*

_____

(Street Address or PO Box Number) City/State Zip Code

_____

Telephone Number Fax Number WARD/COUNTY

Email Address_____

Website Address: _____

Hours of Operation:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Does this location have 24-hour telephone coverage? Yes __No.___

Is this location accessible to public transportation? Yes ___No

Does the location have TDD?___ Yes ____ No

TDD Telephone Number_____

INDEPENDENT CLINICIANS/PROFESSIONALS

PLEASE LIST THE FOLLOWING:
Submit copies of ownership or lease agreement of private office space

LOCATION OF PRIVATE PRACTICE/OFFICE

_____

(Street Address) City/State Zip Code

_____

Telephone Number Fax Number WARD/COUNTY

Email Address_____

SANCTIONS

Has the applicant/provider ever been rejected or suspended from the Medicare or Medicaid program, or has your participation status ever been modified (terminated, suspended, restricted, revoked, limited, cancelled or sanctioned)? Yes ____ No __ N/A___

IF ANSWERED "YES" "PLEASE PROVIDE AN EXPLANATION OR ADDITIONAL INFORMATION". Attach additional documents if answer requires additional room

_____
_____
_____

Within the last five (5) years, has the applicant/provider ever been sanctioned, reprimanded or otherwise disciplined in any Manner by any state licensing authority or other professional board or peer committee? Yes ____ No __ N/A___

IF ANSWERED "YES" "PLEASE PROVIDE AN EXPLANATION OR ADDITIONAL INFORMATION". Attach additional documents if answer requires additional room

_____
_____
_____

SECTION C
HOME AND COMMUNITY BASED SERVICES
Please check which services enrolling to provide

Interested organizations and licensed clinicians must refer to the General Provisions and waiver service descriptions and rules for detailed requirements to become enrolled as a Home and Community Based Services (HCBS) Medicaid Waiver Provider.

Consultant & Professional Services **(Please attach professional licenses and certifications as directed)**

[ ] Creative Art Therapies (See Section 1918, Chapter 19 of Title 29, DCMR,)
Art Therapy Services, utilize art, dance drama, and music therapy to provide therapeutic supports to help a person with disabilities express and understand emotions through artistic expression, and the creative process.

Provider Types and Requirements:

- Provided by a certified practitioner in an independent practice or a practitioner employed by an IDD Waiver Provider enrolled by DDS (Comply with the requirements described under Section 1904 (Provider Qualifications) and Section 1905 (Provider Enrollment Process) of Chapter 19 of Title 29 DCMR)
    - Art Therapist certified to practice art therapy by the American Art Therapy Association, Inc. and/or credentialing of the Art Therapy Credentialing Board.
    - Dance Therapist (as defined in Chapter 71(Dance Therapy), Title 17(Business, Occupations, and Professions) of the DCMR;
    - Drama Therapist (as certified by the National Association for Drama Therapy) and;
    - Music Therapist (as certified by the Certification Board for Music Therapists, which is managed by the American Music Therapy Association).

As this service provides four distinct services please check those that apply for enrollment
[ ] Art Therapist certified to practice art therapy by the American Art Therapy Association, Inc. and/or credentialing of the Art Therapy Credentialing Board.
[ ] Dance Therapist (as defined in Chapter 71(Dance Therapy), Title 17(Business, Occupations, and Professions) of the DCMR;
[ ] Drama Therapist (as certified by the National Association for Drama Therapy) and;
[ ] Music Therapist (as certified by the Certification Board for Music Therapists, which is managed by the American Music Therapy Association).

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service
(Please provide how many persons employed which will determine capacity)

[ ] Art Therapist	
[ ] Dance Therapist	
[ ] Drama Therapist	
[ ] Music Therapist	

Medicaid Reimbursable Services:

- Conduct an assessment
- Develop and implement an individualized art, dance, drama, or music plan for the person that is in keeping with their choices, goals and prioritized needs that includes the following:
    - Treatment strategies including direct therapy, caregiver training, monitoring requirements and instructions, and anticipated outcomes; and
    - Identification of specific outcomes for the person.
- Deliver the completed plan to the person, family, guardian or other caregiver, and the Department on Disability Services (DDS) Service Coordinator prior to the Support Team meeting
- Participate in the ISP and Support Team meetings to provide consultative services and recommendations specific to the expert content;
- Provide necessary information to the individual, family, guardian or caregivers, and/or team, to assist in planning and implementing the approved ISP and Plan of Care;
- Record progress notes on each visit and quarterly reports;
- Conduct periodic examinations and modify treatments for the person receiving services to ensure that the art therapy practitioner's recommendations are incorporated into the ISP, when necessary

[ ] **Behavioral Supports** (See Section 1919, Chapter 19 of Title 29, DCMR)

Behavioral Support services are designed to assist persons who exhibit behavior that is extremely challenging and frequently complicated by medical or mental health factors.

Provider Types & Requirements:-

- A professional service provider in private practice as an independent clinician as described under Section1904 (Provider Qualification), of Chapter 19 of Title 29 DCMR.
- A Mental Health Rehabilitation Services agency (MHRS) certified in accordance with the requirements of Chapter A-34 of Title 22 DCMR.
- Home Health Agency as described under Section1904 (Provider Qualification), of Chapter 19 of Title 29 DCMR.
- An IDD Waiver Provider enrolled by DDS (as defined in Chapter 19, Title 29, DCMR)

Individuals authorized to provide Professional behavioral support services without supervision shall consist of the following individuals as described under Section 1919.22 in Chapter 19, Title 29, DCMR:

- Psychiatrist
- Psychologist
- Licensed Independent Clinical Social Worker
- Advanced Practice Registered Nurse or Nurse-Practitioner

Individuals authorized to provide Paraprofessional behavioral support services under the supervision of qualified professionals described under Section 1919.22 shall consist of the following behavior management specialist:

- Licensed Professional Counselor;
- Licensed Independent Social Worker (LISW);
- License Graduate Social Worker (LGSW);
- Board Certified Behavior Analyst;
- Board Certified Assistant Behavior Analyst; and
- Registered Nurse;

Individuals authorized to provide one- to- one supports (Non-Professional BSP) services the following requirements of Direct Support Professional (DSP):

- Comply with Section 1906 (Requirements for Persons Providing Direct Services) of Chapter 19 of Title 29 DCMR;
- Possess specialized training in physical management techniques where appropriate, positive behavioral support practices, and all other training required to implement the person's specific BSP; and
- When providing one-to-one supports, the DSP shall not be assigned other duties so that he/she can ensure the person's safety, health, and well-being.

Medicaid Reimbursable Services:

- Development of a Diagnostic Assessment Report (DAR) in accordance with the requirements described under Section 1919.16;
- Development of a Behavior Support Plan (BSP) in accordance with the requirements described under Sections 1919.17 through 1919.19;
- Implementation of positive behavioral support strategies and principles based on the DAR and BSP;
- Training of the person, their family, the support team, and residential and day staff to implement the BSP;
- On-site counseling, consultation and observations
- Participation in behavioral review or treatment team meetings, delivering notes including emergency case conferences, hospital discharge meetings,
- interagency meetings, pre-ISP and ISP meetings, and human rights meetings
- Quarterly medication reviews, reports and monthly data monitoring
- Evaluation of the effectiveness of the BSP by monitoring the plan at least monthly, developing a system for collecting BSP-related data, and revising the
- BSP;
- Participation in psychotropic medication review meetings to deliver notes
- Counseling and consultation services for the person and their support team;
- Behavior Support one-to-one

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

(Please provide how many persons employed which will determine capacity)

[ ]Professional behavioral support	
[ ]Paraprofessional behavioral support	
[ ]Non-Professional BSP:	

[ ] Companion Services (See Section 1939, Chapter 9 of Title 29, DCMR)
Companion services provide non-medical assistance and supervision to support a person's goals, desires, and needs as identified in the person's Individual Support Plan (ISP), and reflected in his or her Person-Centered Thinking and Discovery tools. Goals may be related to the person's safety, promotion of independence, community integration, and/or retirement. Companion services may be provided in a person's home or in the community
Provider Types & Requirements:

- Comply with Sections 1904 (Provider Qualifications) and 1905 (Provider Enrollment Process) of Chapter 19 of Title 29 DCMR.
- Provide verification of passing the DDS PCR for in-home support, supported living, or respite services for the last three (3) years. For providers with less than three (3) years of PCR certification, provide verification of a minimum of three (3) years of experience providing residential or respite services to the ID/DD population, evidence of certification or licensure from the jurisdiction in which the service was delivered, and evidence of PCR certification for each year that the provider was enrolled as a waiver provider in the District of Columbia if applicable

Medicaid Reimbursable Services:

- Use the DDS-approved Person-Centered Thinking and Discovery tools to develop a support plan, based upon what has been identified as important to and for the person. For people who receive companion services during waking hours, this should include a flexible list of proposed leisure and recreational activities at home and in the community, based upon the person's interests. The support plan must be completed within first week of service, and reviewed and revised quarterly, or more frequently, as needed; and
- Participate in the person's support team meeting, at the person's preference.

[ ] Day Habilitation Services (See Section 1920, Chapter 9 of Title 29, DCMR)
Day habilitation services are aimed at developing activities and skills acquisition to support or further integrate community opportunities outside of a person's home, to foster independence, autonomy or career exploration and encourage development of a full life in the person's community. Day habilitation services are intended to be different and separate from residential services. These services are delivered in group settings or can be provided as day habilitation one-to-one services. Day habilitation one-to-one services shall consist of :(a) Intense behavioral supports that require a behavioral support plan; or (b) Services for a person who has medical needs that require intensive staffing and supports.

Provider Types and Requirements:

- An IDD Waiver Provider enrolled by DDS (as defined in Chapter 19, Title 29, DCMR)

Individuals authorized to provide one- to- one supports (Day Habilitation One to One) services must meet the following requirements of Direct Support Professional (DSP):

- Comply with Section 1906 (Requirements for Persons Providing Direct Services) of Chapter 19 of Title 29 DCMR;
- Possess specialized training in physical management techniques where appropriate, positive behavioral support practices, and all other training required to implement the person's specific BSP; and
- When providing one-to-one supports, the DSP shall not be assigned other duties so that he/she can ensure the person's safety, health, and well-being.

Medicaid Reimbursable Services:

- Service shall be provided in the most integrated setting appropriate to the needs of the person
- Develop a day habilitation plan for each person that corresponds with the person's ISP and Plan of Care that supports the interests, choices, goals and prioritized needs of the person. Activities set forth in the plan shall be functional, chosen by the person, correspond with habilitation
  needs and provide a pattern of life experiences common to other persons of similar age and the community-at-large. To develop the plan, the provider shall:
  - Use observation, conversation, and other interactions, including assessments such as a vocational assessment, as necessary, to develop a functional analysis of the person's capabilities within the first month of participation and annually thereafter;
  - Use the functional analysis, the 1SP and Plan of Care, and other information available to develop a plan with measurable outcomes that develops to the extent possible the skills necessary to allow the person to reside and work in the community while maintaining the person's health and safety; and
  - Focus on enabling each person to attain his/her maximum functional level by coordinating Waiver services with other services provided by any licensed professionals listed in the person's ISP and Plan of Care.

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

Day Habilitation (facility footage): _____

(Please provide how many persons employed which will determine capacity)

[ ]Day Habilitation Specialist (Direct Support	

Professionals)	
[ ]Day Habilitation One to One (Direct Support Professionals)	

[ ] Small Group Day Habilitation (See Section 1920, Chapter 19 Title 29, DCMR)
Day habilitation services may also be delivered in small group settings at a ratio of one-to-three for people with higher intensity support needs. Small group day habilitation settings must include integrated skills building in the community and support access to the greater community. **It cannot be:**

- Provided in the same building as a large day habilitation facility setting; or
- Delivered in groups larger than fifteen (15) people.

Provider Types and Requirements:

- Comply with the requirements described under Section 1904 (Provider Qualifications) and Section 1905 (Provider Enrollment Process) of Chapter 19 of Title 29 DCMR; and
- Maintain the required staff-to-person ratio, indicated on the person's ISP and Plan of Care, to a maximum staffing of 1:3 for people in small group day habilitation.
- Providers of small group day habilitation shall provide documentation that the program manager of the HCBS Waiver provider agency has at least three (3) years of experience working with people with intellectual and developmental disabilities who have complex medical and/or behavioral needs.

[ ] Dental (See Section 1921, Chapter 19 of Title 29, DCMR)
Services provided by a Dental professional in the diagnosis, treatment and prevention of diseases of the teeth and gums.

Provider Types and Requirements

- Provides services consistent with the scope of practice authorized pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201 et seq.) or consistent with the applicable professional practices act within the jurisdiction where services are provided
- Provides services consistent with the standards established by the American Dental Association
- Is enrolled as a Dentist in the District of Columbia Medicaid Program
- Provided by a Dentist, or a Dental Hygienist working directly under the supervision of a dentist
    - Dentist (as defined in District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 [D.C. Law 6-99; D.C. Official Code, Section 3-1201 *et seq.*)
    - Dental Hygienist- An individual who is licensed to practice dental hygiene pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code, Section 3-1201 *et seq.*) or licensed to practice dental hygiene in the jurisdiction where services are provided.

Medicaid Reimbursable Services:

- Medicaid reimbursable dental services under this Waiver are identical to dental services offered under the District of Columbia's Medicaid State Plan and shall be provided in accordance with the applicable requirements set forth in Section 964 (Dental Services) of Chapter 9 of Title 29 DCMR
- Medicaid reimbursement for dental services provided to a person enrolled in the Waiver shall be paid at the reimbursement rate set forth in the District of Columbia Medicaid fee schedule increased by twenty percent (20%). The District of Columbia Medicaid fee schedule is available online at http://www.dc-medicaid.com.
- Develop a written treatment plan for the person receiving dental services after completion of a comprehensive evaluation

[ ] Employment Readiness (See Section 1922, Chapter 9 of Title 29, DCMR)
Employment readiness services occur over a defined period of time with specific outcomes to be achieved, and provide learning and work experiences, including volunteer work, where a person enrolled in the Waiver can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in an integrated community setting. A person receiving employment readiness services may pursue employment opportunities at any time to enter the general work force.

Provider Types and Requirements:

- An IDD Waiver Provider enrolled by DDS (as defined in Chapter 19, Title 29, DCMR)

Medicaid Reimbursable Services:

- Providing opportunities for persons enrolled in the Waiver to develop general, non-job, task-specific strengths and skills that contribute to employability and are consistent with the person's goals;
- Assessment activities that occur annually or more frequently based upon the needs of the person, including customized employment assessment and conducting a person-centered vocational and situational assessment and employment readiness assessments provided at community businesses and other community settings;
- Social and soft skills training, including, but not limited to the following:

    - Following and interpreting instructions;
    - Interpersonal skills;
    - Communication skills for communicating with supervisors, co-workers, and customers;
    - Travel skills;
    - Respecting the rights of others and understanding personal rights and responsibilities; and
    - Decision-making skills and strategies
- Developing work skills which shall include, at a minimum, teaching the person the following
    - Appropriate workplace attire, attitude, and conduct;
    - Work ethics;
    - Attendance and punctuality;
    - Task completion;
    - Job safety;
    - Attending to personal needs, such as personal hygiene or medication management; and
    - Interviewing skills
- Coordinating transportation to community activities utilizing the Medicaid Non-Emergency Transportation Broker
- Coordinating volunteer experiences

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

Employment Readiness (facility footage): _____

(Please provide how many persons employed which will determine capacity)

[ ]Employment Readiness (Direct Support Professionals)	

[ ] Environmental Accessibilities Adaptations (See Section 926, Chapter 19 of Title 29, DCMR)

Environmental Accessibilities Adaptation Services that provide physical adaptations to a home that enable a person to live with greater independence within the home (ex: ramps, grab-bars, lift systems, specialized electric and plumbing systems, etc.)

Provider Types and Requirements

- Non-Profit Organization.
- Home Health Agency (as defined in Chapter 19, Title 29, DCMR).
- Social Service Agency (as defined in Chapter 19, Title 29, DCMR).
- Business Entity (Contractor licensed by the D.C. Department of Consumer and Regulatory Affairs or within the jurisdiction environmental accessibility adaptations are to be provided).

Medicaid Reimbursable Services:

- Provided consistent with any stipulations or recommendations from the licensed contractor or Certified Third Party Construction Inspector
- Provided in accordance with the applicable District, state or local building codes.
- Written documentation of the building inspection
- Development of a construction plan
- Acquisition of permits
- Purchase of materials and
- Labor for construction, renovation, or installation services to be provided

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

(Please provide how many persons employed which will determine capacity)

[ ]Environmental Accessibilities Adaptation Services	

[ ] Family Training (See Section 1924, Chapter 19 of Title 29, DCMR)

Family Training services are training, counseling, and other professional support services offered to uncompensated caregivers who provide support, training, companionship, or supervision to persons enrolled in the IDD Waiver.

Provider Types and Requirements:

- Provided by a certified practitioner in an independent practice or a practitioner employed by an IDD Waiver Provider enrolled by DDS (Comply with the requirements described under Section 1904 (Provider Qualifications) and Section 1905 (Provider Enrollment Process) of Chapter 19 of Title 29 DCMR)
    - Independent Clinical Social Worker (as defined in Chapter 19, Title 29, DCMR).
    - Occupational Therapist (as defined in Chapter 19, Title 29, DCMR).
    - Physical Therapist (as defined in Chapter 19, Title 29, DCMR).
    - Speech, Hearing and Language Therapist (as defined in Chapter 19, Title 29, DCMR).
    - Registered Nurse (as defined in Chapter 19, Title 29, DCMR).

- Special Education Instructor (Master's Degree in Special Education from an accredited college/university with an emphasis on developmental disabilities and mental retardation).

Medicaid Reimbursable Services

- Conduct an assessment of family training needs
- Develop a training plan with training goals and techniques that will assist the waiver participant's unpaid caregivers
- The training plan shall include measurable outcomes and a schedule of approved family training services to be provided
- Instruction about treatment regimens and other services included in the person's ISP and Plan of Care
- Instruction on the use of equipment specified in the person's ISP and Plan of Care
- Counseling aimed at assisting the unpaid caregiver in meeting the needs of the person
- Follow up training necessary to safely maintain the person at home

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

(Please provide how many persons employed which will determine capacity)

[ ] Independent Clinical Social Worker	
[ ] Occupational Therapist	
[ ] Physical Therapist	
[ ] Speech, Hearing and Language Therapist	
[ ] Registered Nurse	
[ ] Special Education Instructor	

[ ] Host Home without Transportation (See Section 1915, Chapter 19 of Title 29, DCMR)

Host Home services enables a person to retain or improve skills related to: health, activities of daily living, money management, community mobility, recreation, cooking, shopping, use of community resources, community safety, and to develop other adaptive skills needed to live in the community.

Provider Types and Requirements:

- Supported Living Service Providers (see Section 993, Chapter 19 of Title 29 DCMR, Supported Living Services)
- Residential Habilitation Service Providers (see Section 946, Chapter 9 of Title 29 DCMR, Residential Habilitation Services)

Medicaid Reimbursable Services:

- Provided in a private home, referred to as "host home", which may be leased or owned by the principal care provider
- Use the Department of Disabilities Services ("DDS") approved person-centered thinking tools to develop an assessment that includes what is important to and for the person, within the first month of the person residing in the home
- Participate in the development of the ISP and Plan of Care to ensure the ISP goals are clearly defined
- Assist in the coordination of all services that a person may receive by ensuring that all recommended and accepted modifications to the ISP are included in the current ISP
- Develop a support plan with measurable outcomes using the information from the DDS approved person-centered thinking tools, the ISP, Plan of Care, and other information as appropriate to assist the person in achieving their goals
- Review the person's ISP and Plan of Care goals, objectives, and activities at least quarterly, and more often as necessary, and submit quarterly reports to the person, family, as appropriate, guardian, and DDS Service Coordinator in accordance with the requirements described, under Section 1908 (Reporting Requirements) and Section 1909 (Records and Confidentiality of Information) of Chapter 19 of Title 29 of the DCMR.

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

Host Homes (How many homes):_____

(Please provide how many persons employed which will determine capacity)

[ ] Host Home Provider (Direct Support Professional)	

[ ] Individualized Day Services (See Section 1924, Chapter 9 of Title 29, DCMR)

Individualized Day Services can only be provided in settings consisting of no more than two (2) individuals. Services may be provided to people who are transitioning into retirement, suffering from degenerative conditions, or for those who have previously participated in a day habilitation service setting, and now wish to participate in smaller individualized day supports settings.

Provider Types and Requirements:

- Have a minimum of one (1) year of experience providing day services to persons with intellectual disabilities and/or developmental disabilities
- For current providers, provide verification of passing the Department on Disability Services (DDS) provider certification review for at least three (3) years

- An IDD Waiver Provider enrolled by DDS (as defined in Chapter 19, Title 29, DCMR)

Medicaid Reimbursable Services:
- Assist with the development of the community integration plan to implement the individualized day supports services
- Coordinate the scheduled activities specified under the community integration plan
- Utilize positive behavioral support strategies and crisis interventions as described in the approved Behavioral Support Plan to address emergency situations

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

(Please provide how many persons employed which will determine capacity)

[ ] Individualized Day Services (Direct Support Professionals)	

[ ] In-Home Supports (See Section 1916, Chapter 19 of Title 29, DCMR)

In-Home Supports Services are services provided to a person to allow him or her to reside successfully at home. In-Home Supports include activities in which the person is assisted by a Direct Support Professional (DSP) to achieve the goals set forth in the Individual Service Plan (ISP). Services may be provided in the home or community, with the place of residence as the primary setting.

Provider Types and Requirements:
- An IDD Waiver Provider enrolled by DDS (as defined in Chapter 19, Title 29, DCMR)

Medicaid Reimbursable Services:
- Provided to a person living in one of the following types of residences
  - The person's own home;
  - The person's family home; or,
  - The home of an unpaid caregiver
- Training and support in activities of daily living and independent living skills
- Training and support to enhance community integration by utilizing community resources, including management of financial and personal affairs and awareness of health and safety precaution
- Training on, and assistance in the monitoring of health, nutrition, and physical condition
- Training and support to coordinate or manage tasks outlined in the Health Management Care Plan

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

(Please provide how many persons employed which will determine capacity)

[ ] In-Home Supports Services (Direct Support Professionals)	

[ ] Occupational Therapy (See Section 1926, Chapter 9 of Title 29, DCMR)

Occupational Therapy services are services that are designed to maximize independence, prevent further disability, and maintain health.

Provider Types & Requirements
- Provided by a certified practitioner in an independent practice or a practitioner employed by an IDD Waiver Provider enrolled by DDS (Comply with the requirements described under Section 1904 (Provider Qualifications) and Section 1905 (Provider Enrollment Process) of Chapter 19 of Title 29 DCMR)
  - Licensed Occupational Therapist (as delineated in the DC Health Occupations Revision Act of 1985, effective March 25, 1986);

Medicaid Reimbursable Services:
- Conduct an assessment of occupational therapy needs
- Develop a therapy plan to provide services.
- Consulting with the person, their family, caregivers and support team to develop the therapy plan
- Implementing therapies described under the therapy plan
- Recording progress notes and quarterly reports during each visit
- Assessing the need for the use of adaptive equipment and verifying the equipment's quality and functioning
- Completing documentation required to obtain or repair adaptive equipment in accordance with insurance guidelines
- Conducting periodic examinations and modified treatments for the person, as needed

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

(Please provide how many persons employed which will determine capacity)

[ ] Licensed Occupational Therapist	

[ ] One-Time Transitional Services (See Section 1913, Chapter 19 of Title 29, DCMR)
One-Time Transitional Services are one-time, non-recurring start-up expenses for persons enrolled in the IDD Waiver, and who are transitioning from an institution or provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for their own living expenses.

Provider Types and Requirements
- A provider of Supported Living services as described under Section1934 of Chapter 19, Title 29, DCMR
- A provider of Residential Habilitation services as described under Section 1929 of Chapter 19, Title 29, DCMR

Medicaid Reimbursable Services:
- Security deposits that are required to obtain a lease for an apartment or home
- Essential household furnishings and expenses required to occupy or maintain an apartment or home
- Start-up fees or deposits for utility or service access, including telephone, gas, electricity, and water
- Services necessary for the person's health, safety and wellbeing, such as pest eradication and one-time cleaning prior to occupancy
- Home accessibility adaptations including carpeting, one-time general home repair, including roof repair, painting and fence repair
- Moving expenses related to transporting personal belongings

[ ] Personal Care Services (See Section 1910, Chapter 19 of Title 29, DCMR)
Personal Care Services are the activities that assist the person with activities of daily living including bathing, toileting, transferring, dressing, eating, feeding, and assisting with incontinence and are offered as an extension of the DC State Medicaid Plan.

Provider Types & Requirements:
- Home Care Agency licensed pursuant to the requirements for Home Care agencies as set forth in the Health Care and Community Residence Facility, Hospice, and Home Care and Community Residence Facility, Hospice and Home Care licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code 44-501 et seq. (2005 Repl. & 2012 Supp.)), and implementing rules.
- A Medicare Home Health Agency qualified to offer skilled services as set forth in Sections 1861 (o) and 1891 (e) of the Social Security Act and 42 CFR 484.

Medicaid Reimbursable Services:
- Personal care services eligible for Medicaid reimbursement shall include, but not be limited to the activities identified under Subsection 5006.7 of Chapter 50 of Title 29 of the DCMR
- Each direct support professional (DSP) including personal care aides providing personal care services shall comply with Section 1906 (Requirements of Direct Support Professionals) of Chapter 19 of Title 29 DCMR.
- Personal care services delivered by a personal care aide shall be supervised by a registered nurse
- Registered nurse shall conduct an initial assessment with the person enrolled in the IDD Waiver within seventy two (72) hours of receiving authorization for personal care services from DDS
- Provider shall comply with the requirements described under Section 1908 (Reporting Requirements) and Section 1911 (Individual Rights) of Chapter 19 of Title 29 DCMR.
- Provider shall comply with the record maintenance requirements described under Section 1909 (Records and Confidentiality of Information) of Chapter 19 of Title 29 of the DCMR, and Section 5013 of Chapter 50 of Title 29 of the DCMR.
- Provider shall comply with the denial, suspension, reduction or termination of services requirements under Section 5007 of Chapter 50 of Title 29 of the DCMR.
- Develop contingency staffing plans to provide coverage for a person receiving personal care services if the assigned personal care aide cannot provide the service or is terminated by the provider.
- Personal care services shall not be provided in a hospital, nursing facility, intermediate care facility, or other living arrangement that includes personal care as part of the reimbursed service

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

(Please provide how many persons employed which will determine capacity)

[ ] Personal Care Services (Direct support professional DSP)	
[ ] Personal Care Services (Licensed Registered Nurse)	
[ ]Personal Care Services (Licensed Practical Nurse):	

[ ] Personal Emergency Response System (PERS) Services (See Section 1927, Chapter 19 of Title 29, DCMR)
Personal Emergency Response System Services) is an electronic device that enables certain individuals at high risk for institutionalization to secure help in emergency situations by activating a system connected to the persons' phone that is programmed to signal a response when a portable "help" button is activated.

Provider Types and Requirements:
- Approved home and community based services provider such as an emergency response center and shall comply with Section 1904 (Provider Qualifications) and Section 1905 (Provider Enrollment Process) of Chapter 19 of Title 29 DCMR.

Medicaid Reimbursable Services:
- In-home installation of equipment;
- Person, caregiver, and responder instruction on usage, and maintenance of system;
- Equipment maintenance, testing, and monitoring;
- Twenty-four (24) hour, seven (7) day per week response center services

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

(Please provide how many persons employed which will determine capacity)

[ ]Twenty-four (24) hour Facility	

[ ] Physical Therapy Services (See Section 1928, Chapter 19 of Title 29, DCMR)
Physical Therapy Services are services that are designed to treat physical dysfunctions or reduce the degree of pain associated with movement, prevent disability, promote mobility, maintain health, and maximize independence.

Provider Types and Requirements:
- Provided by a certified practitioner in an independent practice or a practitioner employed by an IDD Waiver Provider enrolled by DDS (Comply with the requirements described under Section 1904 (Provider Qualifications) and Section 1905 (Provider Enrollment Process) of Chapter 19 of Title 29 DCMR)
    - Licensed Physical Therapist (as delineated in the DC Health Occupations Revision Act of 1985, effective March 25, 1986)

Medicaid Reimbursable Services:
- Conduct an assessment of occupational therapy needs
- Develop a therapy plan to provide services.
- Consulting with the person, their family, caregivers and support team to develop the therapy plan
- Implementing therapies described under the therapy plan
- Recording progress notes and quarterly reports during each visit
- Assessing the need for the use of adaptive equipment and verifying the equipment's quality and functioning
- Completing documentation required to obtain or repair adaptive equipment in accordance with insurance guidelines
- Conducting periodic examinations and modified treatments for the person, as needed

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

(Please provide how many persons employed which will determine capacity)

[ ] Licensed Physical Therapist	

[ ] Respite (See Section 1930, Chapter 19 of Title 29, DCMR) Respite Services provide relief to a person's family or primary caregiver to enable them to participate in scheduled or unscheduled time away from the person, and to prevent gaps in delivery of the person's services.

Provider Types and Requirements:
- A Group Home for a person an Intellectual Disability (GHPID) meeting the requirements set forth in Chapter 35 of Title 22 of the DCMR and certified as an intermediate care facility for persons with intellectual disabilities in accordance with the federal conditions of participation;
- A Department on Disability Services (DDS) certified Residential Habilitation Services facility; or
- A DDS certified Supported Living Residence operated by a provider who has an approved human care agreement with DDS that stipulates the conditions for accepting respite placements.

Medicaid Reimbursable Services:
- Assistance with activities of daily living

- Ensuring access to community activities, including coordination and provision of transportation to participate in community activities consistent with the person's ISP and Plan of Care to allow the person's routine not to be interrupted
- Monitoring of the person's health and physical condition, as well as assistance with medication administration or other medical needs.
-

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

(Please provide how many persons employed which will determine capacity)

[ ] Respite (Direct Support Professionals)	

[ ] Residential Habilitation (See Section 1929, Chapter 9 of Title 29, DCMR)

Residential Habilitation Services are supports provided in a home shared by at least four (4), but not more than six (6) persons, to assist each person in acquiring, retaining, and improving self-care, daily living, adaptive and other skills needed to reside successfully in a shared home within the community.

Provider Types:

- An IDD Waiver Provider enrolled by DDS (as defined in Chapter 19, Title 29, DCMR).
- Have an executed, signed, current Human Care Agreement with DDS, if required by DDS
- Provide verification of passing the Department on Disability Services (DDS), Provider Certification Review (PCR) for In-Home Supports or Respite for the last three (3) years.
- For providers with less than three (3) years of PCR certification, provide verification of a minimum of one (1) year of experience providing residential or respite services to the ID/DD population and evidence of PCR certification for each year that the provider was enrolled as a waiver provider in the District of Columbia
- A Group Home for a person an Intellectual Disability (GHPID) meeting the requirements set forth in Chapter 35 of Title 22 of the DCMR and certified as an intermediate care facility for persons with intellectual disabilities in accordance with the federal conditions of participation;
    - Be licensed pursuant to the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code §§ 44-501 et seq.), no later than sixty (60) days after approval as a Medicaid provider
    - Comply with the requirements set forth in Chapter 35 of Title 22B of the District of Columbia Municipal Regulations (DCMR)
- Each out-of-state group home shall serve at least four (4), but no more than six (6) persons shall be licensed or certified in accordance with the host state's laws and regulations, consistent with the terms and conditions set forth in an agreement between the District of Columbia and the host state
    - Submit to DDS a certificate of registration to transact business within the District of Columbia issued pursuant to D.C. Official Code §§ 29-105.3 et seq
    - Submit to DDS a copy of the annual certification or survey performed by the host state and provider's corrective action plan, if applicable;

Medicaid Reimbursable Services:

- Use observation, conversation, and other interactions, guided by the person-centered thinking process, to develop a functional assessment of the person's capabilities within the first month of the person residing in the home
- Participate in the development of the ISP and Plan of Care to ensure that the ISP goals are clearly defined
- Assist in the coordination of all services that a person may receive by ensuring that all recommended and accepted modifications to the ISP are included in the current ISP
- Develop a support plan with measurable outcomes using the functional analysis, the ISP, Plan of Care, and other information as appropriate, to enable the person to safely reside in the community and maintain their health
- Propose modifications to the ISP and Plan of Care, as appropriate
- Review the person's ISP and Plan of Care goals, objectives, and activities at least quarterly and more often, as necessary, and submit the results of these reviews to the DDS Service Coordinator within seven (7) business days of the end of each quarter
- Keep daily progress notes as described under Subsection 1929.15(h)

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

Residential Habilitation (How many homes): _____

(Please provide how many persons employed which will determine capacity)

[ ] Residential Habilitation (Direct Support Professional)	

[ ] Skilled Nursing (See Section 1931, Chapter 9 of Title 29, DCMR)
Skilled Nursing Services are medical and educational services that address healthcare needs related to prevention and primary healthcare activities. These services include health assessments and treatment, health related training and education for persons receiving Waiver services and their caregivers.

Provider Types and Requirements:

- Home Health Agency (as defined in Section 1904 of Chapter 19, Title 29, DCMR)
    - The duties of a registered nurse (RN) delivering skilled nursing services shall be consistent with the scope of practice standards for registered nurses set forth in § 5414 of Title 17 of the District of Columbia Municipal Regulations (DCMR)
    - The duties of an LPN delivering skilled nursing services shall be consistent with the scope of practice standards for a licensed practical nurse set forth in Chapter 55 of Title 17 of the DCMR
    - A Certificate of Need is required by any person, partnership, or corporation proposing to construct, develop, or otherwise establish a new health care facility, health care service, or home health agency. A Certificate of Need allows health care providers to establish new facilities or services, make certain capital expenditures, or take certain other actions as specified in DC Official Code 44 – 401 et. seq. of the Health Services Planning Program Reestablishment Act of 1996, as amended, and the Certificate of Need (CON) Regulations (Title 22B, DC Municipal Regulations, Sec. 4000, et seq.).

Medicaid Reimbursable Services

- Medicaid reimbursable skilled nursing services shall be provided by an RN or LPN under the supervision of an RN, in accordance with the standards governing delegation of nursing interventions set forth in Chapters 54 and 55 of Title 17 of the DCMR
- Performing a nursing assessment in accordance with the Developmental Disabilities Administration's Health and Wellness Standards
- Assisting in the development of the Health Care Management Plan (HCMP);
- Coordinating the person's care and referrals
- Administering medications and treatment as prescribed by a legally authorized healthcare professional licensed in the District of Columbia or consistent with the requirements in the jurisdiction where services are provided
- Administering medication or oversight of non-licensed medication administration personnel
- Providing oversight and supervision to the licensed practical nurse (LPN), when delegating and assigning nursing interventions
- Training the person, LPN, family, caregivers, and any other individual, as needed
- Recording progress notes during each visit and summary notes at least quarterly
- Immediately reporting, immediately, any changes in the person's condition, to the supervising registered nurse
- Providing wound care, tube feeding, diabetic care, and other treatment regimens prescribed by the physician
- Administering medications and treatment as prescribed by a legally authorized healthcare professional licensed in the District of Columbia. If services are provided in another jurisdiction, the services shall be consistent with that jurisdiction's requirements

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service
(Please provide how many persons employed which will determine capacity)

[ ] Licensed Registered Nurse	
[ ] Licensed Practical Nurse	

[ ] Speech, Hearing & Language Therapy (See Section 1932, Chapter 9 of Title 29, DCMR)
Speech, Hearing and Language Services are therapeutic interventions to address communicative and speech disorders to maximize a person's expressive and receptive communications skills.

Provider Types and Requirements:

- Provided by a certified practitioner in an independent practice or a practitioner employed by an IDD Waiver Provider enrolled by DDS (Comply with the requirements described under Section 1904 (Provider Qualifications) and Section 1905 (Provider Enrollment Process) of Chapter 19 of Title 29 DCMR)
    - Be a speech pathologist or audiologist in a private practice;
        - Speech Pathologist (as defined, licensed or certified by the American Speech Hearing Language Association) or audiologist licensed pursuant to the District of Columbia Health Occupation Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; official Code 3-1201 et. Seq.) and implementing rules;
        - Have a certificate of Clinical Competence in the area of Audiology or Speech Pathology granted by the American-Language-Hearing Association.
        - Have a minimum of two (2) years of experience as a licensed speech-language pathologist or audiologist
    - Be an assistant working under the direct supervision of a licensed speech pathologist or audiologist
        - Be personally supervised by the speech pathologist or audiologist. Personal supervision requires the speech pathologist or audiologist to be in the room during the performance of the service
        - Be employed by the speech pathologist or audiologist or by the speech pathologist or audiologist's employer
        - Comply with Section 1906 (Requirements for Direct Support Professionals) of Chapter 19 of Title 29 DCMR

Medicaid Reimbursable Services

- Conduct a comprehensive assessment

- Develop and implement the speech, hearing, and language treatment plan that describes treatment strategies, including direct therapy, training of caregivers, monitoring requirements and instructions, and anticipated outcomes
- Assist persons with voice disorders to develop proper control of vocal and respiratory systems for correct voice production, if applicable;
- Conduct aural rehabilitation by teaching sign language and lip reading to people who have hearing loss, if applicable
- Participate in ISP and Support Team meetings to provide consultative services and recommendations specific to the expert content
- Record progress notes on each visit and submit quarterly reports
- Verify that the speech, hearing, and language assessment and treatment plan, and daily notes and quarterly reports, are delivered to the person, family or other caregiver, physician, and the Department on Disability Services (DDS) Service Coordinator prior to the person's Support Team meeting
- Assess the need for the use of adaptive equipment
- Routinely assess (at least annually and more frequently as needed) the appropriateness and quality of adaptive equipment to ensure it addresses the person's needs
- Conduct periodic examinations to modify treatments, as appropriate, for the person receiving services and ensure that the speech pathologist's or audiologist's recommendations are incorporated into the ISP; when necessary
- Conduct periodic examinations to modify treatments, as appropriate, for the person receiving services and ensure that the speech pathologist's or audiologist's recommendations are incorporated into the ISP; when necessary

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

(Please provide how many persons employed which will determine capacity)

[ ] Licensed Speech Pathologist	
[ ] Audiologist	
[ ] Speech Pathologist Assistance	

[ ] Supported Employment Services-Individual and small group services (See Section 1933, Chapter 9 of Title 29, DCMR)
Supported Employment Service are designed to provide opportunities for persons with disabilities to obtain competitive work in an integrated work setting, at minimum wage or higher, and at a rate comparable to workers without disabilities, performing the same task. Small Group Supported Employment services are services and training provided in regular business, industry, and community settings for groups of two (2) to eight (8) workers with disabilities.

Provider Types and Requirements:

- Be an approved Home and Community-Based Waiver provider(as defined in Section 1904 of Chapter 19, Title 29, DCMR)
- Each professional or paraprofessional providing Medicaid reimbursable supported
- employment services for a Waiver provider shall meet the requirements in Section 1906 (Requirements for Direct Support Professionals) of Chapter 19 of Title 29 of the District of Columbia Municipal Regulations (DCMR)
    - Professionals authorized to provide Medicaid reimbursable supported employment activities without supervision shall include the following
        - A Vocational Rehabilitation Counselor
        - A Rehabilitation Specialist
        - An individual with a Master's degree and a minimum of one (1) year of experience working with persons with intellectual and developmental disabilities in supported employment
        - An individual with a bachelor's degree and two years of experience working with persons with intellectual and developmental disabilities in supported employment
    - Paraprofessionals shall be authorized to perform Medicaid reimbursable supported employment activities under the supervision of a professional. Paraprofessionals authorized to perform Medicaid reimbursable supported employment activities are as follows:
        - A Job Coach
        - A Employment Specialist

Medicaid Reimbursable Services

- An Individual Job Support Model, which evaluates the needs of the person and places the person into an integrated competitive or customized work environment through a job discovery process
- A Small Group Supported Employment Model, which utilizes training activities for groups of two (2) to eight (8) workers with disabilities to place persons in an integrated community based work setting
- An Entrepreneurial Model, which utilizes training techniques to develop on-going support for a small business that is owned and operated by the person

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

(Please provide how many persons employed which will determine capacity)

[] Vocational Rehabilitation Counselor	
[ ] Rehabilitation Specialist	
[ ] A person with a Master’s degree and a minimum of one (1) year of	

experience working with persons with intellectual and developmental disabilities	
[ ] A person with a Bachelor's degree and a minimum of two (2) year of experience working in supported employment	
[ ] Job Coach	
[ ] Employment Specialist	

[ ] Supported Living Services (See Section 1934, Chapter 9 of Title 29, DCMR)
Supported Living Services are provided to persons enrolled in the Waiver who have limited informal supports and have an assessed need for assistance with acquisition, retention, or improvement in skills related to activities of daily living, and who may require assistance with the development of social and adaptive skills that are necessary to enable the person to reside in the community and successfully, participate in community activities.

Provider Types and Requirements:

- Comply with Section 1904 (Provider Qualifications) and Section 1905 (Provider Enrollment Process) of Chapter 19 of Title 29 of the DCMR
- Have an executed, signed, current Human Care Agreement with DDS, if required by DDS
- Have at least three (3) years of experience providing in-home supports services or respite services, unless waived by DDS, when applicable.
- Provide verification of passing the DDS Provider Certification Review
- a registered
- A nurse delivering twenty-four (24) hour supported living services with skilled nursing shall be consistent with the scope of practice standards for registered nurses set forth in § 5414 of Title 17 of the DCMR
- A licensed practical nurse delivering twenty-four (24) hour supported living services with skilled nursing, shall be consistent with the scope of practice standards for a licensed practical nurse set forth in Chapter 55 of Title 17 of the DCMR
- Each out-of-state provider shall comply with the following additional requirements to receive Medicaid reimbursement, consistent with the terms and conditions set forth in an agreement between the District of Columbia and the host state
    - Submit to DDS a certificate of registration to transact business within the District of Columbia issued pursuant to D.C. Official Code §§ 29-105.3 et seq
    - Submit to DDS a copy of the annual certification or survey performed by the host state and provider's corrective action plan, if applicable;

[ ] Supported Living Services with transportation (See Section 1934, Chapter 9 of Title 29, DCMR)
All requirements as stated above under Supported Living Services and Washington Metropolitan Area Transit Commission (WMAT) Certificate of Authority if providing Supported Living With Transportation

Medicaid Reimbursable Services

- Use observation, conversation, and other interactions, guided by the person-centered thinking process, to develop a functional assessment of the person's capabilities within the first month of the person residing in the home
- Participate in the development of the ISP and Plan of Care to ensure that the ISP goals are clearly defined
- Assist in the coordination of all services that a person may receive by ensuring that all recommended and accepted modifications to the ISP are included in the current ISP
- Develop a support plan with measurable outcomes using the functional analysis, the ISP, Plan of Care, and other information as appropriate, to enable the person to safely reside in the community and maintain their health
- Propose modifications to the ISP and Plan of Care, as appropriate
- Review the person's ISP and Plan of Care goals, objectives, and activities at least quarterly and more often, as necessary, and submit the results of these reviews to the DDS Service Coordinator within seven (7) business days of the end of each quarter
- Develop and implement the Health Management Care Plan, when necessary

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

Supported Living Services (How many homes):_____

(Please provide how many persons employed which will determine capacity)

[ ] Supported Living Services (Direct Support Professionals)	

(Please provide the following information for Supported Living with Transportation)
How many vehicles in each category:

[ ] Direct Support Professional personal motor vehicles	

[ ] Agency motor vehicles • Car	
• Minivan	
• Small Passenger Van (up to 15 passengers)	
• Other (please describe)	

[ ] Vehicle Modifications (See Section 1914, Chapter 19 of Title 29, DCMR)
Vehicle Modification Services are physical adaptations or modification to a vehicle, including the installation of a lift or other physical adaptations to make the vehicle accessible to the person, or to enable the person to drive the vehicle.

Provider Types and Requirements:

- Comply with Section 1904 (Provider Qualifications) and Section 1905 (Provider Enrollment Process) of Chapter 19 of Title 29 of the DCMR
- Demonstrate knowledge in meeting applicable standards of installation, repair, and maintenance of vehicle adaptations and shall also be authorized by the manufacturer to install, repair, and maintain such systems where possible
- Have a current license, certification, or registration with the District of Columbia as appropriate for the services being purchased; and comply with all applicable business licensing requirements in the District of Columbia or in the jurisdiction where Vehicle Modification services are provided

Medicaid Reimbursable Services

- Hydraulic lifts
- Access ramps;
- Modified doors;
- Modified seating;
- Installation of equipment to secure a wheelchair or installing another assistive technology device; or
- Installation of equipment to make access, egress, or travel more comfortable, safe and secure

[ ] Wellness Services (See Section 1936, Chapter 19 of Title 29, DCMR, Wellness Services)
Wellness Services are designed to promote and maintain good health. These services shall assist in increasing the persons' independence, participation, emotional well-being, and productivity in their home, work, and community.

Provider Types and Requirements:

- Provided by a certified practitioner in an independent practice or a practitioner employed by an IDD Waiver Provider enrolled by DDS (Comply with the requirements described under Section 1904 (Provider Qualifications) and Section 1905 (Provider Enrollment Process) of Chapter 19 of Title 29 DCMR)
    - Fitness Trainer shall be certified by the American Fitness professionals and Associates association;
    - Massage Therapist shall be licensed pursuant to the District of Columbia Health Occupation Revision Act of 1985, effective March 25, C. Law 6-99; D.C. Official Code 3-1201 et. eq. 2007 Repl. & 2012 Supp.)), and certified by the National Verification Board for Therapeutic Massage and Body work.
    - Dietician/Nutritionist Licensed to practice dietetics or nutrition pursuant to the D.C. Health Occupations Revisions Act of 1985, effective March 25, 1986; effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code 3-1201 et. Seq.(2007 Repl. & 2012 Supp.).
    - Bereavement Counseling services shall be performed by a professional counselor licensed pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 et seq. (2007 Repl. & 2012 Supp.)) and certified by the American Academy of Grief Counseling as a grief counselor
    - Sexuality Education certified to practice sexuality education by the American Association of Sexuality Educators, Counselors Therapist Credentialing Board; or any the following professionals: Psychologist; Psychiatrist; Licensed Independent Clinical Social Worker; or Licensed Professional Counselor;

As this service provides four distinct services please check those that apply for enrollment
[ ] Fitness Trainer
[ ] Massage Therapist
[ ] Dietician/Nutritionist
[ ] Bereavement Counseling
[ ] Sexuality Education may be delivered by:

- A Sexuality Education Specialist who is certified to practice sexuality education by the American Association of Sexuality Educators, Counselors, Therapist Credentialing Board; or
- Any the following professionals: Psychologist; Psychiatrist; Licensed Independent Clinical Social Worker; or Licensed Professional Counselor;

Medicaid Reimbursable Services

- Conduct an intake assessment within the first two (2) hours of delivering the service with long term and short term goals;
- Develop and implement a person-centered plan consistent with the person's choices, goals, and prioritized needs.
- The plan shall include treatment strategies including direct therapy, caregiver training, monitoring requirements and instructions, and specific outcomes;
- Deliver the completed plan to the person, family, guardian or other caregiver, and the Department on Disability Services (DDS) Service Coordinator prior to the Support Team meeting;
- Participate in the ISP and Support Team meetings to provide consultative services and recommendations specific to the wellness professional's area of expertise;
- Provide necessary information to the person, family, guardian or caregivers and assist in planning and implementing the approved ISP and Plan of Care;
- Record progress notes on each visit and quarterly reports; and
- Conduct periodic examinations and modify treatments for the individual receiving services to ensure that the wellness professional's recommendations are incorporated into the ISP, as necessary

CAPACITY: Please provide the capacity of the how many persons your agency will be able to serve for each service

(Please provide how many persons employed which will determine capacity)

[ ] Fitness Trainer:	
[ ] Massage Therapist	
[ ] Dietician/Nutritionist	
[ ] Bereavement Counseling	
[ ] Sexuality Education Therapist • Counselors	
• Therapist	
• Psychologist	
• Psychiatrist	
• Licensed Independent Clinical Social Worker	
• Licensed Professional Counselor	

DEPARTMENT OF HEALTH CARE FINANCE

Provider Instructions and General Information Pertaining to Disclosure of Ownership and Control Interest Statement and Criminal Information

Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles V, XVIII, XIX and XX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of the appropriate state agency under any of the above-title programs. A full and accurate disclosure of ownership and financial interest is required. Direct or indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the Provider. Failure to submit requested information may result in a refusal by the appropriate State agency to enter into an agreement or contract with any such institution or termination of existing agreement§„. This form must be submitted at the time a Provider is initially enrolling, or revalidating, or reenrolling, or whenever there is a change in ownership of a Provider, or a material change in the information required by this form and/or upon request by the Department of Health Care Finance (DHCF) or federal agencies.

Directions Please answer all questions as of the current date. If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued (For example: Item H. (a) continued.). Return the original to DHCF and please retain a copy for your files. Completely answer the applicable questions. If a question is not applicable to your provider type, please answer not applicable for that question. NO QUESTIONS

touLn BE LEFT BLANK. P.O. Box, website and email addresses are not acceptable answers to any of the questions and should not be referenced in the statement.

This form is submitted to DHCF for either of one (1) or two (2) of the following purposes: (1) to gather information about the provider/entity and (2) to gather personal information about the individual providers.

If you are the only provider furnishing services in this entity you need to fill out only one form. It will contain both the information about the Provider entity (i.e. if you are an LLC you would list the fact that you are a corporation and that you are the 100 percent owner) [Purpose 1] and information about you personally [Purpose 2]. *In all other cases* there must be more than one form. The entity must have an authorized person (i.e. corporate president or a partner in a partnership) fill out the form on behalf of the entity [Purpose 1], while each rendering provider must fill out the form with the personal information applicable to that provider [Purpose 2].

Purpose (1): This form is submitted by all Provider types that are either enrolling or reenrolling as a DC Medicaid program Provider. The form is used for the purposes of capturing information ***about the Provider entity,*** such as, whether the business structure is a corporation, partnership or some other type of business organization. It also collects information about non-provider people associated with the entity like members of Boards of Directors, non-provider owners and managing employees. This information must be collected whether the whenever there is a change in the Provider's ownership or control or, upon request by DHCF or appropriate Federal agencies

Purpose (2): This form is submitted by a new provider in a Group of Practitioners or a Disclosing Entity, whose employment does not change the ownership or control structure of the Group of Practitioners or Disclosing Entity. The Group of Practitioners or a Disclosing Entity as a whole does not need to submit a new form under Purpose 1 of the form as long as the ownership and control functions of the entity have not been changed by the addition of the new Provider(s). The new Provider(s) are responsible for filling out Items I and IV of the form and signing the form. Please ***answer not applicable*** for the remainder of the form.

DEFINITIONS

Agent: any person who has been delegated the authority to obligate or act on behalf of a Provider. 42 C.F.R. §455.101

Convicted or Conviction: a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending. 42 C.F.R. §455.2

Convicted of a Criminal Offense (for purposes of this form):

1. When a judgment of conviction has been entered against the individual or entity by a Federal, State or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;
2. When there has been a finding of guilt against the individual or entity by a Federal, State or local court;
3. When a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State or local court; or
4. When the individual or entity has entered into participation in a first offender, deferred adjudication or other arrangement or program where judgment of conviction has been withheld. 42 U.S.C.A.§1320a-7(i)

Disclosing Entity A Medicaid Provider, such as a Home and Community Based Service (HCBS) Provider (other than an Individual Practitioner or Group of Practitioners) or a fiscal agent.

Fiscal Agent: a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of Practitioners: two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff or common equipment). 42 C.F.R. §455.101 Common location means Providers share physical office space, for example, 101 Main Street, Suite A.

Indirect Ownership Interest: an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. 42 C.F.R. §455.101

> The amount of indirect ownership in the Disclosing Entity that is held by another entity is determined by multiplying the percentage of ownership interest at each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the Disclosing Entity, A's interest equates to an 8 percent indirect ownership interest in the Disclosing Entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the Disclosing Entity, B's interest equates to a 4 percent indirect ownership interest in the Disclosing Entity and need not be reported.

Individual Practitioner: solo physician or non-physician practitioner, who has not reassigned Medicare/Medicaid payments to a Group Practice or Disclosing Entity.

Managing Employee: general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency. 42 C.F.R. §455.101 For purposes of this form DHCF requires that you list as "managing employees" the following persons: the heads of your entity's operating units or divisions (i.e. inpatient care, finance/billing department, personnel department, ambulatory care center, etc.).

Other Disclosing Entity: any other Medicaid Disclosing Entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic or health maintenance organization that participates in Medicare (Title XVIII);
(b) Any Medicare intermediary or carrier; and
(c) Any entity (other than an Individual Practitioner or Group of Practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program under Title V or Title XX of the Act. 42 C.F.R. §455.101

Ownership Interest: the possession of equity in the capital, the stock or the profits of the Disclosing Entity. 42 C.F.R. §455.101

> In order to determine percentage of ownership, mortgage, deed of trust, note or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the Disclosing Entity's assets used to secure the obligation. For example, if Dr. Smith owns 10 percent of a mortgage secured by 60 percent of Dr. Murray's assets, Dr. Smith's interest in Dr. Murray's assets equates to 6 percent and must be reported. Conversely, if Dr. Brad owns 40 percent of a mortgage secured by 10 percent of Dr. Jolie's assets, Dr. Brad's interest in Dr. Jolie's assets equates to 4 percent and need not be reported. 42 C.F.R. §455.102

Provider Person: person who will be billing DHCF for the provision of services to DC Medicaid program beneficiaries.

Provider Entity: a business entity, such as, a solo practice, Group of Practitioners or Disclosing Entity.

Responsible Party: an individual with legal authority to bind the Provider if the Provider is a Provider Entity - for example, a managing partner or corporate president.

Significant Business Transaction: any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a Provider's total operating expenses. 42 C.F.R. §455.101

Subcontractor:

(a) An individual, agency or organization to which a Provider Entity has contracted or delegated some of its management or administrative functions or responsibilities of providing medical care to its patients; i.e. billing, case management, utilization review, etc.; or
(b) An individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment or services provided under the Medicaid agreement which is paid partially or in full by Medicaid funds. 42 C.F.R. §455.101

Supplier: an individual, agency or organization from which your organization purchases goods and services with Medicaid funds used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmaceutical firm). 42 C.F.R. §455.101

Wholly owned supplier: Supplier whose total ownership interest is held by a provider or by a person, or persons or other entity with an ownership or control interest in a provider, 42 C.F.R. §455.101.

The following instructions are intended to clarify certain questions on the form. Instructions are listed in order of question for easy reference.

ITEM I

a. If you are filling this out as a Provider Person, specify the name of the Provider Person. Do not include a name of a contact person. List the Provider Person's national provider identifier(s) (NPI), social security number (SSN) and Medicaid ID number.

b. List the Provider Entities' doing business as (DBA) name, NPI(s), federal tax identification number(s) (TIN) and Medicaid ID number. This line is for the name of a Provider Entity (i.e. Family Medical Group of Any-town). This line would also be used for the DBA name of an Individual (i.e. John Smith Pediatrics P.C.).

c. Specify whether your business is operated as: 1) an Individual by yourself; 2) in a group of Provider Persons at the same location or 3) in any other practice organization.

d. Enter the address of both the Provider Person and the Provider Entity. P.O. Boxes are not acceptable addresses. All practice locations must be listed.

ITEM II

a. List the name, home address, date of birth (DOB), SSN and percentage owned for each person with a direct or indirect ownership or control interest of five (5) percent or more in the Provider Entity. If you are a Provider Person and own 100 percent of your practice then you would just list yourself. In addition, list the same information for any Subcontractor in which the Provider Person or Provider Entity has direct or indirect ownership or control interest of 5 percent or more.

b. List whether any of the persons named in II(a) is related to another as a spouse, parent, child or sibling; and

c. List the name, address and TIN of any other Provider Entity in which a Person with an Ownership or Control Interest in the Provider Entity also has an Ownership or Control Interest. 42 C.F.R. §455.104

ITEM III

a. A Provider Entity must list the name, address, DOB, SSN and TIN for any Subcontractor with whom the Provider Entity has had singular business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

b. A Provider Entity must list any significant business transactions between the Provider Entity and any Subcontractor or Wholly Owned Supplier during the 5-year period ending on the date of the request. 42 C.F.R. §455.105

ITEM IV (if you are a sole Provider you will fill out both parts of this item --- a) is about your employees b) is about yourself

a. If you are filling out this form for Purpose 1 (i.e. on behalf of the Provider Entity) please list the following:

   1. List the name, home address, DOB and SSN of each Person with an Ownership or Control Interest in the Provider Entity or is an Agent or Managing Employee of the Provider Entity;
   2. Please list the name, home address, DOB and SSN of each Person with an Ownership or Control Interest in the Provider Entity that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the title XX services program since the inception of those programs. 42 C.F.R. §455.106 Provider Entities shall search the List of Excluded Individuals/Entities (LEIE) each month for the names of the Providers Entities' employees and contractors.

b. If you are filling out this form for Purpose 2 (i.e. enrollment of a Provider Person) please fill out this section providing information only about yourself.

Signature: If this form is being completed for a Provider Entity, the signature below **MUST** be the written signature of a Responsible Party for the business. If the form is being filled out for a Provider Person the person must sign the form.

PROVIDER DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT AND CRIMINAL INFORMATION FORM

If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. For example, Item 11. (a) continued.

Item I. Identifying information

(a) Name of Provider Person, Personal National Provider Identifier(s) (NPI), Social Security Number (SSN), Date of Birth (DOB) and Medicaid ID Number(s)

NPI	SSN	DOB	Medicaid ID Number

Add more rows if needed

(b) Provider Entities' Name and DBA Name, National Provider Identifier(s) (NPI), Federal Tax Identification Number(s) (TIN) and Medicaid

Number(s)

Entity Name	DBA Name	NPI	TIN	Medicaid ID Number

Add more rows if needed.

(c) Check Business/Organization Type:

(1) ❑ Are you the only provider person in your practice?
(2) ❑ Do you all practice with other provider person(s) in all the same location(s)?
(3) ❑ Are you any other practice type?

(d) Address (P.O. Boxes are not permitted. List all practice locations.):

Provider or DBA Name(s)	Address	City	State	Zip Code (5+4)

Add more rows if needed

Item II. Ownership and Control Information 42 C.F.R. §455.100 and 42 C.F.R. §455.104

(a) List the name, home address (no P.O. Box addresses), Date of Birth (DOB), Social Security Number (SSN) and percentage owned for each person with a direct or indirect ownership or control interest of 5 percent or more in the provider entity. In addition, list the same information for any subcontractor in which the provider entity has direct or indirect ownership or control interest of 5 percent or more. If you are an individual AND you are a solo practitioner and you own 100 percent of your practice then you would just list yourself as 100% owner.

Name	SSN	DOB	% of Ownership or Control	Address	City	State	Zip (5+4)
		\			c		

Add more rows if needed

(b) List whether any of the persons named in **II** (a) is related to another as a spouse, parent, child or sibling.

Name	SSN	Relationship

Add more rows if needed

(c) List the name, address and TIN of any other provider entity in which a person with an ownership or control interest in this provider entity also has an ownership or control interest.

Name	TIN(s)	Address (no P.O. Boxes)	City	State	Zip (5+4)

Item III Business Transaction Information 42 C.F.R. §455.105

(a) List the name, address, DOB, SSN and TIN (if a business) for any subcontractor with whom the provider entity has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

Name	SSN	DOB	TIN(s)	Address (no P.O. Boxes)	City	State	Zip (5+4)

Add more rows if needed.

(b) List any significant business transactions between the provider entity and any subcontractor, or wholly owned supplier, during the 5- year period ending on the date of the request.

Date of Transaction	Person or Entity Name	Amount of Transaction

Add more rows if needed.

Item IV Criminal Offense Information 42 C.F.R. §455.106

Purpose (1) On behalf of the provider entity (a) List the name, home address, DOB and SSN of each person with an ownership or control interest in the provider entity or is an agent or managing employee of the provider entity. If additional space is needed, please note on the form that this answer is being continued, and attach a sheet referencing this item number

Name	SSN	DOB	HOME ADDRESS	CITY	STATE	ZIP	ROLE OR TITLE

Add more rows if needed.

(c) List the name, home address, DOB and SSN of each person with an ownership or control interest in the provider entity or is an agent or managing employee of the provider entity, that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

Name	**Home Address**	**SSN**	**DOB**	**Time Frame of the Offense**	**Matter of the Offense**	**Jurisdiction and Date of the Offense**	**Program Area of the Offense**	**Sanction Period of the Offense**

Add more rows if needed.

Purpose (2) On behalf of the provider person have you ever been convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of these programs.

❑ Yes ❑ No

If "Yes" is checked, provide the name of the Federal District of conviction for a federal offense(s): _____
And /or the County name of conviction for State offense(s): _____
If "Yes" is checked, provide the following information:

Name	**Home Address**	**SSN**	**DOB**	**Time Frame of the Offense**	**Matter of the Offense**	**Jurisdiction and Date of the Offense**	**Program Area of the Offense**	**Sanction Period of the Offense**

Add more rows if needed

The State or Federal Medicaid agency may refuse to enter into, renew or terminate an agreement with a provider if it is determined that a provider did not fully, accurately and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. §455.106

The signature below **MUST be the written** signature of the provider, if being filled out by an individual practitioner. If the form is being filled out for a provider entity the signature below MUST be the written signature of a responsible party, an individual with legal authority to bind the provider.

Name of Provider Person or Provider Entities' Responsible Party — Printed	**Title**
Signature of Provider Person or Provider Entities' Responsible Party	**Date**

Form **W-9**
(Rev. January 2002)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 2.

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number
☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number
☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here Signature of U.S. person ▶ Date ▶

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments after December 31, 2001 (29% after December 31, 2003). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions on page 2 and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

The person who gives Form W-9 to the partnership for purposes of Establishing its U.S. status and avoiding withholding on its allocable Share of net income from the partnership conducting a trade or business in the United States is in the following cases:
• The U.S. owner of a disregarded entity and not the entity,
• The U.S. grantor or other owner of a grantor trust and not the trust, And;
• The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.
Foreign person If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).
Non-resident alien who becomes a resident alien: Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.
If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:
1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.
Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.
If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.
What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.
You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding.
See the instructions below and the separate Instructions for the Requester of Form W-9.
Also see *Special rules for partnerships* on page 1.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.
Civil penalty for false information with respect to withholding: If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.
Criminal penalty for falsifying information: Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment. **Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.
If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.
Sole proprietor; Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.
Partnership, C Corporation, or S Corporation: Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.
Disregarded entity: Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.
Note. Check the appropriate box for the federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).
Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation. If you are an LLC that is Disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other Entities; Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/ disregarded entity name" line.

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/disregarded entity name," sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
2. The United States or any of its agencies or instrumentalities,
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,
7. A foreign central bank of issue,
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
9. A futures commission merchant registered with the Commodity Futures Trading Commission,
10. A real estate investment trust,
11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
12. A common trust fund operated by a bank under section 584(a),
13. A financial institution,
14. A middleman known in the investment community as a nominee or custodian, or
15. A trust exempt from tax under section 664 or described in section 4947. The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . . THEN the payment is exempt for . . .

Interest and dividend payments All exempt payees except for 9 Broker transactions Exempt payees 1 through 5 and 7 through 13.lso C -corporations. Barter exchange transactions and patronage dividends Exempt payees 1 through 5 Payments over $600 required to be reported and direct sales over $5,000 [1]

Generally, exempt payees;

1 through 7 [2]

1 See Form 1099-MISC. Miscellaneous Income, and its instructions.

2 However, the following payments made to a corporation and reportable on Form1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below. If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, below, and items 4 and 5 on page 4 indicate otherwise. For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number to Give the Requester

For this type of account: Give name and SSN of:

1. The individual
2. Two or more individuals (joint account)
The actual owner of the account or,
if combined funds, the first individual on the account 1
3. Custodian account of a minor
(Uniform Gift to Minors Act) The minor 2.

4. a. The usual revocable savings
Trust (grantor is also trustee) So-called trust account that is not a legal or valid trust under state law, The grantor-trustee 1
The actual owner 1Sole proprietorship or disregarded
entity owned by an individual The owner 3
6. Grantor trust filing under Optional
Form 1099 Filing Method 1 (see
Regulation section 1.671-4(b) (2)(i)(A))
The grantor*

For this type of account: Give name and EIN of:

7. Disregarded entity not owned by an
Individual the owner
8. A valid trust, estate, or pension trust Legal entity 4
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553 The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization
11. Partnership or multi-member LLC The partnership
12. A broker or registered nominee, The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments-The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))
The trust

1
List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

2
Circle the minor's name and furnish the minor's SSN.

3
You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

4
List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the Number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information Such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at :1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

I authorize the DC Department of Health Care Finance and its affiliates, subsidiaries or related entities to consult with hospital administrators, members of medical staffs of hospitals, malpractice carriers, licensing boards, professional organizations, and other persons to obtain and verify information and I release the carrier and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application; and, I consent to the release by any person to the carrier of all information that may be reasonably relevant to an evaluation of my professional competency, character, and moral and ethical qualification, including any information relating to any disciplinary action, suspension or limitation of privileges, and hereby release any such person providing such information from any and all liability for doing so. This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination. I further agree to notify the carrier of any change to the information provided in this application within thirty (30) days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by the carrier.

_____

Applicant Signature Date

_____

Applicant's Printed Name Telephone

_____

Mailing Address

DEPARTMENT OF HEALTH CARE FINANCE

MEDICAID PROVIDER AGREEMENT

Name of Provider _____

Address _____

Title XIX Provider Number (if applicable):_____

National Provider Number: _____

This Agreement made and entered into this _____ day of _____, 20 ___, by and between the District of Columbia Department of Health Care Finance, hereinafter designated as the Department, and the above-named, a Provider of Medicaid Services, whose address is, as stated above, hereinafter designated as the Provider.

Witnesseth:

WHEREAS, persons receiving public assistance payments from the Department and other persons eligible for care under the Medical Assistance Program operating under Title XIX of the Social Security Act, are in need of medical care;

WHEREAS, Section 1902(a) (27) of Title XIX of the Social Security Act requires the District of Columbia to enter into written agreement with every person or institution providing services under the State Plan for Medical Assistance (Title XIX), or under a Waiver of the Plan;

WHEREAS, pursuant to the "Department of Health Care Finance Establishment Act of 2007," effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code §7-771.01 et seq.), the Department is the single State agency responsible for administering the Medical Assistance Program (Title XIX) in the District of Columbia, and authorizes the Department to take all necessary steps for the proper and efficient administration of the District of Columbia Medical Assistance Program;

WHEREAS, to participate in the District of Columbia Medical Assistance Program, the provider when applicable, must: (1) be licensed in the jurisdiction where located and/or the District of Columbia; (2) be currently in compliance with standards for licensure; (3) ensure that services be administered by a licensed or certified practitioner; and, (4) comply with applicable Federal and District standards for participation in Title XIX of the Social Security Act, and;

WHEREAS, prospective provider has filed an application with the Department to provide medical services to persons eligible under the Medical Assistance Program operated under Title XIX of the Social Security Act and said application is incorporated by reference into this Agreement and made a part hereof the same as if it were written herein.

The Provider agrees:

I. GENERAL PROVISIONS

A. To provide to Medicaid beneficiaries, services as covered in Title XIX of the Social Security Act and the State Plan for Medical Assistance (State Plan), or a Waiver of the Plan.

B. To adhere to the requirements, as listed below, for accepting payment when delivering services in accordance with the State Plan, or a Waiver of the Plan:

1. The provider's payment shall be accepted as payment in full for the care of a beneficiary; and
2. No additional charge shall be imposed on a beneficiary, member of his or her family or to another source for payment of services provided to a beneficiary.

C. To satisfy all applicable requirements of the Social Security Act, as amended, and be in full compliance with the State Plan, or a Waiver of the Plan, and standards prescribed by Federal and State statute and regulations.

D. To accept such amendments, modifications or changes in the program made necessary by amendments, modifications or changes in the Federal or State standards for participation.

E. To comply with any amendments thereto and the rules and regulations there under including, but not limited to, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, 42 CFR Parts 80, 84 and 90 and the Americans with Disabilities Act, P.L. 101-336.

F. To maintain all records relevant to this Agreement at his/her cost, for a period of ten (10) years or until all audits are completed, whichever is longer. Such records shall include all records originated or prepared pursuant to performance under this Agreement, including but not limited to, financial records, medical records, charts and other documents pertaining to costs, payments received and made, and services provided to Medicaid beneficiaries.

G. To provide full access to these records to authorized personnel of the Department, District of Columbia Office of the Inspector General, the United States Department of Health and Human Services, the Comptroller General of the United States or any of their duly authorized representatives for audit purposes.

H. To expeditiously comply with a beneficiary's request to transfer his/her medical records when switching providers.

I. To furnish upon request to the Department, the Federal Government or their agents, information related to business transactions in accordance with 42 CFR § 455.105(b);

J. To identify and disclose information about any person, corporation or entity with or ownership or control interest in the provider, to the Department in accordance with 42 CFR § 455.104(b);

K. To disclose the identity of any person who has ownership or control interest in the provider, or is an agent or managing employee of the provider and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program in accordance with 42 C.F.R. § 455.106(a);

L. To comply with the provider screening and enrollment requirements, including criminal background checks and fingerprinting, as set forth in 42 C.F.R. Part 455 Subpart E.

M. To hold harmless the District of Columbia Government, the Department and Medicaid beneficiaries against any loss, damage, expense, and liability of any kind arising out of any action of the provider or its subcontractors arising out of the performance of this agreement.

N. To indemnify and hold harmless the District of Columbia Government, its officers, agents and employees, from any and all claims and/or lawsuits arising from the care provided by the Medicaid provider, and its officers, agents and employees. This indemnification also extends to and includes any independent acts by the District in hiring, training, or supervising the Medicaid provider so long as the claim or lawsuit arises from or is related to the underlying acts or omissions of the Medicaid provider.

O. To comply with the advance directive requirements contained in 42 CFR, Part 489, Subpart I, as appropriate.

P. To complete and sign a Provider Application to participate in the Medical Assistance Program (Title XIX), and to keep the information in the application current with the understanding that the application becomes a part of this agreement and that each succeeding change in the application constitutes an amendment to the Agreement and failure to keep the information current constitutes a breach of the Agreement.

Q. To conduct a quarterly comparison of employees against the Medicare Exclusion Database (the MED), HHS/OIG List of Excluded Individuals/Entities (LEIE) or the General Services Administration's Excluded Parties List System (EPLS).

R. To provide assurances of compliance with:

1. The Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999, as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002, (D.C. Laws 12-238 and 14-98), D.C. Official Code § 44-551 et seq., which prohibits Medicaid providers from offering employment or contracting with any person who is not a licensed healthcare professional until a criminal background check has been conducted for the person and also prohibits any facility from employing or contracting with any person who has been convicted of certain criminal offenses specified in the law which should be checked no less than once per year; 49 USC § 31306 and 49 CFR 382 which requires employers of commercial drivers to conduct pre-employment, reasonable suspicion, and post-accident testing for controlled substances;

2. The Drug-Free Work Place Act of 1988 (41 USC § 8101 et seq.), which requires the implementation of an alcohol and drug-testing program; and

3. Title VI of the Civil Rights Act of 1964 and 45 CFR 84.52(5)(d) requires that all patients receive the same level of care and service regardless of limited or no English proficiency (LEP) or limited or no hearing ability. All providers serving Medicaid beneficiaries are responsible for ensuring interpreter services are available for patients who need them. Federally Qualified Health Centers (FQHCs), hospitals, and other inpatient facilities must have their own interpreter services available for LEP or hearing impaired/deaf patients. Smaller, independent providers with no direct affiliation with such facilities may be eligible to request an interpreter through the Department.

S. That any breach or violation of any term of this Agreement shall make the entire Agreement, at the Department's option, subject to suspension and termination or imposition of enforcement remedies in conformance with Federal and District laws and regulations.

II. REQUIRED INFORMATION:

A. The address of all sites at which services will be provided to Medicaid beneficiaries including email address(es) and phone number(s);

B. A completed provider application including submission of the W9 form;

C. A copy of the professional or business license (if individual or group);

D. A copy of the hospital license (if a hospital);

E. Proof of liability insurance;

F. Disclosure of ownership and control form; and

G. The submission of any other documentation deemed necessary by the Department for the approval process as a Medicaid provider.

III. CONTRACTS AND SUBCONTRACTS

A. The Department or the provider may terminate this Agreement for convenience by giving ninety (90) days written notice of intent to terminate the Agreement to the party.

B. The provider shall be legally responsible for all activities of its contractor and subcontractors and for requiring that they conform to the provisions of this Agreement. Subject to such conditions any service or function required by the provider pursuant to this Agreement may be subcontracted to any person or organization who/which meets all Federal and District requirements for participation in Medicaid, whether or not they are enrolled as Medicaid providers.

C. Sub-contractual agreement with providers who have been convicted of certain crimes or received certain sanctions as specified in Section 1128 of the Social Security Act is prohibited. Services provided to Medicaid beneficiaries, who qualify also as Medicare crossover beneficiaries, through such subcontracts shall not be eligible for reimbursement by the Department.

D. The Department reserves the right to require the provider to furnish information relating to the ownership of the subcontractor, the subcontractor's ability to carry out the proposed obligations, assurances that the subcontractor shall comply with all applicable provisions of Federal and District law, and regulations pertaining to Title XIX of the Social Security Act and the State Plan for Medical Assistance and with all Federal and District laws and regulations applicable to the service or activity covered by the contract; the procedures to be followed by the provider in monitoring or coordinating the subcontractor's activities and such other provisions as the Department or the Federal Government may reasonably require.

E. Each subcontract shall contain a provision that the subcontractor shall look solely to the provider for payment of covered services rendered.

IV. PAYMENT TO PROVIDER

A. The Department shall reimburse providers for services to Medicaid beneficiaries in accordance with the State Plan or any applicable waiver from the State Plan.

B. The provider shall submit claims for payment according to the Department's requirements.

C. The provider shall furnish to the Department its National Provider Identifier (NPI) and include the NPI on all claims submitted to the Department.

D. The Department shall make payments to the provider in accordance with applicable laws, as promptly as is feasible after a proper claim is submitted and approved.

E. The Department shall notify the provider of any major changes in Title XIX rules and regulations and in the State Plan. Publication in the D.C. Register may satisfy this notice requirement.

F. The provider shall not bill the beneficiary for any part of care or treatment.

V. THIRD PARTY LIABILITY RECOVERY

A. The provider shall utilize and require its subcontractors to utilize, when available, covered medical and hospital services or payments from other public or private sources, including Medicare.

B. The provider shall attempt to recover, and shall require its subcontractors to attempt to recover, monies from third party liability cases involving workers' compensation, accidental injury insurance and other subrogation of benefit settlements.

C. The Department shall notify the provider of any reported third party payment sources.

D. The provider shall verify third party payment sources directly, when appropriate.

E. Payment of Federal and District funds under the State Plan to the provider shall be conditional upon the utilization of all benefits available from such payment sources.

F. Each third party collection by a provider for a Medicaid beneficiary shall be reported to the Department and all recovered monies shall be returned to the Department immediately upon recovery.

VI. SANCTIONS FOR NON-COMPLIANCE

A. If the Department determines that a provider has failed to comply with any applicable Federal or District law or regulation, or any law or order that prohibits discrimination on the basis of race, age, sex, national origin, marital status or physical or mental handicap, the Department may:

1. Take any of the administrative actions described in Chapter 13 of Title 29 of the District of Columbia Municipal Regulations (DCMR). The Department shall comply with the requirements set forth in Chapter 13. These actions include but are not limited to exclusion, termination and/or suspension of the provider from the Medicaid program;

2. If the provider's compliance failure amounts to a credible allegation of fraud, suspend Medicaid payments in accordance with federal law and rules (See 42 CFR §455.23 etc.); or

3. Take any other enforcement action consistent with any applicable District or Federal law, rule, or regulation.

B. The termination of the Agreement shall not discharge the responsibilities of either party with respect to services or items furnished prior to termination, including retention of records and verification of overpayment or underpayment.

C. Upon termination, the provider shall submit to the Department all outstanding claims for allowable services rendered prior to the date of termination in the form prescribed by the Department. Claims submitted not later than thirty (30) days following the termination date shall be adjudicated.

D. The provider also shall submit to the Department all financial performance and other reports required as a condition to this Agreement within ninety (90) days of the termination date.

E. The Department reserves the right to terminate this Agreement immediately if:

1. The United States Department of Health and Human Services withdraws Federal financing participation in all or part for the cost of covered services;
2. District funds are unavailable for the continuation of the Agreement; or
3. Any owner, officer, manager, agent or contractor of the provider is indicted by the U.S. Attorney for fraud or any misconduct related to the provision and reimbursement of services provided by the Medicaid program pursuant to this Provider Agreement.

F. Upon termination of the Agreement for reasons stated in VI. E., the Department will issue a notice stating the basis and reason for the termination and the effective date of the termination. The notice shall also include the procedures and timeframes for filing an appeal. Termination pursuant to VI.E., may not be stayed pending appeal.

G. The following shall trigger use of an enforcement action against a provider:

1. Inability of the provider to provide the services described in this Agreement;
2. Insolvency of the provider;
3. Failure of the provider to maintain its licensure or accreditation;
4. Conviction of the owner, officer, manager or other person with a five percent or greater direct or indirect ownership of certain crimes or the imposition of certain sanctions as specified in Section 1128 of the Social Security Act; or
5. Violation of any provision of applicable Federal or District laws.

H. The provider shall be responsible for providing written notice to beneficiaries prior to the effective date of any termination in a form and manner prescribed by the Department and shall be responsible for notifying the Department of those beneficiaries who are undergoing treatment of an acute condition.

VII. ASSIGNMENT OF RIGHTS

The rights, benefits and duties included under this Agreement shall not be assignable by the provider without receiving the written approval of the Department. The Department, as a condition of granting such approval, shall require that such assignees be subject to all conditions and provisions of this Agreement and all Federal laws and regulations governing the assigned Agreement.

VIII. TERMINATION OR REDUCTION OF THE DEPARTMENT'S SOURCE OF FUNDING

The Department's obligation to pay funds for the purpose of this Agreement is limited solely to availability of Federal and District funds for such purposes. No commitment is made by the Department to continue or expand such activities.

IX. CONFIDENTIALITY OF INFORMATION

A. All information, records and data collected and maintained by the provider or its subcontractor relating to eligible Medicaid beneficiaries shall be protected by the provider from unauthorized disclosure.

B. Except as otherwise provided in Federal law or rules, use or disclosure of information concerning beneficiaries shall be restricted to purposes directly related to the administration of the Medicaid program.

C. Purpose directly related to the Medicaid program shall include the following:
   1. Establishing eligibility;
   2. Providing services; and
   3. Conducting or assisting in an investigation, prosecution, civil or criminal proceeds relating to the administration of the Medicaid program.

D. The type of information to be safeguarded shall include all information listed in 42 CFR 431.

X. EFFECTIVE DATE

The effective date of agreement for provider payments shall be on the date the provider obtains participating status as determined by the Department under Federal and District regulations, and that such determination shall be made a part of this Agreement.

I agree that the receipt by the District of Columbia Medicaid program of the first and each succeeding claim for payment from me will be the Medicaid program's understanding of my declaration that the provisions of this Agreement and supplemental provider's manuals and instructions have been understood and complied with:

_____ _____

Provider's Signature Date

_____

Address

_____ _____

Phone Number Business Email Address

_____

Signature of individuals responsible to enforce compliance with these conditions

_____ _____

Chief Executive Officer (if applicable) Date

_____ _____

Chief Medical Officer (if applicable) Date

_____ _____

Principal Corporate Officer (if applicable) Date

DO NOT WRITE BELOW THIS LINE

Accepted by:

_____ _____

Authorized Signature by: Date
Department of Health Care Finance

For Official Use Only
D.C. Medicaid Provider Number Assigned: _____