



Application Checklist for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION AUTISM WAIVER

If you have any questions, please contact program staff at:
Jeronica Baldwin - Phone: (410) 767-5206 - Email: jeronica.baldwin@maryland.gov

A completed application will include the following:

- Completed and signed Facility/Organization Provider Application
- A copy of your facility/organization NPI printout from NPPES
- Completed and signed Disclosure of Ownership and Control
- Completed and signed Provider Agreement
- Any additional material including application addenda that may be required by specific programs.

FACILITY



Instructions for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

INSTRUCTIONS FOR COMPLETING MARYLAND MEDICAID ENROLLMENT FORMS FOR FACILITIES/ORGANIZATIONS

Should you have any questions, please contact the Provider Enrollment Unit at (410) 767-5340

GENERAL INSTRUCTIONS	
1. Complete ALL items on the form unless otherwise instructed below. Failure to complete all required fields will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid. 2. Completion of signature fields is required. Initials or stamped signatures will not be accepted. 3. Please attach a copy of all requested documents. 4. These instructions do not need to be submitted with the application.	
MAIL TO	Veda Usilton Maryland State Department of Education Division of Special Education/Early Intervention Services 200 W Baltimore Street, 9th Floor Baltimore, MD 21201

TYPE OF REQUEST	
NEW ENROLLMENT	The facility/organization attempting to enroll in Maryland Medicaid has never been enrolled with Maryland Medicaid as a Fee for Service Provider.
RE-ENROLLMENT	The facility/organization has previously been enrolled with Maryland Medicaid as a Fee for Service Provider, but the facility/organization has been suspended or terminated from Maryland Medicaid.
RE-VALIDATION	The facility/organization is actively enrolled in Maryland Medicaid Fee for Service, but, due to required law, is verifying their information with Medicaid on or before their five year Maryland Medicaid enrollment anniversary date.
INFORMATION UPDATE	The facility/organization is actively enrolled in Maryland Medicaid and would like to change the information that is currently on file with Maryland Medicaid for the facility/organization.
APPLICATION SUBMITTED DATE	Date filling out the application.

FACILITY/ORGANIZATION INFORMATION	
NATIONAL PROVIDER IDENTIFIER (NPI)	Enter the unique site specific 10-digit NPI (Entity Type 2 Organization) of the facility/organization who will be providing services to Maryland Medicaid participants. To obtain a NPI, please visit the following website: https://nppes.cms.hhs.gov/NPPES/Welcome.do Please attach a printout from the previous website that lists the NPI information. If the facility/organization is an Atypical provider and is not eligible to obtain a NPI, leave this field blank and Maryland Medicaid will assign a NPI to you.
MARYLAND MEDICAL ASSISTANCE PROVIDER NUMBER	This is a unique provider number generated by Maryland Medicaid for each facility/organization. If you are a new enrollee, please leave this field blank. If you are an existing Maryland Medicaid facility/organization, please fill in your facility/organization's 9-digit Maryland Medicaid Number.
FACILITY/ORGANIZATION PROVIDER TYPE	Enter the two-digit code for the appropriate provider type from the listing provided at the end of these instructions.
TYPE OF PRACTICE	Enter the two-digit code for the appropriate type of practice from the listing provided at the end of these instructions.
SPECIALTY CODE	If applicable enter the two-digit code for the appropriate specialty code from the listing provided at the end of these instructions.
COUNTY CODE	Enter the two-digit code for the appropriate county code from the listing provided at the end of these instructions.
FACILITY/ORGANIZATION NAME	Enter the legal name of the facility/organization as it appears on federal tax documents.
DOING BUSINESS AS (NAME)	If the facility/organization operates under a different name than the legal name, enter that name here.
TAX IDENTIFICATION NUMBER	Enter the 9-digit tax identification number of the facility/organization.



Instructions for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

NAME OF TAX IDENTIFICATION NUMBER OWNER	Enter the name to which the tax identification number of the facility/organization is assigned.
MEDICARE PROVIDER NUMBER	If you participate in Medicare, please list the provider number that has been assigned to you.
MEDICARE FISCAL YEAR END DATE	Complete this field if the facility/organization is a nursing facility or hospital.
TELEPHONE NUMBER	Enter the best number to reach the facility/organization or contact person who can speak on behalf of the facility/organization regarding Maryland Medicaid participation.
E-MAIL ADDRESS	Enter the e-mail address of the facility/organization or contact person who can speak on behalf of the facility/organization regarding Maryland Medicaid participation.

CORRESPONDENCE INFORMATION	
CONTACT INFORMATION	If the application is being filled out on behalf of the facility/organization, enter the Name, Position/Title, Telephone and E-Mail address of the contact person who can speak on behalf of the facility/organization regarding Maryland Medicaid participation.
FACILITY/ORGANIZATION ADDRESS	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the primary address of the facility/organization.
CORRESPONDENCE ADDRESS	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the address where any letters or correspondence should be sent. This address must be kept up to date. Requests to Re-Validate or Update Information are NOT issued electronically and will be sent to this address.
PAY TO ADDRESS	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the address where any paper checks and paper remittance advices should be sent.
ELECTRONIC CORRESPONDENCE	If you prefer to receive electronic correspondence and Remittance Advice through an established eMedicaid account, check Yes.

LICENSE/PERMIT INFORMATION	
	If applicable attach a copy of each license or certificate that is listed.
CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) NUMBER*	Enter your CLIA ID Number, beginning effective date, and expiration date.
DRUG ENFORCEMENT ADMINISTRATION (DEA)	Enter your Drug Enforcement Administration number if applicable.
HOSPITAL FACILITY LICENSE	Enter your Office of Health Care Quality (OHCQ) issued hospital license number, beginning effective date, and expiration date.
MARYLAND LABORATORY PERMIT (MDLAB) OR LETTER OF PERMIT EXCEPTION NUMBER*	Enter your Office of Health Care Quality (OHCQ) issued MDLAB Number, beginning effective date, and expiration date. OR enter your OHCQ issued Letter of Permit Exception Number, beginning effective date, and expiration date.
NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAM (NCPDP)	Enter your NCPDP number if applicable.
PHARMACY	Enter your state issued license number if applicable.
RESIDENTIAL SERVICE AGENCY (RSA)	Enter your OHCQ issued license number if applicable.
OTHER	Enter any other license information as required.
<p>*Medical laboratory providers: Practitioners and other providers that perform medical laboratory services MUST COMPLETE and SUPPLY a copy of their CLIA and MDLAB Permit/Letter of Permit Exception. Out-of-state providers that do not receive specimens originating in Maryland do not have to supply Maryland certification information but do have to state that they do not receive specimens originating in Maryland. Practitioners providing laboratory services to OTHER THAN THEIR OWN PATIENTS MUST enroll as medical laboratory providers.</p>	



Instructions for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

ADDITIONAL INFORMATION	
FACILITY/ORGANIZATION INFORMATION	If the facility/organization is affiliated with a healthcare institution or medical school, please fill in the required fields and attach the required documentation.
LABORATORY INFORMATION	Answer the three questions listed in this section.
INSTITUTIONAL BED DATA	Complete all fields as appropriate for your provider type.
DIALYSIS FACILITIES	Complete this section if applicable.
AUTHORIZATION	Please have the administrator or authorized professional representative sign and date the application.
DISCLOSURE OF OWNERSHIP AND CONTROL	Maryland Medicaid is required to obtain disclosures on ownership and control from disclosing entities, fiscal agents, and managed care entities. Please fill out the six (6) sections and sign and date the Disclosure of Ownership and Control addendum. Failure to complete all required sections will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid.
PROVIDER AGREEMENT	Failure to complete the provider agreement will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid.
PROVIDER ADDENDUM	If applicable to your provider type, please complete the attached addendum.



Instructions for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

PROVIDER TYPE CODES					
1915(i) WAIVER	89	EPSDT THERAPEUTIC NURSERY	52	MEDICAL DAY CARE - CHILDREN	43
ADAA CERTIFIED PROGRAM	50	FREESTANDING BIRTH CENTERS	31	MENTAL HEALTH CASE MANAGEMENT PROVIDER	CM
AMBULANCE COMPANY	T1	FREESTANDING ONCOLOGY CENTERS	36	MENTAL HEALTH CLINIC	MC
AMBULATORY SURGERY CENTERS	39	HEALTHCHOICE MANAGED CARE ORGANIZATIONS	72	MOBILE TREATMENT PROGRAM	MT
AUDIOLOGY PROVIDERS	19	HMO/PACE	70	NURSING FACILITY	57
BRAIN INJURY WAIVER	86	AUTISM WAIVER	40	OLDER ADULT WAIVER	76
CASE MANAGEMENT - NOT ELSEWHERE CLASSIFIED	81	HOME HEALTH AGENCIES	41	OXYGEN PROVIDERS	63
CLINIC, ABORTION	30	HOSPICE PROVIDERS	71	PARTIAL HOSPITALIZATION PROGRAM	MH
CLINIC, DRUG	32	HOSPITALS - ACUTE	1	PERSONAL CARE AGENCY	45
CLINIC, FAMILY PLANNING	33	HOSPITALS - ACUTE REHABILITATION	3	PERSONAL CARE MONITOR	47
CLINIC, FEDERALLY QUALIFIED HEALTH CENTER	34	HOSPITALS - CHRONIC	5	PHARMACY	RX
CLINIC, GENERAL	38	HOSPITALS - CHRONIC REHABILITATION	4	PORTABLE X-RAY	59
CLINIC, LOCAL HEALTH DEPARTMENT	35	HOSPITALS - SPECIAL OTHER ACUTE	6	PSYCHIATRIC REHAB SERVICES FACILITY	PR
CLINIC, RURAL	37	HOSPITALS - SPECIAL OTHER CHRONIC	7	REM PROVIDERS	87
DDA SERVICES PROVIDER	90	INTERMEDIATE CARE FACILITY - ADDICTION	55	RESIDENTIAL SERVICE/HOME HEALTH AIDE AGENCY	53
DIAGNOSTIC SERVICES, OTHER	60	INTERMEDIATE CARE FACILITY - ID	56	RESIDENTIAL TREATMENT CENTER	88
DIALYSIS FACILITIES	61	LABORATORIES	10	URGENT CARE CENTERS	8
DMS/DME PROVIDERS	62	LOCAL EDUCATION AGENCIES/LOCAL LEAD AGENCIES	91	VISION CARE PROVIDERS	12
EPSDT THERAPEUTIC BEHAVIORAL SERVICES	51	MEDICAL DAY CARE - ADULTS	42		

TYPE OF PRACTICE CODES			
HMO	50	PHARMACY, HOSPITAL BASED	23
NURSING HOME	10	PHARMACY, NURSING HOME BASED	24
PHARMACY, SINGLE STORE	20	PHARMACY, TAX SUPPORTED	25
PHARMACY CHAIN, 2-10 STORES	21	OTHER	99
PHARMACY CHAIN, 11+ STORES	22		

COUNTY CODE					
ALLEGANY	01	DORCHESTER	09	SOMERSET	19
ANNE ARUNDEL	02	FREDERICK	10	ST. MARY'S	18
BALTIMORE CITY	30	GARRETT	11	TALBOT	20
BALTIMORE COUNTY	03	HARFORD	12	WASHINGTON	21
CALVERT	04	HOWARD	13	WASHINGTON, DC	40
CAROLINE	05	KENT	14	WICOMICO	22
CARROLL	06	MONTGOMERY	15	WORCESTER	23
CECIL	07	PRINCE GEORGE'S	16	OTHER STATE	99
CHARLES	08	QUEEN ANNE'S	17		

PHARMACY SPECIALTY CODES		KIDNEY DISEASE PROGRAM	
HOME IV THERAPY	147	DIALYSIS FACILITY	K3
HOSPITAL OUTPATIENT PHARMACY	151	HOSPITAL-INPATIENT	K6
INSTITUTIONAL PHARMACY	156	HOSPITAL-OUTPATIENT	K5
MULTI-SPECIALTY PHARMACY	168	MEDICAL LABORATORY	K7
RETAIL CHAIN PHARMACY	202	PHARMACY	K2
RETAIL SINGLE PHARMACY	204	PHYSICIAN	K1
OTHER PHARMACY	184	OTHER (DENTAL, VISION)	K8

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Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION AUTISM WAIVER

<p style="text-align: center;">IMPORTANT: PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING APPLICATION</p>	<p><u>Unless Instructed Otherwise, Mail to:</u> Veda Usilton Maryland State Department of Education Division of Special Education/Early Intervention Services 200 W Baltimore Street, 9th Floor Baltimore, MD 21201</p>
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TYPE OF REQUEST			
Please select one.			
<input type="checkbox"/> NEW ENROLLMENT (Applicant has never enrolled with Maryland Medical Assistance)	<input type="checkbox"/> RE-ENROLLMENT (Provider is currently excluded/terminated from the Maryland Medicaid Program)	<input type="checkbox"/> RE-VALIDATION (Provider is enrolled and required to revalidate)	<input type="checkbox"/> INFORMATION UPDATE (Provider is enrolled and updating information to the provider's file)
Application Submitted Date			

FACILITY/ORGANIZATION INFORMATION	
NPI (Organization)	Maryland Medical Assistance Provider Number (If existing provider)
Provider Type (Refer to instructions for appropriate codes.) 40	Type of Practice (Refer to instructions for appropriate codes.) 99
Specialty Code (Refer to instructions for appropriate codes.)	County Code (Refer to instructions for appropriate codes.)
Facility/Organization Name	Doing Business As (DBA)
Tax Identification Number	Name of Tax Identification Number Owner
Medicare Provider Number	Medicare Fiscal Year End Date
Telephone Number + extension	E-Mail Address

CONTACT INFORMATION		
The contact name and email relate to the person who can answer questions about the information provided in this packet.		
Contact Name	Position/Title	
Telephone	E-Mail Address	
FACILITY/ORGANIZATION ADDRESS		
Street Address	Suite/Department/Floor	
City	State	Zip Code (9 Digit)
Telephone Number + extension	Fax Number	



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

CORRESPONDENCE ADDRESS			
Please indicate where letters and claims forms, if any, should be sent.			
Street Address		Suite/Department/Floor	
City	State	Zip Code (9 Digit)	
Telephone Number + extension		Fax Number	

PAY TO ADDRESS			
Please indicate where checks & remittance statements should be sent.			
Street Address		Suite/Department/Floor	
City	State	Zip Code (9 Digit)	
Telephone Number + extension		Fax Number	

ELECTRONIC CORRESPONDENCE				
Would you prefer to receive electronic correspondence in lieu of paper when available?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

LICENSE/PERMIT INFORMATION				
A copy of the license or certificate from the appropriate board or authority must be included as an attachment to this application. If more space is needed, please attach additional pages.				
CLIA	State Issued	License Number	Date Issued	Expiration Date
DEA	State Issued	License Number	Date Issued	Expiration Date
Hospital Facility License	State Issued	License Number	Date Issued	Expiration Date
MDLAB	State Issued	License Number	Date Issued	Expiration Date
NCPDP	State Issued	License Number	Date Issued	Expiration Date
Pharmacy	State Issued	License Number	Date Issued	Expiration Date
RSA	State Issued	License Number	Date Issued	Expiration Date
Other	State Issued	License Number	Date Issued	Expiration Date



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

FACILITY/ORGANIZATION INFORMATION			
If your facility/organization is affiliated with a health care institution or medical school, please enter the name and full address of the institution or school, your title and a brief explanation of your group's duties.			<input type="checkbox"/> NOT APPLICABLE
Name of Institution			
Title		Duties	
Street Address		Suite/Department/Floor	
City	State	Zip Code (9 Digits)	
Certification Date		Certification Number	
Is your facility/organization salaried by the above institution?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If you are a M.D. or D.O. will you be dispensing pharmaceuticals other than samples (as pharmacy)?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If you are an O.D., are you practicing optometry exclusively?			<input type="checkbox"/> YES <input type="checkbox"/> NO
Or optometry as well as preparing and dispensing eyeglasses (as an optician)?			<input type="checkbox"/> YES <input type="checkbox"/> NO
Is your facility/organization operating a Local Health Department Clinic?			<input type="checkbox"/> YES <input type="checkbox"/> NO
Is your facility/organization operating a Freestanding Clinic?			<input type="checkbox"/> YES <input type="checkbox"/> NO

LABORATORY INFORMATION		
Reimbursement for medical laboratory services you provide to eligible recipients are dependent on answering the following questions and supplying copies of CLIA Certificate and, when required, Maryland Laboratory Permits or Letters of Permit Exception. Practitioner providers cannot be reimbursed for services referred to medical laboratories or other practices. Those laboratories or practices must bill.		
Do you provide medical laboratory services for your own patients?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you provide medical laboratory services for other than your own patients?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you receive specimens that are obtained from other sites located in Maryland?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
All Maryland laboratories are required to have a Maryland Laboratory Permit or Letter of Permit Exception Number (§Health General Article §17-205, Annotated Code of Maryland) and CLIA Certificate Number (Clinical Laboratory Improvement of 1988 Public Law 100-578) to perform laboratory services. Out-of-state providers are only required to provide their CLIA Certificate Number, if they do not receive specimens that originate in Maryland.		



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

INSTITUTIONAL BED DATA	
Acute Inpatient (INP) Number of Beds	Assisted Living Facilities
Chronic Hospital (CHB) Number of Beds	Intellectual Disability (ID)
Number of Beds Nursing Facility (NF) Number of Beds	Other (OTH) Number of Beds

DIALYSIS FACILITIES
Please attach a copy of letter with assigned Medicare Provider Number and a copy of the letter(s) from your intermediary showing all approved services. You will be paid ONLY for the services that are rendered and appear in this/these letter(s).
Medicare Provider Number

AUTHORIZATION		
<p>I, the administrator or authorized professional representative of this facility/organization, hereby affirm that this information given by me is true and complete to the best of my knowledge and belief. I understand that if I or my facility/organization is salaried by a hospital or other institution for patient care, that I or my group will not bill the Maryland Medical Care Program for those services for which I or my facility/organization is salaried.</p>		
<table style="width: 100%; border: none;"> <tr> <td style="width: 80%; border-bottom: 1px solid black; vertical-align: bottom;"> Signature of Administrator or Authorized Professional Responsible for the Quality of Patient Care (No stamps) </td> <td style="width: 20%; border-bottom: 1px solid black; vertical-align: bottom; text-align: center;"> Date </td> </tr> </table>	Signature of Administrator or Authorized Professional Responsible for the Quality of Patient Care (No stamps)	Date
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Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

DISCLOSURE OF OWNERSHIP AND CONTROL

Completion is required by 42 CFR Part 455.104. Failure to provide the information requested will cause the application to be returned. Attach additional pages as needed.

SECTION 1:

Disclosing Entity/Applicant (Facility/organization named on page 1 of this application)

Name		NPI (Organization)	
Address – Street	City & State	Zip Code (9 Digits)	
Federal Employer Identification Number (FEIN)			

Ownership in Applicant (Has direct or indirect ownership interest¹ of 5% or more. Include familial relationship to the Applicant and other Owners (spouse, parent, child, sibling), if any. The address for corporate entities must include every business address. See 42 CFR Part 455.104 (b)(1)(i) for more information.)

Name of Individual or Entity	% of Ownership	NPI (Individual)	
Address (Home Address if individual)	City & State	Zip Code (9 Digits)	
SSN (if individual)		Federal Employer Identification Number (if entity)	
Date of Birth (MM/DD/YYYY)		Familial Relationship (if individual, if any)	

¹ A) “Ownership interest” means the possession of equity in the capital of, stock in, or of any interest in the profits of the disclosing entity.

B) “Indirect ownership interest” means any ownership interest in an entity that has ownership interest in the disclosing entity. The term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

C) “Determination of ownership or control percentage”

1) Indirect ownership interest – the amount of indirect ownership interest is determined by multiplying the percentages of ownership in 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.

2) Person with an ownership or control interest – in order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of the disclosing entity’s assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider’s assets, A’s interest in the provider’s assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider’s assets, B’s interest in the provider’s assets equates to 4 percent and need not be reported.



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

SECTION 2:

Agents and Managing Employees (e.g. office manager, administrator, director or other individuals who exercise operational or managerial control over the day to day operations of the provider. If the applicant is a non-profit organization please include all board members, directors, and managers. Include familial relationship to the Applicant (spouse, parent, child, sibling), if any. If additional space is needed, copy form; all entries must be on the form.)

Name		Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)	
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	

Name		Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)	
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	

Name		Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)	
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	

SECTION 3:

Ownership in Other Disclosing Entities (ODE) (per 42 CFR, Part 455.104 (b)(3)) – (Complete if any identified in Section 1 has an ownership or control interest in ODE)

Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

SECTION 4:

Ownership in Subcontractors (If the Applicant has an ownership or control interest of 5% or more in a subcontractor and an Owner of the Applicant also has an ownership or control interest in the subcontractor, complete the boxes below. If those identified in this Section have a familial relationship with a person with ownership or control interest in one of these subcontractors, complete Section 4).

Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number
Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number
Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number

SECTION 5:

Familial Relationship in Subcontractors (Complete if those identified in Section 3 have a familial relationship (parent, child sibling spouse))

Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship

SECTION 6:

Respond to these questions on behalf of:

1. The Applicant
2. All individuals and entities identified in Sections 1 & 5.
3. Any entity in which the Applicant has a 5% or more ownership.

1. Have any of the individuals/entities (1,2 and 3) been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid Program in Maryland or in any other State, Medicare, or any other governmental or private medical insurance program?

YES NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

2. Have any of the individuals/entities (1,2 and 3) ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any State?

YES NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

3. Have any of the individuals/entities (1,2 and 3) ever had their business or professional license or certification, or the license of an entity in which they had an ownership interested over 5% ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any State?

YES NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

4. Is there currently pending any proceedings that could result in the above stated sanctions for the individuals/entities (1, 2 and 3)?

YES NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

SIGNATURE AND AFFIRMATION

An application is not considered complete unless the applicant signs below. Failure to provide a signature will cause the application to be returned.

I hereby affirm that this information is true and complete to the best of my knowledge and belief, and that the requested information will be updated as changes occur. I further certify that upon specific request by the Secretary of the Department of Health and Human Services, or the Maryland Department of Health and Mental Hygiene, full and complete information will be supplied within 35 days of the date of the request, concerning:

- A. The ownership of any subcontractor with which the Title XIX Provider has had, during the previous 12 months, business transactions in an aggregate amount in excess of \$25,000.00 and
- B. Any significant business transactions², occurring during the 5 year period ending on the date of such request, between the Provider and any wholly-owned supplier³ or any subcontractor.

Authorized Signature (No Stamps)

Date

Position (Type or Print)

² “Significant business transaction” means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of \$25,000 or 5 percent of the total operating expense of a provider.

³ “Supplier” means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g. a commercial laundry, a manufacturer of hospital bed, or a pharmaceutical firm).

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Provider Agreement for Participation in Maryland Medical Assistance Program

This Agreement (the “Agreement”), entered into between the Maryland State Department of Health and Mental Hygiene (the “Department”) and

_____ (Provider Name)

the undersigned Provider or Provider Group and its members or Practitioner(s) (hereinafter called the “Provider”), is made pursuant to Title XIX and Title XXI of the Social Security Act, Health-General, Title 15, Annotated Code of Maryland and state regulations promulgated thereunder to provide medical, healthcare, and home- and community-based services and/or remedial care and services (“Service(s)”) to eligible Maryland Medical Assistance recipients (“Recipient(s)”). On its effective date, this Agreement supersedes and replaces any existing contracts between the parties related to the provision of Services to Recipients.

I. THE PROVIDER AGREES:

- A. To comply with all standards of practice, professional standards and levels of Service as set forth in all applicable federal and state laws, statutes, rules and regulations, as well as all administrative policies, procedures, transmittals, and guidelines issued by the Department, including but not limited to, verifying Recipient eligibility, obtaining prior authorizations, submitting accurate, complete and timely claims, and conducting business in such a way the Recipient retains freedom of choice of providers. The Provider acknowledges his, her or its responsibility to become familiar with those requirements as they may differ significantly from those of other third party payor programs;
- B. To maintain adequate medical, financial and administrative records that fully justify and describe the nature and extent of all goods and Services provided to Recipients for a minimum of six years from the date of payment or longer if required by law. The Provider agrees to provide access upon request to its business or facility and all related Recipient information and records, including claims records, to the Department, the Medicaid Fraud Control Unit (MFCU) of the Maryland Attorney General’s Office, the U.S. Department of Health and Human Services, and/or any of their respective employees, designees or authorized representatives. This requirement does not proscribe record requirements by other laws, regulations, or agreements. It is the Provider’s responsibility to obtain any Recipient consent required to provide the Department, its designee, the MFCU, federal employees, and/or designees or authorized representatives with requested information and records or copies of records. Failure to timely submit or failure to retain adequate documentation for services billed to the Department may result in recovery of payments for Services not adequately documented, and may result in the termination or suspension of the Provider from participation as a Medical Assistance provider.



Provider Agreement for Participation in Maryland Medical Assistance Program

1. Original records must be made available upon request during on-site visits by Department personnel or personnel of the Department's designee.
 2. Copies of records must be timely forwarded to the Department upon written request;
- C. To protect the confidentiality of all Recipient information in accordance with the terms, conditions and requirements of the health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and regulations adopted thereunder contained in 45 CFR 160, 162 and 164, and the Maryland Confidentiality of Medical Records Act (Md. Ann. Code, Health-General §§4-301 *et seq.*);
- D. To provide services on a non-discriminatory basis and to hold harmless, indemnify and defend the Department from all negligent or intentionally detrimental acts of the Provider, its agents and employees. The Provider will not discriminate on the basis of race, color, national origin, age, religion, sex, disabilities, or sexual orientation;
- E. To provide Services in compliance with the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and their respective accompanying regulations, and ensure that qualified individuals with disabilities are given an opportunity to participate in and benefit from its Services, including providing interpretive services for the deaf and hard of hearing when required;
- F. To check the Federal List of Excluded Individuals/Entities on the Health and Human Services (HHS) Office of Inspector General (OIG) website prior to hiring or contracting with individuals or entities and periodically check the OIG website to determine the participation/exclusion status of current employees and contractors. To check the Federal System for Award Management (SAM) prior to hiring or contracting with individuals or entities and periodically check the SAM website to determine the participation/exclusion status of current employees and contractors. To check the Maryland Medicaid List of Excluded Providers and Entities prior to hiring or contracting with individuals or entities and periodically check the website to determine the participation/exclusion status of current employees and contractors. The Provider further agrees to not knowingly employ, or contract with a person, partnership, company, corporation or any other entity or individual that has been disqualified from providing or supplying services to Medical Assistance Recipients unless the Provider receives prior written approval from the Department;



Provider Agreement for Participation in Maryland Medical Assistance Program

- G. To accept the Department's payments as payment in full for covered Services rendered to a Recipient. The Provider agrees not to bill, retain, or accept any additional payment from any Recipient. If the Department denies payment or requests payment from the Recipient, or if the Department denies payment or requests repayment because an otherwise covered Service was not medically necessary or was not preauthorized (if required), the Provider agrees not to seek payment from the Recipient for that Service. The Provider further agrees to immediately repay the Department in full for any claims where the Provider received payment from another party after being paid by the Department;
- H. With the exception of prenatal care or preventive pediatric care, to seek payment from a Recipient's other insurances and resources of payment before submitting claims to the Department, which includes but is not limited to seeking payment from Medicare, private insurance, medical benefits provided by employers and unions, worker compensation, and any other third party insurance. If payment is made by both the Department and the Recipient's other insurance, the Provider shall refund the Department, within 60 days of receipt, the amount paid by the Department;
- I. To accept responsibility for the validity and accuracy of all claims submitted to the Department, whether submitted on paper, electronically or through a billing service;
- J. That all claims submitted under his, her or its provider number shall be for medically necessary Services that were actually provided as described in the claim. The Provider acknowledges that the submission of false or fraudulent claims could result in criminal prosecution and civil and administrative sanctions. This may include his, her or its expulsion from the Maryland Medical Assistance Program and/or referrals by the Department to the HHS OIG for expulsion from the Medicare program;
- K. That if Provider is a physician, he or she will, upon request, submit the name and applicable licensure for each physician extender in his or her employment. The Provider is responsible for knowing and complying with the Maryland Medical Assistance Program's definition of an eligible physician extender and for providing supervision as required by the Maryland Medical Assistance Program;
- L. That in case of a group provider, the individual Provider rendering the service shall include his or her own provider number, as well as the group provider number, on any claim;



Provider Agreement for Participation in Maryland Medical Assistance Program

- M. To furnish the Department, within 35 days of the Department's request, full and complete information about:
1. The ownership of any subcontractor with who the Provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request;
 2. Any significant business transaction between the Provider and any wholly-owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request; and
 3. Any ownership interest exceeding 5 percent held by the Provider in any other Medical Assistance Provider;
- N. That before the Department enters into or renews this Agreement, the Provider agrees to disclose the identity of any person who:
1. Has an ownership or control interest in the Provider, or is an agent or managing employee of the Provider; and
 2. Has been convicted of a criminal offense related to that person's involvement in the Medicaid or Medicare programs;
- O. To exhaust all administrative remedies prior to initiating any litigation against the Department;
- P. Upon receipt of notification that the Provider is disqualified through any federal, state and/or Medicaid administrative action, to not submit claims for payment to the Department for Services performed after the disqualification date;
- Q. Any excessive payments to a Provider may be immediately deducted from future Department payments to any payee with the Provider's tax identification number, at the discretion of the Department;
- R. Continuation of this Agreement beyond the current term is subject to and contingent upon sufficient funds being appropriated, budgeted, and otherwise made available by the State legislature and/or federal sources. The Department may terminate this Agreement and the Provider waives any and all claim(s) for damages, effective immediately upon receipt of written notice (or any date specified therein) if for any reason the Department's funding from State and/or federal sources is not appropriated or is withdrawn, limited or impaired;



Provider Agreement for Participation in Maryland Medical Assistance Program

- S. To comply with the Deficit Reduction Act of 2005 (DRA) employee education requirement imposed upon any entity, including any governmental agency, organization, unit, corporation, partnership or other business arrangement (including any Medicaid MCO), whether for profit or not for profit, which receives annual Medicaid Payments of at least \$5,000,000.

- T. For Provider Groups Only: The Provider Group affirms that it has authority to bind all member Providers to this Agreement and that it will provide each member Provider with a copy of this Agreement. The Provider Group also agrees to provide the Department with names and proof of current licensure for each member Provider as well as the name(s) of individual (s) with authority to sign billings on behalf of the group. The Provider Group agrees to be jointly responsible with any member Provider for contractual or administrative sanctions or remedies including, but not limited to reimbursement, withholding, recovery, suspension, termination or exclusion on any claims submitted or payment received. Any false claims, statements or documents, concealment or omission of any material facts may be prosecuted under applicable federal or state laws.

- U. To notify the Department within five (5) working days of any of the following:
 - 1. Any action which may result in the suspension, revocation, condition, limitation, qualification or other material restriction on a Provider's licenses, certifications, permits or staff privileges by any entity under which a Provider is authorized to provide Services including indictment, arrest, felony conviction or any criminal charge;

 - 2. Change in corporate entity, servicing locations, mailing address or addition to or removal of practitioners or any other information pertinent to the receipt of Department funds; or

 - 3. Change in ownership including full disclosure of the terms of the sales Agreement. When there is a change in ownership this Agreement is automatically assigned to the new owner, and the new owner shall, as a condition of participation, assume liability, jointly and severally with the prior owner for any and all amounts that may be due, or become due to the Department, and such amounts may be withheld from the payment of claims submitted when determined. (NOTE: Section I.S.3 does not apply to Nursing Home Providers)

II. THE DEPARTMENT AGREES:

- A. To reimburse the Provider for medically necessary Services provided to Recipients that are covered by the Maryland Medical Assistance Program. Services will be reimbursed in accordance with all Program regulations and fee schedules as reflected in the Code of Maryland Regulations or other rules, action transmittals or guidance issued by the Department; and



Provider Agreement for Participation in Maryland Medical Assistance Program

- B. To provide notice of changes in Program regulations through publication in the Maryland Register.

III. THE DEPARTMENT AND PROVIDER MUTUALLY AGREE:

- A. That except as specifically provided otherwise in applicable law and regulations, either party may terminate this Agreement by giving thirty (30) days notice in writing to the other party. After termination, the Provider shall notify Recipients, before rendering additional Services, that he or she is no longer a Maryland Medical Assistance participating Provider;
- B. That the effective date of this Agreement shall be _____, provided that the Department verifies the information in the Provider's application. This Agreement shall remain in effect until either party terminates the Agreement (as described in Section III A). Following termination of this Agreement, the Provider must continue to retain records and reimburse the Maryland Medical Assistance Program for overpayments as described in this Agreement and as required by law, including but not limited to Maryland Health-General § 4-403;
- C. That no employee of the State of Maryland, whose duties include matters relating to this Provider's Agreement, shall at the same time become an employee of the Provider without the written permission of the Department;
- D. That this Agreement is not transferable or assignable;
- E. That the Provider Enrollment Application submitted and signed by the Provider is incorporated by reference into this Agreement and is a part hereof as though fully set forth herein; and

Provider Signature (No stamps) Date



Department Authorization Date

Provider Name (Type or Print) Date



Assistant Attorney General Date

Provider Address (Type or Print)



Addendum for Participation in Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

Should you have any questions regarding completing this addendum, please contact:
Jeronica Baldwin - Phone: (410) 767-5206 - Email: jeronica.baldwin@maryland.gov

****You must attend the Maryland State Department of Education (MSDE) Autism Waiver Initial Provider Training and Information Session before enrollment****

If you have attended this training, please provide the date of attendance: _____

If you have not attended the training, please contact MSDE at (410) 767-0100 for information on the next training sessions.

Please include the following materials with your application:

- Copy of the Articles of Incorporation or Articles of Organization;
- Full legal name, DOB, and SSN of the facility's owners;
- Full legal name, DOB and SSN of individuals with as 5% or more direct or indirect ownership;
- Full legal name, DOB and SSN of board of directors;
- Copy of tax ID number letter (IRS Letter); and
- Site license, if applicable.

****Please review and complete the attached documents for the applicable service(s) you will be rendering, and submit with your Medical Assistance Autism Waiver application.****

**Policy and Procedure for Application to Become an Autism Waiver
Service Provider**

I. Introduction:

- A. Services for participants on the Home and Community Based Services Waiver for children with Autism Spectrum Disorder must be provided by individuals or agencies who demonstrate the capacity and qualifications to serve children with Autism Spectrum Disorder. The application process is utilized to afford applicants the opportunity to demonstrate the required capacity and qualifications and for the State to determine if applicants meet required standards. The application process must be administered equitably in the same fashion to all applicants. All individuals and agencies have the right to apply and to receive equitable consistent review and consideration throughout the process regardless of: race, color, religion, gender, sexual orientation, national origin, political affiliation, disability, marital status, age, or union affiliation.

The sensitive nature of children with Autism requires highly qualified, well prepared service providers with substantial experience. The application process does not serve to prepare individuals or agencies to provide services under the Autism Waiver. The State bears no responsibility for the preparedness of applicants, their ability to understand and process application materials, or the quality of their applications. All applicants must independently demonstrate acceptable capacity and qualifications to provide Autism Waiver services.

- B. Determination of acceptable capacity and qualifications must be made through:
- The measurement of all applications against COMAR requirements for Medicaid, including, but not limited to COMAR 10.09.56 and 10.09.36 and guidance issued by the Maryland State Department of Education (MSDE) and the Department of Health and Mental Hygiene (DHMH).
 - The applicant's knowledge of the above regulations, Autism, and Autism Waiver services as indicated by submitted application materials and responses provided in a structured interview.
 - The applicant's ability to effectively and compliantly manage Autism Waiver business operations and service documentation as measured by the submitted implementation plan, other application materials, and responses provided in a structured interview.
 - The applicant's professional qualifications and experience in the field of Autism as demonstrated through submitted references, resume', diploma, licensure, or certification, and responses provided in a structured interview.

- C. It is the responsibility of the applicant to:
- Demonstrate all required qualifications and standards with appropriate documentation and presentation of all required application materials and interview information;
 - Provide all required information and material within the timelines of the application process;
 - Independently understand and process all application materials and procedures.

II. Procedure

- A. Before submitting an application, all prospective applicants must attend the Autism Waiver Initial Provider Training and Information Session, offered once annually by the Maryland State Department of Education (MSDE) and the Department of Health and Mental Hygiene (DHMH). Application materials will not be reviewed for individuals or agencies who have not attended this session.
- B. During participation at the required training and information session, applicants will be provided with a packet of application materials to include:
- An introduction to and explanation of the application process;
 - Contact information for Maryland State Department of Education (MSDE) and Department of Health and Mental Hygiene (DHMH) for the Autism Waiver service provider application process;
 - All required application materials;
 - Directions, including timelines, for the completion of application materials.
- C. Provider applicants with substantial current experience in delivering services to children with autism may apply for approval in more than one service area. Substantial experience refers to the amount (full-time/part-time), duration (years of experience), nature (family member, volunteer, service provider, supervisor, etc.), and intensity (general disabilities, Asbergers, severe autism) of the applicant's background in the area. Determination of "substantial" experience involves consideration of all of these factors to indicate an individual whose experience establishes clear expertise in the area that would transfer directly to any Autism Waiver services. Provider applicants without substantial current experience in delivering services to children with autism may initially apply for only one service. If approved for a single service, expansion to additional service areas will be considered once the new provider has demonstrated the capacity and competency in the provision of services as presented in the MSDE procedure, "Standards for Applications by Current Providers to Expand Services or Sites."
- D. Required application materials and applicant documentation must be submitted to the designated staff member at MSDE. All required application materials must be sent

together. Partial or incomplete application packets from applicants will not be considered for approval and will be returned to the applicant. Upon receipt of all required application materials, MSDE will:

- Issue a notice of receipt to the applicant:
- Review the application and provide the prospective provider with notice of the status of the application as acceptable or unacceptable.
- If acceptable, the applicant will be co-ordinate with MSDE a date to complete the structured interview component of the application process.
- If unacceptable, MSDE will identify any unacceptable component of the application. Applicants will have ninety (90) days from the date of this notice to correct/complete the materials or documentation and return the application to MSDE.
- MSDE will review returned materials within 90 days of their receipt.
- If resubmitted materials are acceptable, the applicant will be provided with a time period for the structured interview component of the application process.
- If resubmitted materials are unacceptable, the application will be rejected, and the applicant must attend a second Autism Waiver Initial Provider Training before submitting revised documents for a final review.

E. A structured interview will be conducted with all providers with accepted applications.

- Only the applicant/owner and individuals with signed employment contracts with the applicant agency will be admitted to the interview.
- Interview questions are designed to measure the applicant's capacity and qualification to provide Autism Waiver services.
- The structured interview will include general questions specific to applicant information, Autism, business management, compliance, COMAR regulations, and Autism Services. The interview will also include questions specific to individual services for which an applicant had applied.
- A set of general and service specific questions, as written and approved by MSDE and DHMH will be utilized in all Autism Waiver service provider application interview.
- Interview questions will be maintained at MSDE. They will not be provided to applicants before the interview or otherwise published in any way. At the conclusion of the interview, the questions will remain the property of MSDE.
- The structured interview will be conducted by no less than two and no more than five Autism Waiver staff from MSDE and/or DHMH.
- All questions will be scored by each interviewer. To be recommended as an Autism Waiver service provider, an applicant must receive an acceptable score on the structured interview.
- The application of individuals or agencies who fail to achieve the required score on the structured interview will be rejected.

- MSDE will not review or discuss interview responses or results with any applicant beyond sharing the average score achieved.
- F. Individuals or agencies whose application materials and documentation are acceptable and who achieve an acceptable score on the interview will be recommended to DHMH for approval as an Autism Waiver service provider. Upon its review and acceptance of the recommendation, DHMH will issue a notice of approval and Medical Assistance provider number to the new service provider.
- G. Individuals or agencies whose applications are rejected, either for unacceptable application documents or for failure to successfully complete the interview phase of the application process, will be recommended to DHMH for denial of the application to provide Autism Waiver services. Upon its review and acceptance of the recommendation, DHMH will issue a notice of denial of the application. Individuals or agencies whose applications are rejected after either the final review or the structured interview may reapply to provide Autism Waiver services after a period of twelve months from the date on the DHMH notice of denial.
- H. Reapplications submitted by previously denied applicants are considered as first time applications and the applicants must attend the Autism Waiver Initial Provider Training and Information Session. All application materials and documentation must be re-submitted to MSDE and will be reviewed against current requirements. Materials and documentation on file from previous, rejected applications will not be reviewed, considered, or accepted as part of the reapplication of any individual or agency.

HOME AND COMMUNITY-BASED SERVICES WAIVER FOR CHILDREN WITH AUTISM SPECTRUM DISORDER

GENERAL CONDITIONS FOR PROVIDER PARTICIPATION

Please initial **ALL** lines, including each of those under item #4, and sign in blue or black ink.

All Autism Waiver Providers must:

- _____ 1. Meet all of the conditions for participation set forth in COMAR 10.09.36 regarding General Medical Assistance Provider Participation Criteria, including authorization and billing requirements.
- _____ 2. Agree to provide services in accordance with the requirements of the approved waiver proposal, the waiver regulations at COMAR 10.09.56, and all other relevant State, federal, and local laws and regulations.
- _____ 3. Have a signed provider agreement in effect with the Medical Assistance Program, and be approved for each waiver service the provider intends to provide.
- _____ 4. Meet the following conditions:
 - _____ Have not been suspended or removed from participating as a Medicaid provider in the past 24 months;
 - _____ Have not undergone the imposition of sanctions by the Medicaid program in the past 24 months;
 - _____ Have no cited deficiencies in the past 24 month of operation which, present serious danger to service recipients' health and safety;
 - _____ Have not experienced a termination of a reimbursement agreement with or been barred from work or participation by a public or private agency due to failure to meet contractual obligations or due to fraudulent billing practices with the past 24 months; and
 - _____ Have not had a license or certificate revoked as a health provider within the past 24 months.
- _____ 5. Maintain detailed, written documentation of services rendered to waiver participants.
- _____ 6. Make available to the Department and federal funding agents all records, including but not limited to personnel files for each individual employed, and financial, treatment, and service records for inspection and copying and agree to cooperate with required inspections, reviews, and audits by authorized governmental representatives and their designees.

- _____7. Agree not to suspend, terminate, increase, or reduce services for a waiver participant without authorization from MSDE or their designee.
- _____8. Agree to inform MSDE within 1 business day, and within 7 days file a written report on a form designated by the Department, about any interruption of the participant's service or threat to the participant's health, safety, or welfare (e.g., potential eviction or suspected abuse or neglect).
- _____9. Provide documentation required by the department at the time of initial approval or as requested by MSDE or by DHMH.
- _____10. Attend additional waiver trainings as set forth in COMAR 10.09.56.
- _____11. Maintain general liability insurance and provide proof of such insurance at the time of initial approval and as requested by MSDE or DHMH.
- _____12. Agree to notify Child Protective Services at the local department of social services if the provider has reason to believe that the waiver participant has been subjected to abuse, neglect, self-neglect, or exploitation.
- _____13. Agree to provide monthly reports on employee background checks from CJIS.
- _____14. Agree to comply with the requirements in the Department's quality

By signing below, I agree, on behalf of the provider organization applicant, to adhere to the general conditions for provider participation detailed above.

Signature: _____ Date: _____

Printed Name: _____

Organization Name: _____

**PROVIDER APPLICATION FOR
HOME AND COMMUNITY-BASED SERVICES WAIVER FOR CHILDREN
WITH AUTISM SPECTRUM DISORDER**

Section 1:

Name of Business: _____
 Provider's Name: _____
 Provider's Correspondence Address: _____
 City _____ State _____ Zip Code _____
 Day Telephone Number: _____ FAX Number: _____
 Agency's Email Address _____ Personal Email Address _____
 Provider's Social Security Number or Federal Tax ID Number: _____
 To Whom Does This Social Security Number or Tax ID Belong? _____
 List Any Previous Federal Tax ID Numbers or Business Names: _____
 Provider's Current Medicaid Provider Number(s) (if any): _____
 Services for Which Provider Is Currently Reimbursed by Medicaid: _____
 Check whether you are self-employed ___ or an agency/facility/program___.
 Date of Attendance at the Autism Waiver Initial Provider's Workshop_____.

Section II:

Check Off the Waiver Service(s), Which the Provider Proposes to Provide:

<input type="checkbox"/> Therapeutic Integration
<input type="checkbox"/> Residential Habilitation
<input type="checkbox"/> Respite Care
<input type="checkbox"/> Family Consultation
<input type="checkbox"/> Environmental Accessibility Adaptations
<input type="checkbox"/> Adult Life Planning
<input type="checkbox"/> Intensive Individual Support Services

Section III:

Check-off the jurisdiction(s) you intend to serve. You may provide services in multiple jurisdictions. This is for informational purposes only, and does not lock you into serving only the indicated jurisdictions.

<input type="checkbox"/> Allegany	<input type="checkbox"/> Carroll	<input type="checkbox"/> Harford	<input type="checkbox"/> Somerset
<input type="checkbox"/> Anne Arundel	<input type="checkbox"/> Cecil	<input type="checkbox"/> Howard	<input type="checkbox"/> St. Mary's
<input type="checkbox"/> Baltimore City	<input type="checkbox"/> Charles	<input type="checkbox"/> Kent	<input type="checkbox"/> Talbot
<input type="checkbox"/> Baltimore County	<input type="checkbox"/> Dorchester	<input type="checkbox"/> Montgomery	<input type="checkbox"/> Washington
<input type="checkbox"/> Calvert	<input type="checkbox"/> Frederick	<input type="checkbox"/> Prince George's	<input type="checkbox"/> Wicomico
<input type="checkbox"/> Caroline	<input type="checkbox"/> Garrett	<input type="checkbox"/> Queen Anne's	<input type="checkbox"/> Worcester

Provider's Signature: _____ **Date:** _____

MSDE Approval: _____ **Date:** _____

DHMH Approval: _____ **Date:** _____

MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER FOR CHILDREN WITH AUTISM SPECTRUM DISORDER

All documentation checked below MUST be provided to MSDE with the application to be an Autism Waiver service provider. Original signature required on all documents.

REQUIRED DOCUMENT	SERVICE:	IISS	TI	RC	FC	ALP	EAA	Residential					
MSDE Provider Application		X	X	X	X	X	X	X					
DHMH Provider Application		X	X	X	X	X	X	X					
Provider Agreement		X	X	X	X	X	X	X					
Provider Ownership and Disclosure Form		X	X	X	X	X	X	X					
General Conditions for Provider Participation		X	X	X	X	X	X	X					
Professional License or Certification Documents for All Professional Staff, Supervisors, and On-call Consultants		X	X	X	X	X		X					
State License (ie., contractor or Builder)							X						
Resume/Proof of Experience for All Staff		X	X	X	X	X		X					
Job Descriptions for All Positions		X	X	X	X	X		X					
Three References & Supervision Form		X	X	X	X	X		X					
Attestation of CJIS Clearance		X	X	X	X	X		X					
Introductory Letter to Families		X	X	X	X	X		X					
Liability Insurance		X	X	X	X	X	X	X					
Dishonesty Bond		X		X			X						
Zoning and Fire Approval			X										
Health Department Approval			X										
Treatment Plan(s) & Data Sheet		X	X		X	X		X					
Crisis Intervention Plan/Emergency Contacts List		X	X	X	X	X		X					
Dipolma/GED for Direct Care Workers		X	X	X	X	X		X					
Written Policies and Procedures		X	X	X	X	X		X					
Ratified Contract/Letter of Employment		X	X	X	X	X		X					
Business Plan Description		X	X		X	X		X					
Owner/administrator must have CJIS report sent to DHMH		X	X	X	X	X		X					

Provider Name _____

Contact Person _____ Phone/Email _____

Home and Community Based Services Waiver for Children with Autism Spectrum Disorder

Respite Care Provider Application Checklist

In order to qualify as a Respite Care service provider, the following documentation must be provided with your application.

Staff Qualifications: The name and title of the actual individual filling each professional position below must be provided. Additionally, the resume' for each individual must present the educational and experience requirements listed below and a copy of the license/diploma, and or certificate must be attached)

_____ **Supervisor**

_____ Licensed Psychologist, Certified School Psychologist, Certified Special Educator, Licensed Certified Social Worker, Licensed Nurse, Licensed Professional Counselor, Licensed Occupational Therapist, or Board Certified Behavior Analyst

-OR-

_____ Masters or doctorate degree in special education or a related field and at least 5 years experience providing training or consulting in the area of Autism Spectrum Disorder

_____ **Direct Care Workers - The following information must be provided to demonstrate compliance with regulations for Respite Direct Care workers:**

_____ Job description including on job responsibilities, educational requirements (HS/GED), experience requirements (1 yr. with ASD), training topics and policies

_____ Plan for supervision by a qualified professional, including specific supervisory strategies

_____ Forms used for Reference Check (Must have 3 references) - Attach Forms

_____ Attestation of CJIS Clearance (Attach Form)

_____ **Policies and Procedures** (Providers **must** include written policies and procedures for the implementation of services including: plans for the quality assurances, for the hiring and training of staff. Also required are policies and procedures for abuse, neglect, and exploitation, for positive behavior intervention and restraints, the maintenance of required documentation, plans for emergency situations CJIS plan, HIPP Plan and for a "backup plan" which is necessary when a scheduled worker is unable to report).

_____ **Proof of Liability Insurance** (Attach Copy)

_____ **Proof of Dishonesty Bond** (Attach Copy)

_____ **Letter of Introduction to Family** (Attach Letter/Form)

**** A respite care provider, including the supervisor, shall have at least one (1) year of experience or training in providing services to children with autism spectrum disorder or other developmental disabilities.****

Provider Name _____

Contact Person _____ Phone/Email _____

Note: Agency owner (s) must have their criminal background (CJIS) report sent to Jeronica Baldwin at Department of Health and Mental Hygiene, 201 W. Preston Street, Baltimore, Maryland, 21201. Her CJIS authorization number is: 0500040015.

11/28/16

Provider Name _____

Contact person _____ Phone/Email _____

Home and Community Based Services Waiver for Children with Autism Spectrum Disorder

Adult Life Planning Application Checklist

In order to qualify as an Adult Life Planning (ALP) provider, the following documentation must be provided to the Maryland State Department of Education (MSDE). This checklist must be returned with all required documents.

Provider Type: (Check One)

_____ Individual Practitioner or _____ Agency:

Agency: Is your business licensed in Maryland? _____ Yes _____ No

Do you have on staff an employee with a Master's Degree in Human Services and five years of full time experience serving autism/ Developmentally disabled adults? _____ (Yes) or _____ (No)

If no, do you plan to hire a qualified contractor to provide ALP services? _____ (Yes) or _____ (No)

Attach a copy of your agency's contract for an Adult Life Planner. The contract must contain the following components:

_____ Scope of services;

_____ Requirement to comply with all applicable Medicaid regulations;

_____ Written documentation of service delivery expectations; and

_____ A clause that no monies shall be sought from the waiver participant or the participant's family if the contract is breached by either the provider or contractor.

Professional Qualifications:

Individual's Name: _____

Education:

_____ **Masters Degree** in Human Services or a related field (Attach copy of degree.)

_____ **Experience:** Must reflect at least five years of full time experience serving **adults with** autism /developmental disabilities. (Attach copy of current resume with detailed description of five years experience.)

Provider Name _____

Contact person _____ Phone/Email _____

_____ **Relevant Training:** (Attach documentation related to additional training received regarding the adult developmental disabilities program.)

Employment Requirements:

_____ **Three Written References** (Attach copies of written references.)

_____ **Attestation Form (CJIS) Please sign the form and return**

_____ **Job Description** (Attach a description of the duties and responsibilities of the position.)

_____ **Documentation Plan** (Attach a detailed description explaining how services will focus on supporting the family in accessing adult community services on behalf of the participant, as well as on the strategies needed to develop a plan for a “Circle of Support.”)

_____ **Policies and Procedures** (Providers **must** include written policies and procedures for the implementation of services including: plans for the quality assurances, for the hiring and training of staff. Also required are policies and procedures for abuse, neglect, and exploitation, for positive behavior intervention and restraints, the maintenance of required documentation, plans for emergency situations CJIS plan, HIPP Plan and for a “backup plan” which is necessary when a scheduled worker is unable to report).

_____ **Adult Life Planning Treatment Plan as per COMAR 10.09.56.04.K** (Attach copy.)

_____ **Proof of Liability Insurance** (Attach copy.)

_____ **Letter of Introduction to Family** (Attach letter.)

_____ **Business Plan Description**

Note: Agency owner (s) must have their criminal background (CJIS) report sent to Jeronica Baldwin at Department of Health and Mental Hygiene, 201 W. Preston Street, Baltimore, Maryland, 21201. Her CJIS authorization number is: 0500040015.

To be conducted after review and approval of above items:

_____ **Face-to-Face MSDE Interview** **Date of Interview** _____

Acceptable Interview: Yes _____ **No** _____

Comments:

Provider Name _____

Contact Person _____ Phone/Email _____

Home and Community Based Services Waiver for Children with Autism Spectrum Disorder

Environmental Accessibility Provider Application Checklist

Qualifications for Professional

_____ State License (Certificate and/or License Attached)

_____ Evidentiary

_____ Proof of Liability Insurance (Attach Copy)

_____ Bonded (Attach Copy)

_____ Able to service or maintain the adaptation, as necessary

_____ Able to install the adaptation, if necessary

_____ Be the store, vendor, contractor or builder from which the adaptation was purchased.

Provider Name _____

Contact Person _____ Phone/Email _____

Home and Community Based Services Waiver for Children with Autism Spectrum Disorder

Therapeutic Integration Provider Application

In order to qualify as a Therapeutic Integration service provider, the following documentation must be provided with your application.

Staff Qualifications: The name and title of the actual individual filling each professional position below must be provided. Additionally, the resume' for each individual must present the educational and experience requirements listed below and a copy of the license/diploma, and or certificate must be attached)

_____ **Program Director** (Full-time)

_____ Certified special education supervisor, principal, or special educator and at least three years of successful teaching experience

-OR-

_____ At least three years of relevant experience in counseling/supervision

_____ **On-site Supervisor**

_____ Licensed Psychologist, Certified School Psychologist, Certified Special Educator, Licensed Certified Social Worker, Licensed Professional Counselor, Board Certified Behavior Analyst, Licensed/Certified as Music, Art Drama, Dance or Recreation Therapist

-OR-

_____ Masters or doctorate degree in special education or a related field and at least 5 years experience providing training or consulting in the area of Autism Spectrum Disorder

_____ **On Call Professional** (Attach Copy of License and/or Certificate)

_____ Licensed Physician, Psychologist, Certified School Psychologist, Licensed Certified Social Worker, Certified Special Educator, Licensed Nurse Psychotherapist, Licensed Professional Counselor, Occupational or Physical Therapist, Registered Nurse, Speech Therapist, or Board Certified Behavior Analyst

-OR-

_____ Masters or doctorate degree in special education or a related field and at least 5 years experience providing training or consulting in the area of Autism Spectrum Disorder, and

_____ Experience Working with Children with Autism or other developmental disabilities,

_____ Background in Behavior Management Techniques

Provider Name _____

Contact Person _____ Phone/Email _____

_____ Direct Care Workers - The following information must be provided to demonstrate compliance with regulations for TI direct care workers:

_____ Job description including on job responsibilities, educational requirements, experience requirements, training topics and policies

_____ Plan for supervision by a qualified professional, including specific supervisory Strategies (Attached form)

_____ Forms used for Reference Check (Attach Form)

_____ Attestation Form for all staff (Attach Form)

Evidence of Capability and Capacity- The following documentation must be included in your application to demonstrate your capability and capacity to provide IT services:

_____ **Policies and Procedures** (Providers **must** include written policies and procedures for the implementation of services including: plans for the quality assurances, for the transportation of participants, and for the hiring and training of staff. Also required are policies and procedures for abuse, neglect, and exploitation, and for positive behavior intervention and restraints. Plans must also be presented for the implementation of treatment plans, the maintenance of required documentation, plans for emergency situations, CJIS Plan, HIPP Plan and for a “backup plan” which is necessary when a scheduled worker is unable to report.

_____ **Business Plan Description**

_____ **TI Treatment Plan as per COMAR 10.09.56. 06-1.N** (Attached Copy)

_____ **Proof of Liability Insurance** (Attach Copy)

_____ **Letter of Introduction to Family** (Attach Letter/Form)

_____ **Crisis Intervention/Availability Plan** (Must be available for emergency 24/7)

_____ **Facility Compliance** (See below: Attach Copy of Verification by Appropriate Authority, if applicable)

_____ **Rental Agreement**

_____ **Fire Department**

_____ **Health Department**

_____ **Zoning Commission**

Note: Agency owner(s) must have their criminal background (CJIS) report Jeronica Baldwin at Department of Health and Mental Hygiene, 201 W. Preston Street, Baltimore, Maryland, 21201. Ms. Baldwin CJIS authorization number is 0500040015.

Provider
Name _____

Contact Person _____ Phone/Email _____

Home and Community Based Services Waiver for Children with Autism Spectrum Disorder

IISS Provider Application Checklist

**In order to qualify as an IISS provider, the following
documentation must be provided with your application.**

Staff Qualifications: The name and title of the actual individual filling each professional position below must be provided. Additionally, the resume' for each individual must present the educational and experience requirements listed below and a copy of the license/diploma, and or certificate must be attached)

_____ **Program Director (Full-time)**
(Name)

_____ Certified special education supervisor, principal, or special educator, and

_____ At least three years of successful teaching experience

-OR-

_____ At least three years of relevant experience in counseling/supervision

_____ **Supervisor (Circle Title)**
(Name)

_____ Licensed Psychologist, Certified School Psychologist, Certified Special Educator,
Licensed Certified Social Worker, Licensed Professional Counselor, or Board
Certified Behavior Analyst

-OR-

_____ Masters or doctorate degree in special education or a related field and at least 5
year's experience providing training or consulting in the area of Autism Spectrum
Disorder.

_____ **On Call Professional for Crisis Intervention (Circle Title)**
(Name) (Attach Copy of License and/or Certificate)

_____ Licensed Physician, Psychologist, Certified School Psychologist, Licensed
Certified Social Worker, Certified Special Educator, Licensed Nurse Psychotherapist,
Licensed Professional Counselor, Occupational or Physical Therapist, Registered Nurse,
Speech Therapist, or Board Certified Behavior Analyst

-OR-

_____ Masters or doctorate degree in special education or a related field and at least 5 years experience providing training or consulting in the area of Autism Spectrum Disorder (ASD);

_____ Experience Working with Children with Autism or other developmental disabilities; and

_____ Background in Behavior Management Techniques.

_____ **Direct Care Workers - The following information must be provided to demonstrate compliance with regulations for IISS direct care workers:**

_____ Job description including job responsibilities, educational requirements (at least S/GED), experience requirements with children with Autism Spectrum Disorder, or other developmental disabilities as a service provider or a family member and, training requirements.

_____ Plan for supervision by a qualified professional, including specific supervisory strategies;

_____ Forms used for Reference Check (Must have 3 references)-Attach Copy; and

_____ **Policies and Procedures** (Providers **must** include written policies and procedures for the implementation of services including: plans for the quality assurances, for the transportation of participants, and for the hiring and training of staff. Also required are policies and procedures for abuse, neglect, and exploitation, and for positive behavior intervention and restraints. Plans must also be presented for the implementation of treatment plans, the maintenance of required documentation, plans for emergency situations CJIS plan. HIPPP Plan and for a “backup plan” which is necessary when a scheduled worker is unable to report).

_____ **Business Plan Description**

_____ **Attestation of CJIS Clearance (Attach Form)**

_____ **IISS Treatment Plan as per COMAR 10.09.56. 06. K (Attach Copy)**

_____ **Proof of Liability Insurance (Attach Copy)**

_____ **Letter of Introduction to Family (Attach Letter/Form)**

_____ **Crisis Intervention/Availability Plan (Must be available for emergency 24/7)**

Note: Agency owner (s) must have their criminal background (CJIS) report sent to Jeronica Baldwin at Department of Health and Mental Hygiene, 201 W. Preston Street, Baltimore, Maryland, 21201. Her CJIS authorization number is: 0500040015.

Provider Name _____

Contact Person _____ Phone/Email _____

Home and Community Based Services Waiver for Children with Autism Spectrum Disorder

Family Consultation Provider Application

In order to qualify as a Family Consultation provider, the following documentation must be provided with your application.

Professional Qualifications:

_____ **Education (The family consult's resume' must reflect at least one of the following qualifications and certificate and/or license must be attached)**

_____ Certified Special Educator (COMAR 13A.12.01)

_____ Certified School Psychologist (COMAR 13A.12.01)

_____ Certified School Speech Therapist (COMAR 13A.12.01)

_____ Licensed Psychologist

_____ Licensed Certified Social Worker

_____ Licensed Nurse Psychotherapist

_____ Licensed Occupational Therapist

_____ Licensed Speech Therapist

_____ Licensed Professional Counselor

_____ Licensed Marriage and Family Counselor

_____ Nationally Certified Board Certified Behavior Analyst

-OR-

_____ Masters or doctorate degree in special education or a related field and at least 5 year's experience providing training or consulting in the area of Autism Spectrum Disorder

_____ **Resume:** Must have at least two years experience in providing services to children with Autism spectrum disorder as a provider or as a family member, with experience relevant to:

Provider Name _____

Contact Person _____ Phone/Email _____

- the family's consultation needs
- behavior intervention
- keeping the child safe in the home environment

_____ **Policies and Procedures** (Providers **must** include written policies and procedures for the implementation of services including: plans for the quality assurances, for the transportation of participants, and for the hiring and training of staff. Also required are policies and procedures for abuse, neglect, and exploitation, and for positive behavior intervention and restraints. Plans must also be presented for the implementation of treatment plans, the maintenance of required documentation, plans for emergency situations, CJIS plan, HIPP Plan and for a "backup plan" which is necessary when a scheduled worker is unable to report).

_____ **Business Plan Description**

_____ **Attestation of CJIS Clearance (Attach Form)**

_____ **Family Consultation Treatment Plan as per COMAR 10.09.56.08.D (Attach Copy)**

_____ **Proof of Liability Insurance (Attach Copy)**

_____ **Letter to Family (Attach Letter/Brochure)**

Note: Agency owner (s) must have their criminal background (CJIS) report sent to Jeronica Baldwin at Department of Health and Mental Hygiene, 201 W. Preston Street, Baltimore, Maryland, 21201. Her CJIS authorization number is: 0500040015.

11/28/16

**Home and Community Based Services Waiver for Children
with Autism Spectrum Disorder**

Residential Habilitation Provider Checklist

Name of Provider

Provider Requirements

- Medicaid Provider Application
- Liability Insurance (copy)
- COMAR 10.22.08 and 10.22.02 licensed group home or alternative living unit **or** COMAR 14.31.06 (residential child care programs) (Copy of License)
- 3 years experience habilitation to children with autism

Staffing Requirements

- Program Director (Job Description)
 - Special Education Supervisor-copy of certification
 - Special Education Principal-copy of certification
 - Special Educator-copy of certification
 - **Or** 3 years experience providing Counseling or Supervision (resume/references)
- House Supervisor (24 hours a day - Resumes/Job Description)
 - Bachelors in Human Services with 3 years experience with autism
 - Qualified Mental Retardation / Developmental Disabilities Professional

Staffing Requirements: (continued)

- Consultant Licenses
(Description of Arrangements, Copies of Contracts,
Purchase Orders)
 - Physician
 - Registered Nurse
 - Occupational Therapist
 - Physical Therapist
 - Licensed certified Social Worker
 - Certified Special Educator
 - Licensed Nurse Psychotherapist

- Crisis intervention licensed/certified professional (on-call)
(Identify specific individuals to be called)
 - Physician
 - Psychologist
 - School Psychologist
 - Social Worker
 - Special Educator
 - Nurse Psychotherapist

- Has experience providing services to children with autism
- Background in behavior management
- Knows each child participating in program

- Direct Care Workers (Job Descriptions, Hiring Protocol,
Training Schedule, Supervision Record)
 - Trained to Provide services to Children with autism
 - Work under licensed/certified staff
 - Approved to meet child's needs

Program Requirements

- Policies and Procedures that include Implementation Plan
 - Assure LRE
 - Evidence integration with day habilitation, IEP, IFSP, education, community services

- Medical Services Policies and Procedures
 - Document medical needs of participant
 - Transportation
 - Emergency plan

- Approvals (Copy of Approval)
 - Local Health Department
 - Fire Safety
 - Zoning

- Round-the-clock staffing-Staffing Schedule
 - 1 direct care staff for every three children
 - Specify Weekend or Weekdays
(Number of Nights per week)

Name of Reviewer

Date of Review

Note: Agency owner (s) must have their criminal background (CJIS) report sent to Jeronica Baldwin at Department of Health and Mental Hygiene, 201 W. Preston Street, Baltimore, Maryland, 21201. Her CJIS authorization number is: 0500040015.