MARYLAND
Department of Health

Addendum Cover Page for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

PT 42 MEDICAL DAY CARE – ADULTS

If you have questions, please contact the Provider Enrollment Helpline at **1-844-4MD-PROV (1-844-463-7768)**
Monday – Friday from **7am – 7pm.**

All providers are required to use the **e**lectronic **P**rovider **R**evalidation and **E**nrollment **P**ortal, or ePREP (eprep.health.maryland.gov) for enrollment, information updates, provider affiliations and revalidations.

Please fill out the information below and upload the completed addendum to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional documents requested within the addendum.

Provider Information

NPI:

Tax ID:

MA Provider Number (if already enrolled in Maryland Medicaid):

Please visit health.maryland.gov/ePREP for more information about ePREP

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Please upload this form to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional applicable supporting documents requested below.

Section I:
Please upload the following documents to ePREP :

1. A copy of the Adult Medical Day Care (AMDC) Orientation Certificate
2. Completed Adult Medical Day Care Provider Supplemental Application (attached)
3. Copy of tax ID number letter from the IRS
4. A copy of the staff organization chart
5. A copy of the Physical/Occupational Therapist's contract
6. A copy of CPR and First Aid certifications of staff member(s) who will be on-site at the center when participants are in attendance, during outings, medical appointments or during transportation of participants.

MARYLAND DEPARTMENT OF HEALTH
LONG TERM SERVICES AND SUPPORT ADMINISTRATION
NURSING AND WAIVER SERVICES
DIVISION OF COMMUNITY LONG TERM CARE
201 WEST PRESTON STREET, ROOM 133-J
BALTIMORE MD 21201

ADULT MEDICAL DAY CARE PROVIDER APPLICATION

NAME OF FACILITY: _____

ADDRESS: _____

CONTACT PERSON: _____

TELEPHONE NO.: _____ FAX NO.:_____

EMAIL ADDRESS: _____

GENERAL QUESTIONS (Attach a separate sheet)

1. What are the philosophies and objectives of your adult day care program?

2. Describe the participant population that your adult day care center intends to service. Are there any health conditions that would make a person ineligible to attend your center?

3. What are the geographic areas you intend to serve?

4. What are your hours of operation?

   Hours that the staff is present: _____-_____

   Hours the participants may be present: _____-_____

5. What days will the facility be open? (Please circle)

   SUN MON TUE WED THUR FRI SAT

CONDITIONS FOR PARTICIPATION (COMAR 10.09.36)

Have you read the section for Conditions for Participation? Yes ☐ No ☐

Do you agree to comply with all of these requirements? Yes ☐ No ☐
If no, please explain. (Attached a separate sheet of paper)

CONDITIONS FOR PARTICIPATION (COMAR 10.09.07)

Have you read the section for Conditions for Participation? Yes ☐ No ☐

Do you agree to comply with all of these requirements? Yes ☐ No ☐
If no, please explain. (Attached a separate sheet of paper)

STAFFING REQUIREMENTS (COMAR 10.09.07.04)

Medical Day Care regulations require each center to have a program director, registered nurse, activities coordinator, licensed social worker and medical director. Attach copies of all job descriptions, resumes, licenses, and degrees for the above staff.

Please indicate how many hours per week staff will work at the center and whether they are full-time, part-time or contractual (according to regulation).

Name the full-time staff member(s) who have been designated as:

Registered Nurse: _____

Program Director: _____

STAFF TRAINING (COMAR 10.09.07.03)

Attach your plan to provide training to staff in emergency procedures, cardiopulmonary resuscitation and first aid.

POLICIES AND PROCEDURES (COMAR 10.09.07)

Attach your policies and procedures for quality assurance. Include material concerning utilization review and health care audits.

Attach your policies and procedures concerning the composition and responsibilities of the multi disciplinary team.

COVERED SERVICES (COMAR 10.09.07.05)

Attach your policies and procedures for physical therapy services and occupational therapy services. (10.09.07.05(3) and (4)

Attach your policies and procedures for discharge planning and referral. (10.09.07.05 A (7) (C)

Attach a description of how transportation services will be provided. Include contract(s), if applicable. (10.09.07.05 A (9)

OTHER SERVICES

Attach a description of services, if any that are not covered but will be available to participants. Explain how these services will be provided.

PARTICIPANT REGISTER (COMAR 10.09.07.01B (4)

Attach a blank copy of your attendance record form (see Medical Day Transmittal No. 38 for requirements). Submit policy and procedures of how attendance will be taken to account for the physical presence and absence of each participant.

_____
Type or Print Name of Authorized Official Title

_____
Signature of Authorized Official Date

_____
Type or Print Name of Preparer (if other than above)

_____
Signature of Preparer Date

Rev. 08/17/18