MARYLAND
Department of Health
Developmental Disabilities Administration

DDA OPERATED MEDICAID WAIVER PROGRAMS
LICENSED PRACTITIONER APPLICATION AND AGREEMENT

This application and agreement may only be used by individuals who have a license to practice behavioral analysis, psychology, nursing, social work, speech-language pathology, and/or physical/occupational therapy from one of Maryland's health occupations licensing boards, practice that health occupation, and intend to provide services to participants in a DDA operated Medicaid Waiver program.

Practitioner Name:_____License Number: _____
Practitioner Address: _____

Practitioner Phone:_____Practitioner Email Address: _____

Select Practitioner Type: ☐ Licensed Behavior Analyst ☐ Licensed Psychologist ☐Licensed Psychology Associate ☐Licensed Professional Counselor ☐ Registered Nurse ☐ Licensed Social Worker ☐ Speech Language Pathologist ☐ Physical Therapist/Occupational Therapist

SECTION 1

By submitting this application,_____(practitioner name), seeks a waiver from the Developmental Disabilities Administration (DDA) licensing requirements to be a Developmental Disabilities Administration ("DDA") provider.

I, _____, (practitioner name) certify as follows:

☐ I have a license to practice _____ issued by _____ (insert name of health occupations board) on _____ (insert date) with an expiration date of _____ (insert date).
*Attach a copy of that license to this application.

☐ I practice the above health occupation as a sole proprietor of a business or ☐ I am an employee or individual contractor of a sole proprietor.

☐ I understand and agree that if my waiver application is granted, the Deputy Secretary of the Maryland DDA may revoke that waiver if I become out of compliance with the applicable laws and regulations of my health occupation licensing board or the laws and regulations of the Maryland Department of Health or the applicable requirements of the DDA operated Medicaid Waivers under which I may be approved to offer services.

☐ I understand and agree that I must comply with applicable laws and regulations, including but not limited to The Civil Rights Act of 1964, The Rehabilitation Act of 1973, The Americans with Disabilities Act, and The Drug Free Workplace Act of 1988, and certify, as a business owner, manager, or employee, that I have not been sanctioned, charged or convicted for violating these acts.

SECTION 2 - QUALIFICATION VERIFICATION

I, _____, (practitioner name) certify as follows:

☐ I have professional general liability insurance. A copy of my policy is attached.

☐ Action has not been taken in the past, and no action is pending, to suspend or revoke my license to practice a health occupation in Maryland or in another state. My health occupations license is not currently surrendered in any state, and I have nor surrendered any such license in the past;

☐ I have not resigned or been dismissed from any place of employment after notice of allegations of misconduct involving a vulnerable person.

☐ I have never been disciplined in a manner which resulted in a reprimand, suspension, or expulsion from participating in a state, federal or local program or contract, (i.e., Medicaid or Medicare), or a private program.

☐ I will ensure that services or supports meet required qualifications including education, licensing, certifications, and training prior to service delivery and continuing thereafter.

SECTION 3 - CONDITIONS OF PARTICIPATION TO PROVIDE SERVICES UNDER HCBS WAIVERS

If approved for a DDA provider waiver and the DDA verifies my qualifications to provide services under a DDA operated Medicaid Waiver,

I,_____, (practitioner name) attest as follows and agree to be bound by the same:

1. I will maintain compliance with the statutory and regulatory requirements of the State of Maryland health occupations licensing board that has issued me my license.
2. After approval, I will submit a renewal application every three (3) years.
3. I will meet all applicable regulatory and industry standards including applicable provisions of COMAR 10.22, as well as complying with DDA's Policy on Reportable Incidents and Investigations as a mandated reporter, including cooperating with inspection or monitoring by the Office of Health Care Quality in response to a reported incident or complaint concerning the abuse, neglect, death, exploitation of a participant or any matter deemed a serious reportable incident or complaint as set forth in COMAR 10.22.02.01 and .03 and 10.09.36.03.
4. I will follow best practices and reasonable standards (meaning professional methods, procedures, or goods which have been deemed acceptable, prudent and most effective) when providing services or goods to a vulnerable person.
5. I will provide person-centered services in accordance with the participant's person-centered plan and the participants wishes.
6. I will maintain records (written or electronic) of services or products rendered and dates of services and goods delivered for a period of six (6) years and in accordance with applicable laws governing confidentiality of those records.

7. I will maintain detailed records, available for review by the participant(s), DDA, and its designee. I also agree to cooperate with inspections, reviews, audits, and other oversight activities by DDA staff and governmental representatives.

8. I will bill for services as required by the Department including sending invoices to the participant's Financial Management and Counseling Services provider if applicable.
9. I understand that the participant(s) must be approved by DDA and have the funding in their budget for services.
10. I will satisfactorily complete any applicable DDA training, as noted in the waivers and DDA policy requirements and based on my specialty, to support people with developmental disabilities.
11. I will notify the participants and their team as applicable in writing should I decide, or the team mutually agrees, to end the professional relationship.
12. I will adopt written policies and procedures in compliance with this provider agreement.
13. I will notify the participant(s) and DDA within five (5) business days of any disciplinary action taken against my license by a health occupations licensing board. The DDA Statewide Director of Provider Services should be notified at leslie.thompson@maryland.gov.
14. I agree that if this application is approved, I will not group together with other similarly waivered individual providers, or allow my waiver to be so grouped, in order to avoid DDA requirements for an agency that provides services to individuals with developmental disabilities.
15. I agree that if this waiver application is approved, the DDA may revoke its waiver if I do not comply with this agreement, applicable regulations, statutes, or DDA operated waivers, or I have made false statements in connection with this application. I agree to assist with the development of a transition plan should DDA agree to terminate the health services provided by me.
16. I agree that if this application is approved, I will review and sign the provider agreement and any addendums to that agreement.

_____ _____

Date Signature of Applicant

Privacy Notice – The information in my application is not routinely shared with other governmental agencies. However, by accepting this notice of privacy, I understand that the Department of Health's Medicaid Program, auditors, inspectors and other government officials may review it.

Please submit this application, along with all required documentation, to the appropriate DDA Regional Office via email at providerapplications.dda@maryland.gov.

DDA DETERMINATION

I hereby determine that_____(practitioner name) above waiver application is approved.

I hereby determine that _____(practitioner name) above waiver application is hereby denied.

_____ _____

Date Signature of Deputy Secretary of DDA or Designee