DEVELOPMENTAL DISABILITIES ADMINISTRATION
Organized Health Care Delivery System Application
for the Community Pathways Waiver

Provider Name: _____
Provider Address: _____
_____
Provider Phone: _____

By submitting this application, _____ (organization name) seeks designation from the Developmental Disabilities Administration (DDA) to be an Organized Health Care Delivery System (OHCDS). As an OHCDS, _____ (organization name) will have authorization to subcontract with qualified providers for approved services for individuals served through DDA.

I, _____, _____ of _____,
(Name) (Title – CEO or Board President) (Name of Organization)
have authority to bind the organization and attest as follows:

- _____ (organization name) provides at least one Medicaid service directly (with its own employees). MA Provider Number: _____. _____(initials)
- All subcontractors will meet all applicable regulatory and industry standards (including where COMAR 10.22. applies). _____ (initials)
- _____ (organization name) will submit claims for Federal Financial Participation (FFP) monthly, or as otherwise stipulated by DDA. ____ (initials)
- _____ (organization name) will adhere in total to COMAR 10.22.20 in the execution of all subcontracts. _____ (initials)
- In the performance of duties as an OHCDS, _____ (organization name) will comply with all aspects of the DDA provider agreement. ____ (initials)
- _____ (organization name) will maintain detailed records, available for DDA, its designee or respective consumer review at any time, on the purchase of services from qualified entities or individuals. These records will be maintained for a period not less than 6 years.
- _____ (organization name) will submit, in addition to all other DDA required reports and statements, an aggregate annual summary, on a form developed by DDA, delineating OHCDS activities, including subcontractor names, amounts paid per subcontractor, nature of services and number of individuals served by each subcontractor. This report will be due within 30 days of the close of the State fiscal year. _____(initials)

I attest that _____ (organization name) will abide by the stipulations above, will notify DDA immediately of any changes, and will abide by any additional other relevant governing authority.

_____ _____ _____
Date Printed Name Signature
(CEO or Board President)

Approval:

_____ _____
Date DDA Director