MARYLAND
Department of Health

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

PT 40 AUTISM WAIVER

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

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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Monday – Friday from **7am – 7pm.**

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.

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

If you have not attended the training, please contact **MSDE** at **(410) 767-0046** for information on the next training sessions.

Section I:
Please respond to the question below:

1. Have you attended the MSDS Autism Waiver Initial Provider Training and Information Session?

   ☐ YES ☐ NO

   - If yes, please provide the date of attendance: _____

Section II:
Please upload the following document to ePREP :

1. Completed MSDE services application for the applicable service(s) you will be rendering (attached).

MARYLAND STATE DEPARTMENT OF EDUCATION
Department of Special Education-Early Intervention Services
Special Services Branch, Health Related Services Section

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 Maryland Department Health (MDH).
- 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 Maryland Department of Health (MDH). 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 Maryland Department of Health (MDH) 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 MDH 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 MDH.
- 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 MDH for approval as an Autism Waiver service provider. Upon its review and acceptance of the recommendation, MDH 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 MDH for denial of the application to provide Autism Waiver services. Upon its review and acceptance of the recommendation, MDH 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 MDH 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 MDH.

_____10. Attend additional waiver trainings as set forth in COMAR 10.09.56.

_____11. Maintain general liability insurance e and provide proof of such insurance at the time of initial approval and as requested by MSDE or MDH.

_____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: _____

MDH form revised 7/24/18

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:

☐ **Therapeutic Integration**
☐ **Residential Habilitation**
☐ **Respite Care**
☐ **Family Consultation**
☐ **Environmental Accessibility Adaptations**
☐ **Adult Life Planning**
☐ **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.

☐ Allegany	☐ Carroll	☐ Harford	☐ Somerset
☐ Anne Arundel	☐ Cecil	☐ Howard	☐ St. Mary's
☐ Baltimore City	☐ Charles	☐ Kent	☐ Talbot
☐ Baltimore County	☐ Dorchester	☐ Montgomery	☐ Washington
☐ Calvert	☐ Frederick	☐ Prince George's	☐ Wicomico
☐ Caroline	☐ Garrett	☐ Queen Anne's	☐ Worcester

Provider's Signature: _____ Date: _____

MSDE Approval: _____Date: _____

MDH Approval: _____ Date: _____

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					
MDH 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 MDH		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 Maryland Department of Health, 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 Maryland Department of Health, 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 Maryland Department of Health, 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. 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)**

☐ **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 Maryland Department of Health, 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 Maryland Department of Health, 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

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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)
- o Special Education Supervisor-copy of certification
- o Special Education Principal-copy of certification
- o Special Educator-copy of certification
- o **Or** 3 years experience providing Counseling or Supervision (resume/references)

❑ House Supervisor
(24 hours a day - Resumes/Job Description)

- o Bachelors in Human Services with 3 years experience with autism
- o Qualified Mental Retardation / Developmental Disabilities Professional

Staffing Requirements: (continued)

❑ Consultant Licenses
(Description of Arrangements, Copies of Contracts, Purchase Orders)

- o Physician
- o Registered Nurse
- o Occupational Therapist
- o Physical Therapist
- o Licensed certified Social Worker
- o Certified Special Educator
- o Licensed Nurse Psychotherapist

❑ Crisis intervention licensed/certified professional (on-call)
(Identify specific individuals to be called)

- o Physician
- o Psychologist
- o School Psychologist
- o Social Worker
- o Special Educator
- o 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)

- o Trained to Provide services to Children with autism
- o Work under licensed/certified staff
- o Approved to meet child's needs

Program Requirements

❑ Policies and Procedures that include Implementation Plan

- o Assure LRE
- o Evidence integration with day habilitation, IEP, IFSP, education, community services

❑ Medical Services Policies and Procedures

- o Document medical needs of participant
- o Transportation
- o Emergency plan

❑ Approvals (Copy of Approval)

- o Local Health Department
- o Fire Safety
- o Zoning

❑ Round-the-clock staffing-Staffing Schedule

- o 1 direct care staff for every three children
- o Specify Weekend or Weekdays (Number of Nights per week)

_____ _____

Name of Reviewer Date of Review

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