MARYLAND
Department of Health

Addendum for Maryland Medical Assistance Program Application

FACILITY/ORGANIZATION

PT 76 ASSISTED LIVING FACILITY

If you have questions, please contact the Provider Enrollment Helpline at **1-844-4MD-PROV (1-844-463-7768)** **Monday – Friday** from **9am – 5pm.**

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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Section I:

Please utilize this checklist to confirm you have submitted all the required documents uploaded to your application in ePREP.

Staff & Facility Requirements	Required Documentation
Assisted Living Manager (ALM)	☐ Current Medication Technician Certification (not required if Registered Nurse (RN), but must upload their current RN license) ☐ Current CPR and First Aid certifications ☐ Assisted Living Management Training - A five (5) or more bed facility manager must have the 80-hour Management Training Course ☐ 20 hrs of continued education within the past 2 yrs ☐ Current annual training covering the following topics: fire and life safety, infection control, emergency disaster plans, and basic food safety ☐ Criminal Background checks through CJIS under the facility name ☐ 2 current forms of identification (driver's license, passport,social security card) ☐ A copy of current resume for the Assisted Living Manager documenting a minimum of three (3) years of direct patient care experience
Alternate Assisted Living Manager (AALM)	☐ Current Medication Technician Certification (not required if RN, but must upload their current RN license) ☐ Current CPR and First Aid certifications ☐ Initial 20 hr training ☐ 20 hrs of continued education within the past 2 yrs ☐ Current annual training covering the following topics: fire and life safety, infection control, emergency disaster plans, and basic food safety ☐ Criminal Background checks through CJIS under the facility name ☐ 2 current forms of identification (driver's license, passport,social security card) ☐ A copy of current resume for the Alternate Assisted Living Manager documenting a minimum of three (3) years of direct patient care experience

RN Delegated Nurse	☐ Current Registered Nurse (RN) license ☐ 1 additional current form of photo identification (driver's license, passport) ☐ Copy of the verification of completion of the Delegated Nurse Curriculum ☐ Delegated Nurse Contract with the Assisted Living Facility (ALF) ☐ Current CPR/BLS certification
Additional Staff	☐ Criminal Background checks through CJIS under the facility name ☐ Current CPR and First Aid certifications ☐ Current Medication Technician Certification for any Medication Technician on staff ☐ 2 current forms of identification (driver's license, passport,social security card) ☐ Include a note stating if the facility does not have additional staff
Facility Requirements	☐ A copy of Residential Agreement, including business name, address, and resident acknowledgement section ☐ A copy of Resident Rights, including business name and address ☐ A copy of Resident House Rules, including business name, address, and resident acknowledgement section ☐ A copy of literature that is used to promote your facility, i.e. brochures etc.

Note: Criminal Background Checks: The facility must have an account with the Criminal Justice Information System (CJIS) to perform criminal history record checks. CJIS Checks submitted for review must have the facility name on them. Other types of Criminal Record Checks are not acceptable.

Note: Documentation of Assisted Living Management Training consisting of the following:

Alzheimer's, Dementia and Mental Illness: Caring for persons with Cognitive Impairment and related Mental Health Issues - Fire and Life Safety - Infection Control/Standard Precautions - Basic Food Safety - Emergency Disaster Plans - Resident Assessment Process - Use of Service Plans - Psychosocial Needs of the Population Being Served - Resident's Rights Providing Assistance with Activities of Daily Living

***All trainings must be conducted by an approved OHCQ Assisted Living Management Trainer: Approved OHCQ Vendors**

Section II:
Please read the Agreement of General Conditions for Provider Participation below, initial each line and sign on page 5.

General Conditions for Provider Participation

Provider's initials: **(Initial each line)**

A: To participate as a provider, The Provider Shall:

_____1. Meet all of the conditions for participation as a Maryland Medical Assistance Program provider as set forth in COMAR 10.09.36, except as otherwise specified in this chapter.

_____2. Agree to verify the qualification of all individuals who render services on the provider's behalf and provide a copy of the current license or credentials upon request.

_____3. Agree to implement the reporting and follow-up of incidents and complaints in accordance with the Department's established reportable events policy by reporting incidents and complaints within 24 hours of knowledge of the event by submitting a written report within 7 calendar days on a form designated by the Department and notifying the local department of social services immediately if the provider has a reason to believe that the participant has been subjected to abuse, neglect, self-neglect, or exploitation, in accordance with COMAR 07.02.16

_____4. Agree to cooperate with required inspections, reviews, and audits by authorized governmental representatives.

_____5. Agree to provide services, and to subsequently bill the Department in accordance with the reimbursement methodology provided to participants for a period of 6 years, in a manner approved by the Department.

_____6. Agree to maintain and have available written documentation of services, including dates and hours of services provided to participants for a period of 6 years, in a manner approved by the Department.

_____7. Agree not to suspend, terminate, increase, or reduce services for an individual without authorization from the Department and with consultation and input from the participant or a participant's representative when applicable.

_____8. Agree to submit a transition plan to the case manager or support planner and participant or participant's representative when applicable when suspending or terminating services.

_____9. Agree to demonstrate substantial, sustained compliance with requirements of this chapter for at least 24 months after a cited deficiency which presented serious danger to participants' health and safety.

_____10. Agree to verify Medicaid eligibility at the beginning of each month that services will be rendered.

_____11. Agree to not be a Medicaid provider or principal of a Medicaid provider that has overpayments that remain due to the Department.

_____12. If the provider renders health-related services, agree to periodically indicate the condition of a participant in accordance with the procedures and forms designated by the Department which shall be shared and discussed at the request of the participant

B. Agree that within the past 24 months you have not:

_____ Had a license or certificate suspended or revoked as a health care provider, health care facility or provider of direct care services.

_____Been suspended or removed from participating as a Medicaid provider of personal care under COMAR 10.09.20

_____Undergone the imposition of sanctions under COMAR 10.09.36.08

_____Been subject to disciplinary action, including actions by the licensing board or any provider or principal of any provider agency.

_____Been cited by a State agency for deficiencies which affect participants' health and safety.

_____Experienced a termination of a Medicaid provider agreement or been barred from work or participation by a public or private agency due to failure to meet contractual obligations or fraudulent billing practices

PROVIDER APPLICANT'S SIGNATURE OF AGREEMENT OF GENERAL CONDITIONS FOR PROVIDER PARTICIPATION

_____ _____
Signature Date

CFC Division Approval: _____ Date: _____