



Addendum Cover Page for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION PT 86 BRAIN INJURY 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 electronic **Provider Revalidation and Enrollment Portal**, or ePREP (eprep.health.maryland.gov) for enrollment, information updates, provider affiliations and revalidations.

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

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):



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*It's recommended that you attend the Behavioral Health Administration (BHA) Brain Injury Waiver Information Session for interested providers before enrollment. All questions and inquiries regarding the Information Session should go to elena.janetopoulos@maryland.gov

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 document to **ePREP** :

Completed waiver services application for the applicable service(s) you will be rendering (attached)

Medicaid Home and Community Based Services Waiver for Individuals with Brain Injury (BI Waiver) Provider Application

Summary of Provider Requirements

*Per COMAR 10.09.46, providers of BI Waiver services must submit documentation that supports the agency's adherence to the licensing, accreditation, and program requirements described on the following pages. **In addition to the licensing requirements, providers that are not already CARF accredited for Brain Injury must submit evidence of the agency's history and expertise in serving individuals with brain injury.**

History of serving individuals with brain injury for at least the past 2 years

* The number and percent of consumers who have a brain injury, served by the agency in the past two years

A program of specialized services appropriate for the needs of individuals with brain injury

*A program service plan that includes a description of the specialized programming offered to meet the needs of individuals with brain injury

Availability of licensed healthcare professionals with experience in the provision of services to individuals with brain injury to supervise, train, or consult with program staff regarding the needs of waiver participants

*A list of licensed professionals, employed or contracted by the agency, who are trained to work with individuals with brain injury (include credentials and number of years of experience working with this population)

Provide an annual continuing education program approved by BHA for all staff working with waiver participants on the needs of individuals with BI that may include:

1. Types of brain injury;
2. Behavioral, emotional, cognitive, and physical changes after brain injury; and
3. Strategies for compensation and remediation of deficits caused by a brain injury;
4. Curriculum outlines, credentials of trainer(s), frequency of training if offered, policy related to staff requirement for initial and annual/ on-going brain injury training.

Provider's Business Name: _____

Check Off the area(s) you intend to serve. You may provide services in multiple areas. This is for informational purposes only and does not lock you into serving only the indicated areas.

<input type="checkbox"/> Allegany		<input type="checkbox"/> Charles		<input type="checkbox"/> Prince George's	
<input type="checkbox"/> Anne Arundel		<input type="checkbox"/> Dorchester		<input type="checkbox"/> Queen Anne's	
<input type="checkbox"/> Baltimore City		<input type="checkbox"/> Frederick		<input type="checkbox"/> Somerset	
<input type="checkbox"/> Baltimore Co.		<input type="checkbox"/> Garrett		<input type="checkbox"/> St. Mary's	
<input type="checkbox"/> Calvert		<input type="checkbox"/> Harford		<input type="checkbox"/> Talbot	
<input type="checkbox"/> Caroline		<input type="checkbox"/> Howard		<input type="checkbox"/> Washington	
<input type="checkbox"/> Carroll		<input type="checkbox"/> Kent		<input type="checkbox"/> Wicomico	
<input type="checkbox"/> Cecil		<input type="checkbox"/> Montgomery		<input type="checkbox"/> Worcester	

Brain Injury Waiver Services to be provided by Agency

1. Select the service(s) that agency intends to provide (Residential Habilitation, Day Habilitation, Supported Employment, and/or Individual Support Services).
2. For each service that the agency intends to provide, initial the descriptions of the service, indicating that you understand the covered services described, AND
3. Initial the licensing and training items that apply to your provider organization. Be sure to enclose supporting documentation for each license and training requirement.

Waiver Service: Residential Habilitation

- **Description of Service**

___ Assistance with acquisition, retention, or improvement in skills related to activities of daily living and the social and adaptive skills necessary to enable the individuals to live in a non-institutional setting.

___ Waiver participants will receive this service at one of three levels, depending upon the participant's needs. The level of service will be documented in the waiver plan of service and must be authorized through BHA's Administrative Service Organization.

1. Minimum of 1:3 staff to participant ratio during the day and evening shifts and non-awake supervision during overnight shift or an awake staff person covering more than one site during the overnight shift.
2. Minimum of 1:3 staff to participant ratio during the day and evening shift and awake, on-site supervision during overnight shift.
3. Minimum of 1:1 staff to participant ratio during the day and evening shift and awake on-site supervision during overnight shift.

- **Licensing**

___ Copy of current license(s) by the Department of Health and Mental Hygiene (Developmental Disabilities Administration) for Community Residential Services under COMAR 10.22.08 (for all units where waiver recipients could reside), and

___ Summary of Program's history, experience, and expertise in serving individuals with brain injury

OR

___ Copy of current Brain Injury Program Accreditation through the Rehabilitation Accreditation Commission (CARF)

- **Training and Credentialing**

___ Summary of Provider brain injury training program for staff

Waiver Service: Day Habilitation

- **Description of Service**

___ Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regular basis, for one or more days per week.

___ Waiver participants will receive this service at one of three levels, depending upon the participant's needs. The level of service will be documented in the waiver plan of service and must be authorized through BHA's Administrative Service Organization.

1. Minimum of 1: 6 staff to participant ratio
2. Minimum of 1:4 staff to participant ratio
3. 1:1 staffing ratio

- **Licensing**

___ Copy of current license(s) by the Department of Health and Mental Hygiene (Developmental Disabilities Administration) for Day Habilitation Services under COMAR 10.22.08, and

___ Summary of Program's history, experience, and expertise in serving individuals with brain injury

OR

___ Copy of current Brain Injury Program Accreditation through the Rehabilitation Accreditation Commission (CARF)

- **Training and Credentialing**

___ Summary of Provider brain injury training program for staff

Waiver Service: Supported Employment

- **Description of Service**

___ Includes activities needed to support paid work by individuals receiving waiver services, including supervision and training.

___ Waiver participants will receive this service at one of three levels, depending upon the participant's needs. The level of service will be documented in the waiver plan of service and must be authorized through BHA's Administrative Service Organization.

1. Staff provides daily contacts to waiver recipient
2. Staff provides a minimum of 1 hour of direct support/ day
3. Staff provides continuous support for a minimum of 4 hours of service per day

- **Licensing**

___ Copy of current license(s) by the Department of Health and Mental Hygiene (Developmental Disabilities Administration) for Vocational Program under COMAR 10.22.08, and

___ Summary of Program's history, experience, and expertise in serving individuals with brain injury

OR

___ Copy of current Brain Injury Program certification through the Rehabilitation Accreditation Commission (CARF)

OR

___ Copy of approval as Mental Health Vocational Program from the Department of Health and Mental Hygiene under COMAR 10.21.28

- **Training and Credentialing**

___ Summary of Provider's brain injury training program for staff

Waiver Service: Individual Support Services

- **Description of Service**

___ Includes assistance provided to an individual to enable participation in the community, which may include, but are not limited to, supports involving: budgeting; medication administration; counseling; helping an individual to access and complete the individual's education; participating in recreational and social activities; accessing community services; grocery shopping; behavioral and other services and supports needed by the family of the individual; and developing relationships.

___ Waiver participants may receive up to eight hours per day of this service. The amount and duration of services will be documented in the waiver plan of service and must be authorized through BHA's Administrative Service Organization.

- **Licensing**

___ Copy of current license(s) by the Department of Health and Mental Hygiene (Developmental Disabilities Administration) for Family and Individuals Support Services under COMAR 10.22.08, and

___ Summary of Program's history, experience, and expertise in serving individuals with brain injury

OR

___ Copy of current Brain Injury Program certification through the Rehabilitation Accreditation Commission (CARF)

- **Training and Credentialing**

___ Summary of Provider's brain injury training program for staff

GENERAL CONDITIONS FOR PROVIDER PARTICIPATION

Provider Initials

1. Meet all of the conditions for participation set forth in COMAR 10.09.46 regarding General Medical Assistance Provider Participation Criteria
2. Provide services in accordance with the requirements of the approved waiver proposal, the waiver regulations at COMAR 10.09.46, and all other relevant State, federal, and local laws and regulations
3. Provide waiver services as specified in a participant's plan of care.
4. Maintain detailed, written documentation of services rendered to waiver participants.
5. Agree to cooperate with required inspections, reviews, and audits by authorized governmental representatives.
6. Agree to provide and bill Medicaid for only those services preauthorized in the participant's waiver plan of care, which are provided after the participant's waiver enrollment.
7. **Room and Board: Providers of Residential Waiver Services for Individuals with Brain Injury are expected to provide room and board to waiver participants. Room and Board is not a Medicaid reimbursable expense. Providers may require waiver participants to pay provider up to \$420.00 monthly to cover the cost of room and board. Waiver Providers are expected to develop an agreement with the waiver participant to this affect. Additionally, waiver participants should maintain a minimum of \$100.00 of their monthly income for personal needs.**

Provider Applicant's Signature attesting to accuracy of information provided in this application.

_____ Date: _____

Provider's Business Name: _____