MARYLAND
Department of Health

Addendum Cover Page for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION PT CM MENTAL HEALTH CASE MANAGEMENT

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

NPI:

Tax ID:

MA Provider Number (if already enrolled in Maryland Medicaid):

After you receive your Medical Assistance enrollment approval, please register with Optum Maryland for authorization.

Visit maryland.optum.com to register with Optum Maryland for access to their Incedo Provider Portal

Should you have any questions regarding Optum Maryland registration, please contact:
Optum Provider Relations: Phone: (800) 888-1965 – Email: omd_providerrelations@optum.com

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

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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 documents to ePREP :

For child and adolescent providers:

1. Completed child and adolescent provider attestation form (attached)
2. Letter of Support from the Core Service Agency (CSA) or Local Behavioral Health Authority (LBHA)

For additional information contact the **Behavioral Health Administration's Child and Adolescent Services** at **410-402-8314** or one of the local core service agencies listed here: https://www.marylandbehavioralhealth.org/

For adult providers:

1. Completed adult case management provider attestation form (attached)
2. Letter of Support from the Core Service Agency (CSA) or Local Behavioral Health Authority (LBHA)

For additional information contact the Behavioral Health Administration at **410-402-8353** or **trina.ja'far@maryland.gov**

STATE OF MARYLAND
Maryland Department of Health
MARYLAND MEDICAL ASSISTANCE

PROVIDER APPLICATION FOR PROVIDERS OF

MENTAL HEALTH CASE MANAGEMENT: CARE COORDINATION FOR CHILDREN AND YOUTH

As the authorized agent for _____, I hereby attest that our agency will:
Name of Agency

Initial

1. Meet the provider requirements for the Mental Health Case Management: Care Coordination for Children and Youth program set forth in COMAR 10.09.90 ☐

2. Meet the applicable requirements for the "Intensive Behavioral Health Services for Children, Youth, and Families- 1915(i) state plan amendment program" governed by COMAR 10.09.89 for all service recipients served who are enrolled in this program ☐

3. Meet the requirements for General Medical Assistance Provider Participation Criteria set forth in COMAR 10.09.36 ☐

In addition, as a part this provider agreement, I also attest that our agency will adhere to the following specific requirements established by the Department and provide documentation to support each of them if applicable or requested:

1. Our agency has been selected by the _____, the Local Behavioral Health Authority/Core Service Agency for _____. (Attach documentation) (Jurisdiction) ☐

2. Our agency will explain to qualified Medical Assistance recipients the types of case management for which they may be eligible in addition to Mental Health Case Management: Care Coordination for Children and Youth. We will offer them ***a choice*** of case management from among these options. In particular, young adults who turn 18 while in this program may be eligible for Mental Health Case Management: Care Coordination for Adults and they will be offered a choice of program upon reaching the age of majority. In order to fulfill this and other COMAR requirements, our agency will maintain a manual of policies and procedures that assure documentation of choices made by legal guardians or adult individuals and all other requirements stipulated COMAR. I further attest these policies and procedures will be followed by our agency. ☐

Initial

3. Our agency will comply with the training requirements set forth by MDH for provider participation in this program and maintain sufficient staff to assure that families are well served in their community as determined by both the Department and its local agent, the above referenced LBHA/CSA. ☐

4. Our agency will comply with reporting requirements set forth by the Department for this program including but not limited to critical incident reporting (e.g. change of placement of a child, especially placement into a group home or group residential facility which will disqualify them from participation in the 1915(i) program). ☐

By signing this document, I declare and affirm that our organization will meet these requirements and adhere to all attestations contained herein.

_____

Signature of Authorized Agency Representative Date

_____

Printed Name and Title

_____

Applicant Organization Name

Principal Organizational Address: _____

Principal Organizational Phone: _____ Principal Organizational Fax: _____

Provider Site Address (for the referenced county): _____

Provider Site Phone: _____ Provider Site Fax: _____

STATE OF MARYLAND
MARYLAND DEPARTMENT OF HEALTH
MARYLAND MEDICAL ASSISTANCE

PROVIDER APPLICATION FOR PROVIDERS OF

MENTAL HEALTH CASE MANAGEMENT FOR ADULTS

As the authorized agent for_____, I hereby attest that our agency will :
Name of Agency

Initial

a. Meet the provider requirements for the Mental Health Case Management for Adults set forth in COMAR 10.09.45 ☐

b. Meet the requirements for General Medical Assistance Provider Participation Criteria set forth in COMAR 10.09.36 ☐

In addition, as a part this provider agreement, I also attest that our agency will adhere to the following specific requirements established by the Department and provide documentation to support each of them if applicable or requested:

1. Our agency has been selected by_____, the Core ☐

Service Agency for_____.(attach documentation)
(jurisdiction)

2. Our agency will explain to qualified Medical Assistance recipients the types of case management for which they may be eligible in addition to Mental Health Case Management for Adults. We will offer them ***a choice*** of case management from among these options. In order to fulfill this and other COMAR requirements, our agency will maintain a manual of policies and procedures that assure documentation of choices made by adult individuals and all other requirements stipulated in COMAR. I further attest these policies and procedures will be followed by our agency. ☐

3. Our agency will comply with the training requirements set forth by DHMH for provider participation in this program and maintain sufficient staff to assure that individuals and families are well served in their community as determined by both the Department and its local agent, the above referenced CSA. ☐

4. Our agency will comply with reporting requirements set forth by the Department for this program including. ☐

By signing this document, I declare and affirm that our organization will meet these requirements and adhere to all attestations contained herein.

_____

Signature of Authorized Agency Representative Date

_____

Printed Name and Title

_____

Applicant Organization Name

Address of the Provider Site
for the above referenced county_____

_____

Phone:_____ Fax_____

5/11/2016 (rts)

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