MARYLAND
Department of Health

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

PT GK - MEDICAL DAY CARE 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 (required if already enrolled in Maryland Medicaid):

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 document to ePREP :

1. Copy of tax ID number letter from the IRS
2. A copy of the staff organization chart pertaining to medical day care case management, listing names, titles, and contact information for each individual.
3. Completed case management provider attestation form (attached)
4. A copy of CPR certifications of staff member(s) who will be engaged in participant contact.

PROVIDER APPLICATION FOR MEDICAL DAY CARE CASE MANAGEMENT

Please initial the boxes below

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

(Name of Agency)

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

In addition, as a part of 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 Maryland Department of Health (Department) for _____(Jurisdiction), which is noted by the attached documentation. ☐

2. Our agency will explain to qualified Medical Assistance participants case management and the services for which they may be eligible. 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/authorized representatives and all other requirements stipulated by COMAR and departmental policy. I further attest that these policies and procedures will be followed by our agency. ☐

3. Our agency will comply with the training requirements set forth by the Department for case management services and participation in this program and maintain sufficient staff to assure that participants are well served in their community as determined by the Department. ☐

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., suspected neglect or abuse of a vulnerable individual, placement into a long term care/skilled nursing facility which will disqualify them from participation in the 1915(c) program). ☐

5. Our agency will comply with reporting requirements set forth by the Department for this program, including but not limited to submitting background checks performed by the Maryland Department of Public Safety and Correctional Services for each case manager and supervisor. ☐

6. Our agency will comply with the Final Work Plan submitted to the Department for case management participation in this 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:_____