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

PT 76 COMMUNITY OPTIONS

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

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

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:

Community Personal Assistance/Community First Choice/Home and Community Based Options Waiver - Please check all services that you intend to provide and upload this form, as well as a copy of the corresponding requirement(s) for each of the services checked, to ePREP (eprep.health.maryland.gov).

X	Service	Required Documentation
☐	Personal Assistance Services	1. Residential Services Agency License (Level 2 or 3, or Home Health Aide) 2. Medication Administration Policy 10.07.05.12 3. Staffing Requirements a. Registered Nurse (RN) b. Certified Nursing Assistant (CNA) c. Certified Medication Technician (CMT) *This requirement can be fulfilled by an additional RN or LPN (Licensed Practical Nurse), or by a CNA with CMT certification Four documents needed per staff member above: 1. License or Certification 2. CPR Card 3. Photo ID 4. CJIS Background Check (in the agency/business name)

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X	Service	Required Documentation
☐	Accessibility Adaptations	1. Proof that you are the store vendor or the company who sells, rents, installs, services, runs the device or service (i.e. promotional literature, brochure, website, etc.) 2. Trader or MHIC Licensing 3. Proof of Liability Insurance
☐	Assistive Technology	1. Proof that you are the store vendor or the company who sells, rents, installs, services, runs the device or service (i.e. promotional literature, brochure, website, etc.) 2. Trader or MHIC Licensing 3. Proof of Liability Insurance
☐	Behavioral Health Consultation	1. Registered Nurse, Psychologist, or Licensed Clinical Social Worker License 2. Photo ID 3. CJIS Background Check (in the agency/business name)
☐	Consumer Training	1. Agency License 2. Registered Nurse License or Credential of licensed professionals that may perform the services or resume of individuals that demonstrates experience developing and implementing skills that incorporate a consumer directed philosophy of services 3. Photo ID 4. CJIS Background Check (in the agency/business name)
☐	Dietician and Nutrition	1. Agency License 2. Dietitian or Nutritionist License 3. Photo ID 4. CJIS Background Check (in the agency/business name)

X	Service	Required Documentation
☐	Environmental Assessments **Individual**	1. Occupational Therapist License 2. Sample Assessment Form 3. Photo ID 4. CJIS Background Check (in the agency/business name)
☐	Environmental Assessments	1. Agency License (must state OT, PT, and Speech), which employs or contracts with an occupational therapist; or professional group employing a licensed occupational therapist 2. Sample Assessment Form 3. Occupational Therapist License 4. Photo ID 5. CJIS Background Check (in the agency/business name)
☐	Family Training	1. Agency License 2. Registered Nurse, Licensed Practical Nurse, Certified Medication Technician, Certified Nursing Assistant, Physician, Occupational Therapist, Physical Therapist, Speech Pathologist, Nutritionist, or Dietician License 3. Photo ID 4. CJIS Background Check (in the agency/business name)
☐	Home Delivered Meals	1. Proof of Food Services License issued by the local health department 2. Copy of most recent inspection (can be obtained by requesting from the jurisdiction associated with the provider service address)

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X	Service	Required Documentation
☐	Personal Emergency Response Systems	1. Proof that you are the store vendor or the company who sells, rents, installs, services, runs the device or service (i.e. promotional literature, brochure, website, etc.) 2. Trader or MHIC Licensing 3. Proof of Liability Insurance
☐	Senior Center Plus	1. Be approved and monitored by the Maryland Department of Aging as a nutrition service provider (Senior Center Plus Certificate) 2. Health Professional or Licensed Social Worker License

Section II:

Please check all area(s) you intend to serve. You may provide services in multiple jurisdictions.

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

Section III:

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 supports 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: __________________________