



Addendum for Participation in Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

PT 90 DDA

Additional documentation may be required to enroll as this provider type.

To obtain additional application materials, or if you have any questions, please contact the responsible DDA Provider Services Regional Team.

For additional assistance on completing the addendum, please contact the responsible DDA Provider Services Regional Office team.

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 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:

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 7am – 7pm.**



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Please indicate the type of application you are completing and follow the instructions associated with the application type:

Select:	Description:	Instructions:
<input type="checkbox"/> DDA Approved Service MA Application	Enroll a direct-pay enabled MA number to bill for all DDA Approved community-based services provided by your agency.	<ul style="list-style-type: none"> Complete Table 1, indicating all of the DDA approved community-based services provided by your agency (any site-based services at your admin location will require a licensed site MA application)
<input type="checkbox"/> DDA Licensed Site MA Application	Enroll a direct-pay enabled MA number to bill for site-specific, licensed services. This application is for a single licensed site .	<ul style="list-style-type: none"> Complete Table 2, indicating only the services that are rendered at the site you are applying for
<input type="checkbox"/> Supplemental (Update)	Update an existing MA number	Depending on the type of MA enrollment you are making an update to: <ul style="list-style-type: none"> Complete Table 1, if you are making an update to a DDA Approved Service MA number OR Complete Table 2, if you are making an update to a DDA Licensed Site MA number OR Complete Table 1 and 2, if you are making an update to a DDA Provider (before 7/1/20) MA number
<input type="checkbox"/> Revalidation	Revalidate (renew) an existing MA number	Depending on the type of MA enrollment you are making an update to: <ul style="list-style-type: none"> Complete Table 1, if you are revalidating a DDA Approved Service MA number OR Complete Table 2, if you are revalidating a DDA Licensed Site MA number OR Complete Table 1 and 2, if you are making an update to a DDA Provider (before 7/1/20) MA number



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Please complete the appropriate table based on the type of application you are submitting and the instructions above. Please attach the required documentation with your addendum submission.

TABLE 1: DDA APPROVED COMMUNITY-BASED SERVICES

Service	Required Documentation	Service	Required Documentation
<input type="checkbox"/> DDA Approved Behavioral Supports (2G) <ul style="list-style-type: none"> ○ Behavioral Assessment ○ Behavioral Plan ○ Behavioral Consultation ○ Brief Support Implementation Services 	DDA Service Approval Letter	<input type="checkbox"/> DDA Approved Community Development Services (2H)	DDA Service Approval Letter
<input type="checkbox"/> DDA Approved Employment Services (2I) <ul style="list-style-type: none"> ○ Discovery ○ Job Development ○ Follow Along Supports ○ Ongoing Job Supports ○ Co-worker Employment Supports ○ Customized Self-Employment 	DDA Service Approval Letter	<input type="checkbox"/> DDA Approved Fiscal Management Agency (2K)	DDA Service Approval Letter
<input type="checkbox"/> DDA Approved Family Supports (2J) <ul style="list-style-type: none"> ○ Family and Peer Mentoring Supports ○ Family Caregiver Training and Empowerment ○ Participant Education, Training and Advocacy 	DDA Service Approval Letter	<input type="checkbox"/> DDA Approved Housing Supports (2L)	DDA Service Approval Letter
<input type="checkbox"/> DDA Approved Nursing (2M) <ul style="list-style-type: none"> ○ Nurse Health Case Management ○ Nurse Case Management and Delegation 	DDA Service Approval Letter	<input type="checkbox"/> DDA Approved Organized Health Care Delivery System (2N) <ul style="list-style-type: none"> ○ Assistive Technology and Services ○ Environmental Assessment ○ Environmental Modification ○ Live-in Caregiver Supports 	DDA Service Approval Letter, Signed Organized Health Care Delivery System Form



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		<ul style="list-style-type: none"> ○ Respite – 15 minutes (Hourly) ○ Respite Daily (CLGH SITES ONLY) ○ Respite Camp ○ Transportation ○ Transition Services ○ Vehicle Modification 	
<input type="checkbox"/> DDA Approved Personal Supports (2O)	DDA Service Approval Letter	<input type="checkbox"/> DDA Approved Respite Care Services (2P) <ul style="list-style-type: none"> ○ Respite Care (Hour) ○ Respite Care (Camp) 	DDA Service Approval Letter
<input type="checkbox"/> DDA Approved Remote Support Services (2S)	DDA Service Approval Letter	<input type="checkbox"/> DDA Approved Supported Living (2R)	DDA Service Approval Letter
<input type="checkbox"/> DDA Approved Shared Living (2Q)	DDA Service Approval Letter	<input type="checkbox"/> DDA Approved Targeted Case Management Services (WA) (Coordination of Community Services)	DDA Service Approval Letter
<input type="checkbox"/> DDA Approved Vocational Services (2E) <ul style="list-style-type: none"> ○ Career Exploration – Large Group ○ Career Exploration – Small Group 	DDA Service Approval Letter		

Does your agency render services to individuals under the age of 21 (i.e. 20 years old and younger)? If yes, please submit required documentation.

Select:	Required Documentation
<input type="checkbox"/> Yes (2T)	Department (DDA and OHCQ) Approval to Render Services and Supports in DDA's Home and Community-Based Waivers - Children's Provider
<input type="checkbox"/> No	



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TABLE 2: DDA LICENSED SITE-BASED SERVICES

Service	Required Documentation	Service	Required Documentation
<input type="checkbox"/> Licensed DDA Community Living Services (2B) - formerly Residential Habilitation <ul style="list-style-type: none"> ○ Community Living - Group Home ○ Respite Care (Daily) <i>*Providers approved for Respite Daily AND CSW also need 2U COS Code</i>	DDA Service Approval Letter, OHCQ Issued DDA Facility License, OHCQ Site List	<input type="checkbox"/> Licensed DDA Community Living Enhanced Support Services (2A) <ul style="list-style-type: none"> - Community Living Enhanced <ul style="list-style-type: none"> ○ Supports 	DDA Service Approval Letter, OHCQ Issued DDA Facility License, OHCQ Site List
<input type="checkbox"/> Licensed DDA Day Habilitation (2C / 2D) <ul style="list-style-type: none"> ○ Day Habilitation 	DDA Service Approval Letter, OHCQ Issued DDA Facility License, OHCQ Site List	<input type="checkbox"/> Licensed DDA Vocational Services (2E / 2F) <ul style="list-style-type: none"> ○ Career Exploration <ul style="list-style-type: none"> - Facility Based 	DDA Service Approval Letter, OHCQ Issued DDA Facility License, OHCQ Site List

Are you authorized to provide services indicated above to individuals under the age of 21 (i.e. 20 years old and younger) at this site? If yes, please submit required documentation.

Select:	Required Documentation
<input type="checkbox"/> Yes (2T)	Department (DDA and OHCQ) Approval to Render Services and Supports in DDA's Home and Community-Based Waivers - Children's Provider
<input type="checkbox"/> No	



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To obtain additional application materials, or if you have any questions, please contact the responsible DDA Provider Services Regional Team.

Please include the following materials with your application:

- Full legal name, DOB and Contact Information for the Chair of the Board of Directors;
- Copy of tax ID number letter (IRS Letter);
- W-9 with address that matches Pay-To Address in application EXACTLY;
- DDA Service Approval Letter;
- OHCQ License, if applicable;
- OHCQ Site List, if applicable; and

General Conditions for Provider Participation

In addition to meeting all the requirements set forth in the Provider Agreement for Participation in Maryland Medical Assistance Program (the “Medicaid Provider Agreement”), each Provider must meet all of the following conditions to participate as a Provider in one of the Developmental Disabilities Administration’s (“DDA”) three Section 1915(c) Medicaid Home & Community Based Waiver Programs: Community Pathways Waiver, Family Supports Waiver, and Community Supports Waiver (each a “DDA Medicaid Waiver Program”). The terms “Services,” “Recipient,” “Department,” and “Provider” have the same meaning here as in the Medicaid Provider Agreement.

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

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 COMAR 10.09.26 (Community Pathways Waiver), COMAR 10.09.48 (Targeted Case Management or Coordination of Community Services), and the federally-approved DDA Medicaid Waiver Program application.¹
2. Meet all regulatory requirements to be licensed or approved as a DDA Provider set forth in COMAR Title 10, Subtitle 22, DDA Medicaid Waiver Program application requirements, and other

¹ You may access the Waiver application for the Community Pathways Waiver at:
<https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8492>.

You may access the Waiver application for the Community Supports Waiver at:
<https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=44862>.

You may access the Waiver application for the Family Supports Waiver at:
<https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=44861>.



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DDA requirements. If the provider is also a DDA Approved Children’s Provider, the provider must meet the requirements set forth in COMAR 14.31.05, COMAR 14.31.06, and COMAR 14.31.07.

____ 3. Agree to verify the qualifications of all individuals who render services on the Provider’s behalf and provide a copy of its verifications upon request to the Department. Qualifications include, but are not limited to, any applicable licensure or certification requirements, criminal background checks, and other staff / provider requirements set forth in the federally-approved DDA Medicaid Waiver Program application administered by the DDA, applicable regulations, or Department or DDA policies.

____ 4. Agree to comply with the DDA’s Policy on Reportable Incidents and Investigations (“PORII”), incorporated by reference at COMAR 10.22.02.01, including reporting incidents and complaints using the form and process designated by DDA.

____ 5. Agree to cooperate with required inspections, reviews, and audits by authorized governmental representatives, including but not limited to DDA, the Department’s Office of Health Care Quality, the Office of the Inspector General, Medicaid Program, and the Medicaid Fraud Control Unit, in accordance with § 7-909 of the Health-General Article of the Maryland Annotated Code and other applicable law and regulations.

____ 6. Agree to provide Services in accordance with the DDA Medicaid Waiver Program application requirements and applicable regulations and to bill the Department in accordance with applicable law, regulations, policies, and procedures, including limiting billing to only Services that have been authorized by DDA and actually rendered by the Provider to the Recipient.

____ 7. Agree to suspend, terminate, or reduce services for a Recipient in accordance with DDA policy and with appropriate authorization from DDA and consultation from the Recipient or the Recipient’s representative(s).

____ 8. Agree to work with the Recipient, or the Recipient’s representative(s), and their Coordinator of Community Services to implement the person-center plan and assist with transitioning a Recipient to new services and / or a new Provider as applicable.

____ 9. Agree to demonstrate substantial, sustained compliance in accordance with a Plan of Correction after a cited deficiency.



MARYLAND
Department of Health

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

Signature

Date