




## Welcome to the e PREP provider portal page!

1. For DDA Services Providers enrolling with Maryland Medicaid for the first time, you will need to create a user profile. In order to begin this process, please click the “Sign Up” hyperlink shown below:

 **Welcome to ePREP!**  
Let's Sign in

Best viewed in:  Chrome

  
**Maryland**  
DEPARTMENT OF HEALTH

Username

E-mail address

Don't have a User Profile? [Sign Up](#)

**⚠ WARNING! ⚠**

You have accessed Maryland Medicaid's Internal Test Site - **NOT** Intended For Public Use  
Applications submitted from this environment **WILL NOT** be processed by Maryland Medicaid.

To access Maryland Medicaid's Public Site [CLICK HERE](#)

2. On this page, you will enter your personal information (first and last name), create a username, password and fill in all corresponding information followed by selecting the “Next” button when completed.



### Welcome to ePREP!

My name is Lucy. I'm here to help you create your ePREP User Profile. This profile allows you to securely login to the ePREP Portal at any time (24/7) from an up-to-date web browser: Chrome, Firefox, Safari, IE Explorer.

Let's get started!

This is an CAPTCHA code being prepared. Please report a bug on about if you are seeing this.

I'm not a robot




By selecting Next you agree to the [Terms and Conditions](#).

Best viewed in  Chrome





3. In an attempt to increase security measures within the portal, please determine how you would like to receive your authentication code - once you have made your selection, please click 'Next'.




We have increased our security levels and need to **verify** your device.

Choose an [option below](#) to receive your security code.

Once you receive the code, you will enter it here in ePREP before you can login.

- Send text message to my phone number
- Call my phone number
- Send to my recovery email address

4. Please enter your 6 digit authentication code and click 'Verify'.



I'm sending you the verification code to this location. This code will expire in 90 minutes. This code can only be generated up to 5 times within a 24 hour period.

The verification code has been sent to your [Phone Number](#):

(410) \_\_\_\_\_

ePREP- Enter 6 digit Verification Code



**You did it!**

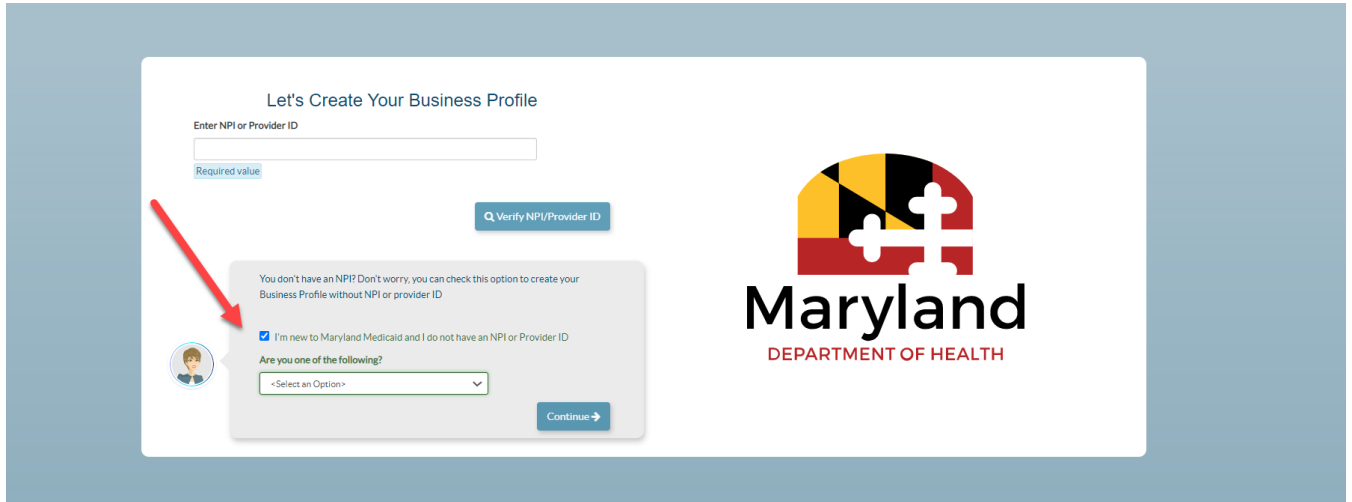


Select Login to continue

LOGIN

5. Once you have successfully entered and verified your security code, users will need to login for the first time with your username (email address) and password. Both of which were entered and created in the steps above.

6. Once you have entered your credentials, you will be asked to create your business profile. In order to do this, you must select “I’m new to Medicaid and I don’t have an NPI or provider ID.”



7. You will then be asked “Are you one of the following?” You will always select **Atypical Provider** for DDA Services. The question box will turn green, and you will be able to continue.



8. Once you have entered your business profile name. The business profile name box will turn green, and you will be able to create your business profile. (We recommend you use the legal business name, which can be found on your IRS letter.)

Let's Create Your Business Profile

Thank you! It looks like your organization is new to ePREP. Enter the Business Profile name that represents your organization. Create Business Profile

Business Profile Name  
Gold Hands, Inc

Create Business Profile

Maryland  
DEPARTMENT OF HEALTH

9. **Security questions portion:** please select and correctly answer three corresponding security questions as they pertain to your business. Once you have completed this portion, you will be able to continue moving forward through the business profile creation process by selecting “Next”.

First Question  
What is your date of birth?

Answer  
03/15/1988  
Correct Answer

Second Question  
What are the last 4 digits of your SSN?

Answer  
1234  
Correct Answer

Third Question  
What is your phone number for your service address?

Answer  
1234567890  
Correct Answer

Congratulations!  
You have successfully linked your account(s) to your Business Profile.  
To see your account(s) now click [here](#) or select continue to go

Maryland  
DEPARTMENT OF HEALTH

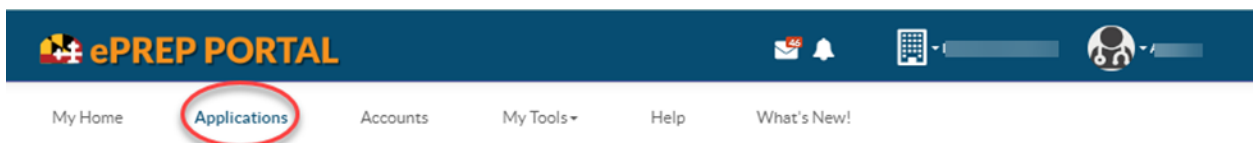
ePREP Portal  
Version: 4.15.12.0 Build #1235  
Copyright © 2019 Digital Harbor Inc. All rights reserved.

**\*\*It's important to note that sometimes these security questions are bypassed and are able to be completed later in the enrollment process\*\***

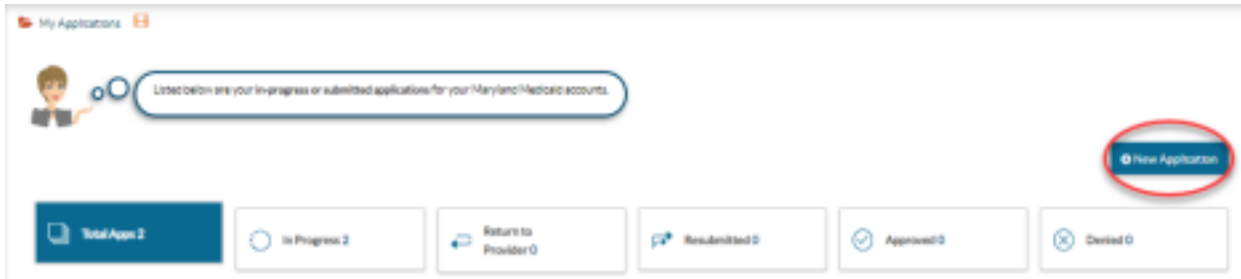
10. Once your business profile has been created, you will be taken to the e PREP home page shown below:



11. From here, please click the “My Applications” tab / or building with the “My Applications” heading attached shown above.



12. Once you have successfully entered the “My Applications” tab, you will need to create a new application in order to enroll your provider type with Maryland Medicaid. \*\*Circled in the screenshot below.\*\*



13. **Application generation:** Once you have clicked the “New Application” button, the following selection will need to take place in order to generate your enrollment application.

14. **Application Generation Selection:** please make the selections listed below:

- I'm new to Maryland Medicaid, and I want to create a new application
  - I'm a Facility, Clinic, Health Care Organization or Waiver Provider.
- (We are always a waiver provider with DDA Services)

Please answer this simple questionnaire to help me to determine the correct type of application for you. If you need help with any of these options, you can watch the [Questionnaire in-context tutorial](#). Let's get started!

I'm enrolled in Maryland Medicaid, and I want to create an application

I'm enrolled in Maryland Medicaid, and I want to affiliate with another provider

I'm new to Maryland Medicaid, and I want to create a new application

What kind of provider are you?

I'm an Individual health care practitioner

I'm a Group or FQHC health care practice

I'm a Facility, Clinic, Health Care Organization or Waiver Provider.

I want to revalidate or reenroll

I want to make changes to my account

Once you have made your choice, select **Continue**.

[← Previous](#) [Continue →](#)

Here three business structures are presented: Please select the third option “**Waiver Provider**”.



- **“Waiver Provider”**

Great! Now select the business structure which best fits you as a Facility, Clinic, Health Care Organization or Waiver Provider.

I need a Maryland Medicaid account to bill for health care services and I am applying as:

- Facility
- Other Health Care Organization
- Waiver Provider

Required value

Once you have made your choice, select Continue

[← Previous](#) [Continue →](#)

- Then you are asked are you a **“Solo Practitioner”** or **“Organization”**.


If you are a **Solo Practitioner**:

- You own the business 100 %
- You practice your business independently (no other employees)
- You are registered with the State Department of Assessment and Taxation (SDAT) as a sole practitioner

If you are an **organization**: Which most are with DDA Services.

- There are at least 2 or more employees for this business
- You are **not** registered as a sole proprietor with SDAT
- Your business provides and submits Maryland Medicaid claims for health care services at the location disclosed.

Select the option that best corresponds to your business and continue.



Great! Now select the business structure which best fits you as a Facility, Clinic, Health Care Organization or Waiver Provider.

I need a Maryland Medicaid account to bill for health care services and I am applying as:



- Facility
- Other Health Care Organization
- Waiver Provider
  - Solo Practitioner
  - Organization
    - This business provides and submits Maryland Medicaid claims for health care services at the location disclosed on my application.
    - This business is not a sole proprietorship.
    - The owners of this business are responsible for all this organizations obligations.

Once you have made your choice, select **Continue**

[← Previous](#) [Continue →](#)

You will now be asked your **Provider Type**:

- **Provider type** - in the drop-down box menu, please select the provider type **DDA Services Provider** and click continue.



Okay, you have chosen Waiver Organization for your application. Select your Provider Type from the drop-down list and press Continue.

**Provider Type**

DDA Services Provider

When you are ready, select **Continue**.

[← Previous](#) [Continue →](#)


**15. Successful Application Generation** - Once you have generated the application, you will be able to complete each required section from start to submission.


Application ID 229DORT7  
 Creation Date 09/09/2022  
 Package Type Waiver Organization

Content Expand All

- Getting Started
- Getting Started
- Business Information
- Practice Information
- Disclosure Information
- Signature
- Submit Application

Getting Started

In-Context Tutorials (ICTs) are available to assist in general areas of the Portal while filling out your application  
 Just look for the  icon.

Getting Started 

Familiarize yourself with all the elements of this page, including:

- Application structure
- Social tools
- Status indicators

Getting Started

Check out these other helpful ICTs for [Social Chat](#), [Explanations](#), [Share and Messages](#)

Continue →

## 16. Business Information:

Here you are asked to enter your business legal name. (As listed on your IRS letter).  
 Once you have entered your business legal name the name with turn green.

Content Expand All

- Getting Started
- Business Information
- Business Profile
- Contact Person
- Addresses
- Logistics
- Practice Information
- Disclosure Information
- Signature
- Submit Application

Business Profile TIN/SDAT & Business License Summary

Please share some basic information about your business.

Legal name  Required value

Does your business use a registered Doing Business As (DBA) name?  Yes  No Required value

Entity type  Required value

Business number  Required value


Extension

Global Hands, Inc Practice Website's URL

Previous Continue →


Please make sure to answer the following question correctly.

Does your business use a registered Doing Business As (DBA) name?  Yes  No



If you select “Yes”, please attached enter the DBA name and the DBA statement document.


Does your business use a registered Doing Business As (DBA) name?  Yes  No



DBA name

Required value

Doing Business As (DBA) statement

 Drag and drop here or [browse](#)  
50MB Maximum

17. **Entity Type:**

In this portion you will enter your Entity Type, the most common used for DDA services are:

- Corporation
- Limited Liability Company
- Non- profit 501 organization

If you select “**Corporation**” please upload Articles of Incorporation as seen below. Enter corporate number and state incorporated.

Does your business use a registered Doing Business As (DBA) name?  Yes  No

Entity type: Corporation

Articles of Incorporation: Drag and drop here or [browse](#) 50MB Maximum

Corporate number: [Empty field] Required value

State incorporated: <Select a State> Required value

Business number: [Empty field] Required value

Extension: [Empty field]

Global Hands, Inc Practice Website's URL: [Empty field]

← Previous Continue →

If you select “**Non-Profit 501(c)**” please upload 501(c) certificate along with your article of Incorporation.

Entity type: Non-profit Organization 501(c)

NPO - Non-profit Organization 501(c)

Drag and drop here or [browse](#) 50MB Maximum

**18. Business Number, Extension and Website’s URL:**

Enter your business number which is your personal number. If you have a website for your business enter the website’s URL.

Business number	<input type="text" value="(301) 779-9200"/>	88
Extension	<input type="text"/>	
Global Hands, Inc Practice Website's URL	<input type="text"/>	

### 19. TIN/SDAT & Business License:

The following segment you will enter your Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN). Along with your IRS letter in which they assigned you your TIN or EIN number.

All should have an (SDAT) number. An SDAT number is a 9-digit number issued by the State of Maryland department of assessment and taxation. If you do not know your number, you can find it here: <https://egov.maryland.gov/BusinessExpress/EntitySearch>


State Department of Assessment and Taxation (SDAT) number  N/A

Required value

[← Previous](#) [Continue →](#)

20. **Summary:** A summary will be generated with all the information entered in this section thus far. After reviewing the information, select continue.

Business Profile      TIN/SDAT & Business License      **Summary**

 Let's check it again to avoid any possible mistakes.

**Summary: Business Profile**

**Business Profile** [Edit](#)


Legal name      Global Hands , Inc

Does your business use a registered Doing Business As (DBA) name?

Yes  No

Entity type      Non-profit Organization 501(c)

NPO - Non-profit Organization 501(c)

 Drag and drop here or [browse](#)  
50MB Maximum

Business number


Extension

Global Hands , Inc Practice Website's URL

**TIN/SDAT & Business License** [Edit](#)

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)      88-008\*\*\*\*

TIN/EIN

 Drag and drop here or [browse](#)  
50MB Maximum

State Department of Assessment and Taxation (SDAT) number       N/A

## 21. *Contact Person Information:*

Please be sure to fill out the contact information correctly. **The contact person should be the managing employee of the application. If there are any questions regarding the application, this person will be the direct contact person. Additionally, this person can be contacted during regular business hours.**

The screenshot shows a web application interface for entering contact information. On the left is a sidebar with a 'Content' menu and an 'Expand All' button. The menu items are: Getting Started, Business Information (selected), Business Profile, Contact Person, Addresses, Logistics, Practice Information, Disclosure Information, Signature, and Submit Application. The main content area has a progress bar at the top with 'Contact Person Information' selected and 'Summary' next to it. A callout box with a woman icon asks: 'Who should I contact if I have questions about your application? Please choose a contact person who will be available during regular business hours.' Below this are seven form fields: First name, Last name, Title/Position, Business number, Extension, Fax Number, and Correspondence email address. Each field has a 'Required value' label below it. At the bottom are 'Previous' and 'Continue' buttons.

22. **Summary:** A summary will be generated with all the information entered in this section thus far. After reviewing the information, select continue.



Content Expand All

- Getting Started
- Business Information**
- Business Profile
- Contact Person**
- Addresses
- Logistics
- Practice Information
- Disclosure Information
- Signature
- Submit Application

Contact Person Information Summary

Who should I contact if I have questions about your application?  
Please choose a contact person who will be available during regular business hours.

**Summary: Contact Person**

**Contact Person Information** [Edit](#)

First name

Last name

Title/Position

Business number

Extension

Fax Number

Correspondence email address

### 23. *Service Address:*

It important to remember the **Service Address** will change during each phase. For Phase 1- the Service Address you should enter should be the administrative office location. Please do not enter a P.O. Box. Enter physical location only.

Content Expand All

- Getting Started
- Business Information**
- Business Profile
- Contact Person
- Addresses**
- Logistics
- Practice Information
- Disclosure Information
- Signature
- Submit Application

Service Address
Pay to Address
Mailing Address
Summary

Your Maryland Medicaid account is based on the location where health care services will be provided. As you type, a suggested address will appear that can auto-fill the rest of the form for you. Remember that a P.O. box cannot be used as a service address.

[View Address](#)

Street  Required value

Ste. / Apt. #

City  Required value

State/Province  Required value

County  Required value

ZIP Code/Postal Code  Required value

Please make sure to answer the following questions correctly. The first question all should answer “Yes”.

Is this service location ADA (American Disabilities Act) accessible?  Yes  No

Does this service location have TTY capability?  Yes  No

← Previous Continue →

#### 24. Pay to Address:

Here you will enter the address of where you want to receive payment for the services provided. If it's the same address as your administrative location, you can select Same as Service Address as shown below:

Content Expand All

- Getting Started
- Business Information**
  - Business Profile
  - Contact Person
  - Addresses**
  - Logistics
- Practice Information
- Disclosure Information
- Signature
- Submit Application

Service Address **Pay to Address** Mailing Address Summary

Please let me know the address where you want to receive payments.

Same as Service address

[View Address](#)

Street: 19 Bell Ln

Ste. / Apt. #: Suite/Apt

City: Whaleyville

State/Province: Maryland, MD

County: Worcester

ZIP Code/Postal Code: 21872-0000

← Previous Continue →

**However, if you would like payments to be sent to a P.O. Box you can add the address.**

25. **Mailing Address:** Please enter an address where you would like MDH to send you official correspondence. Again, you are given the option of selecting the same as service address or same as pay to address. You can even enter a different address. Once the information has been entered. Select Continue.

The screenshot shows a web application interface for entering a mailing address. On the left is a navigation menu with categories: Getting Started, Business Information (selected), Practice Information, Disclosure Information, Signature, and Submit Application. The 'Business Information' section includes sub-items: Business Profile, Contact Person, Addresses (highlighted), and Logistics. The main content area has a progress bar at the top with four steps: Service Address, Pay to Address, Mailing Address (current step), and Summary. A callout bubble with a person icon says: "Last step! Add a mailing address where you want receive official Maryland Medicaid correspondence." Below this are two checkboxes: "Same as Service address" (checked) and "Same as pay to address." (unchecked). A "View Address" link is present. The address fields are: Street (19 Bell Ln), Ste./ Apt. # (Suite/Apt), City (Whaleyville), State/Province (Maryland, MD), County (Worcester), and ZIP Code/Postal Code (21872-0000). At the bottom are "Previous" and "Continue" buttons, with the "Continue" button circled in red.

26. **Summary:** A summary will be generated with all the information entered in this section thus far. After reviewing the information, select continue.

**27. Logistics & Practice Operation:**

In this portion you will specify the hours of operations for your business. More importantly your admin hours.

Once you have selected “Open on specific business days/hours “you are able to change the hours/days” accordantly. As shown below:

Content Expand All

Getting Started ●

**Business Information** ●

- Business Profile ●
- Contact Person ○
- Addresses ●
- Logistics ○

Practice Information ○

Disclosure Information ○

Signature ○

Submit Application ●

---

**Practice Operations** Summary

Now for some more information about your business. Please answer these questions so I can learn more about your operations.

What are the business hours for this service location?  Open 24/7  
 Open on specific business days/hours

Monday	From <input type="text" value="08:00 AM"/>	To <input type="text" value="05:00 PM"/>
Tuesday	From <input type="text" value="08:00 AM"/>	To <input type="text" value="05:00 PM"/>
Wednesday	From <input type="text" value="08:00 AM"/>	To <input type="text" value="05:00 PM"/>
Thursday	From <input type="text" value="08:00 AM"/>	To <input type="text" value="05:00 PM"/>
Friday	From <input type="text" value="08:00 AM"/>	To <input type="text" value="05:00 PM"/>
Saturday	From <input type="text" value=""/>	To <input type="text" value=""/>
Sunday	From <input type="text" value=""/>	To <input type="text" value=""/>

Please make sure to answer the following questions correctly.

Has the staff of  , Inc completed cultural competence training?  Yes  No

Is  Inc accepting new patients?  Yes  No

For the following question **“What is the age range of the individual that will be treated at the location?”** you are able to enter the specific ages you were approved to provide services. (Note if you are providing services to DDA Adults the age for an adult starts at age 21.)

You will only select **“All ages”** if approved to provide services for youth and adults.

Has the staff of [redacted], Inc completed cultural competence training?  Yes  No ⌘

Is [redacted], Inc accepting new patients?  Yes  No ⌘

What is the age range of the patients that will be treated at this service location?  Enter age range  All ages ⌘

Starting age

⌘

Up to

[Required value](#)

The last question in this segment allows you to add the languages provided in your administrative location. As shown below:

Does [redacted], Inc provide language services to their patients, other than English, at this location?  Yes  No ⌘

Language Services Offered

- Spanish
- Portuguese
- Italian
- French
- Japanese
- Cantonese
- Mandarin
- Other Chinese
- Korean
- German
- Arabic
- Armenian
- Cambodian
- Farsi
- Hmong
- Vietnamese
- Russian
- Tagalog
- Hindi

⌘

[← Previous](#) [Continue →](#)

28. **Summary:** A summary will be generated with all the information entered in this section thus far. After reviewing the information, select continue.

Getting Started

Business Information

- Business Profile
- Contact Person
- Addresses
- Logistics

Practice Information

Disclosure Information

Signature

Submit Application

Practice Operations Summary

Thanks for all those details. Take a quick look at what you gave me to check for any errors. You can always select Edit to make a correction.

Summary: Logistics

Practice Operations Edit

What are the business hours for this service location?

Open 24/7

Open on specific business days/hours

Monday	From 08:00 AM	To 05:00 PM
Tuesday	From 08:00 AM	To 05:00 PM
Weonnesday	From 08:00 AM	To 05:00 PM
Thursday	From 08:00 AM	To 05:00 PM
Friday	From 08:00 AM	To 05:00 PM

Has the staff of [redacted], Inc completed cultural competence training?

Yes  No

Is [redacted], Inc accepting new patients?

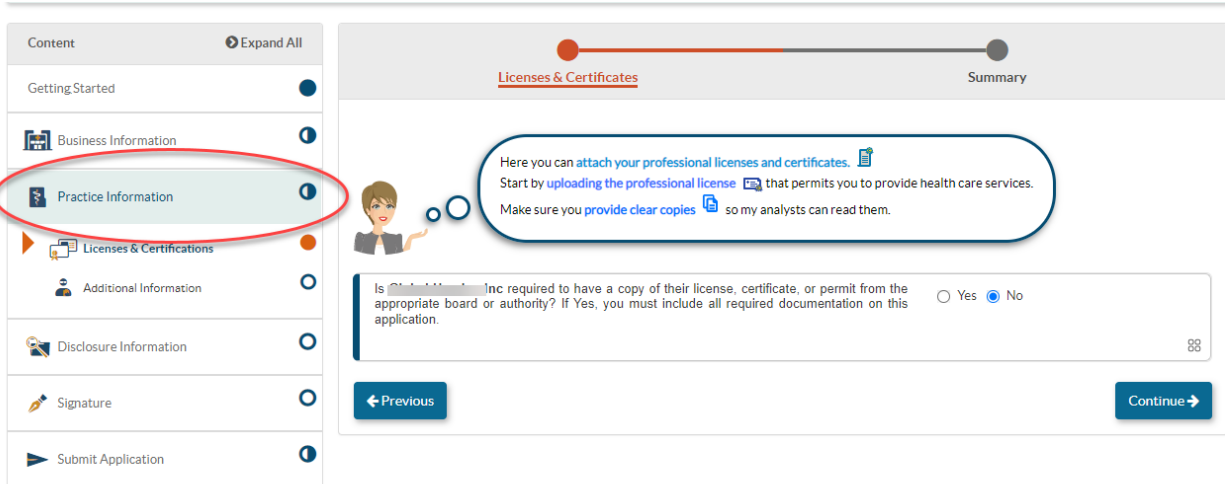
Yes  No

What is the age range of the patients that will be treated at this service location?

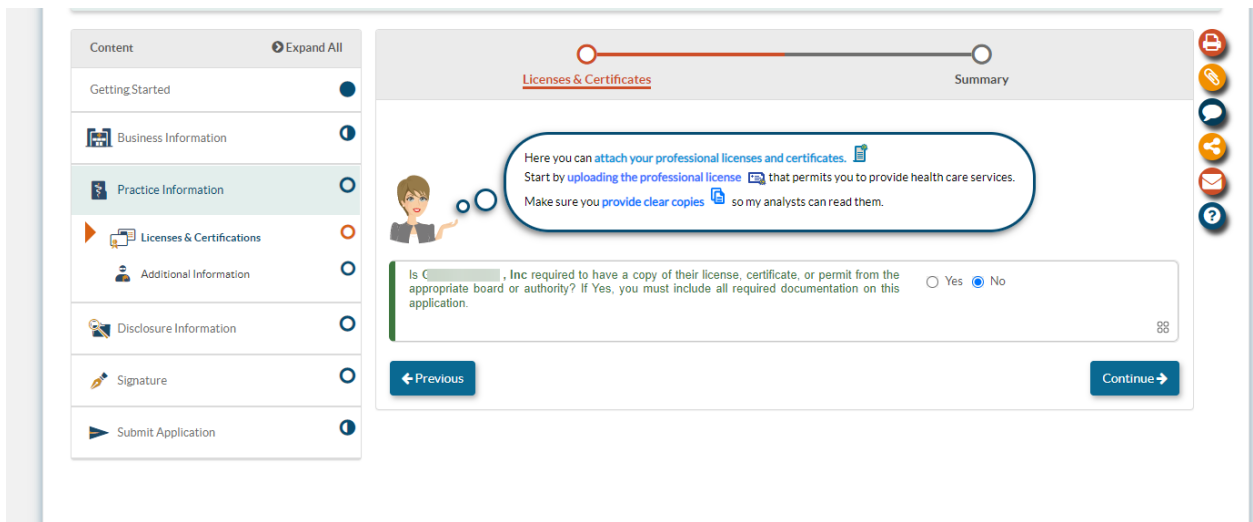
Enter age range  All ages

Starting age	21
Up to	100

29. **Practice Information:** Please enter all provider information into the corresponding data fields within this section. Select continue, after all information has been added.

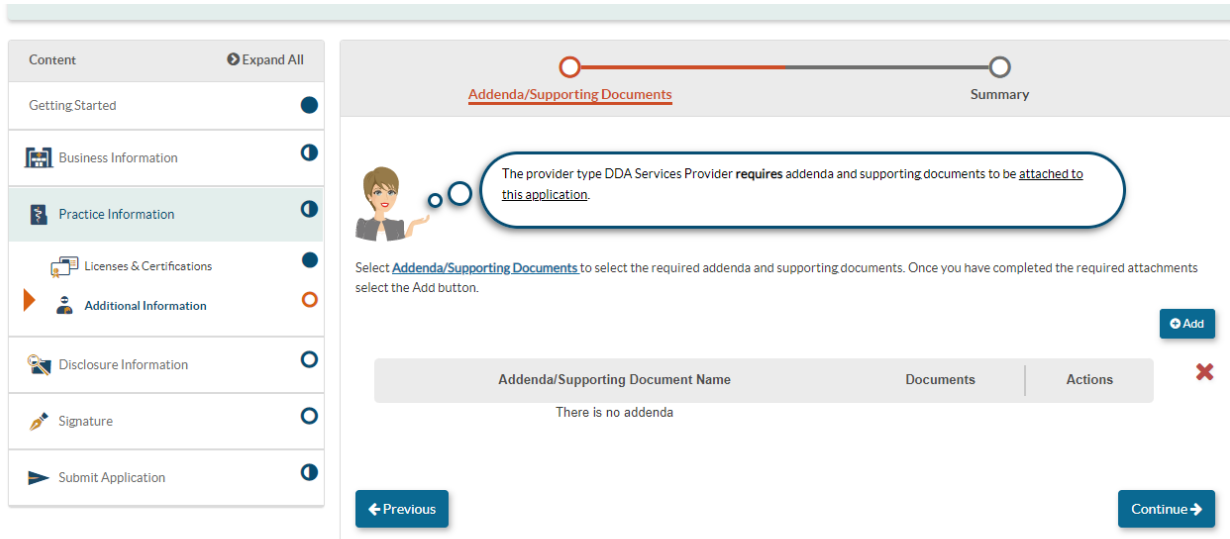


30. **Licenses & Certification:** All DDA providers will answer “No” in this section at all phases.

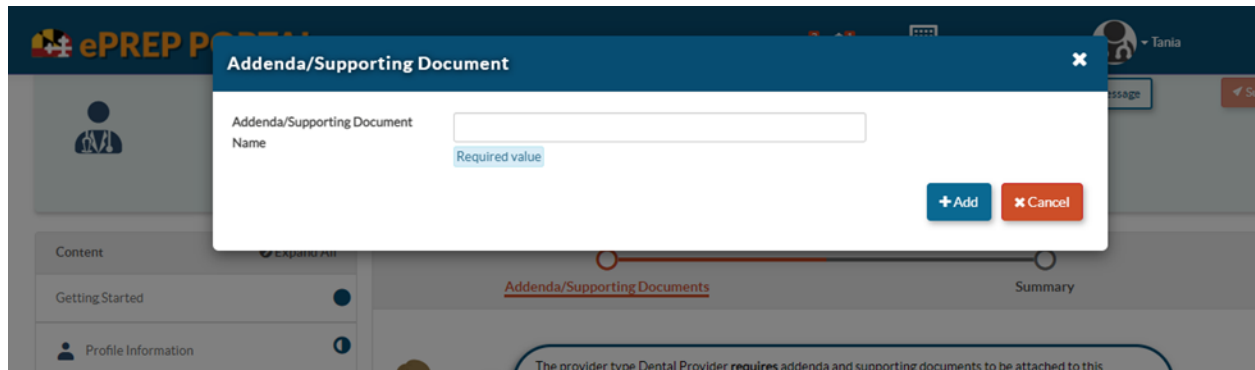


31. **Additional Information:** The **DDA Services** provider type has a required addendum that must be uploaded to the application submission.





- Select the +ADD button to upload the addenda. In this section, you can also add any other supporting documents. Please click on the ‘Add’ button to name the Addendum.



**32. Addenda/ Supporting Documents** - Please be sure to attach the Medical Assistance Program Application Addendum

- **PT 90 – DDA Provider** is the correct addenda needing to be attached to this section of the application.
- You can find the needed Addendum by going to the Maryland Medicaid website or by clicking on the following link and downloading the Addendum:

<https://health.maryland.gov/mmcp/Pages/Provider-Enrollment.aspx>

**PT 90 – DDA Provide Services Addendum Example Phase 1:**



**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 relations regional team.

**For additional assistance on completing the addendum, please contact the responsible DDA Provider Relations regional team.**

- SMRO – [smro.providerrelations@maryland.gov](mailto:smro.providerrelations@maryland.gov)
- CRMO – [cmro.providerrelations@maryland.gov](mailto:cmro.providerrelations@maryland.gov)
- ESRO – [esro.providerrelations@maryland.gov](mailto:esro.providerrelations@maryland.gov)
- WMRO – [wmro.providerrelations@maryland.gov](mailto:wmro.providerrelations@maryland.gov)

All providers are required to use the electronic **Provider Revalidation and Enrollment Portal**, or ePREP ([eprep.health.maryland.gov](http://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](http://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](http://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.**

On page 2, of the addendum please select” **DDA Approved Service MA Application**”.

You are then instructed to completed **Table 1 only**. As shown in the instruction box in red.



**MARYLAND**  
Department of Health

**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 relations regional team.

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

Select:	Description:	Instructions:
<input checked="" 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 (7/1/20 and after).	<ul style="list-style-type: none"> <li>Complete Table 1, indicating all of the DDA approved community-based services provided by your agency</li> <li><i>If you render licensed site-based services at your primary office address, please complete Table 2, indicating the licensed services rendered at that address</i></li> </ul>
<input type="checkbox"/> DDA Licensed Site MA Application	Enroll a direct-pay enabled MA number to bill for site-specific, licensed services (7/1/20 and after). This application is for a <b>single licensed site</b> .	<ul style="list-style-type: none"> <li>Complete Table 2, indicating <b>only</b> the services that are rendered at the site you are applying for</li> </ul>
<input type="checkbox"/> DDA Provider (before 7/1/20)	Enroll as a Maryland Medical Assistance DDA Provider to provide DDA services (before 7/1/20).	<ul style="list-style-type: none"> <li>Complete Table 1 and 2. For Table 2, please indicate the licensed services rendered at <b>all</b> locations</li> </ul>
<input type="checkbox"/> 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"> <li>Complete Table 1, if you are making an updated to a DDA Approved Service MA number</li> <li><b>OR</b></li> <li>Complete Table 2, if you are making an update to a DDA Licensed Site MA number</li> <li><b>OR</b></li> <li>Complete Table 1 and 2, if you are making an update to a DDA Provider (before 7/1/20) MA number</li> </ul>


V2 2021 effective 1/06/2021

Page 2 of 8

**PT 90 DDA**

**Table 1: DDA Approved Community – Based Services**

On page 3, Please only select services in which you have been approved. **Don't select services you have not been approved for.**



**MARYLAND**  
Department of Health

**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 relations regional team.

---

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

Page 3 of 8

V2 2021 effective 1/06/2021
PT 90 DDA

At the end of **Table 1**: You are asked if you have been approved to provide services to the youth. If so, you will select “Yes” if not you will select “NO”.

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	

Additional information is needed to upload in this portion of the application. The following documents are required:

- **IRS Letter**
- **Board of Directors- full names, DOB, and Contact Information**
- **OHCQ License**
- **DDA Approval Letter**
- **PT 90 addenda**

Please select continue once the documents have successfully been uploaded to the application.


The screenshot displays the 'Addenda/Supporting Documents' section of an application. On the left is a sidebar with navigation items: Getting Started, Business Information, Practice Information (highlighted), Licenses & Certifications, Additional Information, Disclosure Information, Signature, and Submit Application. The main content area has a header with 'Addenda/Supporting Documents' and 'Summary'. A callout box with a woman icon states: 'The provider type DDA Services Provider requires addenda and supporting documents to be attached to this application.' Below this, text reads: 'Select [Addenda/Supporting Documents](#) to select the required addenda and supporting documents. Once you have completed the required attachments select the Add button.' An 'Add' button is visible. A table lists the required documents:

Addenda/Supporting Document Name	Documents	Actions
IRS Letter	<a href="#">Attach</a>	<a href="#">Edit</a> <a href="#">Delete</a> <a href="#">More</a>
Board of Directors	<a href="#">Attach</a>	<a href="#">Edit</a> <a href="#">Delete</a> <a href="#">More</a>
OHCQ License	<a href="#">Attach</a>	<a href="#">Edit</a> <a href="#">Delete</a> <a href="#">More</a>
DDA Approval Letter	<a href="#">Attach</a>	<a href="#">Edit</a> <a href="#">Delete</a> <a href="#">More</a>
PT 90 Addenda	<a href="#">Attach</a>	<a href="#">Edit</a> <a href="#">Delete</a> <a href="#">More</a>

Below the table, it says 'Showing 5 records per page.' and 'Page 1 of 1'. At the bottom are 'Previous' and 'Continue' buttons.

33. **Summary:** A summary will be generated with all the information entered in this section thus far. After reviewing the information, select continue.

Addenda/Supporting Documents Summary



Okay, your provider type **DDA Services Provider** requires specific addenda to be included in this application for enrollment approval. Please add them by selecting the hyperlink.

Summary: Additional Information

Addenda/Supporting Documents Edit

Addenda/Supporting Document Name	Documents	Actions
IRS Letter	<a href="#">Attach</a>	
Board of Directors	<a href="#">Attach</a>	
OHCQ License	<a href="#">Attach</a>	
DDA Approval Letter	<a href="#">Attach</a>	
PT 90 Addenda	<a href="#">Attach</a>	

Showing  records per page. < >

← Previous
Continue →

**34. Disclosure Information:**

**Adverse Action:** Please fill out any adverse action information.

Content Expand All

- Getting Started
- Business Information
- Practice Information
- Disclosure Information
  - Adverse Actions**
  - Fines and Debts (Gov.)
  - Subcontractors
  - Ownership/Control Interest
  - Significant Transactions
  - Delegated Officials
- Signature
- Submit Application

Contract/Program Actions
Summary

Now please provide information about any adverse actions as specifically asked in the following questions with a clear copy of each requested document.  
This information must be accurate, complete and true to the best of your knowledge and belief.

Has **ChloroAlloys, Inc** been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid program in Maryland or in any other State, Medicare, or any governmental or private medical insurance program? Yes  No

Required value

Has **ChloroAlloys, Inc** ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense against public administration or against public health and morals in any State? Yes  No

Required value

Has **ChloroAlloys, Inc** ever been found liable for fraud or abuse involving a government program in any civil proceeding? Yes  No

Required value

Has **ChloroAlloys, Inc** ever entered into a settlement to resolve a proceeding related to fraud or abuse involving a government program? Yes  No

Required value

Has **ChloroAlloys, Inc** ever had their business or professional license or certification suspended, surrendered, or in any way restricted by probation or agreements by any licensing authority in the state? Yes  No

Required value

Are there currently any proceedings that could result in the above-stated sanctions? Yes  No

Required value

← Previous
Continue →

Once you have completed the adverse action page, please click continue. Please fill out any fines or debts that the organization has. If the organization has none, please check the box shown in the screenshot below: Select continue.

Content Expand All

- Getting Started
- Business Information
- Practice Information
- Disclosure Information
  - Adverse Actions
  - Fines and Debts (Gov.)**
  - Subcontractors
  - Ownership/Control Interest
  - Significant Transactions
  - Delegated Officials
- Signature
- Submit Application

Fines and Debts (Gov.)
Summary

If you have any fines or debts to any organization related to Medicare, Medicaid or any other federal or state health care programs, please let me know of your payment arrangements.

This business has no current State or Federal government Fines/Debts Add

Type	Agency Name	Amount	Date Issued	Date to be Paid-in-full	Documents	Actions
No Fines/Debts listed						

← Previous
Continue →

### 35. *Subcontractors:*

Please answer 'Yes' or 'No' to this question as it corresponds to your organization.

Content Expand All

- Getting Started
- Business Information
- Practice Information
- Disclosure Information
- Adverse Actions
- Fines and Debts (Gov.)
- Subcontractors
- Ownership/Control Interest
- Significant Transactions
- Delegated Officials
- Signature
- Submit Application

Subcontractors Summary

Thanks for the information! Before moving on, please check this page for accuracy, and make any changes if needed.

Summary: Subcontractors

Subcontractors Edit

Does [redacted] have any subcontractors to which the applicant has contracted or delegated some of its management functions or responsibilities of providing healthcare services, equipment, or supplies or with whom the applicant has entered into a contract, agreement, purchase order, lease, or leases of real property, to obtain space, supplies, equipment, or services provided under the Maryland Medicaid Program?

Yes  No

Previous Continue

### 36. *Ownership/ Control Interest:*



- Please click ‘Add.’ Please enter each board member's name and address.
- Please identify if the organization is owned by an entity or an individual.

Once you have made the appropriate selection: entity or individual; please list the name and select + add to continue.

**Add Ownership/Control Interest** ✕

Entity  Individual

First name   
Required value

Middle name

Last name   
Required value

+ Add ✕ Cancel

Please fill out the ownership individual/entity information.

**Individual Information**

Ownership/Control  
Interest

Associations

Adverse Actions

Summary

Please enter the following information

First name

Middle name

Last name

Primary Residence Address

[View Address](#)

Street   
Required value


Ste. / Apt. #


City   
Required value



State/Province   
Required value

County   
Required value


ZIP Code/Postal Code   
Required value

Social Security Number    
Required value

National Provider Identification (NPI)  N/A 

Date of birth     
Required value

Age

Does  currently participate or has ever participated as a provider in the Maryland Medicaid program or in another states' Medicaid program?  Yes  No  
Required value 

[Continue →](#)

Please make the appropriate selection for the individual/ entity listed as it corresponds to their ownership involvement:

- The example shown below illustrates how you will need to add your Board President, Director, or Chair of the Board.

**You will need to select “Board Member”, enter the date in which they joined the organization, and select “other “then enter under Specify their title within the organization.**

Individual Information Ownership/Control Interest Associations Adverse Actions Summary

Please select one or more of the options that apply to:

5% or more Ownership Interest

Partnership

Board Member

Effective date of control  
09/05/2022

Managing Employee

Agent

Director/Officer

Other

Specify  
Director

Effective date  
Required value

← Previous Continue →

Please answer the 'Yes' or 'No' questions about the associations involving the entity or individual

Individual Information    Ownership/Control Interest    Associations    Adverse Actions    Summary

Associations/Family relations with subcontractors and owners of subcontractors

Ownership of 5% or more on any subcontractor

Does T [redacted] have ownership with any of [redacted], Inc subcontractors disclosed in this application?  Yes  No  
Required value 88

Family Relations with subcontractor or subcontractor's owner(s)

Does T [redacted] have family relations with an [redacted] s, Inc subcontractors disclosed in this application?  Yes  No  
Required value 88

Does [redacted] o have any family relations with any owner(s) of [redacted], Inc subcontractors?  Yes  No  
Required value 88

Associations/Family Relations with Individuals (owners/control interest of Applicant)

Is Ta [redacted] affiliated with any Entities or is family related to any Individuals disclosed in this application?  Yes  No  
Required value 88

Other Associations

Does [redacted] have any ownership or Control Interest in any other health care provider participating or not participating in Maryland Medicaid?  Yes  No  
Required value 88

[← Previous](#) [Continue →](#)

**37. Adverse Actions:**

Please answer 'Yes' or 'No' to the questions involving any adverse actions associated with the individual listed:

Content Expand All

- Getting Started
- Business Information
- Practice Information
- Disclosure Information
- Adverse Actions
- Fines and Debts (Gov.)
- Subcontractors
- Ownership/Control Interest
- Significant Transactions
- Delegated Officials
- Signature
- Submit Application

Individual Information
Ownership/Control Interest
Associations
Adverse Actions
Summary

**Program Actions**

Has [redacted] ever terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid program in Maryland or in any other State, Medicare, or any governmental or private medical insurance program?  Yes  No

Required value

88

Has [redacted] ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense against public administration or against public health and morals in any State?  Yes  No

Required value

88

Has [redacted] ever been found liable for fraud or abuse involving a government program in any civil proceeding?  Yes  No

Required value

88

Has [redacted] ever entered into a settlement to resolve a proceeding related to fraud or abuse involving a government program?  Yes  No

Required value

88

Has [redacted] ever had their business or professional license or certification suspended, surrendered, or in any way restricted by probation or agreements by any licensing authority in the state?  Yes  No

Required value

88

Are there currently any proceedings that could result in the above-stated sanctions?  Yes  No

Required value

88

← Previous
Continue →

**38. Significant Transactions:** Please mark 'Yes' to the following question:

Content Expand All

- Getting Started
- Business Information
- Practice Information
- Disclosure Information
- Adverse Actions
- Fines and Debts (Gov.)
- Subcontractors
- Ownership/Control Interest
- Significant Transactions
- Delegated Officials
- Signature
- Submit Application

Significant Transactions
Summary

Please carefully read this question and answer accordingly.

I, [redacted], agree that upon request by the Secretary of the Maryland Department of Health, or the Maryland Department of Health, full and complete information will be supplied within 35 days of the date of request, concerning:

A. The ownership of any subcontractor with which the Title XIX Provider has had, during the previous 12 months, business transactions in an aggregate amount in excess of **\$25,000.00** and

B. Any significant business transactions, occurring during the 5 year period ending on the date of such request, between the provider and any wholly-owned supplier or subcontractor.

Yes  No

88

← Previous
Continue →

### 39. **Delegated Officials:**

Please list any associated delegated officials in this section of the application by selecting the 'Add' option. Should your organization chose not to disclose any delegated officials at this time, please check the option shown below. Note that all individuals identified in the Ownership/Control Interest section **can already act** as a delegated official for the business.

Content Expand All

- Getting Started
- Business Information
- Practice Information
- Disclosure Information
- Adverse Actions
- Fines and Debts (Gov.)
- Subcontractors
- Ownership/Control Interest
- Significant Transactions
- Delegated Officials**
- Signature

Delegated Officials Summary

Here's where you can designate all Delegated Officials for your health care business. A Delegated Official is either 1) an individual with ownership/control interest or 2) a W-2 employee (not a contractor) to whom you wish to give authorization to sign Affiliate applications on behalf of your Group or Organization.

Adding a Delegated Official is optional. If you choose not to add one, that means only your Group/Organization's authorized individuals may sign Affiliate applications.

Inc does not want to report any Delegated Officials at this time.

**Add**

Legal Name	Reported by	Added Date	Last Update	Status	Actions
No Delegated Officials listed.					

**40. Signature Portion:** Please read the required provider agreement and click 'Agree' Please fill out the required information to sign the application and once completed, click submit:



Content Expand All
Declarations
E-Signature
Summary

Getting Started

Business Information

Practice Information

Disclosure Information

Signature

E-Signature

Submit Application

You're almost ready to sign your application!

Even though you're completing and submitting your application through ePREP Portal and not on paper, your signature is still required. Using the electronic signature feature, you can submit this application just like your handwritten signature.

Please read the Maryland Medicaid Provider Agreement, and then check the boxes to declare that you agree with this process.

Please note that in order to continue with the e-Signature process, you must read the Provider Agreement.

[Maryland Medicaid Provider Agreement](#)  
review is required

I, [redacted] have read, understood, and agree with the terms of the Maryland Medicaid Provider Agreement.

Required value

I, [redacted] declare that I have legal authorization to sign this application for and on behalf of GLOBAL HANDS, INC.

Required value

I, [redacted] have reviewed my application and believe all information and attachments are correct to the best of my knowledge.

Required value

I, [redacted] declare under penalty of perjury under the laws of Maryland that the foregoing information and the information on all attachments is true, accurate and complete, to the best of my knowledge and belief, and that I am authorized to sign this application pursuant to State Regulations.

Required value

← Previous
Continue →

41. **E- Signature:** Please fill out the required fields and select continue.

Content

- Getting Started
- Business Information
- Practice Information
- Disclosure Information
- Signature
- E-Signature**
- Submit Application

Declarations **E-Signature** Summary

To continue with the e-Signature process, I need to verify your personal information.  
 After agreeing to the declaration, make sure your Social Security Number and Date of Birth **are identical** to what you entered in the **Personal Information** section of the **Ownership/Control Interest** sub-form.  
 Please treat this section the same way as if you were using your PIN at an ATM.

If you need help with this section, please watch this In-Context Tutorial about e-signing a Group application.

I, [redacted], agree that my electronic signature is attributable as defined in Commercial Law Article § 21-208.

SSN (last 4 digits) [input field]

Year of birth [input field]

Email address [input field]

Password [input field]

[← Previous](#) [Continue →](#)

42. Before submitting the application. A final checklist will appear.

- Submit Application**
- Checklist
- Submit

43. A green check mark will be seen, if all documentation associated with each section's data fields has been completed. If a document has not been uploaded, or the corresponding data associated with a portion of the application is missing, a red X will appear next to the incomplete section.

Form/SubForm/Section	Documents	Social Chat	Explanations	Messages	Shared	Complete	% Completed	Actions
Getting Started						✓	100	
Getting Started						✓	100	
Business Information						✗	50	
Business Profile						✗	0	

44. Once all sections have a green check mark. Application is ready to be submitted. Select Submit Application.

The screenshot displays the application submission interface. On the left, a sidebar menu lists various sections: Getting Started, Business Information, Practice Information, Disclosure Information, Signature, Submit Application (highlighted), Checklist, and Submit. The main content area features a 'Submit Application' button circled in red. Above this button, a message box with a cartoon character says: "Oops! It seems your application isn't ready to be submitted. Please review the checklist again to be sure you have added all the required documents." Below the message, there is a link to "Show common mistakes that cause application deficiencies" and a "Show Me" button. At the bottom of the main content area, there is a "Previous" button.

***Should you have any additional questions regarding the enrollment process, please contact us at: [mdh.providerenrollment@maryland.gov](mailto:mdh.providerenrollment@maryland.gov)***

***Once you have successfully completed phase I, you will receive a base MA# to bill for unlicensed services in our LTSS billing system. This billing includes billing for:***

- ***Personal Supports (via EVV), and***

- *Supported Living*