DEVELOPMENTAL DISABILITIES ADMINISTRATION
ORGANIZED HEALTH CARE DELIVERY SYSTEM APPLICATION
COMMUNITY PATHWAYS WAIVER

Provider Name:_____ Medicaid Provider Number: _____
Provider Address: _____

_____

Provider Phone:_____ Provider Email Address: _____

By submitting this application,_____(agency name), seeks certification from the Developmental Disabilities Administration (DDA) to be an Organized Health Care Delivery System (OHCDS). As an OHCDS,_____(agency name), will have authorization to subcontract with qualified providers to provide approved waiver services for individuals served through DDA.

I,_____(name),_____(title-CEO or Board President) of _____(agency name), have the authority to bind the organization and attest as follows:

1. _____(agency name) provides at least one Medicaid service directly (with its own employees).
2. _____(agency name) maintains good standing as a DDA and Medicaid provider.
3. All Subcontractors will meet all applicable regulatory and industry standards (including where COMAR 10.22 applies).
4. _____(agency name) will submit claims for Federal Financial Participation (FFP) monthly, or as otherwise stipulated by DDA.
5. _____'s (agency name) administrative fee for providing the service shall not exceed 15% of the total cost of the service provided.
6. In the performance of duties as an OHCDS,_____(agency name) will comply with all aspects of the DDA provider contract.
7. _____(agency name) will maintain detailed records, available for DDA, its designee, or respective consumer, review at any time, on the purchase of services from qualified entities or individuals.
8. _____(agency name) will submit, in addition to all other DDA required reports and statements, an aggregate annual summary, on a form developed by DDA, delineating OHCDA activities, including subcontractor names, amounts paid per subcontractor, nature of services, and number of individuals served by each subcontractor. This report will be due within 30 days of the close of the State fiscal year.

I attest that_____(agency name) will abide by the stipulations above, will notify DDA immediately of any changes, and will abide by any additional relevant governing authority.

_____ _____
Date Signature of CEO or Board President

I hereby certify that_____(agency name) is approved by the DDA as an OHCDS in Maryland. The DDA maintains the right to rescind this certification at any time that _____(agency name) does not comply with this agreement.

_____ _____
Date Signature of Deputy Secretary of DDA or Designee