

Welcome to the e PREP provider portal page!

1. New providers / groups enrolling with Maryland Medicaid for the first time 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

Username

E-mail address

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

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!

First name Last name

Username

Password Confirm

Phone number

Recovery email address



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) _____

[BACK](#) [CALL INSTEAD](#) [VERIFY](#)



You did it!

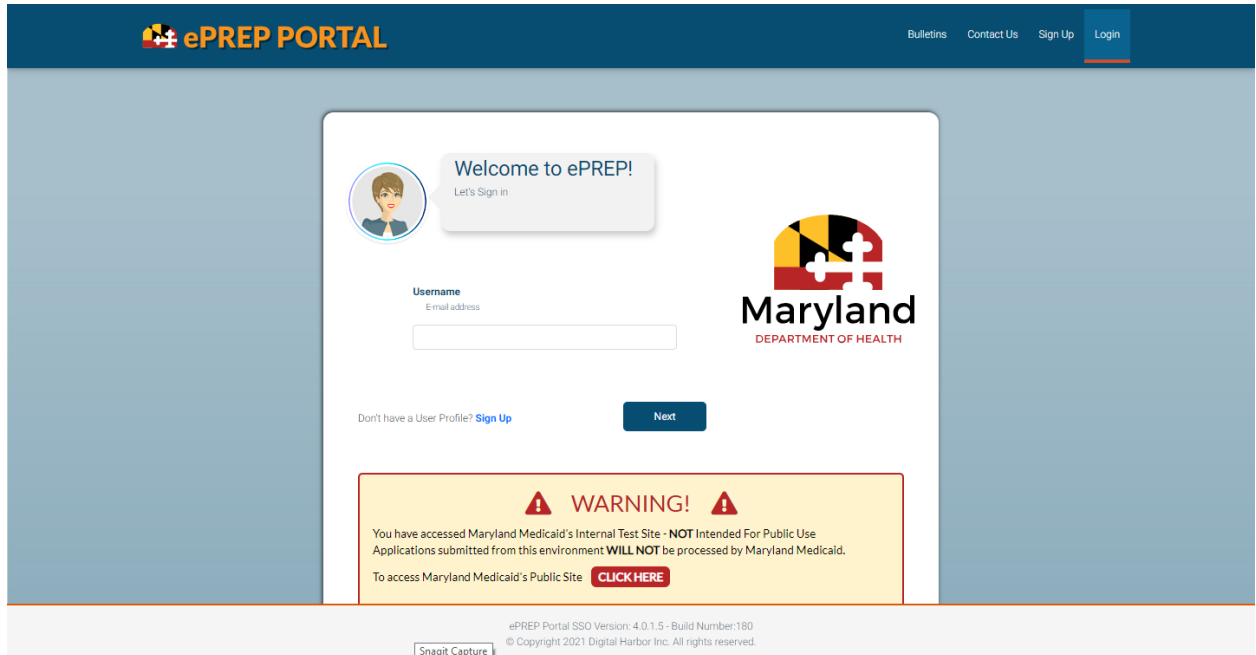


Success

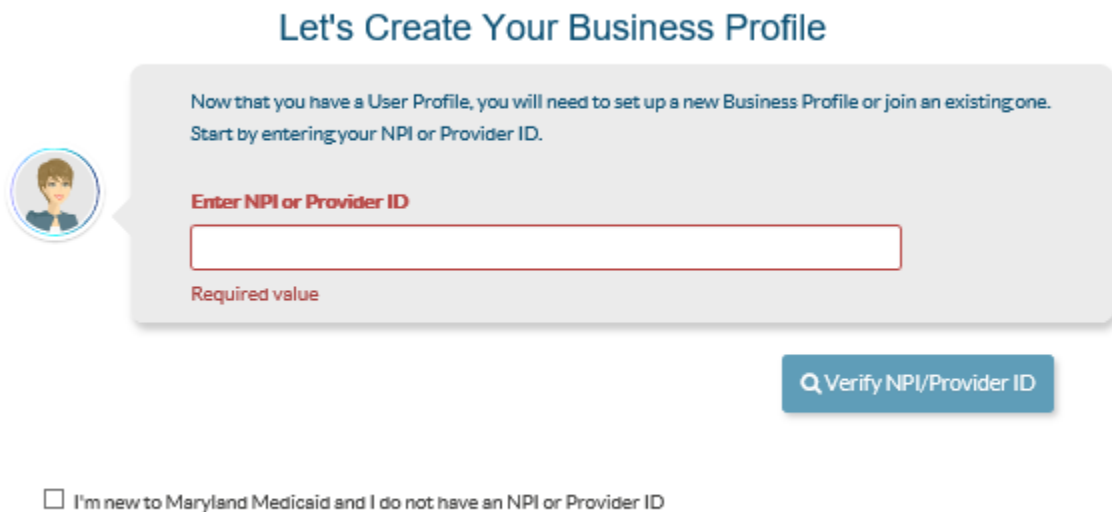
Select [Login](#) to continue

[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.

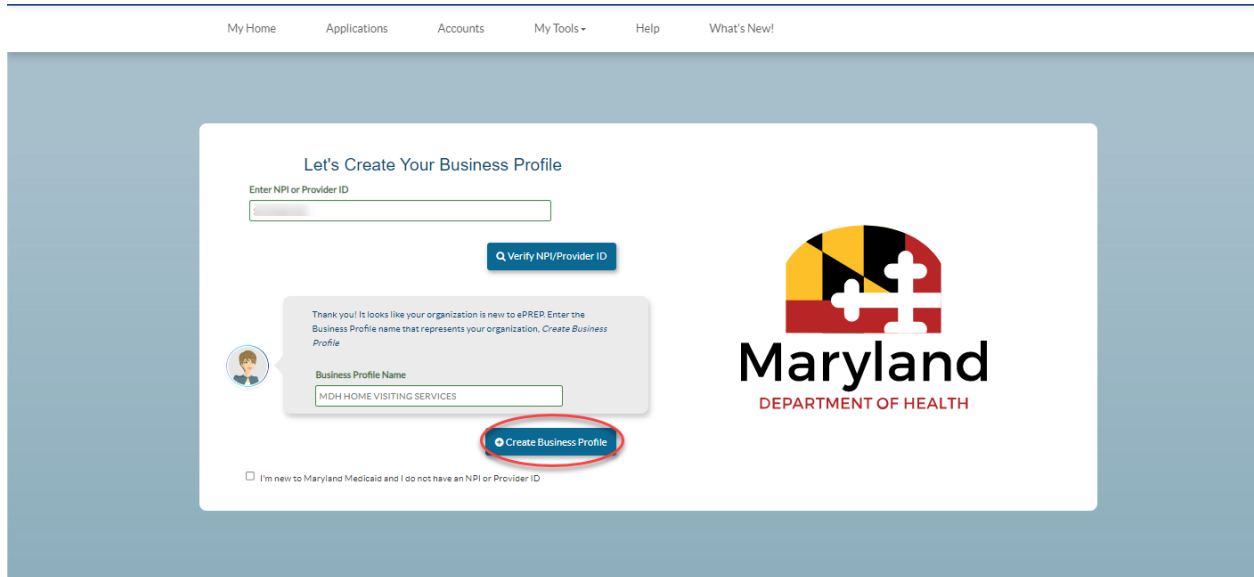


6. Once you have entered your credentials, you will be asked to create your business profile. In order to do this, you must first enter and verify your NPI number.

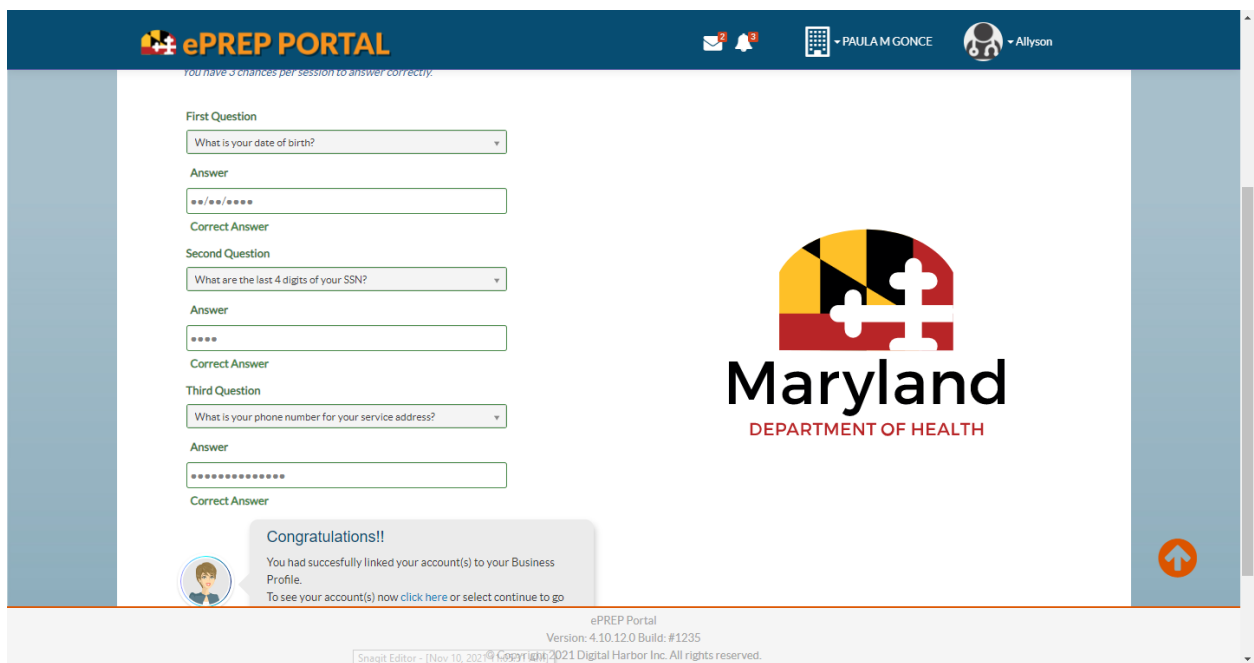


7. Once you have entered and verified your NPI, the provider ID box will turn green and you will be able to enter the provider / group name you are attempting to enroll.

****This is the name that will be listed on your provider business profile.****



8. 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”.



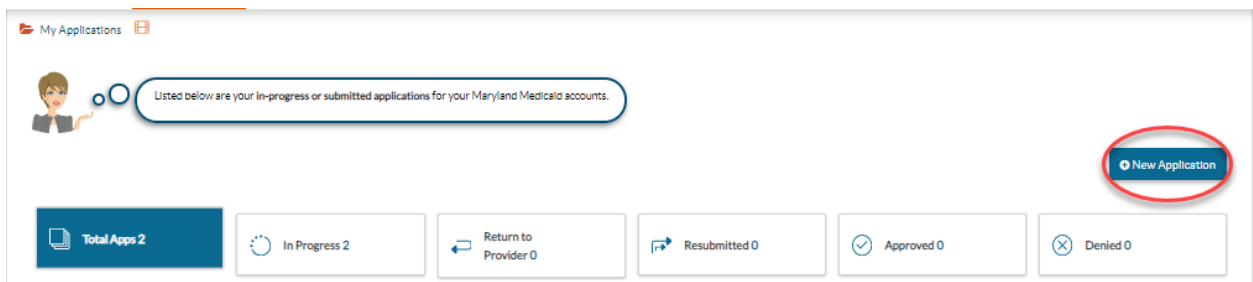
****It's important to note that sometimes these security questions are bypassed and are able to be completed later in the enrollment process****

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



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

11. 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.**



10. **Application Generation:** One you have clicked the 'New Application' tab, the following selection will need to take place in order to generate your enrollment application.

11. **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.

Start Application Business Structure NPI Provider Type

Hello, Allyson!

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 make changes to my account

Once you have made your choice, select [Continue](#).

[← Previous](#) [Continue →](#)



- Select the option: Other Healthcare Organization

Start Application **Business Structure** NPI Provider Type

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

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

[← Previous](#) [Continue →](#)

Start Application Business Structure **NPI** Provider Type

Okay, you have chosen Resource for your application. Please enter your Type 2 National Provider Identifier (NPI) that you want to use for this application, and select **Verify**.

National Provider Identifier (NPI) [Verify >](#)

Required value

When you have entered and verified your NPI, select **Continue**.

[← Previous](#) [Continue →](#)

12. Once you have entered your NPI, please click the 'verify' option. Once the NPI has been verified, the NPI box will turn green and you will be able to successfully continue through the application generation process.

****Please ensure that the Legal name, Provider type, entity type and Taxonomy are correct****


The screenshot shows a progress bar at the top with four stages: 'Start Application', 'Business Structure', 'NPI', and 'Provider Type'. The 'NPI' stage is currently active, indicated by a red line and a red circle around the 'NPI' label. Below the progress bar, a message bubble says: 'Terrific! Now I have your registry! To be safe, check if your information is correct before moving on.' The form contains the following fields: 'National Provider Identifier (NPI)' with a text input field and a 'Verify >' button circled in red; 'National Provider Identifier (NPI)' with a text input field; 'Type' with a dropdown menu showing '2-Organization'; 'Legal name' with a text input field containing 'MDH HOME VISITING SERVICES'; 'Taxonomy Code(s)' with a text input field; and 'NPPES address (registered)' with a text input field. Below these fields, there is a question 'Is this information correct?' with radio buttons for 'Yes' (selected) and 'No'. At the bottom, there is a 'Continue' button circled in red, and a 'Previous' button on the left. A small orange arrow icon is visible on the right side of the page.

13. If all of the organizational information displays correctly, please select 'Yes' and continue.

14. **Provider Type** - in the drop down box menu, please select the provider type **Home Visiting Services** and click continue.

The screenshot shows the same progress bar as the previous image, but now the 'Provider Type' stage is active, indicated by a red line and a red circle around the 'Provider Type' label. A message bubble says: 'Now that your NPI has been verified, select your Group's Provider Type from the drop-down list, and press Continue to move on.' The form contains a 'Provider Type' dropdown menu with 'HOME VISITING SERVICES' selected. Below the dropdown, there is a 'Continue' button circled in red and a 'Previous' button on the left.

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



Provider Name **MDH HOME VISITING SERVICES**

Provider Type [REDACTED]

Application ID 2111G210

Creation Date 11/16/2021

Package Type Facility

16% Complete 16%


0% Documents 0%

[New Message](#) [Submit](#)


Content Expand All


- Getting Started ●
- Getting Started ◐
- Business Information ◐
- Practice Information ◐
- Disclosure Information ◐
- Rendering Provider Affiliations ◐
- 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:

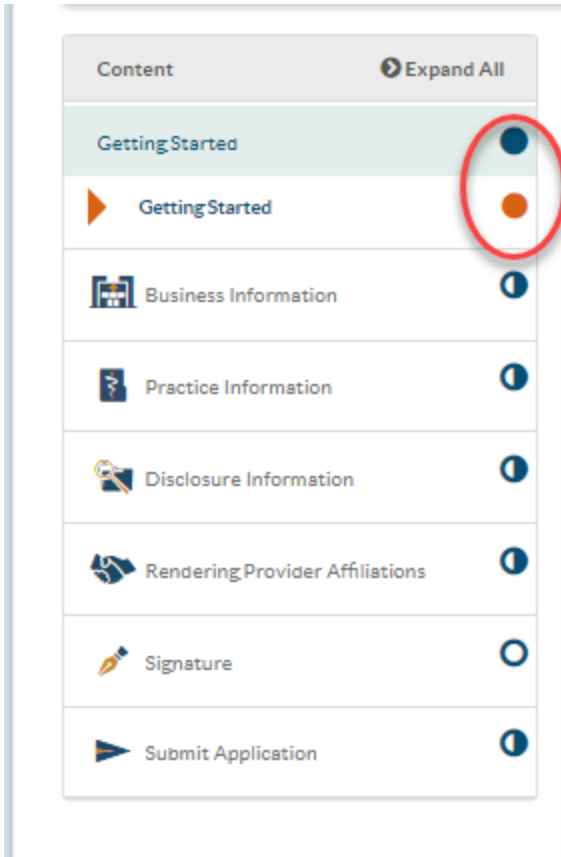
- Application structure
- Social tools
- Status indicators

Getting Started 

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

[Continue](#) →

16. As you navigate the application, this side bar will indicate your progress. A fully shaded circle denotes a finished section, while a half shaded circle signifies an incomplete section. Example shown below:



Business Information: Please enter all provider information into the corresponding data fields within this section.

17. If your organization has a DBA name, please select 'Yes' and enter the DBA name in addition to adding the supporting documentation for this DBA.
 - If your organization does not have a DBA, please select 'No'

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Business Profile TIN/SDAT & Business License Summary

Please share some basic information about your business.

Legal name: MDH HOME VISITING SERVICES

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

Entity type: Required value

Business number: Required value

Extension:

Practice:

Website's URL:

Previous Continue



Content Expand All
Business Profile
TIN/SDAT & Business License
Summary

Getting Started

Business Information

Business Profile

Contact Person

Addresses

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Signature

Submit Application

Please share some basic information about your business.

Legal name

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

Entity type

Required value

Business number

Required value

Extension

Practice Website's URL

For Entity type, please choose the entity that best fits your organization. Please be prepared to upload all supporting documentation for this choice ex: Non-profit Organization requires a 501(c) be attached to the application.

The screenshot displays a web application interface for the 'Business Profile' section. On the left, a sidebar menu lists various steps: 'Getting Started', 'Business Information' (selected), 'Business Profile', 'Contact Person', 'Addresses', 'Logistics', 'Practice Information', 'Disclosure Information', 'Rendering Provider Affiliations', 'Signature', and 'Submit Application'. The main content area features a progress bar at the top with three stages: 'Business Profile' (active), 'TIN/SDAT & Business License', and 'Summary'. Below the progress bar, a message box asks the user to share basic business information. The form fields include:

- Legal name:** MDH HOME VISITING SERVICES
- DBA name:** A text box with the question 'Does your business use a registered Doing Business As (DBA) name?' and radio buttons for 'Yes' and 'No' (selected).
- Entity type:** A dropdown menu set to 'Non-profit Organization 501(c)'. Below it, a dashed box contains the text 'NPO - Non-profit Organization 501(c)' and a 'Drag and drop here or browse' button with a file icon and '50MB Maximum' limit.
- Business number:** An empty text box with a red border and the label 'Required value' below it.
- Extension:** An empty text box.
- Website's URL:** An empty text box.

 At the bottom of the form are 'Previous' and 'Continue' buttons. A vertical toolbar on the right side of the page contains icons for help, search, and other utility functions.

18. **TIN / SDAT Business License:** Please enter your TAX ID number into the corresponding data field. Once entered, please click on the 'Select your file' button to upload the TIN/EIN document and name your document in the 'Document Name' box.

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

I need some additional information about your business. Don't forget to attach a clear copy of your documentation.

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

TIN/EIN

N/A

State Department of Assessment and Taxation (SDAT) number

Required value

Previous Continue



Upload Document



Drag and drop here, or [Select your file ...](#)

File size can not be greater than 50 MB

Please note that in order for your document to be reviewed, you must remove any passwords that have been used to keep it secure.

Section Name TIN/SDAT & Business License

Document Name

Title

Required value

Description

Share it in Document Library.

This is a sensitive document.

 Attach

 Cancel

Example of a TIN / EIN Letter:

Date of this notice: [REDACTED]

Employer Identification Number: [REDACTED]

Form: [REDACTED]

Number of this notice: [REDACTED]

For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank you for applying for an Employer Identification Number (EIN). We assigned you EIN [REDACTED]. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

IMPORTANT REMINDERS:

- * Keep a copy of this notice in your permanent records. This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you. You may give a copy of this document to anyone asking for proof of your EIN.
- * Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.
- * Refer to this EIN on your tax-related correspondence and documents.

If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub.

Your name control associated with this EIN is CAME. You will need to provide this information, along with your EIN, if you file your returns electronically.

Thank you for your cooperation.

19. **State department of Assessment and Taxation (SDAT)** number, please enter your business SDAT number.


- Providers are required to obtain and disclose their SDAT number on all applications that request it. Please do not check 'N/A'.

20. **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.

Content Expand All

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- Business Profile
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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.

First name	<input type="text"/>
	<small>Required value</small>
Last name	<input type="text"/>
	<small>Required value</small>
Title/Position	<input type="text"/>
Business number	<input type="text"/>
	<small>Required value</small>
Extension	<input type="text"/>
Fax Number	<input type="text"/>
Correspondence email address	<input type="text"/>
	<small>Required value</small>

[← Previous](#)
[Continue →](#)

21. **Service Address:** Please fill out the service address portion of the application

Content Expand All

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1 Service Address
2 Pay to Address
3 Mailing Address
4 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

22. Please answer the following “Yes” or “No” questions as they pertain to the organization.

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

Required value

Does this service location have TTY capability? Yes No

Required value

← Previous

Continue →

23. **Pay-to Address:** Please enter the pay to address of the group. If the pay-to address is the same as the group’s service address, please select the “same as service address” check box.

- If you are not registered for EFT, this is the address the payment will be sent to.

The screenshot displays a web application interface for entering a mailing address. On the left is a sidebar with a 'Content' menu and an 'Expand All' button. The main content area features a progress bar at the top with four steps: 'Service Address', 'Pay to Address' (the current step), 'Mailing Address', and 'Summary'. A callout box with a woman's icon asks, 'Please let me know the address where you want to receive payments.' Below this is a checkbox labeled 'Same as Service address', which is circled in red. The form includes fields for 'Street', 'Ste. / Apt. #', 'City', 'State/Province', 'County', and 'ZIP Code/Postal Code'. A 'View Address' link is also present. At the bottom are 'Previous' and 'Continue' buttons.

24. Please fill out the Mailing Address for the location. If there is a specific person that needs correspondence, please identify them. Please say: **ATTN:LAST NAME, FIRST NAME**

- If the mailing address is the same as either the service address or pay-to address (or both), please check the boxes circled below.

Content Expand All

Getting Started

Business Information

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Submit Application

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

Last step! Add a mailing address where you want receive official Maryland Medicaid correspondence.

Same as Service address

Same as pay to address.

[View Address](#)

Street

Ste./ Apt. #

City

State/Province

County

ZIP Code/Postal Code

Required value

h.maryland.gov/ProviderPortal/applications.do?nth=he&prid=4...

Logistics / Practice Operations - Please answer the following questions as they pertain to your business:

25. What are the business hours for this business location?

- If you are open 24/7, please check the box.
- If you are open for specific business hours, please list them here

What are the business hours for this business location?

Open 24/7

Open on specific business days/hours

Required value

☐

Content Expand All

- Getting Started
- Business Information**
- Business Profile
- Contact Person
- Addresses
- Logistics
- Practice Information
- Disclosure Information
- Rendering Provider Affiliations
- 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 business location?

Open 24/7
 Open on specific business days/hours

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

26. Has the staff of (Organization) completed cultural competency training? Please answer yes or no.

Has the staff of **MDH HOME VISITING SERVICES** completed cultural competence training? Yes No

27. Is (Organization) accepting new patients? Please answer yes or no.

Is **MDH HOME VISITING SERVICES** accepting new patients? Yes No

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

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

Required value

⌘

29. Does (Organization) see fee-for-services (FFS) Medicaid participants? Please answer **'yes'** to the following question.

Does MDH HOME VISITING SERVICES see fee-for-service (FFS) Medicaid participants? Yes

No, I only accept HealthChoice managed care patients

⌘

30. Does (Organization) provide language services to their patients, other than English, at this location? Please answer yes or no.

Does MDH HOME VISITING SERVICES provide language services to their patients, other than English, at this location? Yes No

⌘

Does MDH HOME VISITING SERVICES provide language services to their patients, other than English, at this location?

Yes No



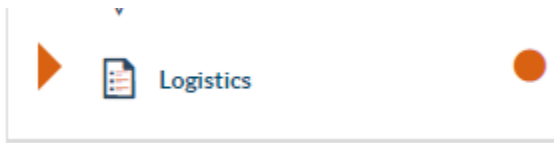
Language Services Offered

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

Required value



31. Once you have completed filling out all of the Business Information, the circle will be completely filled in.



Practice Information: License and Certifications

32. Please select 'No' for any questions regarding license / Certifications / DEA / NCPDP / and Laboratory certifications

- In the explanation box, please enter 'N/A'

33. NPI/ Taxonomy/ Specialty page: Please double check that the NPI listed on this page is correct.

- Taxonomy code should match what is in NPPES
- Specialty codes are assigned by MDH staff, Leave specialty codes blank - please select 'N/A'

Great! Now let's check the NPI number you provided and verified when you created your application. Then enter your taxonomies. Don't forget to have ready a Primary Taxonomy Code.

National Provider Identification (NPI) [REDACTED]

Associated Taxonomy Codes

+ Add

Description	Taxonomy Code	Type	Actions
No taxonomy code listed.			

Associated Specialty Codes

N/A

+ Add

Specialty Code	Description	Type	Actions
No Specialty code listed.			

Please list the associated taxonomy code. This taxonomy code is listed in NPPES and was given to you when you first registered for the NPI.

Add Taxonomy Code

Taxonomy code: 174H00000X - Health Educator

Type: Primary Secondary

+ Add × Cancel

Content Expand All

- Getting Started
- Business Information
- Practice Information
- Licenses, Certifications & Permits
- NPI/Taxonomy/Specialty**
- Additional Information
- Disclosure Information
- Rendering Provider Affiliations
- Signature
- Submit Application

NPI/Taxonomy/Specialty Summary

Great work! Now let's check the NPI number you provided and verified when you created your application. Then enter your taxonomies. Don't forget to have ready a Primary Taxonomy Code.

National Provider Identification (NPI)

Associated Taxonomy Codes Add

Description	Taxonomy Code	Type	Actions
Health Educator	174H00000X	Primary	

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34. This is the Addenda/ Supporting Documents page. Please be sure to attach the 'Medical Assistance Program Application Facility / Organization: PT Home Visiting Services.

Content Expand All

- Getting Started
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- Practice Information
- Licenses & Certifications
- NPI/Taxonomy/Specialty
- Additional Information**
- Disclosure Information
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Addenda/Supporting Documents Summary

The provider type Medical Assistance Program Application Facility / Organization: PT Home Visiting Services requires addenda and supporting documents to be attached to this application.

Select [Addenda/Supporting Documents](#) to select the required addenda and supporting documents. Once you have completed the required attachments select the Add button.

N/A Add

Addenda/Supporting Document Name	Documents	Actions
Addenda	Attach	


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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>

The following screenshot is an image of the needed Addendum.

The screenshot shows a form titled "Addendum for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION Home Visiting Services". The form is from the Maryland Department of Health. It includes contact information for the Provider Enrollment Helpline (1-844-4MD-PROV) and instructions for using the ePREP portal. The form contains several sections with checkboxes for attestation, including: "Attestation of Evidence-based Home Visiting Model Certification", "Attached Documentation of HFA/NFP accreditation status", "Attestation of HFA/NFP Home Visitors Certification", "Attestation of HFA or NFP Recognized Organization Record Keeping", and "Attestation of Fingerprint Criminal Background Check Completion".


MARYLAND
Department of Health

**Addendum for Maryland
Medical Assistance Program Application
FACILITY/ORGANIZATION
Home Visiting Services**

If you have questions, please contact the Provider Enrollment Helpline at **1-844-4MD-PROV (1-844-463-7768)**
Monday – Friday from 7am – 7pm.

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.

Attestation of Evidence-based Home Visiting Model Certification [Check all that apply]

- The organization attests that they have obtained and maintained either 1) Healthy Families America (HFA) OR 2) Nurse Family Partnership (NFP) accreditation.
- The organization maintains and has attached below documentation from either HFA or NFP indicating their status and will notify Maryland Department of Health (MDH) of any change in recognition status within 30 days.

Attached Documentation of HFA/NFP accreditation status [Check one]

- Yes
- No. If no, please attach explanation.

Attestation of HFA/NFP Home Visitors Certification [Check all that apply]

- The organization attests that all employed home visitors have successfully completed the requirements for HFA or NFP home visitor certification and have exhibited the competencies necessary to deliver home visiting services as stipulated by HFA or NFP through the most current standards.
- The organization maintains a typed roster of all home visitors who are in good standing, which includes each home visitor's full name, NPI number (optional), birth date, and Social Security Number; with proof of their qualifications as described above, and will be able to provide supporting documentation if requested by MDH.

Attestation of HFA or NFP Recognized Organization Record Keeping

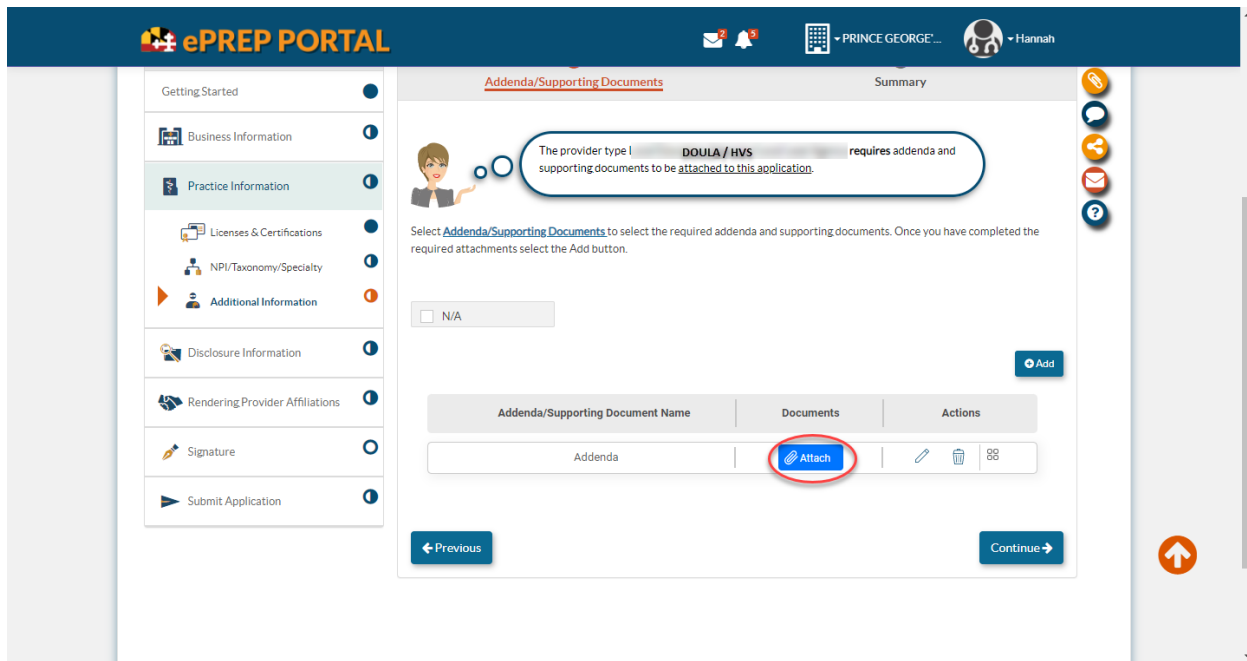
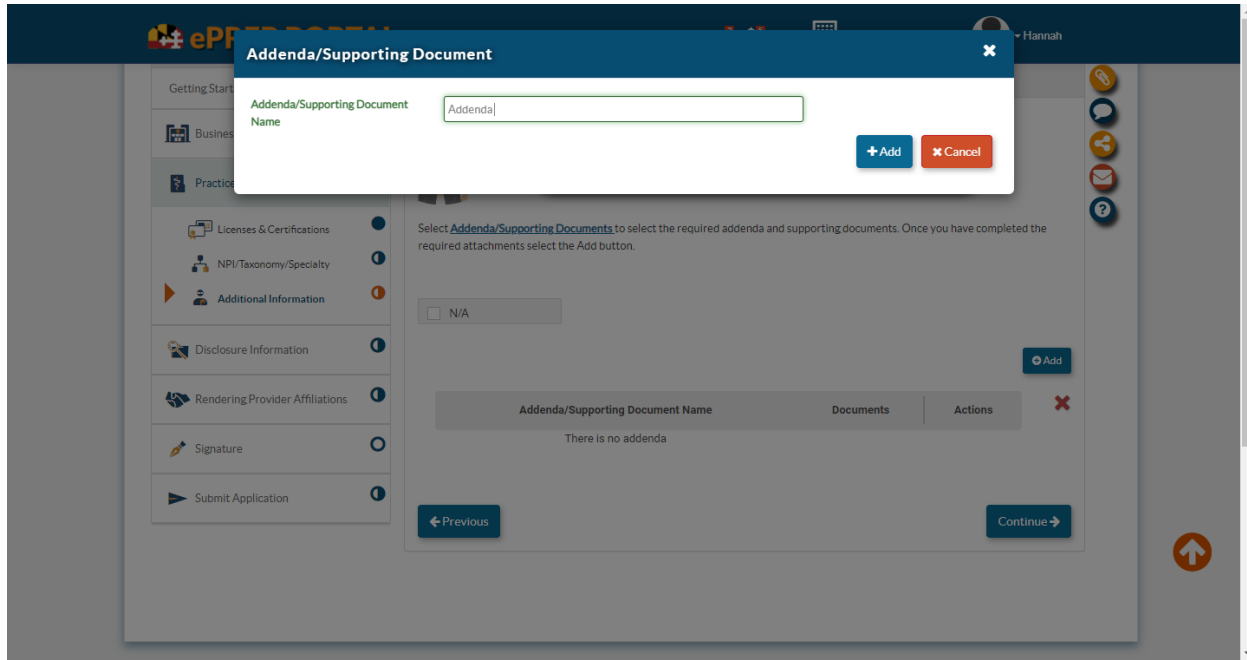
- The organization's records will include an attestation from HFA or NFP, as applicable, that the Medicaid participant for whom it is submitting a claim to the Managed Care Organization (MCO), has met the eligibility and engagement criteria as described in the Maryland Medicaid **HealthChoice** Home Visiting Services program eligibility criteria and reimbursement methodology.

Attestation of Fingerprint Criminal Background Check Completion

- The organization understands that all owners with 5% or more direct or indirect ownership interest will be required to complete a Fingerprint Criminal Background Check (FCBC) as required by the Centers for Medicare and Medicaid Services (CMS).

If you answered 'Yes' and additional documentation is needed, please upload it to the application.

35. Please click on the 'Add' button to name the Addendum



36. Once the Addendum is uploaded, please click continue.

Continue →

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


The screenshot shows a web application interface with a sidebar on the left and a main content area on the right. The sidebar contains a list of menu items: Getting Started, Business Information, Practice Information, Disclosure Information, Adverse Actions (highlighted with a red arrow), Fines and Debts (Gov.), Subcontractors, Ownership/Control Interest, Significant Transactions, Delegated Officials, Rendering Provider Affiliations, Signature, and Submit Application. The main content area features a blue header with a speech bubble containing the instruction: "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." Below this are six question boxes, each with a radio button for "Yes" and "No", and a "⌘" icon in the bottom right corner of each box. The questions are: 1. "Has MDH HOME VISITING SERVICES 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?" 2. "Has MDH HOME VISITING SERVICES 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?" 3. "Has MDH HOME VISITING SERVICES ever been found liable for fraud or abuse involving a government program in any civil proceeding?" 4. "Has MDH HOME VISITING SERVICES ever entered into a settlement to resolve a proceeding related to fraud or abuse involving a government program?" 5. "Has MDH HOME VISITING SERVICES 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?" 6. "Are there currently any proceedings that could result in the above-stated sanctions?" At the bottom of the form are two buttons: "← Previous" and "Continue →".

38. Once you have completed the adverse action page, please click continue. Please fill out any fines or debts that the organization has.

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
- Rendering Provider Affiliations
- 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

← Previous
Continue →








39. Subcontractors: please list any subcontractors the business currently has. If none, please select 'no.'

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
- Rendering Provider Affiliations
- Signature
- Submit Application

Subcontractors
Summary








Awesome, MDH HOME VISITING SERVICES! This part is even simpler. It's related to any subcontractors you may or may not have.

Does MDH HOME VISITING SERVICES 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 lease of real property, to obtain space, supplies, equipment, or services provided under the Maryland Medicaid Program? Yes No

Does MDH HOME VISITING SERVICES have direct or indirect ownership of 5% or more in any of its subcontractors? Yes No

Add

Type	Subcontractor's Name	Address	Ownership/Control Interest	Title/Role	Status	Actions
No Subcontractors listed						

← Previous
Continue →

40. **Ownership/ Control Interest:** Please list all individuals / entities who currently own 5% or more of the organization.

41. Please identify if the organization is owned by an entity or an individual; click 'add.'

Add Ownership/Control Interest

Entity Individual

Required value

+ Add **✕ Cancel**

42. With either the entity or individual, please identify their name.

Add Ownership/Control Interest

Entity Individual

Is this Entity a corporation?

Yes No

Required value

Legal name

Required value

+ Add **✕ Cancel**

Add Ownership/Control Interest

Entity Individual

First name

Required value

Middle name

Last name

Required value

+ Add **✕ Cancel**

43. Please fill out the ownership individual/entity information.

- Business Information 0
- Practice Information 0
- Disclosure Information 0
- Adverse Actions 0
- Fines and Debts (Gov.) 0
- Subcontractors 0
- Ownership/Control Interest 0
- Significant Transactions 0
- Delegated Officials 0
- Rendering Provider Affiliations 0
- Signature 0
- Submit Application 0

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

Required value

Date of birth
Required value

Age

Does **Allyson League** 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 select the correct option as it pertains to each individual / entity and enter the corresponding ownership percentage:

Content
Expand All

Individual Information
Ownership/Control Interest
Associations
Adverse Actions
Summary

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

Please select one or more of the options that apply to Allyson League

5% or more Ownership Interest

% Amount

Required value

Effective date of Ownership

📅

Required value

Partnership

Board Member

Managing Employee

Agent

44. Please answer the yes or no questions about the ownership entity or individual.

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
- Rendering Provider Affiliations
- Signature
- Submit Application

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 **Allyson League** have ownership with any of **MDH HOME VISITING SERVICES** subcontractors disclosed in this application? Yes No Required value

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

Does **Allyson League** have family relations with any of **MDH HOME VISITING SERVICES** subcontractors disclosed in this application? Yes No Required value

Does **Allyson League** have any family relations with any owner(s) of **MDH HOME VISITING SERVICES** subcontractors? Yes No Required value

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

Is **Allyson League** affiliated with any Entities or is family related to any Individuals disclosed in this application? Yes No Required value

Other Associations


Does **Allyson League** have any ownership or Control Interest in any other health care provider participating or not participating in Maryland Medicaid? Yes No Required value

45. This is the 'Significant Transactions' page. 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
- Rendering Provider Affiliations
- Signature
- Submit Application

Significant Transactions Summary

 Please carefully read this question and answer accordingly:

I, **MDH HOME VISITING SERVICES**, 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:

Yes No

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.

Previous Continue

46. Please identify any delegated officials. If you do not wish to disclose any delegated officials, please check the box associated with the question.

The screenshot shows a web application interface. On the left is a navigation menu with a 'Content' header and an 'Expand All' button. The menu items are: Getting Started, Business Information, Practice Information, Disclosure Information (highlighted), Adverse Actions, Fines and Debts (Gov.), Subcontractors, Ownership/Control Interest, Significant Transactions, Delegated Officials (highlighted with a red bar), Rendering Provider Affiliations, Signature, and Submit Application. The main content area is titled 'Delegated Officials' and has a progress indicator with 'Delegated Officials' selected and 'Summary' next to it. A blue callout box contains the following text: '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.' Below the callout is a text input field containing the text: 'MDH HOME VISITING SERVICES does not want to report any Delegated Officials at this time.' At the bottom of the form are two buttons: 'Previous' and 'Continue'.

47. Home Visiting Services for Doula's are not required to add rendering provider affiliations, please select 'No'.

The screenshot shows a web application interface. On the left is a navigation menu with a 'Content' header and an 'Expand All' button. The menu items are: Getting Started, Business Information, Practice Information, Disclosure Information, Rendering Provider Affiliations (highlighted), Rendering Provider Affiliations (highlighted with a red bar), Signature, and Submit Application. The main content area is titled 'Rendering Provider Affiliations' and has a progress indicator with 'Rendering Provider Affiliations' selected and 'Summary' next to it. A blue callout box contains the following text: 'Please disclose each Rendering provider affiliation by selecting Add Rendering (at least one is required). If an individual is disclosed in the Ownership/Control Interest sub-form and renders services at this location, they must also be added as a Rendering provider.' Below the callout is a text input field containing the text: 'Is MDH HOME VISITING SERVICES required to disclose all non-billing health care professionals who will render health care services at the location listed on this application?' To the right of the text are two radio buttons: 'Yes' and 'No', with 'No' selected. At the bottom of the form are two buttons: 'Previous' and 'Continue'.

48. Once onto the signature portion, please fill out the required information and click submit.

Content Expand All

- Getting Started
- Business Information
- Practice Information
- Disclosure Information
- Rendering Provider Affiliations
- Signature
- E-Signature
- Submit Application

Declarations
E-Signature
Summary

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

I, Allyson League, have read, understood, and agree with the terms of the Maryland Medicaid Provider Agreement. 88

I, Allyson League, declare that I have legal authorization to sign this application for and on behalf of MDH HOME VISITING SERVICES. 88

I, Allyson League, have reviewed my application and believe all information and attachments are correct to the best of my knowledge. 88

I, Allyson League, 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. 88

← Previous
Continue →

Content Expand All

- Getting Started
- Business Information
- Practice Information
- Disclosure Information
- Rendering Provider Affiliations
- 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 Facility application.

I, Allyson League, agree that my electronic signature is attributable as defined in Commercial Law Article § 21-208. 88

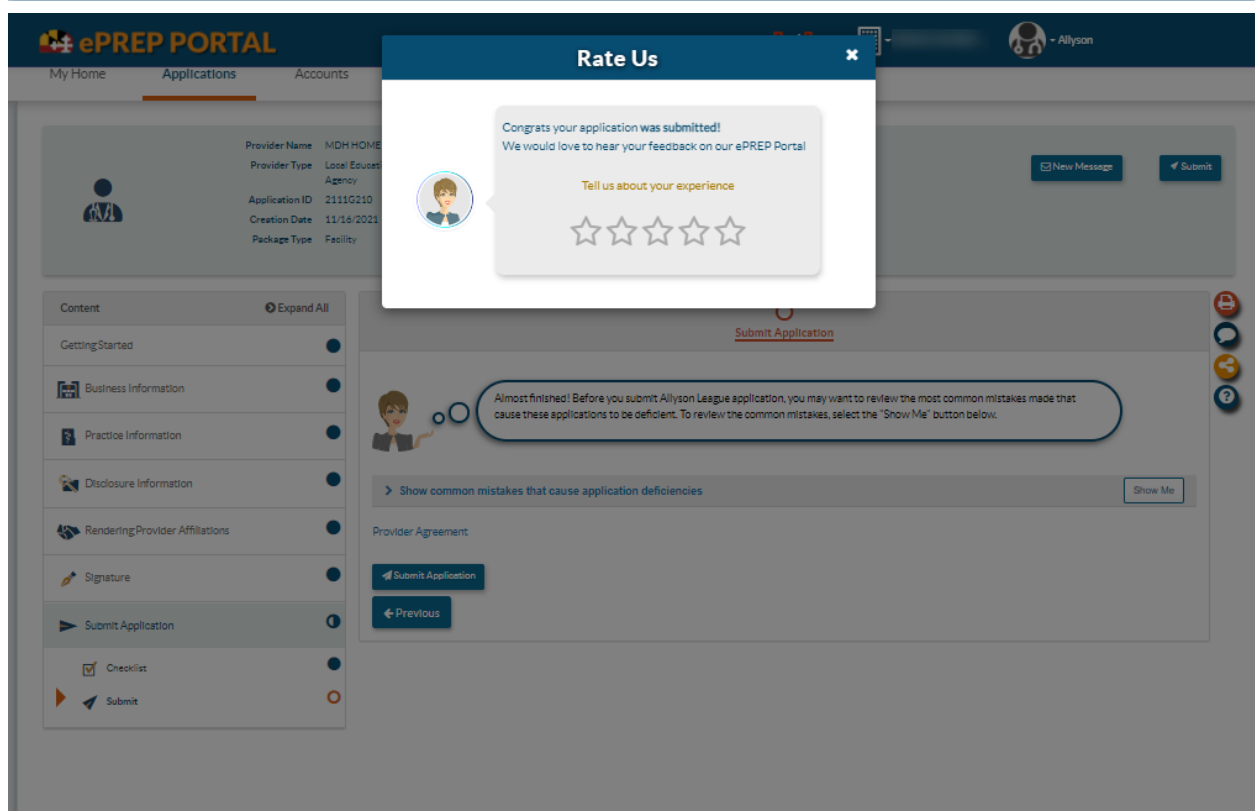
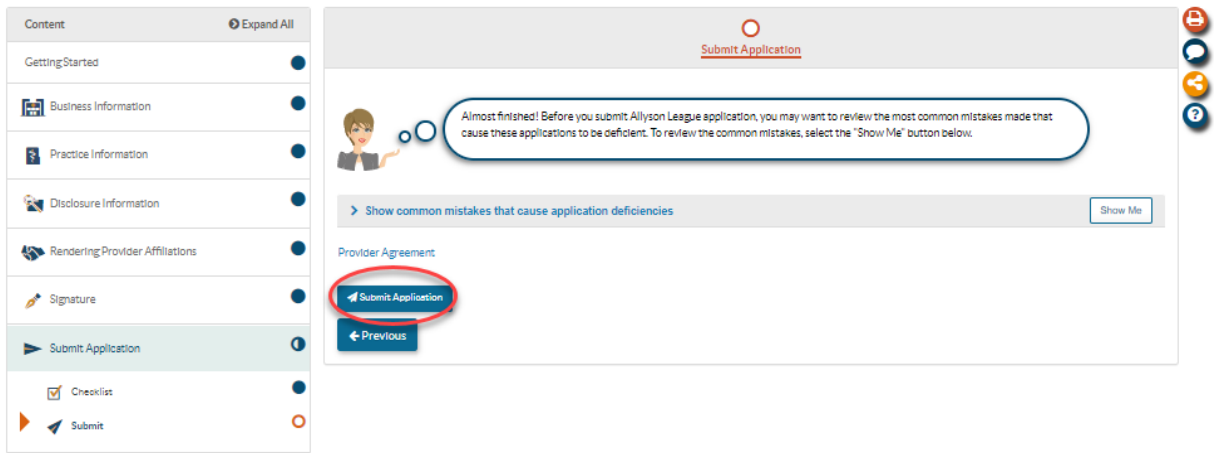
SSN (last 4 digits) Required value

Year of birth Required value

Email address

Password

← Previous
Continue →



Please feel free to rate the e PREP system and leave any comments that pertain to your application submission.

Thank you for your time.

If you have any questions, please contact us at
mdh.providerenrollment@maryland.gov