MARYLAND
Department of Health

Addendum for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

PT 76 ASSISTED LIVING FACILITY

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 **e**lectronic **P**rovider **R**evalidation and **E**nrollment **P**ortal, or ePREP (eprep.health.maryland.gov) for enrollment, information updates, provider affiliations and revalidations.

Please fill out the information below and upload the completed addendum to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional documents requested within the addendum.

Provider Information

Tax ID:

MA Provider Number (if already enrolled in Maryland Medicaid):

Please visit health.maryland.gov/ePREP for more information about ePREP

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Please upload this form to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional applicable supporting documents requested below.

Section I:
Please upload the following documents to ePREP :

1. A copy of current resume for the Assisted Living Manager documenting a minimum of three (3) years direct patient care experience plus certifications i.e., Medication Technician, CPR, First Aid, Assisted Living Management Training etc. (A five (5) or more bed facility manager must have the 80-hour Management Training Course)
2. A copy of current resume for the Alternate Assisted Living Manager documenting a minimum of three (3) years direct patient care experience plus certifications i.e., Medication Technician, CPR, First Aid, Assisted Living Management Training etc.
3. If you are a registered nurse:
   a. A copy of your license, CPR certification and assisted living management training
4. For the Delegated Nurse:
   a. A copy of the Delegated Nurse's license
   b. A copy of the verification of completion of the Delegated Nurse Curriculum
   c. A copy of the Delegated Nurse Contract
5. Copies of all Employee's Certifications including current First Aid, CPR cards, Med.Tech Certificate, Criminal Background Checks and two forms of ID.
   Note: Criminal Background Checks: The facility must have an account with the Criminal Justice Information System (CJIS) to perform criminal history record checks. CJIS Checks submitted for review must have facility name on them. Other types of Criminal Record Checks are not acceptable.
6. A copy of Resident Agreement
7. A copy of Resident Rights
8. A copy of Resident House Rules
9. A copy of literature that is used to promote your facility, i.e. brochures etc.

Note: Documentation of Assisted Living Management Training* consisting of the following: Alzheimer's, Dementia and Mental Illness: Caring for persons with Cognitive Impairment and related Mental Health Issues - Fire and Life Safety - Infection Control/Standard Precautions - Basic Food Safety - Emergency Disaster Plans - Resident Assessment Process - Use of Service Plans - Psychosocial Needs of the Population Being Served - Resident's Rights Providing Assistance with Activities of Daily Living

***Training must be conducted by an approved OHCQ Assisted Living Management Trainer**

Section II:

Please check all that apply and upload this form to ePREP (eprep.health.maryland.gov).

Home and Community-Based Options Waiver, Community First Choice and Community Personal Assistance Services

1. Please check all services that you intend to provide:

☐ Accessibility Adaptations	☐ Family Training
☐ Assisted Living	☐ Home Delivered Meals
☐ Assistive Technology	☐ Items or Services that Substitute for Human Assistance
☐ Behavioral Health Consultation	☐ Personal Assistance Services (Agency)
☐ Consumer Training	☐ Personal Emergency Response Systems
☐ Dietitian and Nutrition Services	☐ Senior Center Plus
☐ Environmental Assessments	

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

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

Section III:

Please read the Agreement of General Conditions for Provider Participation below, initial each line and sign on page 5.

General Conditions for Provider Participation

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

A: **To participate as a provider, The Provider Shall:**

_____1. Meet all of the conditions for participation as a Maryland Medical Assistance Program provider as set forth in COMAR 10.09.36, except as otherwise specified in this chapter.

_____2. Agree to verify the qualification of all individuals who render services on the provider's behalf and provide a copy of the current license or credentials upon request.

_____3. Agree to implement the reporting and follow-up of incidents and complaints in accordance with the Department's established reportable events policy by reporting incidents and complaints within 24 hours of knowledge of the event by submitting a written report within 7 calendar days on a form designated by the Department and notifying the local department of social services immediately if the provider has a reason to believe that the participant has been subjected to abuse, neglect, self-neglect, or exploitation, in accordance with COMAR 07.02.16

_____4. Agree to cooperate with required inspections, reviews, and audits by authorized governmental representatives.

_____5. Agree to provide services, and to subsequently bill the Department in accordance with the reimbursement methodology provided to participants for a period of 6 years, in a manner approved by the Department.

_____6. Agree to maintain and have available written documentation of services, including dates and hours of services provided to participants for a period of 6 years, in a manner approved by the Department.

_____7. Agree not to suspend, terminate, increase, or reduce services for an individual without authorization from the Department and with consultation and input from the participant or a participant's representative when applicable.

_____8. Agree to submit a transition plan to the case manager or supports planner and participant or participant's representative when applicable when suspending or terminating services.

_____9. Agree to demonstrate substantial, sustained compliance with requirements of this chapter for at least 24 months after a cited deficiency which presented serious danger to participants' health and safety.

_____10. Agree to verify Medicaid eligibility at the beginning of each month that services will be rendered.

_____11. Agree to not be a Medicaid provider or principal of a Medicaid provider that has overpayments that remain due to the Department.

_____12. If the provider renders health-related services, agree to periodically indicate the condition of a participant in accordance with the procedures and forms designated by the Department which shall be shared and discussed at the request of the participant

B. Agree that within the past 24 months you have not:

_____ Had a license or certificate suspended or revoked as a health care provider, health care facility or provider of direct care services.

_____Been suspended or removed from participating as a Medicaid provider of personal care under COMAR 10.09.20

_____Undergone the imposition of sanctions under COMAR 10.09.36.08

_____Been subject to disciplinary action, including actions by the licensing board or any provider or principal of any provider agency.

_____Been cited by a State agency for deficiencies which affect participants' health and safety.

_____Experienced a termination of a Medicaid provider agreement or been barred from work or participation by a public or private agency due to failure to meet contractual obligations or fraudulent billing practices

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

_____ _____

Signature Date

CFC Division Approval: _____ Date: _____