MARYLAND
Department of Health

Addendum Cover Page for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

PT 76 COMMUNITY OPTIONS

If you have questions, please contact the Provider Enrollment Helpline at **1-844-4MD-PROV (1-844-463-7768)**
Monday – Friday from **9am – 5pm.**

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:

Community Personal Assistance/Community First Choice/Home and Community Based Options Waiver - Please check all services that you intend to provide and upload this form, as well as a copy of the corresponding requirement(s) for each of the services checked, to ePREP (eprep.health.maryland.gov).

X	Service	Required Documentation
☐	Accessibility Adaptations	Proof that you are the store vendor or the company who sells, rents , installs, services, runs the device or service
		Copy of appropriate Tax ID, Trader , MHIC Licensing and proof of Liability insurance
☐	Assistive Technology	Proof that you are the store vendor or the company who sells, rents , installs, services, runs the device or service
		Copy of appropriate Tax ID, Trader , MHIC Licensing and proof of Liability insurance
☐	Behavioral Health Consultation	Copy of license as psychologist, registered nurse, or licensed clinical social worker
☐	Consumer Training-Individual	Copy of current resume demonstrating experience developing and implementing skills that incorporate a consumer –directed philosophy of services
☐	Consumer Training-Facility	Copy of Agency license which employees or contracts with individuals providing the training
		Copies of credentials of licensed professionals that may perform the services or resume of individuals that demonstrates experience developing and implementing skills that incorporate a consumer –directed philosophy of services
☐	Dietitian and Nutrition-Individual	Copy of Dietitian or Nutritionist license
		Copy of license that includes relevant experience
☐	Dietitian and	Copy of Agency license which employees or contracts with licensed

	Nutrition-Facility	professionals (listed in Individual)
		Copies of credentials of licensed professionals that may perform the services
☐	Environmental Assessments-Individual	Copy of license as occupational therapist or agency or professional group employing a licensed occupational therapist
		Sample Assessment form
		Copy of drivers' license or state issued valid photo identification
☐	Environmental Assessments-Facility	Copy of Agency license which employees or contracts with licensed professionals listed above
		Copies of credentials of licensed professionals that may perform the services
☐	Family Training-Individual	Copy of registered nurse, occupational therapist, speech pathologist, or physical therapy license.
☐	Family Training-Facility	Copy of agency license that employs or contracts with a licensed professional (listed under individual)
☐	Home Delivered Meals	Proof of food services license issued by the local health department
		Copy of most recent inspection
☐	Items or Services that Substitute for Human Assistance: Assistive Devices, Equipment or Technology (KA, 280)	Copy of tax appropriate tax ID
		Proof that you are a store vendor or the company who sells, rents , installs, services , runs the device or service
☐	Personal Assistance Services-Facility	Copy of Residential Services Agency license. The services provided section of license must either read: 1. Skilled Nursing and Aides; Level of Care: Complex Care Provided by RN/LPN and RN Supervision Aides **OR** 2. Skilled Nursing and Aides; Level of Care: RN Supervision of Aides with Medication Administration
		Registered Nurses and employee documents: 1. Copy of RN License and CPR Card 2. Copies of Criminal Background Checks: An Agency must have an account with the Criminal Justice Information System (CJIS) to perform criminal history record checks. CJIS submitted for review must have Agency Name on them. 3. Copies of Employee's Certifications including current CNA and Med. Tech Certificates and CPR cards.

		4. Copies of Social Security card or proof of eligibility for employment in Maryland 5. Copy of driver's license or birth certificate
☐	Personal Emergency Response Systems	Proof that you are the store vendor or the company who sells, rents , installs, services , runs the device or service
		Copy of appropriate Tax ID, Trader, MHIC Licensing and proof of Liability insurance
☐	Senior Center Plus	Be approved and monitored by the Maryland Department of Aging as a nutrition service provider (Senior Center Plus Certificate)
		Copy of license as a health Professional or licensed social worker

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 Medical Assistance Personal Care

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	☐ Support Planning Services

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 6.

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: _____