GEORGIA DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

APPLICATION TO BECOME A PROVIDER OF DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY BASED WAIVER SERVICES FOR **EXISTING DBHDD DEVELOPMENTAL DISABILITIES PROVIDERS**

SECTION I: LEGAL NAME & ADDRESS

(Legal name and address as registered with the Georgia Secretary of State's office)

Legal Name:			
Tax ID #:			
National Provider ID (NPI) #:			
Street Address:			
City:	County:	State:	Zip Code:
Mailing Address (if different):			
City:	County:	State:	Zip Code:
Owner:			
Office Telephone:			
Cell Phone:	Fax:		
Email Address:			
CEO / Director:			
Office Telephone:			
Cell Phone:	Fax:		
Email Address:			
Contact Name for this application:			
Office Telephone:			
Cell Phone:	Fax:		
Email Address:			
Human Rights Contact:			
Office Telephone:			
Cell Phone:	Fax:		
Email Address:			
Website:			

SECTION II: APPLICATION TYPE

Check one:

❒ 1. Current Department of Behavioral Health and Developmental Disabilities (DBHDD) Developmental Disabilities Provider, Applying for New Service at a New Site. **Submit simultaneously, the Department of Community Health (Medicaid Application) Additional Location Application.**

❒ 2. Current DBHDD Developmental Disabilities Provider, Applying for New Service at a Currently Established Site.

Check one:

ACCREDITED: ❒ YES ❒ NO

If YES: **Accrediting Body:** ____________________

Expiration Date: ____________________

COMMUNITY SERVICE STANDARDS QUALITY REVIEW COMPLETED: ❒ **YES** ❒ **NO**

IF YES: **Expiration Date:** ____________________

NOTE:

Include the following documents if they have been updated, issued or renewed since they were last submitted to the Office of Provider Network Management:

- **Copy of your agency's current Accreditation or Community Service Standards Quality Review certificate**
- **Copy of current Commercial General Liability Insurance certificate**

SECTION III: SERVICE DELIVERY SITE FOR NOW AND/OR COMP SERVICES

Complete this section for each NOW/COMP service and/or sites for which you are applying. If applying for multiple services and/or sites please submit a separate page for each service and/or site .

Category of Service (COS): ❒ 680 - New Option Waiver (NOW) ❒ 681 - Comprehensive Supports Waiver (COMP)				
Waiver Service:				
HIPAA Code:				
Site Name:				
Street Address:				
City:	State:	County:	Zip Code:	DBHDD Region:
Counties to be Served from this location:				
Site Manager:				
Site Telephone Number:			Site Fax Number:	
Name and Credentials of the Developmental Disabilities Professional (DDP):				
DDP E-Mail Address:				

This site will serve:

❒ Children only ❒ Adults only ❒ Both children and adults

This site is licensed by Healthcare Facility Regulation (HFR) as a:

❒ Child Placing Agency (CPA) ❒ Community Living Arrangement (CLA)

❒ Home Health Agency (HHA) ❒ Private Home Care (PHC)

❒ Personal Care Home (PCH) **Only applicable for Respite 15 Minutes / Out of Home Respite**

Is this an existing DBHDD DD site? ❒ YES ❒ NO

If yes, Existing NOW Provider Number for **this site**: ____________________

Existing COMP Provider Number for **this site**: ____________________

Please select one:

❒ License is site specific ❒ License is agency specific ❒ License is not required for this service

Is this site a Host Home? ❒ YES ❒ NO

If yes, include a copy of the Host Home Self Study

Date Host Home Self Study completed: ____________________

Host Home Provider's Name: ____________________

To your knowledge are other agencies using this home as a Host Home? ❒ **YES** ❒ **NO**

Staffing Schedule: All staffing assigned to proposed service at site:

NAME	POSITION TITLE	Indicate Fulltime or Part-time or Pro re nata (PRN)
		❒ Fulltime ❒ Part Time ❒ PRN
		❒ Fulltime ❒ Part Time ❒ PRN
		❒ Fulltime ❒ Part Time ❒ PRN
		❒ Fulltime ❒ Part Time ❒ PRN
		❒ Fulltime ❒ Part Time ❒ PRN
		❒ Fulltime ❒ Part Time ❒ PRN
		❒ Fulltime ❒ Part Time ❒ PRN
		❒ Fulltime ❒ Part Time ❒ PRN

Include the following documentation with each Host Home Self Study:

A general health examination of each member living in the potential Host Home.

1. Evidence of screening for tuberculosis and communicable disease for each member living in the potential Host Home.

2. Criminal History Records Check of all the household members age seventeen (17) and above. Please note that this does not include individuals receiving DD Waiver services. Please review policy found: **Criminal History Records Checks for Contractors, 04-104: PolicyStat**

3. A minimum of three (3) character references for the potential Host Home/Life-Sharing provider (s)

4. Proof of homeowner's or renter's insurance .

5. Statement as to whether or not there are firearms in the home.

6. Documentation of home ownership (e.g. current mortgage statement) or renter's lease. Document(s) must be in the name of the potential Host Home provider.

7. The home study shall be completed, signed and dated by a designated employee of the agency or professional under contract with the agency and reviewed, signed and dated by the Agency/Program Director or Developmental Disabilities Professional (DDP).

8. Signed statement from potential Host Home provider indicating the receipt and review of the Host Home Policy and Procedures and the Policy for Enrolling, Matching and Monitoring Host Homes for DBHDD Community Providers.

The adult family member who shall have primary responsibility to the individual and for providing services to the individual shall have at least the following training ***prior*** to the DBHDD provider agency making application for a site specific Medicaid provider number:

- Person centered values, principles and approaches
- Human Rights and responsibilities
- Recognizing and Reporting Critical Incident
- Individual Service Plan
- Confidentiality of individual information, both written and spoken
- Fire Safety
- Emergency and disaster plans and procedures
- Techniques of standard precautions
- Basis cardiac life support (BCLS)
- First aid and safety
- Medication Administration and Management/Supervision of Self-Medication

Submit evidence of the type of training, content, dates, length of training, and/or copies of certificates. A signed attestation between the agency and the potential host home provider, which indicates the receipt of trainings, must also be submitted.

SECTION IV – CO-EMPLOYER APPLICATION

(Only applicable if this application is for Co-Employer services)

I. Descriptions of Co-Employer services must include how the agency will facilitate and support the co-employment of the employees of the agency and the participants/ representatives who opt to participant direct through the co-employer option. These service descriptions must address the differences of co-employer service delivery and traditional service delivery.

The descriptions must describe how the agency will support the following co-employer responsibilities of the participant/representative:

1. Recruit staff.
2. Refer staff to co-employer agency for hiring.
3. Hire staff.
4. Determine staff duties consistent with service specifications.
5. Determine staff wages and benefits subject to applicable State limits.
6. Schedule staff.
7. Orient and instruct staff in duties.
8. Supervise staff.
9. Evaluate staff performance.
10. Verify time worked by staff and approve time sheets.
11. Recommend to the co-employer agency discharging staff from providing services to the participant.

Additionally, the descriptions of co-employer services must describe how the agency will meet the following co-employer responsibilities of the agency:

1. Obtain criminal history and/or background investigation of co-employees.
2. Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance for co-employees.
3. Conduct skills training and provides technical assistance to participants and/or their representatives on employer-related responsibilities.
4. Process and bill for services approved in the service plan.
5. Document co-employer services delivery and maintain records.

Note:

1. **Each** of the above responsibilities must be addressed in your description of co-employer services.
2. The above descriptions should address how conflicts between the co-employer agency and the participant/representative will be resolved.

II. Agencies applying for Co-Employer of applicable waiver services **MUST** meet the following requirements and attest that the Agency has the staff and organizational capacity to:

1. Verify staff qualifications of potential employees referred by the Participant who self-directs their services and supports through the co-employer option.
2. Obtain Criminal History Records Check of co-employees.
3. Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance for co-employees.
4. Conduct skills training and provide technical assistance to participants and/or their representatives on employer-related responsibilities.
5. Process and bill for services approved in the service plan

III. Please check the waiver services for which you are applying for Co-Employer status:

☐ **Community Access**

A. Submit a letter signed by the agency director stating:
   1. An understanding of requirements if staff members are transporting participants.
   2. An understanding of DCH and DBHDD requirements for Co-Employer services.

☐ **Community Guide**

A. Submit a letter signed by the agency director stating:
   1. An understanding of the Community Guide education, training, and experience requirements.
   2. An understanding of DBHDD requirements for Community Guide mandatory training.
   3. An understanding of DCH and DBHDD requirements for Co-Employer services.

☐ **Community Living Support**

A. Submit a letter signed by the agency director stating:
   1. An understanding of the Direct Support Professional (DSP) requirements, including training/orientation, annual health examination; criminal records check prior to providing services, and any additional requirements specific to the service and DCH or DBHDD.
   2. An understanding of Class C driver's license requirements, mandatory vehicle insurance if transporting clients, and driver's Motor Vehicle Record (MVR) requirements.
   3. An understanding of DCH and DBHDD requirements for Co-Employer services.

☐ **Respite**

A. Submit a letter signed by the agency director stating:
   1. An understanding that out-of-home Co-employer Respite Services can ***only*** be rendered in the private residence of the provider (i.e., a home owned or rented by the provider or an employee of the provider).
   2. An understanding of DCH and DBHDD requirements for Co-Employer Services ***and,***
   3. An understanding of driver's license, mandatory vehicle insurance requirements, and driver's Motor Vehicle Record (MVR), if transporting participants.

☐ **Supported Employment**

A. Submit a letter signed by the agency director stating:
   1. An understanding of the requirements of Supported Employment Specialists, including training/orientation, and criminal records check prior to providing services.
   2. An understanding of DCH and DBHDD requirements for Co-Employer services.
   3. An understanding of transportation license requirements, if staff transports participants.

☐ **Transportation**

A. Submit a letter signed by the agency director stating:
   1. An understanding of the requirements of agency staff, including trainings, orientation, and any additional requirements specific to the service of DCH and DBHDD.
   2. An understanding of DCH and DBHDD requirements for Co-Employer services.
   3. An understanding that DD Service Provider Agency driver staff providing Transportation Services must hold the class of license appropriate to the vehicle operated as defined by the Georgia Department of Driver Services, have mandatory vehicle insurance, and meet Motor Vehicle Record (MVR) requirements.
   4. An understanding attesting that appropriate staff members have had a criminal records check .

Authorized Agent

Under applicable state and federal laws, I do hereby affirm that I am the authorized agent to complete this application and attest that the Agency has the staff and organizational capacity to provide the Co-Employer services selected above.

______________________________	______________________________
Print Name	Title
______________________________	______________________________
Signature of CEO/Director/Owner	Date

ATTESTATIONS

Developmental Disabilities Services

The Georgia Department of Behavioral Health and Developmental Disabilities requires that services be provided according to the service guidelines and that agencies operate in accordance with applicable standards, rules, regulations and policies.

Policy Manual Attestation

By signing below, I hereby certify and attest that my staff, agents, credentialing personnel, contractors, subcontractors, billing agent(s) and I have accessed and reviewed and agree to comply with the terms and conditions set forth in the following:

- Provider Manual for Community Developmental Disabilities Providers
- Rules and Regulations of Department of Behavioral Health and Developmental Disabilities - Client's Rights (Chapter 290-4-9)

Department of Community Health (DCH) Policies and Procedures Manuals, found at the following links:

- Part I Policies and Procedures / Billing Manual
- Part II– Policies and Procedures for COMPREHENSIVE SUPPORTS WAIVER PROGRAM (COMP)
- Part III– Policies and Procedures for COMPREHENSIVE SUPPORTS WAIVER PROGRAM (COMP)
- Part II– Policies and Procedures for NEW OPTIONS WAIVER PROGRAM (NOW)
- Part III– Policies and Procedures for NEW OPTIONS WAIVER PROGRAM (NOW)

I understand and acknowledge that the policies and procedures manuals are amended when either Department finds its necessary or appropriate to do so, and that it is my responsibility as well as the responsibility of my staff, agents, credentialing personnel, contractors, subcontractors, and billing agent(s) to check periodically for any revisions pertaining to the delivery of or reimbursement for services rendered to eligible individuals. I further understand that failure to abide by either Department's policies and procedures will result in adverse actions including, but not limited to the denial of claims, monetary recoupment, termination, suspension of payments, and reduction of reimbursement.

I certify and attest that I have reviewed the entire contents of the completed application and that the information provided is accurate and complete. I understand that inaccurate, incomplete or omitted data may lead to sanctions against me or my facility.

Authorized Agent

Under applicable state and federal laws, I do hereby affirm that I am the authorized agent to complete this application and that the information contained in this application is complete, true, and correct.

______________________________	______________________________
Print Name	Title
______________________________	______________________________
Signature of CEO/Director/Owner	Date