

**GEORGIA DEPARTMENT OF  
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES**

**APPLICATION USER'S GUIDE**

**APPLICATION TO BECOME A PROVIDER OF MENTAL RETARDATION AND  
DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY BASED WAIVER  
SERVICES FOR**

**EXISTING DBHDD DEVELOPMENTAL DISABILITIES PROVIDERS**



**DBHDD**

## OVERVIEW

The purpose of this user's guide is to provide instructions on completing the Existing Provider application for Developmental Disabilities services.

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### How to Complete Medicaid Application:

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As an existing provider, you may need to submit the DCH Georgia Department of Community Health (DCH), Division of Medical Assistance (DMA) **Additional Location Application** (latest version). Click the following link, [Medicaid Additional Location Application](#) print and complete, if applicable. Please note that each residential site (Community Residential Alternative) needs a site specific application. There can be no other service added to a Community Residential Alternatives service provider number. If you are adding other services to an existing provider number please submit the existing number which you will like to have the services added to.

The website for more details regarding Medicaid provider requirements is [www.mmis.georgia.gov](http://www.mmis.georgia.gov). Click on the "Provider Information" tab and the link to "Medicaid Provider Manuals", particular attention should be given to 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 \(NOW\)](#)

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### Submission Requirements:

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- One hard copy of each of the completed applications (DBHDD and DCH) must be sent to the address listed below via US Postal Service or other recognized mail carrier such as UPS, FedEx, etc.:

**Provider Enrollment Unit  
Office of Provider Network Management  
Department of Behavioral Health and Developmental Disabilities  
2 Peachtree Street, Ste. 23.247  
Atlanta, Georgia 30303**

- Once the Department receives the complete application, a tracking number will be assigned.
- Application receipt confirmation and the tracking number will be submitted to the organization via email within two business days. This email will be from [MHDDAD-serviceapps@dbhdd.ga.gov](mailto:MHDDAD-serviceapps@dbhdd.ga.gov). **Please be sure to add this email address to your electronic address book.**
- **Any questions regarding your application must be submitted via email to the following address: [MHDDAD-serviceapps@dbhdd.ga.gov](mailto:MHDDAD-serviceapps@dbhdd.ga.gov).** This includes all communications, updates, requests for additional information, etc.. Please be sure to reference the assigned tracking number.

## HOW TO COMPLETE EACH SECTION OF YOUR APPLICATION:

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### Section I – Legal Name & Address

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All fields are required for a complete application.

1. Legal Name: Indicate the legal name of your agency as registered with the Georgia Secretary of State
2. Tax Identification Number: This is the number assigned by the Internal Revenue Service and should match the number on file with DBHDD
3. National Provider Identification (NPI) number: Please complete if applicable. This is obtained through Medicaid. Please visit the following website for more information and application.  
<http://www.cms.hhs.gov/NationalProvIdentStand/>
4. Address: Indicate the legal address for the of the agency as registered with the Georgia Secretary of State
5. Mailing Address: Indicate the mailing address if different from the legal address.
6. Owner: Indicate the name of the Owner for the agency.
7. Telephone: This is the office and cell telephone numbers for the Owner listed.
8. Fax: Indicate the fax number for the Owner listed.
9. Email: Enter the email address for the Owner listed.
10. CEO / Director: Indicate the name of the CEO / Director for the agency.
11. Telephone: This is the office and cell telephone numbers for the CEO / Director listed.
12. Fax: Indicate the fax number for the CEO / Director listed.
13. Email: Enter the email address for the CEO / Director listed.
14. Contact Name for this application: Provide the name of the Contact person for this application. The person identified, as the contact should be easily accessible via email for providing additional information should it be required.
15. Telephone: This is the office and cell telephone numbers for the Contact listed.
16. Fax: Indicate the fax number for the Contact listed.
17. Email: Enter the email address for the Contact listed.
18. Human Rights Contact: Indicate the name of the Human Rights Contact for the agency.
19. Telephone: This is the office and cell telephone numbers for the Human Rights Contact listed.
20. Fax: Indicate the fax number for the Human Rights Contact listed.
21. Email: Enter the email address for the Human Rights Contact listed.
22. Provide Website address if, applicable

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## Section II – Application Type

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Please select the applicable box. **Please note that both children and adults cannot receive Community Residential Alternative services at the same location.**

If Application Type selected is:

1. **Current Department of Behavioral Health and Developmental Disabilities (DBHDD) Developmental Disabilities Provider: Applying for New Service at a New Site. DCH Medicaid Provider numbers are service/site specific. Providers must submit simultaneously the [Department of Community Health \(Medicaid Application\) Additional Location Application](#).**
2. **Current DBHDD MRDD Provider: Applying for New Service at a Currently Established Site.** Indicate the existing provider number(s) for the site to which the new service should be added. If the site is a CRA site a new DCH Additional Location application is required. Please note that only Nursing Services, Environmental Adaptation, Specialized Medical Supplies (SMS), Specialized Medical Equipment (SME), and Transportation can be provided at an approved CRA site.

**Please 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 Commercial General Liability Insurance certificate**

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## Section III – Service Delivery Location

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Complete a Service Delivery Site form for each service for which you are applying. In addition, please provide the following information for this site. **If applying for multiple services or sites please submit a separate form for each.**

1. Select the appropriate waiver Category of Service (COS), both Categories may be selected, if applicable.
2. Waiver Service: Indicate the appropriate name of the service for which you are applying. *See Appendix A.*
3. HIPAA Code: Indicate the code that corresponds with the waiver service for which you are applying. *See Appendix A.*
4. Site Name: Name of the home or site of the service for which you are applying. For example, ABC Community Living Home or XYZ Service Center.
5. Site Address: Enter the actual address where the proposed site or service will be provided. For community services enter the office address.
6. DBHDD Region: Indicate which Region (1-6) your proposed site or service is located. *See Appendix B.*
7. Counties to be served at this location: List the counties that this location is requesting to serve. For services that require a Private Home Care license, include documentation from Health Facility Regulation indicating the counties that were approved under that license.

8. Site Manager: This is the name of the agency's manager designated for the proposed site. **It should be the Administrator /Director listed with the Health Facility Regulation (HFR) office for licensed residential sites.**
9. Telephone and Fax Number: Enter the telephone and fax number for the site to which calls and correspondence will be sent.
10. Developmental Disabilities Professional (DDP): Indicate the person who is the DDP assigned to this site. Please list the degree qualifications of the DDP. Include a current copy of the resume if not on file with the Office of Provider Network Management.
11. DDP's email address: Enter the email address of the agency's DDP assigned to this site.
12. Indicate which population this site will serve: Children only, Adults only or Both children and adults. **Please note that both children and adults cannot receive Community Residential Alternative services at the same location. If the population selected is Children, please include a copy of the agency's Child Placing Agency (CPA) license.**
13. If applicable, for the service indicate the type of Healthcare Facility Regulation (HFR) license / permit for this site or service and include a copy.
14. Host Home: If the site is a host home complete this section. Include a copy of the Host Home Self Study.
15. Staffing Schedule: Enter ALL staff assigned to proposed site or service. Enter the name of the staff, position title and employment status of fulltime, part-time, or PRN.

**Host Home study must include the following Supporting documents:**

- A general health examination of each member living in the potential Host Home
- Evidence of screening for tuberculosis and communicable disease for each member living in the potential Host Home
- 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](#)
- A minimum of three (3) character references for the potential Host Home/Life-Sharing provider (s)
- Proof of homeowner's, renter's insurance
- Statement as to whether or not there are firearms in the home
- Documentation of home ownership (ex. current mortgage statement) or renter's lease. Document(s) must be in the name of the potential Host Home provider.
- 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 Director or Developmental Disabilities Professional (DDP).
- 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

The DBHDD provider agency must 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

Please review the [Host Home Life Sharing Guidelines](#) found on the department's website for detailed information

**NOTE:**

- The DDP listed for each Agency must be primarily employed by the agency submitting application. While contract staff, and consultants are allowed, NOW and COMP Provider Manual Part II and Part III state that staff must be present in numbers to provide services and supports to participants as required. Each Development Disability Professional (DDP) must have a specified schedule or contract with sufficient hours per week to meet the duties of the DDP and level of need for individuals receiving services. A DDP consulting with multiple agencies on a contract basis may be required to provide evidence that (s)he is available as required, based on the services and support needs of the individuals served.
- Co-employer option is a service delivery option where the participant and/or family functions as the managing employer (co-employer) of workers who provide services. Please complete only if you are applying to provide Co-Employer Services. Select the Co-Employer service and submit the documents requested. Please be sure to complete the Authorized Agent information.

The **Attestations** should be completed, signed and submitted by the CEO/Director/Owner.

**CHECK LIST: FOR EXISTING PROVIDER ADDING NEW SERVICE(S) OR SITE(S)**

APPLICATION ITEMS:	Page #
1. Section I - Legal Name and Address	1
2. Section II – Application Type	2
3. Section III - Service Delivery Site <ul style="list-style-type: none"> <li>• Service Delivery Site</li> <li>• Staffing Schedule</li> <li>• If applicable, copy of:               <ul style="list-style-type: none"> <li>○ Child Placing Agency License</li> <li>○ Community Living Arrangement License</li> <li>○ Personal Care Home Permit</li> <li>○ Private Home Care License</li> <li>○ Home Health Agency</li> </ul> </li> </ul>	3-4
4. <a href="#">Host Home Self Study</a> , if applicable.  The following items must be included in each self study for each Host Home application: <ol style="list-style-type: none"> <li>i. A general health examination of each member living in the potential Host Home.</li> <li>ii. Evidence of screening for tuberculosis and communicable disease for each member living in the potential Host Home.</li> <li>iii. <a href="#">Criminal History Records Check</a>.</li> <li>iv. A minimum of three (3) character references for the potential Host Home/Life-Sharing provider (s)</li> <li>v. Proof of homeowner’s, renters insurance or personal property insurance</li> <li>vi. Statement as to whether or not there are firearms in the home.</li> <li>vii. 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.</li> <li>viii. 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 Director or Developmental Disabilities Professional (DDP).</li> <li>ix. 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.</li> <li>x. Evidence of the type of training, content, dates, length of training, and/or copies of certificates for each potential host home provider.</li> <li>xi. Signed attestation between the agency and the potential host home provider, which indicates the receipt of trainings, must also be submitted.</li> </ol>	5
6. Section IV – Co- Employer Services, if applicable	6-8
7. Attestations	9
8. Other Required Information: <ul style="list-style-type: none"> <li>○ Resume of Developmental Disabilities Professional (DDP), if not on file with DBHDD</li> <li>○ Copy of Accreditation or Certification if new or recertified since the last time your agency submitted an application</li> <li>○ Copy of Commercial or Comprehensive Liability Insurance, if renewed since the last time your agency submitted an application.</li> <li>○ Department of Community Health Application, Division of Medical Assistance (Medicaid)               <ul style="list-style-type: none"> <li>▪ <a href="#">Additional Location Form</a> for each location, if applicable <b>(MUST INCLUDE THE PROVIDER PAYEE NUMBER)</b></li> </ul> </li> </ul>	
Please Mail Application to:	
<b>Provider Enrollment Unit            Office of Provider Network Management            Department of Behavioral Health and Developmental Disabilities            2 Peachtree Street, Ste. 23.247            Atlanta, Georgia 30303</b>	
Any questions regarding your application must be submitted via email to the following address: <a href="mailto:MHDDAD-serviceapps@dbhdd.ga.gov">MHDDAD-serviceapps@dbhdd.ga.gov</a> .	

**SERVICE INFORMATION – COMMUNITY SERVICES**

<b>Waiver Service</b>	<b>Category of Service (COS)</b>	<b>HIPAA Code</b>	<b>Specialty Codes</b>	<b>Type of Applicant (Agency or Individual)</b>	<b>Required License / Credentials</b>
Behavioral Support Consultation	680 and 681	H2019	289	Individual Only	If applicable: <ul style="list-style-type: none"> <li>• Licensed Clinical Social Worker;</li> <li>• Licensed Professional Counselor;</li> <li>• Psychiatrist;</li> <li>• Psychologist</li> </ul>
Community Access - Group Services	680 and 681	T2025 HQ	412	Agency or Individual	Not Applicable
Community Access - Group Services Co-Employer	680 and 681	T2025 HQ/UA	414	Agency Only	Not Applicable
Community Access - Individual Services	680 and 681	T2025 UB	412	Agency or Individual	Not Applicable
Community Access - Individual Co-Employer Services	680 and 681	T2025 UB/UA	414	Agency Only	Not Applicable
<b>Community Guide –Co-Employer Services *</b>	680 and 681	H2015 UA	417	Agency Only	Not Applicable
Community Living Support Services – 15 minutes	680 and 681	T2025 U5	418	Agency or Individual	Agency: Private Home Care license (PHC)  Individual: Not Applicable
Community Living Support - Co-Employer Services -15 minutes	680 and 681	T2025 U5/UA	420	Agency Only	Private Home Care license (PHC)
Community Living Support Services – Daily	<b>681 ONLY</b>	T2025 U6	418	Agency or Individual	Agency: Private Home Care license (PHC)  Individual: Not Applicable
Community Living Support - Co-Employer Services Daily	<b>681 ONLY</b>	T2025 U6/UA	420	Agency Only	Private Home Care License (PHC)
Community Living Support – Registered Nurse ( RN) Services	680 and 681	T1002 U1	249	Agency or Individual	Agency: Private Home Care License and RN license for staff/contractors  Individual: Georgia RN license
Community Living Support - Licensed Practical Nurse (LPN) Services	680 and 681	T1003 U1	249	Agency or Individual	Agency: Private Home Care license and LPN license for staff/contractors  Individual: Georgia LPN license



Waiver Service	Category of Service (COS)	HIPAA Code	Specialty Codes	Type of Applicant (Agency or Individual)	Required License / Credentials
Community Residential Alternative Services (CRA)	<b>681 ONLY</b>	T2033	272	Agency Only	Adults: Community Living Arrangement License (CLA) <ul style="list-style-type: none"> <li>Not Applicable if Host Home for Adult Participants</li> </ul> Participants under the age of 19: Child Placement Agency (CPA) license
Community Residential Alternative - Registered Nurse (RN) Services	<b>681 ONLY</b>	T1002 U2	415	Agency Only	Agency: Community Living Arrangement License or Private Home Care License and RN license for staff/contractors
Community Residential Alternative Services – Licensed Practical Nurse (LPN)	<b>681 ONLY</b>	T1003 U2	415	Agency Only	Agency: Community Living Arrangement License or Private Home Care License and LPN license for staff/contractors
Environmental Accessibility Adaptation	680 and 681	S5165	067	Agency  Individual (Builder, Plumber, or Electrician)	Environmental Accessibility Adaptations are made by building, plumbing or electrical contractors with applicable Georgia license (OCGA 43-14-2 or 43-41-2) or individual builders, plumbers or electricians with applicable Georgia business license as required by the local, city or county government in which the services are provided.
Natural Support Training Service	680 and 681	T2025 UD	423	Agency or Individual	Agency: License if applicable for Developmental Disability Professional  Individual: Must meet the requirements for a DDP
Prevocational Services	680 and 681	T2015	421	Agency Only	Not Applicable
Respite - 15 minutes	680 and 681	S5150	243	Agency or Individual	Agencies: <ul style="list-style-type: none"> <li>Provider agencies that render Respite Services in the participant's own or family home must have a Private Home Care Provider license.</li> <li>Provider agencies that render out-of-home Respite Services in a Personal Care Home must have a Personal Care Home Provider license</li> </ul>

Waiver Service	Category of Service (COS)	HIPAA Code	Specialty Codes	Type of Applicant (Agency or Individual)	Required License / Credentials
Respite Services Co- Employer - 15 minutes	680 and 681	S5150 UA	426	Agency Only	Agencies: <ul style="list-style-type: none"> <li>Provider agencies that render Respite Services in the participant's own or family home must have a Private Home Care Provider license.</li> <li>Provider agencies that render out-of- home Respite Services in a Personal Care Home must have a Personal Care Home Provider license</li> </ul>
Respite - Overnight	680 and 681	S5151	244	Agency or Individual	Agencies: <ul style="list-style-type: none"> <li>Provider agencies that render Respite Services in the participant's own or family home must have a Private Home Care Provider license.</li> <li>Provider agencies that render out-of- home Respite Services in a Personal Care Home must have a Personal Care Home Provider license</li> </ul>
Respite Services - Overnight Co-Employer	680 and 681	S5151UA	428	Agency Only	Agencies: <ul style="list-style-type: none"> <li>Provider agencies that render Respite Services in the participant's own or family home must have a Private Home Care Provider License.</li> <li>Provider agencies that render out-of- home Respite Services in a Personal Care Home must have a Personal Care Home Provider license</li> </ul>
Specialized Medical Supplies	680 and 681	T2028	273	Agency or Individual Vendor/Dealer	Not Applicable
Specialized Medical Equipment	680 and 681	T2029	058	Agency or Individual Vendor/Dealer	Not Applicable
<b>Support Coordination *</b>	680 and 681	T2022	030	Agency Only	Not Applicable
Supported Employment Group Services	680 and 681	T2019 HQ	259	Agency or Individual	Not Applicable
Supported Employment Group Services Co-Employer	680 and 681	T2019 HQ/UA	430	Agency Only	Not Applicable

<b>Waiver Service</b>	<b>Category of Service (COS)</b>	<b>HIPAA Code</b>	<b>Specialty Codes</b>	<b>Type of Applicant (Agency or Individual)</b>	<b>Required License / Credentials</b>
Supported Employment Individual Services	680 and 681	T2019 UB	259	Agency or Individual	Not Applicable
Supported Employment Individual Services Co-Employer	680 and 681	T2019 UB/UA	430	Agency Only	Not Applicable
Transportation Encounter / Trip	680 and 681	T2003	400	Agency or Individual	Individual Providers rendering Transportation Services must hold a valid Class C license  DD Service Provider Agency driver staff providing Transportation Services must hold the class of license appropriate to the vehicle operated
Transportation Encounter / Trip Co-Employer	680 and 681	T2003 UA	402	Agency Only	DD Service Provider Agency driver staff providing Transportation Services must hold the class of license appropriate to the vehicle operated
Transportation Commercial Carrier, Multi-Pass	680 and 681	T2004	403	Agency Only	None
Vehicle Adaptations	680 and 681	T2039	275	Agency or Individual Vendor	Vehicle Adaptations are made by vendors with the applicable Georgia business license

**\* PROVIDERS APPLYING FOR THIS SERVICE MAY NOT APPLY TO DELIVER ANY OTHER NOW OR COMP SERVICE**

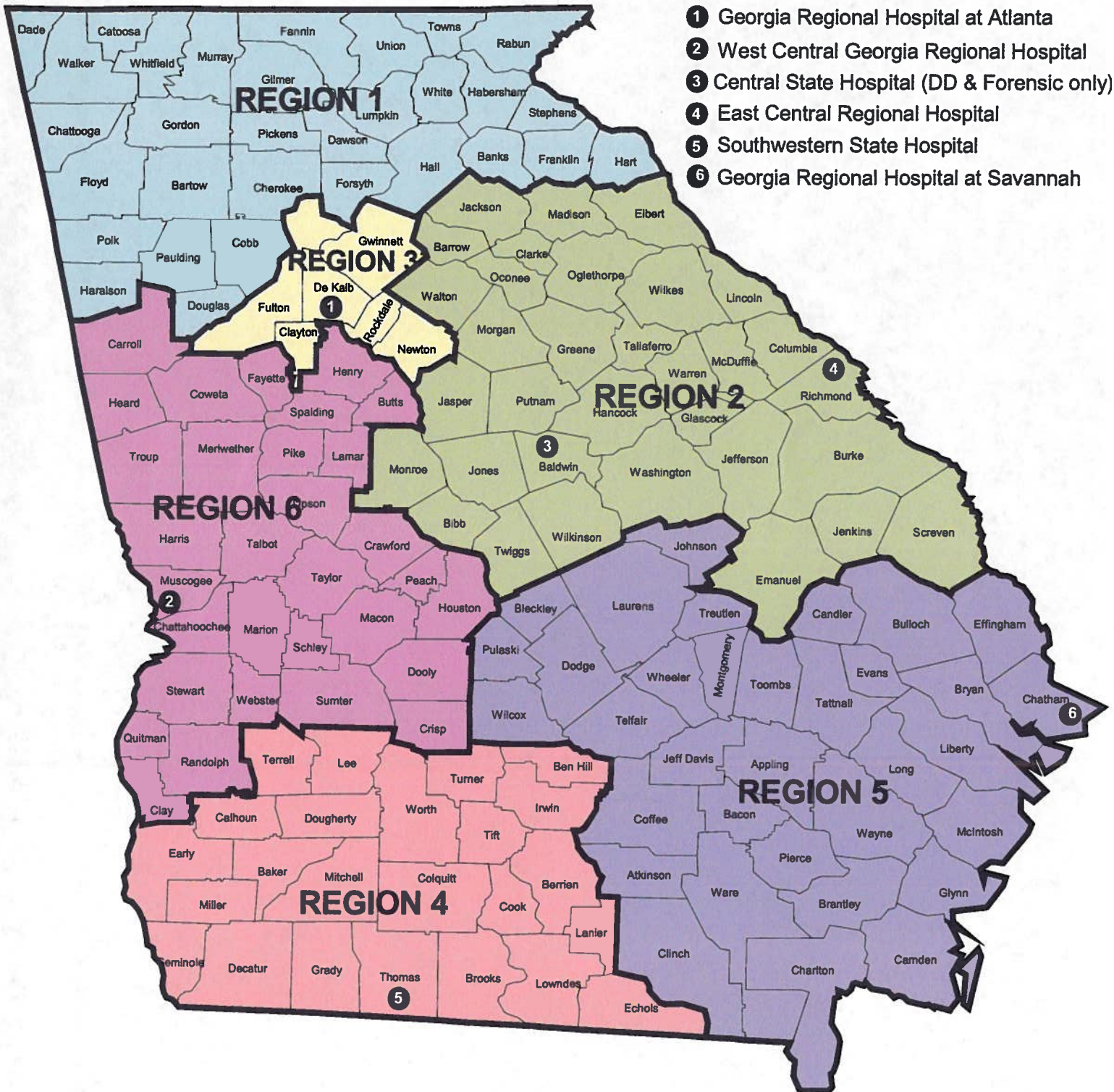
**SERVICE INFORMATION – ADULT THERAPY SERVICES**

<b>Waiver Service</b>	<b>Category of Service (COS)</b>	<b>HIPAA Code</b>	<b>Specialty Codes</b>	<b>Type of Applicant (Agency or Individual)</b>	<b>Required License / Credentials</b>
OT - Evaluation	680 and 681	97003	151	Agency or Individual	Agency: Staff / Contractors must be Georgia Licensed Occupational Therapist  Individual: Georgia Licensed Occupational
OT - Therapeutic Activities	680 and 681	97530 GO	151	Agency or Individual	Agency: Staff / Contractors must be Georgia Licensed Occupational Therapist  Individual: Georgia Licensed Occupational
OT - Sensory Integrative Techniques	680 and 681	97533 GO	151	Agency or Individual	Agency: Staff / Contractors must be Georgia Licensed Occupational Therapist  Individual: Georgia Licensed Occupational
PT- Evaluation	680 and 681	97001	201	Agency or Individual	Agency: Staff / Contractors must be Georgia Licensed Physical Therapist  Individual: Georgia Licensed Physical Therapist
PT - Therapeutic Procedures	680 and 681	97110	201	Agency or Individual	Agency: Staff / Contractors must be Georgia Licensed Physical Therapist  Individual: Georgia Licensed Physical Therapist
Speech Language Evaluation	680 and 681	92506	251	Agency or Individual	Agency: Staff / Contractors must be : Georgia Licensed Speech and Language Pathologist  Individual: :Georgia Licensed Speech and Language Pathologist
Speech Language Therapy	680 and 681	92507 GN	251	Agency or Individual	Agency: Staff / Contractors must be : Georgia Licensed Speech and Language Pathologist  Individual: :Georgia Licensed Speech and Language Pathologist
Speech-Generating Device Therapy	680 and 681	92609	251	Agency or Individual	Agency: Staff / Contractors must be : Georgia Licensed Speech and Language Pathologist  Individual: Georgia Licensed Speech and Language Pathologist

# Georgia Department of Behavioral Health & Developmental Disabilities REGION MAP (Effective July 1, 2011)

## STATE HOSPITALS

- ① Georgia Regional Hospital at Atlanta
- ② West Central Georgia Regional Hospital
- ③ Central State Hospital (DD & Forensic only)
- ④ East Central Regional Hospital
- ⑤ Southwestern State Hospital
- ⑥ Georgia Regional Hospital at Savannah



Department of Behavioral Health and  
Developmental Disabilities  
Information Management Unit

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