

**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: PRIMARY GEORGIA SITE

(Legal name and address that is registered with the 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: | | | |
| Telephone: | | Fax: | |
| Email Address: | | | |
| Director: | | | |
| Telephone: | | Fax: | |
| Email Address: | | | |
| Contact Name: | | | |
| Telephone: | | Fax: | |
| Email Address: | | | |
| Human Rights Contact: | | | |
| Telephone: | | 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, Division of Medical Assistance (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: _____

DBHDD CERTIFICATION: YES NO

IF YES: **Expiration Date:** _____

NOTE:

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

- **Copy of your agency's Accreditation or Certification certificate**
- **Copy of Commercial General Liability Insurance certificate**

SECTION III: SERVICE DELIVERY SITE

Complete the following information for each service for which you are applying. If applying for multiple services or sites please submit a separate form for each.

| | | | | |
|---|--------|---------|------------------|---------------|
| Category of Service (COS): <input type="checkbox"/> 680 - New Option Waiver (NOW) <input type="checkbox"/> 681 - Comprehensive Supports Waiver (COMP) | | | | |
| Waiver Service: | | | | |
| HIPAA Code: | | | | |
| Site Name: | | | | |
| Street Address: | | | | |
| City: | State: | County: | Zip Code: | DBHDD Region: |
| 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) Personal Care Home (PCH)
 Private Home Care (PHC)

Is this an existing DBHDD MRDD 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) |
|------|----------------|---|
| | | <input type="checkbox"/> Fulltime <input type="checkbox"/> Part Time <input type="checkbox"/> PRN |
| | | <input type="checkbox"/> Fulltime <input type="checkbox"/> Part Time <input type="checkbox"/> PRN |
| | | <input type="checkbox"/> Fulltime <input type="checkbox"/> Part Time <input type="checkbox"/> PRN |
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| | | <input type="checkbox"/> Fulltime <input type="checkbox"/> Part Time <input type="checkbox"/> PRN |
| | | <input type="checkbox"/> Fulltime <input type="checkbox"/> Part Time <input type="checkbox"/> PRN |

Include the following documentation with each Host Home Self Study:

1. A general health examination of each member living in the potential Host Home.
2. Evidence of screening for tuberculosis and communicable disease for each member living in the potential Host Home.
3. Criminal records check/clearance.
4. A minimum of three (3) character references.
5. Proof of homeowner's, renters insurance or personal property insurance.
6. Statement as to whether or not there are firearms in the home.
7. 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.
8. 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).
9. 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. Conduct criminal records checks 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 provides technical assistance to participants and/or their representatives on employer-related responsibilities.
5. Process and bill for services approved in the service plan.
6. 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:
- A. Verify staff qualifications of potential employees referred by the Participant who self-directs their services and supports through the co-employer option.
 - B. Obtain criminal history and/or background investigation of co-employees.
 - C. Conduct criminal records checks of co-employees.
 - D. Process payroll, withholding, filing and payment of applicable federal, state and local employment- related taxes and insurance for co-employees.
 - E. Conduct skills training and provide technical assistance to participants and/or their representatives on employer-related responsibilities.
 - F. 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 MHDDAD 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; national criminal records check (NCIC) 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 national criminal records check (NCIC) 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 national criminal records check (NCIC).

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.

Name of Organization (please print)

Name of CEO/ Director/ Owner (please print)

Signature of CEO/ Director/ Owner

Date