DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES PROVIDER LETTER OF INTENT FOR SUPPORT COORDINATION INTENSIVE SUPPORT COORDINATION

DBHDD

To ensure timely processing of your Letter of Intent, please return the following checklist and documents.

CHECKLIST:

- ☐ Certificate of Attendance at the most recent DD Provider Forum
- ☐ Completed Letter of Intent form
- ☐ Completed Service Location Addendum(s) - <u>One Per Service Location</u>
- ☐ Copy of last two years agency's business Tax Returns or audited financials to support assertions that applicant has been in business for a year
- ☐ Agency Bank Statements – business statements for previous 6 months
- ☐ Copy of IRS letter that verifies Tax ID number, e.g., Form 147C or Form CP575A
- ☐ Copy of IRS Exempt Letter (Non Profits only)
- ☐ Three Professional Reference Letters
- ☐ Providers approved to operate outside the State of Georgia, submit a Statement of Participation or other documentation from the state authority that indicates the provider is in good standing
- ☐ Copy of "DBA" or trade name Registration filed with the Clerk of the Superior Court of the county of the corporation's domicile, if the applicant operated or will operate under a trade name or "DBA"
- ☐ Copy of the Current Georgia Secretary of State registration
- ☐ Copy of each site County/City Business license or permit. If not required by municipality, documentation from municipality stating not required
- ☐ Accreditation Certificate(s)
  - o TJC – The Joint Commission
  - o CARF – Commission on Accreditation of Rehabilitation Facilities
  - o COA – Council On Accreditation
  - o CQL – Council on Quality and Leadership
- ☐ Employment Attestations
  - o Developmental Disabilities Director
  - o Developmental Disabilities Professional
  - o Medical or Clinical Director *(resume or curriculum vitae required at application following LOI)*
- ☐ Resume of:
  - o Developmental Disabilities Director
  - o Developmental Disabilities Professional
- ☐ Completed Narrative (Page 7)

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I. GENERAL INFORMATION

A. Georgia Agency Legal Name: _____

DBA/Trade Name: _____

Address: _____

City: _____ County: _____

State: _____ Zip Code (9 Digits): _____

Phone #: (___)_____

TAX ID#:_____ DUNS Number, if applicable: _____ Fiscal Year End:_____

Mailing Address (if different): _____

City: _____ County: _____

State: _____ Zip Code (9 Digits): _____

B. Agency Point of Contact

Chief Executive Officer: _____

Phone: _____ E-mail: _____

Developmental Disabilities Director: _____

Phone: _____ Email: _____

Developmental Disabilities Professional: _____

Phone: _____ Email: _____

Person completing this application / Title: _____

Phone: _____ Email: _____

Website Address of Agency: www._____

C. Please complete if agency is part of a corporate system:

Corporate Name: _____

Contact Name: _____ Title: _____

Primary Mailing Address: _____

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City: _____ County : _____

State _____ Zip Code (9 Digits): _____

Phone #: _____ Email address: _____

D. Business Classification (Please Check only one box for Ownership and only one box for Status)

1. Ownership: ☐ Private ☐ Public ☐ Government Program

2. Status: ☐ For-Profit ☐ Not-for-Profit

E. This organization is accredited by one or more of the following:

☐ Not Accredited

☐ The Joint Commission (TJC)

Certificate No. _____ Effective Date:_____ Expiration Date:_____

☐ Commission on Accreditation of Rehabilitation Facilities (CARF)

Certificate No. _____ Effective Date:_____ Expiration Date:_____

☐ Council On Accreditation (COA)

Certificate No. _____ Effective Date:_____ Expiration Date:_____

☐ Council on Quality and Leadership (CQL)

Certificate No. _____ Effective Date:_____ Expiration Date:_____

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Developmental Disabilities -- Attestation of the Agency Director

The minimum responsibilities of the agency's Director are specified below. My signature indicates that I have read these responsibilities, discussed them with (Owner or CEO)

_____

Name of Owner or CEO

I agree that I will be employed by this agency and accountable for meeting each of these requirements. I also agree that I have reviewed my resume submitted by this agency and agree that it accurately reflects both my education and experience.

Duties of the Agency Director include, but are not limited to:

- Overseeing the day-to-day operation of the agency;
- Managing the use of agency funds;
- Ensuring the development and updating of required policies of the agency;
- Managing the employment of staff and professional contracts for the agency;
- Designating another agency staff member to oversee the agency in my absence.

_____ _____

Signature Date

_____

Printed Name

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Attestation of the Agency Developmental Disabilities Professional (DDP)

The minimum responsibilities of the agency's DDP are specified below. My signature indicates that I have read these responsibilities, discussed them with (Owner or CEO)

_____
Name of Owner or CEO

I agree I will be employed by this agency and accountable for meeting each of these requirements. I also agree that I have reviewed my resume submitted by this agency and agree that it accurately reflects both my education and experience.

At least one agency employee or professional under contract with the agency must be a Developmental Disability Professional (DDP) (for definition, see *Part II Policies and Procedures for COMP, Appendix I);*

Duties of the DDP include, but are not limited to:

- Overseeing the services and supports provided to participants;
- Supervising the formulation of the participant's plan for delivery of all waiver services provided to the participants by the provider;
- Supervising high intensity services
- Coordinating and/or participating in the agency's quality improvement planning and evaluation.

_____ _____
Signature Date

_____
Printed Name

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SERVICE(s) REQUESTED:

☐ **Support Coordination**

☐ **Intensive Support Coordination**

SERVICE LOCATION: **BILLING ADDRESS:** (Please confer with your Billing Dept.)

Site Name:_____

Address Line 1: _____ Address Line 1::_____

Address Line 2: _____ Address Line 2: _____

City, State: _____ City, State: _____

ZIP (9 Digit): _____ Zip (9 Digit): _____

Phone Number: _____ Phone Number: _____

Region(s) Requested:

☐ Region 1

☐ Region 2

☐ Region 3

☐ Region 4

☐ Region 5

☐ Region 6

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Narrative

Please answer the following questions:

All applicants:

1. Does this agency provide any Waiver funded services other than case management/support coordination?
   ☐ Yes ☐ No
   If yes, please describe how applicant agency will assure compliance with conflict free case management as outlined in 42 CFR §441.301(b)(1).

2. Document the agency's background (minimum of five years) of business experience and oversight of 5 or more employees in the health care, behavioral health or case management field. Include a description of the primary function of the business, type and number of employees, type of services provided, and date the business opened.

Support Coordination applicants:

1. Provide evidence of your agency's experience in providing home and community based case management services for individuals with disabilities or the aging populations. A minimum of five years of agency experience in the field is required. Examples of evidence include: an executed contract that describes the service provided; evidence of continuous enrollment in a publicly-funded program serving one or more of the populations named above; a memorandum of understanding with a healthcare provider, State Agency, or managed care organization that describes the service to be delivered.

2. Provide an explanation of your agency's experience as it relates to the following key functions of case management:
   - Use of person-centered preferences and assessed needs in development and periodic revision of individual service plans
   - Measuring quality of services and satisfaction with services, ensuring that the services that are provided are consistent with quality measures and expectations of the individual
   - Coordination of resources and services offered through Medicaid Waiver Programs as well as the larger community and healthcare system
   - Crisis response
   - Recognition, intervention and follow up on unmet needs

Intensive Support Coordination applicants:

1. Provide evidence of your agency's experience serving individuals at risk due to medical, functional, and/or behaviorally complex conditions. A minimum of five years of agency experience in the field is required. Examples of evidence include: an executed contract that describes the service provided; evidence of continuous enrollment in a publicly-funded program serving one or more of the populations named above; a memorandum of understanding with a healthcare provider, State Agency, or managed care organization that describes the service to be delivered.

2. Provide an explanation of your agency's experience as it relates to the following key functions of case management:
   - Use of person-centered preferences and assessed needs in development and periodic revision of individual service plans
   - Management and support of self-direct services
   - Coordination of resources and services offered through Medicaid Waiver Programs as well as the larger community and healthcare system
   - Crisis response
   - Periodic evaluation of complex medical and behavioral needs
   - Recognition, intervention and follow up on unmet needs

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PROVIDER PROFILE QUESTIONS

PLEASE ATTACH A DETAILED EXPLANATION FOR ANY QUESTIONS BELOW THAT WERE ANSWERED "YES"

A. Please answer the following questions regarding your organization's **programs:**

1. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had its professional liability or malpractice insurance refused, revoked, declined or accepted on special terms in the past five (5) years? ☐ Yes ☐ No

2. Has any government agency suspended, revoked, or taken other action against the organization's license to practice or to conduct business in the past five years, or taken such an action in the past five years against any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee? (To include Medicaid /Medicare) ☐ Yes ☐ No

3. Have any accreditations or memberships in professional organizations been revoked, reduced, denied, or suspended by others or voluntarily given up by the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, in the last five years, or are any actions now under way which may lead to such sanctions? ☐ Yes ☐ No

4. Has any Owner, Managing Employee, officer, or shareholder of the organization **ever** been convicted of a crime, excluding minor traffic misdemeanors? ☐ Yes ☐ No

5. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, **ever** been previously denied acceptance into, disenrolled from, or withdrawn from GA DBHDD or GA Collaborative ASO network participation? ☐ Yes ☐ No

6. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had any settled claims or judgments relating to sexual misconduct or civil rights violations in the past five years? If **Yes**, enter the total number: _____ ☐ Yes ☐ No

7. In the past five years, has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had any settled claims or judgments relating to any other matter not disclosed in the response to Question 6 above?
   If **Yes**, enter the total number:_____ ☐ Yes ☐ No

8. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, been a defendant in five (5) or more lawsuits within the **past five (5) years?**
   If **Yes**, enter the total number: _____ ☐ Yes ☐ No

9. Does the organization hire, continue to employ, or contract with individuals listed on the Office of Inspector General's List of Excluded Individuals/Entities (to include owners, officers, employees, subcontractors, and others identified in §1128)? ☐ Yes ☐ No

10. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, filed for Bankruptcy in the past five years? ☐ Yes ☐ No

MALPRACTICE CLAIM INFORMATION WORKSHEET

Please attach information on what the organization's response was to the allegations and what steps were taken to prevent any future incidents for each claim listed below. This page can be copied to accommodate additional claim information.

1. Date of Occurrence: _____ Date Claims Filed: _____ Date of Settlement: _____

   Allegations and Action Taken: _____

   _____

   _____

   Case Settled: ☐ In Court with Prejudice ☐ Out of Court without Prejudice

   Total Amount Paid to Claimant on Behalf of Agency: _____

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2. Date of Occurrence: _____ Date Claims Filed: _____ Date of Settlement: _____

   Allegations and Action Taken:_____

   _____

   _____

   Case Settled: ☐ In Court with Prejudice ☐ Out of Court without Prejudice

   Total Amount Paid to Claimant on Behalf of Agency: _____

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3. Date of Occurrence: _____ Date Claims Filed: _____ Date of Settlement: _____

   Allegations and Action Taken: _____

   _____

   _____

   Case Settled: ☐ In Court with Prejudice ☐ Out of Court without Prejudice

   Total Amount Paid to Claimant on Behalf of Agency: _____

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4. Date of Occurrence:_____ Date Claims Filed: _____ Date of Settlement: _____

   Allegations and Action Taken: _____

   _____

   _____

   Case Settled: ☐ In Court with Prejudice ☐ Out of Court without Prejudice

   Total Amount Paid to Claimant on Behalf of Agency: _____

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PARTICIPATION STATEMENT:

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

By signing below, I hereby certify and attest that my staff, agents, contractors, subcontractors, billing agent(s) and I have reviewed and agree to comply with the terms and conditions set forth in the applicable DBHDD and Department of Community Health (DCH)/ Medicaid Provider manuals.

I understand and acknowledge that the policies and procedures manuals are amended (generally on a quarterly basis) when either Department finds it necessary or appropriate to do so, and that it is my responsibility 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 (DBHDD or DCH) 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.

Under applicable state and federal laws, I do hereby affirm that I am the authorized agent to complete this document and that the information contained herein this document is complete, true, and correct to the best of my knowledge. I understand that material misrepresentation and/or falsification of any information contained herein shall result in the immediate removal of further consideration for participation.

_____
Agency Name

_____ Date (mm/dd/yy): _____/_____/_____
Authorized Signature

_____
Name (Please Print)

_____
Title

DISCLOSURE OF OWNERSHIP FORM

Directions: In order to comply with Federal law (42 CFR 420.200 - 420.206 and 455.100- 455.106) health plans with Medicaid or Medicare business are required to obtain certain information regarding the ownership and control of entities with which the health plan contracts for services for which payment is made under the Medicaid or Medicare program or any line of business that provides healthcare for federal employees. The Centers for Medicaid and Medicare Services (CMS) requires the Georgia Collaborative to obtain this information to demonstrate that we are not contracting with an entity that has been excluded from federal and state health programs, or with an entity that is owned or controlled by an individual who has been convicted of a criminal offense, has had civil monetary penalties imposed against them, or has been excluded from participation in Medicare or Medicaid.
Please complete the following 3 pages below. This form is required if you wish to participate or continue to participate in the plan. You are also reminded that any changes to this information in the future must be reported to the Georgia Collaborative within 35 business days of the change and updated information will be requested upon recredentialing. Please provide information for Owners, persons with Control interests, Agents and Managing employees of the Provider Entity. Attach a separate sheet/report if needed. If the agency is a non-profit please put N/A in % ownership column.

Definitions:

Owner (1) is a person or business entity which owns 5% or more of the assets, stock or profits of the Provider Entity. This 5% may be Direct ownership or Indirect ownership i.e., an individual might own 50% of an agency that owns the actual Provider Entity meaning their indirect ownership is 50%. In addition to ownership of stock, (2) Owner is also a person who owns a legal obligation like a mortgage or loan that is secured by the assets of the Provider Entity.

Control Interest is someone who directs the Provider Entity and includes Directors, Trustees and Officers of Corporations and Partners in a Partnership. If the Provider Entity is a non-profit entity, respond N/A in the column for % of ownership.

Managing Employee is someone who makes the day to day decisions for the Provider Entity. These individuals include office or billing managers for smaller providers, and for larger Provider Entities the heads of the major operating groups of the provider like, Head of Accounting, or Director of same day services. In other words, the line of individuals typically listed below the corporate officers on an organizational chart.

Agent is an individual who has the legal ability to bind the Provider Entity, i.e., the Provider Entity may use an Agent to obtain contracts for it.

Debarred or Excluded means an individual or entity that is not allowed to do business with the Federal government, including healthcare programs receiving Federal funding or reimbursement.

Terminated means the Provider lost the right to bill a State's Medicaid or CHIP programs for a cause related to fraud or abuse.

Immediate Family is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. Member of Household is, with respect to a person, any individual with whom they are sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

A **Subcontractor** is a person or agency that this Provider Entity has contracted with to do some of the Provider Entities' management functions, i.e., billing agent, or provide medical services i.e. a medical lab.

Supplier means an individual, agency, or organization from which the Provider Entity purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmacy.)

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Master List: The list of owners the provider will be disclosing on form.

Provider Entity: Any individual or entity engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in that State if such licensure or certification is required by State law or regulation

I. IDENTIFYING INFORMATION

Name of person Completing form	Phone number of person completing form
Provider Name:	

Provider Entity Name	Provider Entity DBA Name (if different from Provider Entity name)	Provider Entity Federal Tax Id number

Provider Entity NPI Number (If you have one, if not indicate if applicable)	Provider Entity Medicaid ID number (If you have one, if not indicate if applied for.)	Provider Entity Telephone Number

Provider Entity Address- Must include at least one street address. List all Practice locations (attach a separate sheet if needed).	City	State	Zip

II. OWNER OR CONTROL INFORMATION

A. Master List- If attaching reports please indicate corresponding columns below.

Name	Address (For *individuals* use Home address. For *business entities* that might have Ownership/Control interest use all street addresses (if more than one location), and P.O. Box address if any.)	City	ST	ZIP	DOB	SSN for individuals or Tax ID for business entities	% owner-ship.	Title

B. Specific Questions

1) Is any person on the **Master List** related to another person on the **Master List** as a spouse, parent, child or sibling? If attaching a report, please indicate corresponding columns below.

Yes ☐ No ☐ If yes, please provide the following information about the related persons:

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Name of First related person	Name of Second related Person	Type of relation

2) Does any person or entity in the **Master List** have an **Ownership** or **Control** interest in any other **Provider Entity**? If attaching a report, please indicate corresponding columns below.

Yes ☐ No ☐ If "yes", please provide the following information about the other Provider Entity the person on the Master List has an interest in.

Name of other Provider Entity	Address	City	State	Zip	Tax I.D.

Have any of the individuals or entities on the **Master list** been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Tricare or the CHIP services program since the inception of those programs?

Yes ☐ No ☐. If yes, please provide the information requested below:

Name on Court records	SSN /TIN	Matter of the Offense	Date of the Conviction	Exclusion Period of the Offense if you were excluded by the Federal Office of the Inspector General(OIG)

3) Have any of the individuals or entities on the **Master List** ever been **Debarred or Excluded** from participation in Federal Government contracts (Medicaid, Medicare, CHIP or Tricare)?

Yes ☐ No ☐ If 'yes' is checked, provide the following information:

When you were debarred	Length of Debarment	Reason for Debarment

4) Has any person or entity on the **Master List** ever been **Terminated or had Civil Monetary Penalties** from a State's Medicaid or CHIP programs for reasons having to do with Program Integrity (fraud or abuse)?

Yes ☐ No ☐ If "Yes", please supply the following information:

State where practicing when terminated	Reason for termination	Date of termination

5) Did anyone on the **Master List** obtain their **Direct or Indirect Ownership** interest 1) as a result of a transfer of Direct or Indirect ownership from someone who was about to be Excluded or Terminated from participation in a Federal healthcare program, or was in fact Excluded or terminated from participation in a federal healthcare program and 2) where the original **Owner** is or was a member of the **current Owner's Immediate Family** or M**ember of** the current owner's household, at the time of the transfer of ownership? If attaching a report, please indicate corresponding columns below.

Yes ☐ No ☐ If "Yes", please supply the following information:

Name of original Owner	SSN or TAX ID of original Owner	Place of Transfer	Date of Transfer

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6a) List any **Subcontractor** in which this **Provider Entity** has a Direct or Indirect **Ownership** interest of at least a 5%. A **Subcontractor** is a person or agency that this **Provider Entity** has contracted with to do some of the **Provider Entities'** management functions, i.e., billing agent, or provide medical services i.e. a medical lab. If attaching a report, please indicate corresponding columns below.

Name of Subcontractor	Address	City	State	Zip	Tax I.D.

6b) For each **Subcontractor(s)** listed in 6a above please provide the following information for the individuals with an Direct or Indirect **Ownership** or **Control Interest** in the **Subcontractor(s).** See the Introduction section above for a definition of those terms. Attach a separate sheet if necessary. If attaching a report, please indicate corresponding columns below.

Name	**Address** (for individuals use Home address, for business entities that might have Ownership/Control interest use all street addresses (if more than one location), and P.O. Box address (if any)	City	ST	Zip	DOB	**SSN** for individuals **or Tax ID** for business entities	**% of owner - ship**	Title

6c) Is anybody in the list in 6b list related to any person in the **Master List** above? If attaching a report, please indicate corresponding columns below.

Yes ☐ No ☐ If yes, please supply the following information about the related persons:

Name of First related person	Name of Second related Person	Type of relation

III. BUSINESS TRANSACTIONS

1) Please list the **Subcontractors** with whom you have done business over the last 5 years where the contract is worth at least 5% of your **Provider Entities'** total operating expenses *or* $25,000 *whichever is less*. Use a separate sheet if necessary. *Do not* include the Subcontractors listed in II.7a. in which you have an **Direct or Indirect Ownership interest**. If attaching a report, please indicate corresponding columns below.

Name	Address	City	State	Zip

2) Does the **Provider Entity** *wholly own* a **Supplier**? If attaching a report, please indicate corresponding columns below.

Yes ☐ No ☐ If yes, supply the following information about the **Supplier:**

Name	Address	City	State	Zip	NPI	TIN

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Answer the following questions by checking '"Yes" or "No'•. If any of the questions are answered "Yes," list names and addresses of individuals or corporations and/or provide date and an explanation.

1. Has there been a change in ownership or control within the last year? If yes, give date and provide an explanation: _____ Yes ☐ No ☐

2. Do you anticipate any change of ownership or control within the year? If yes, provide date and explanation. _____ Yes ☐ No ☐

3. Do you anticipate filing for bankruptcy within the year? If yes, when? _____ Yes ☐ No ☐

4. Is this facility, agency, institution or organization operated by a management agency, or leased in whole or part by another organization? If yes, give date of change in operations and provide explanation. Yes ☐ No ☐
_____

5. Has there been a change in CEO, DD Director, DDP, Clinical Director, or Medical Director within the last year? Yes ☐ No ☐

6. Is this facility, agency, institution or organization chain affiliated? (If yes, list name, address of Corporation, and EIN) _____ Yes ☐ No ☐

IV. SIGNATURE

Department of Behavioral Health and Developmental Disabilities (DBHDD) may refuse to enter into, renew, or terminate an agreement with a Provider if it is determined that a Provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106. The signature below **MUST** be the written signature of an individual who can legally bind this **Provider Entity**;

Name of Person (Printed)	Signature of Person	Title	Date