GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Medical Assistance Administration

DEPARTMENT ON DISABILITY SERVICES (DDS)
WAIVER PROVIDER ENROLLMENT APPLICATION PACKAGE

APPLICATION PROCESS

Step One
Applicants are required to first submit an application with a signed DDS Waiver Provider Agreement and any information and documentation requested. DDS will review the application. If the application is complete a determination will be made with 15 business days of receipt. If the application is not complete DDS will contact the provider and provide a description of any additional information or documentation that is required to complete the application. DDS will provide Technical Assistance with completing the application if requested.

Step Two
Applicants successfully completing Step One of the process will be officially enrolled as a DDS Medicaid Waiver Provider and given a Medicaid Provider Number.

Step Three
After successfully completing Steps One and Two, providers will be required to complete a mandatory DDS Provider Training (to include additional staff as appropriate) and ACS training in the provider billing and reimbursement process.

GUIDELINES

- Submission of an application does not constitute automatic acceptance into the program
- Anticipated processing time for applications in Step One is approximately fifteen (15) business days
- ***"In State"*** DDS Waiver Providers are defined as entities located inside the geographic boundaries of the District of Columbia
- ***"Out of State"*** DDS Waiver Providers are defined as entities located outside the geographic boundaries of the District of Columbia
- Electronic copies of the DDS Waiver Provider Enrollment Package can be found on the DDS website at dds.dc.gov.
- ***Direct questions to:***
  Department on Disability Services (DDS)
  HCBS Provider Enrollment
  Tel (202) 730 1800
  e-mail: ddsmedicaidwaiver@dc.gov
- ***Mail completed application package to:***
  Department on Disability Services (DDS)
  HCBS Provider Enrollment
  1125 15th Street, NW, 9th Floor
  Washington, DC 20005

APPLICATION INSTRUCTIONS

[redacted]

- National Provider Identifier (NPI) is mandatory.
- Medicaid Provider Number

[redacted]

- Check one box **only**
- Partnerships must attach a legible copy of the partnership agreement.
- If Other is checked, write in type of entity.
- Attach legible copies of all requested documents as instructed in Section 15.

[redacted]

3a) Company Name

- Individual practitioners should provide full name.
- Give company name or corporate group name as registered with the Internal Revenue Service (IRS) and under which business is conducted.
- Provide primary business location address, telephone and fax numbers, website and email address.

3b) Out of State Applicant/Provider ONLY

- Attach a copy of your District of Columbia Certificate of Authority (Obtained through the DC Department of Consumer and Regulatory Affairs)
- Provide information regarding your District of Columbia registered agent.
- Attach a Medicaid Provider Number.

3c) Company Information

- Attach copies of **all** requested documents.

[redacted]

- Minimum coverage is $300,000.
- Exceptions: (Providers required to maintain $1,000,000 in coverage)
    - Occupational Therapy (Private Practice)
    - Personal Care Services
    - Physical Therapy (Private Practice)
    - Speech, Hearing & Language Therapy (Private Practice)
- Provide information as requested.
- Attach copy of Certificates of Insurance for the business address listed on the application as instructed in Section 15

[redacted]

- If available, attach copies of current (within the past 90 days) Background Checks for each “unlicensed” professional or administrator.
- Indicate the number of Background Checks that are included.

[redacted]

- Service Locations and Hours of Operation
  - Provide requested information for the service location.
  - Post Office Boxes are ***prohibited.***

[redacted]

- Where do you want payments sent? A Post Office Box is acceptable.
- Where do you want Remittance Advices sent? A Post Office Box is acceptable.
- Only one Remittance Address is allowed per provider number.
- Check whether you will use electronic or paper billing.

[redacted]

- Give us the mailing address to which correspondence (manual updates, memoranda, etc.) can be sent. A Post Office Box address is acceptable.
- Only one Correspondence Address is allowed per provider number.

[redacted]

Included in this section are definitions of DDS Waiver Service categories along with some of the important provider requirements for each. Each Waiver Service is governed by the rule found in parenthesis next to the Service name. A copy of the rule can be downloaded from dds.dc.gov (when available) and reviewed to identify **all** requirements necessary to perform the service.

Check **ALL** categories that apply. Remember to attach copies of licenses and certifications behind the cover page for Section 9.

[redacted]

10a -10i) Check 'Yes,' 'No' or 'N/A' in response to the questions listed.

10j) If 'Yes' is checked for #2, provide the name and telephone number of the person who holds ownership of the warehouse, along with the owner's complete address.

10k – 10n Check 'Yes,' 'No' or 'N/A' in response to the questions listed.

10o– 10r) Check 'Yes,' 'No' or 'N/A' in response to the questions listed. If 'Yes' is checked, please explain in the space provided in Section 11.

10s) Check 'Yes,' 'No' or 'N/A' in response to the questions listed. If 'Yes' is checked provide the information requested behind page 32.

[redacted]

If you answered "YES" to questions '10o,', '10p,', '10q,'" and '10r' please provide an explanation or additional information for each.

[redacted]

Follow the instructions found in this section to complete the form. Remember to sign the document.

[redacted]

Follow the instructions found in this section to complete the form. Remember to sign the document.

[redacted]

Review this document carefully. Don't forget to sign and date it.

Section 15 PROVIDER AGREEMENT

Review and sign.

[redacted]

- Application packages MUST be assembled according to the instructions.
- Please use attached Cover Sheets found in this Section to assemble your application package.
- Place your attachments behind the appropriate cover sheet.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
Medical Assistance Administration

DEPARTMENT ON DISABILITY SERVICES (DDS)
WAIVER PROVIDER ENROLLMENT APPLICATION PACKAGE

Important:
- Read all instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return the completed application package and accompanying documentation in the format specified to:

Department on Disability Services
HCBS Provider Enrollment
1125 15th Street, NW, 9th Floor
Washington, DC 20005

Do not use staples on this application or on any attachments. Do not leave any questions, boxes or lines blank. Enter N/A if not applicable.

[redacted]

National Provider Identifier (NPI): _____ Medicaid Provider Number: _____
(Attach legible copy of NPI letter)

[redacted]

☐ Sole proprietor ☐ Partnership (attach legible copy of agreement) ☐ Government Entity
☐ Corporation: ☐ Limited Liability Company (LLC): ☐ Nonprofit Corporation
☐ Other: _____

State Registered/Filed: _____

2b) BUSINESS LICENSE/CERTIFICATE OF OCCUPANCY/PERMITS/CERTIFICATES/ CERTIFICATE OF NEED/JACO CERTIFICATION/HUMAN CARE AGREEMENT (Attach legible copies as instructed in Section 15)

3a) COMPANY NAME (as listed with the IRS)

_____

Name of Owner(s)_____ _____

Doing Business as _____

Primary Business Address _____

City/State/Zip _____

Telephone _____ Fax _____

Website _____ Email _____

3b) OUT OF STATE APPLICANTS "ONLY" (Attach copy of D.C. Certificate of Authority)

1. Registered Agent (**PO Box Prohibited**):

   Name (Last, First, Middle) _____

   Company Name_____

   Address_____

   City/State/Zip_____

   Telephone_____ Email_____

   Website_____

   Medicaid Provider Number in the state of your service location _____
   (Attach copy proof of Medicaid enrollment in your State)

   Medicare Provider Number_____
   (Attach copy of CMS Supplier Letter)

3c) COMPANY INFORMATION (Attach documents as directed in Section 15)

1. Description of ownership and a list of major owners (stockholders owning or controlling ten (10) percent or more outstanding shares);
2. List of Board Members and their affiliations (if applicable);
3. A copy of the basic organizational documents of the provider, a roster of key personnel with titles, including an organizational chart;
4. Copy of corporate by-laws;
5. Copy of most recent audited financial statement; and
6. Copy of CMS Supplier Letter ("In State" Applicants attach, if available).

[redacted]

Name of Insurance Company _____

_____
Insurance Policy Number Date Policy issued (mm/dd/yyyy) Expiration Date of Policy (mm/dd/yyyy)

_____
Insurance Agent's Name (Last, First, MI)

_____
Telephone Number ( ) Fax Number ( ) Email Address

Name of Insurance Company _____

_____
Insurance Policy Number Date Policy issued (mm/dd/yyyy) Expiration Date of Policy (mm/dd/yyyy)

_____
Insurance Agent's Name (Last, First, MI)

_____
Telephone Number ( ) Fax Number ( ) Email Address

[redacted]

Attach copies of current (within the past 90 days) background checks for all **unlicensed** professionals.

How many background checks have you included? _____

[redacted]

PLEASE LIST THE FOLLOWING:

Address | City/State | Zip Code

Telephone Number | Fax Number | WARD/COUNTY

Email Address

Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Does this location have 24-hour Telephone coverage? Yes ___ No ___

Phone: ( ) _____

Is this location accessible to public Transportation? Yes ___ No ___

Does this location meet with the Americans with Disabilities Act? Yes ___ No ___

Does the location have TDD? ___ Yes ____ No TDD Telephone Number _____

[redacted]

Pay To Address | City/State | ZIP Code

Remittance Address (if difference from Pay to Address) | City/State | ZIP Code

How are you billing? ___ Electronic ___ Paper

[redacted]

Correspondence Address | City/State | ZIP Code

[redacted]

Check (√) ALL that applies.

Consultant & Professional Services (attach professional licenses and certifications as directed)

☐ **Behavioral Supports** (See Section 937, Chapter 9 of Title 29, DCMR, Behavioral Support Services)
Services designed to support and encourage the person in his or her decision to reside within the community; decrease the impact of a behavioral event; assist the person in developing alternative and more effective communication, adaptive and coping mechanisms; and enable the person to achieve positive personal outcomes.

Provider Types & Requirements:
- An independent professional in private practice (as defined in Chapter 19, Title 29, DCMR)
  - Licensed Independent Clinical Social Worker
  - Advanced Practice Registered Nurse or Nurse-Practitioner
  - Licensed Professional Counselor
  - Certified Behavior Analysts®
  - Psychologist
  - Psychiatrist
- A Freestanding Mental Health Clinic (as defined in Chapter 8, Title 29, DCMR)
- Home Health Agency (as defined in Chapter 19, Title 29, DCMR)
- Social Service Agency (as defined in Chapter 19, Title 29, DCMR)

☐ **Community Support Team** (See Section 1912, Chapter 19 of Title 29, DCMR, Community Support Team Services)
Team services designed to provide intensive behavioral and psychiatric supports for participants who are it imminent risk of institutionalization.

Provider Types & Requirements
- An independent professional in private practice (as defined in Chapter 19, Title 29, DCMR)
  - Advanced Practice Registered Nurse
  - Licensed Independent Clinical Social Worker
  - Licensed Professional Counselor
  - Psychiatrist
  - Psychologist
- Home Health Agency (as defined in Chapter 19, Title 29, DCMR)
- Social Service Agency (as defined in Chapter 19, Title 29, DCMR)
- Freestanding Mental Health Clinic (as defined in Chapter 8, Title 29, DCMR)

☐ **Dental** (See Section 936, Chapter 9 of Title 29, DCMR, Dental Services)
Services provided by a dental professional in the diagnosis, treatment and prevention of diseases of the teeth and gums.

Provider Types and Requirements
- Dentist (as defined in District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 [D.C. Law 6-99; D.C. Official Code, Section 3-1201 *et seq*.)

☐ **Environmental Accessibilities Adaptations** (See Section 926, Chapter 9 of Title 29, DCMR, Environmental Accessibilities Adaptation Services)
Services that provide physical adaptations to a home that enable a person to live with greater independence within the home (ex: ramps, grab-bars, lift systems, specialized electric and plumbing systems, etc.)

Provider Types and Requirements
- Non-Profit Organization
- Home Health Agency (as defined in Chapter 19, Title 29, DCMR)
- Social Service Agency (as defined in Chapter 19, Title 29, DCMR)
- Business Entity (Contractor licensed by the D.C. Department of Consumer and Regulatory Affairs or within the jurisdiction environmental accessibility adaptations are to be provided)

☐ **Family Training** (See Section 942, Chapter 9 of Title 29, DCMR, Family Training Services)
Services consisting of training, counseling, coordination and other professional support services offered to families or other uncompensated individuals.

Provider Types and Requirements:
- Independent Social Worker (as defined in Chapter 19, Title 29, DCMR)
- Independent Clinical Social Worker (as defined in Chapter 19, Title 29, DCMR)
- Professional Counselor (as defined in Chapter 19, Title 29, DCMR)
- Occupational Therapist (as defined in Chapter 19, Title 29, DCMR)
- Physical Therapist (as defined in Chapter 19, Title 29, DCMR)
- Speech, Hearing and Language Therapist (as defined in Chapter 19, Title 29, DCMR)

- Registered Nurse (as defined in Chapter 19, Title 29, DCMR)
- Special Education Instructor (Master's Degree in Special Education from an accredited college/university with an emphasis on developmental disabilities and mental retardation)

☐ **Nutrition Evaluation & Consultation Services** (See Section 930, Chapter 9 of Title 29, DCMR, Nutrition Evaluation and Consultation Services)
Services that address issues of weight gain or loss that creates a health risk; identification of diets for therapeutic purposes; oral-motor problems; allergies, other food intolerances or drug-nutrient interactions. Provide counseling on shopping, cooking, meal planning/preparation, safe storage or nutritional information about food.

Provider Types:

Requirements:
- Licensed to practice dietetics or nutrition pursuant t the D.C. Health Occupations Revisions Act of 1985, effective march 25, 1986
- Licensed to practice dietetics or nutrition in the jurisdiction where services are provided
- Minimum of one (1) year experience working with persons with mental retardation and developmental disabilities

☐ **Occupational Therapy** (See Section 935, Chapter 9 of Title 29, DCMR, Occupational Therapy Services)
Services that are reasonably and necessary to the treatment of a person's illness, injury, long term disability or to the restoration or maintenance of function affected by the injury, illness or long term disability.

Provider Types:
- Licensed Occupational Therapist (as delineated in the DC Health Occupations Revision Act of 1985, effective March 25, 1986)

Requirements:
- Employed by a Home Health Agency (as defined in Chapter 19, Title 29, DCMR)
- Maintain a private practice
    - Maintain a minimum of 1,000,000 in liability insurance (if, engaged in private practice)

☐ **One-Time Transitional Services** (See Section 1913, Chapter 19 of Title 29, DCMR, One-Time Transitional Services)
Services that are non-recurring set-up expenses for persons transitioning from an institution to another provider-operated or residence living arrangement (ex: security deposits, household furnishings, moving expenses, one-time cleaning, etc)

Provider Types and Requirements
- Non-profit organizations (as defined in Chapter 19, Title 29, DCMR)
- Home Health Agency (as defined in Chapter 19, Title 29, DCMR)
- Social Service Agency (as defined in Chapter 19, Title 29, DCMR)

☐ **Personal Care Aide** (See Section 1910, Chapter 19 of Title 29, DCMR, Personal Care Services)
Services that provide hands-on assistance with activities of daily life that would maintain a clean, sanitary and safe living condition in the home.

Provider Types:
- Home Health Agency (as delineated in Sections 5003.1 – 5003.3, Chapter 50, Title 29, DCMR)

Requirements:
- Registered Nurse supervision (as delineated in Sections 5002.5 – 5002.6, Chapter 50, Title 29, DCMR)
- $1,000,000 blanket malpractice insurance (as delineated in Section 5001.1, Chapter 50, Title 29, DCMR)
- At minimum, $1,000,000 liability insurance (as delineated in Section 5001.1, Chapter 50, Title 29, DCMR)

☐ **Personal Emergency Response System (PERS) Services** (See Section 907, Chapter 9 of Title 29, DCMR, Personal Emergency Response System Services)
Services that provide access to emergency assistance through a two-way communication system.

Provider Types and Requirements:
- Home Health Agency (as defined in Chapter 19, Title 29, DCMR)
- Social Service Agency (as defined in Chapter 19, Title 29, DCMR)

☐ **Physical Therapy** (See Section 934, Chapter 9 of Title 29, DCMR, Physical Therapy Services)
Services that are necessary to the treatment of a person's illness, injury or long term disability, or to the restoration or maintenance of function affected by the injury, illness or long term disability.

Provider Types:
- Licensed Physical Therapist (as delineated in the DC Health Occupations Revision Act of 1985, effective March 25, 1986)

Requirements:
- Employed by a Home Health Agency (as defined in Chapter 19, Title 29, DCMR)
- Maintain a private practice
  - Maintain a minimum of 1,000,000 in liability insurance (if, engaged in private practice)

☐ **Professional Services** (See Section 1918, Chapter 19 of Title 29, DCMR, Professional Services)
Services, provided by a licensed or certified professional, that are necessary for the treatment, restoration or maintenance of function affected by injury, illness or long-term disability.

Provider Types and Requirements:
- Acupuncturist (as defined in Chapter 47, Title 17, DCMR)
- Art Therapist (as defined by the American Art Therapy Association, Inc. and/or Art Therapy Credentialing Board)
- Dance Therapist (as defined in Chapter 71, Title 17, DCMR)
- Drama Therapist (as defined and certified by the National Association for Drama Therapy)
- Fitness Trainer (as defined by the Fitness Standards Council Personal Trainer Accreditation)
- Massage Therapist (as defined in Chapter 75, Title 29, DCMR)
- Music Therapist (as defined by the American Music Therapy Association and certified by the Certification Board for Music Therapists)
- Sexuality Education Specialist (as defined and certified by the American Association of Sexuality Educators, Counselors and therapists Credentialing Board)
  Sexuality Education can also be delivered by a:
  - Psychologist (as defined in Chapter 19, Title 29, DCMR)
  - Psychiatrist (as defined in Chapter 19, Title 29, DCMR)
  - Licensed Clinical Social Worker (as defined in Chapter 19, Title 29, DCMR)
  - Licensed Professional Counselor (as defined in Chapter 19, Title 29, DCMR)

☐ **Respite** (See Section 994, Chapter 9 of Title 29, DCMR, Respite Services)
Services provided to a person on a short-term basis because of the absence, or need for relief, of the primary caretaker.

Provider Types and Requirements:
- Social Service Agency (as defined in Chapter 19, Title 29, DCMR)
- Home Health Agency (as defined in Chapter 19, Title 29, DCMR)

☐ **Skilled Nursing** (See Section 933, Chapter 9 of Title 29, DCMR, Skilled Nursing Services)
Services provided by a registered nurse that are reasonable and necessary to the treatment of a person's illness or injury.

Provider Types and Requirements:
- Home Health Agency (as defined in Chapter 19, Title 29, DCMR)
- Nurse Staffing Agency (as defined in the Nurse Staffing Agency Act of 2003, effective November 25, 2003)
- Registered Nurse (as defined in the DC Health Occupations Revisions Act of 1985, effective March 25, 1986)

☐ **Speech, Hearing & Language Therapy** (See Section 932, Chapter 9 of Title 29, DCMR, Speech, Hearing and Language Services)
Services provided to address problems involving swallowing, communicative, vocal, or speech disorders.

Provider Types:
- Home Health Agency (as defined in Chapter 19, Title 29, DCMR)
- Social Service Agency (as defined in Chapter 19, Title 29, DCMR)
- Speech Pathologist (as defined, licensed or certified by the American Speech Hearing Language Association)
- Audiologist (as defined, licensed or certified by the American Speech Hearing Language Association)

Requirements:
- Maintain a minimum of $1,000,000 in liability insurance (if, engaged in private practice)

☐ **Vehicle Modifications** (See Section 1914, Chapter 19 of Title 29, DCMR, Vehicle Modification Services)
Services that provide physical adaptations to a vehicle that are necessary to ensure the health, welfare, and safety of a person or that enable a person to live with greater independence in the community.

Provider Types and Requirements:
- Non-Profit Organization

HABILITATION SERVICES

☐ **Day Habilitation** (See Section 945, Chapter 9 of Title 29, DCMR, Day Habilitation)
Services designed to support the person outside the home through training and skills development that help the person to achieve greater participation in integrated community activities and vocational settings.

Provider Types and Requirements:
- Social Service Agency (as defined in Chapter 19, Title 29, DCMR)

☐ **Host Home** (See Section 1915, Chapter 19 of Title 29, DCMR, Host Home Services)
Services provided through a residential arrangement where a homeowner provides room, board, personal supports and assistance to a person in a host home.

Provider Types and Requirements:
- Supported Living Service Providers (see Section 993, Chapter 9 of Title 29 DCMR, Supported Living Services)
- Residential Habilitation Service Providers (see Section 946, Chapter 9 of Title 29 DCMR, Residential Habilitation Services)

Requirements:
- Human Agreement

☐ **In-Home Supports** (See Section 1916, Chapter 19 of Title 29, DCMR, In-Home Supports Services)
Services that provide periodic support to a primary caregiver and/or enable a person to live independently and participate fully in community activities.

Provider Types and Requirements:
- Home Health Agency (as defined in Chapter 19, Title 29, DCMR)
- Supported Living Service Providers (see Section 993, Chapter 9 of Title 29 DCMR, Supported Living Services)
- Residential Habilitation Service Providers (see Section 946, Chapter 9 of Title 29 DCMR, Residential Habilitation Services)

Requirements:
- Human Agreement

☐ **Live-In Caregiver** (See Section 1917, Chapter 19 of Title 29, DCMR, Live-In Caregiver Services)
Services provided by a direct care worker in a person's home that affords the person an opportunity to live more independently and participate fully in community activities.

Provider Types and Requirements:
- Supported Living Service Providers (see Section 993, Chapter 9 of Title 29 DCMR, Supported Living Services)
- Residential Habilitation Service Providers (see Section 946, Chapter 9 of Title 29 DCMR, Residential Habilitation Services)

Requirements:
- Human Agreement
- Live-In Caregiver Services Agreement

☐ **Prevocational Habilitation** (See Section 920, Chapter 9 of Title 29, DCMR, Prevocational Services)
Services designed to prepare a person for paid or unpaid employment. These services exclude developing specific job skills.

Provider Types and Requirements:
- Home Health Agency (as defined in Chapter 19, Title 29, DCMR)
- Social Service Agency (as defined in Chapter 19, Title 29, DCMR)

☐ **Residential Habilitation** (See Section 946, Chapter 9 of Title 29, DCMR, Residential Habilitation Services)
Services to assist a person in the acquisition, retention, and improvement of skills related to activities of daily living (ex: personal grooming, household chores, eating and food preparation, social adaptive skills).

Provider Types:
- Group Home for Mentally Retarded Persons (see Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code Sections 44-501 *et seq.*)
- Social Service Agency (as defined in Chapter 19, Title 29, DCMR)

Requirements:
- Human Care Agreement

☐ **Supported Employment** (See Section 929, Chapter 9of Title 29, DCMR, Supported Employment Services)
Services intended for a person where competitive employment has not traditionally occurred or has been interrupted.

Provider Types and Requirements:
- Social Services Agency (as defined in Chapter 19, Title 29, DCMR)
- Vocational Rehabilitation Counselor

☐ **Supported Living** (See Section 933, Chapter 9 of Title 29, DCMR, Supported Living Services)

Services that assist a person in the acquisition, retention and improvement of skills related to activities of daily living (ex: personal grooming, household chores, eating and food preparation, social and adaptive skills).

Provider Types and Requirements:

- Social Service Agency (as defined in Chapter 19, Title 29, DCMR)

Requirements:

- Human Care Agreement

[redacted]

10a) Do you have the retail business open and available to the general public, which meets all local laws and ordinances regarding business licensing and operations and is readily identifiable as a place in which you sell, rent, or lease durable medical equipment, prosthetics, incontinence medical supplies, and/or medical supply items? Yes __ No __ N/A__

10b) Do you have a visible sign and posted hours of operation? Yes __ No __ N/A___

10c) Do you have inventory or contracts with other companies to ensure the ability to fill orders? Yes __ No __ N/A___

10d) Do you honor all warranties expressed and implied under State law? Yes __ No __ N/A___

10e) Do you have a written complaint resolution process? Yes __ No __ N/A___

10f) Will records stored at the service location? **Records must be maintained for 10 years** Yes __ No __ N/A___
If not, where are they stored? Provide Address _____

10g) Do you own the building in which your business is located? Yes __ No __ N/A___

10h) Do you lease the building in which your business is located? Yes __ No __ N/A___

10i) Is your equipment and/or supplies:
a) In stock on the premise, and/or Yes __ No __ N/A---
b) In a warehouse under the applicant's or provider's direct control Yes __ No __ N/A___
(if checked provide the following information for the warehouse):

Name of Person who holds ownership in the warehouse:

_____ Telephone Number:

Address: City/State Zip Code _____

_____

10j) Do you have the necessary equipment, office supplies, and facilities available to carry out your business, including storing and retrieving such records as are necessary to fully disclose the type and extent of services provided to Medicaid customers? Yes __ No __ N/A___

10k) Does you business involve the trade, sale rental, or transfer of upholstered - furniture (including wheelchairs) or bedding? Yes __ No __ N/A___

10l) Does your business involve the trade, sale, rental or transfer of medical devices or durable medical equipment/devices for use in the home to treat acute or chronic illness of injuries? Yes __ No __ N/A___

10m) Does your business involve the trade, sale, rental or transfer of dangerous or legend drugs and/or dangerous or legend medical equipment devices? Yes __ No __ N/A___

10n) Does the applicant/provider provide custom rehabilitative equipment and custom rehabilitative technology services to Medicaid customers? Yes __ No __ N/A___

If Yes, does the applicant/provider have on staff, either as an employee or independent contractor, or does the applicant/provider have a contractual relationship with a qualified rehabilitation professional who was directly involved in determining the specific custom rehabilitation equipment needs of the patient and was directly involved with, or closely, supervised, the final fitting and delivery of the custom rehabilitation equipment? Yes __ No __ N/A___

10o) Has any officer and/or employee of the business ever been convicted of a felony? Yes __ No __ N/A___
If Yes, please explain in Section 11

10p) Has the applicant/provider ever been rejected or suspended from the Medicare or Medicaid program, or has your participation status ever been modified (terminated, suspended, restricted, revoked, limited, cancelled or sanctioned)? Yes __ No __ N/A___
If Yes, please explain in Section 11

10q) Within the last five (5) years, has the applicant/provider ever been sanctioned, reprimanded or otherwise disciplined in any manner by any state licensing authority or other professional board or peer committee? Yes __ No __ N/A___
If Yes, please explain in Section 11

10r) Does applicant/provider own, have an investment in, manage, own stock in, participate in a joint venture, or act as a partner, contract consultant or medical/dental advisor in any medical/dental enterprise or medical/dental supplier outside of the business identified in this application where you would financially benefit directly or indirectly? Yes __ No __ N/A___
If Yes, please explain in Section 11

10s) Does the applicant provide direct support services? If yes, attach a copy of a: Yes___ No___ N/A___
If Yes, please attach a copy of each document behind Section 10 cover page.

Quality Improvement Plan
Policies and Procedures

IF YOU ANSWERED "YES" TO QUESTIONS "10o", "10p", "10q" and "10r", PLEASE PROVIDE AN EXPLANATION OR ADDITIONAL INFORMATION FOR EACH.

QUESTION 10o

_____

_____

_____

_____

QUESTION 10p

_____

_____

_____

_____

QUESTION 10q

_____

_____

_____

_____

QUESTION 10r

Name of Organization _____ Type of Organization _____

Mailing Address _____

Telephone Number _____ Tax ID Number _____

Percent of Business Owned/Invested by You _____ Nature of Business Investment (Owner, Partner, Investor, etc.)

_____

INSTRUCTION FOR COMPLETING DISCLOSURE OF OWNERSHIP AND

CONTROL INTEREST STATEMENT (DC-1513)

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Titles V, XVIII, XIX, AND XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the District of Columbia state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the D.C. State Agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS
All title XX providers must complete Part II (a) and (b) of this form. Only those Title XX providers rendering medical, remedial, or health related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III.

General Instructions

For definitions, procedures and requirements refer to the appropriate Regulations:

Title V -42CFR 51a.144
Title XVIII -42CFR 420.200-206
Title XIX -42CFR 455.100-106
Title XX -45CFR 228.72-73

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original copy to the State agency: retain the photocopy for your files.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the from. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

Item I – Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

Item II- Self-explanatory

Item III- List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined, as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity .The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity, which may be maintained, by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV-VII- Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the ownership partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation or any change of ownership.

For Items IV-VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV- (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate that date in the appropriate space.

Item V- If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI- If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII- A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII -If yes, list the actual number of beds in the facility now and the previous number

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DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Identifying Information

(a). Name of Entry	D/B/A	Provider No.	Vendor No.
Telephone No.			
Street Address		City, County, State	Zip Code

II. 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 under Remarks on page 2. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVII, XIX, or XX?

□Yes □ No

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVII, XIX, or XX?

□ Yes □ No

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVII providers only)

□ Yes □ No

III. (a.) List names, addresses for individuals, or the EIN for organization having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN

(b) Type of Entity: □ Sole Proprietorship □ Partnership □ Corporation
□ Unincorporated Associations □ Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

□ Yes □ No

Name	**Address**	**Provider Number**

IV.

(a). Has there been a change in ownership or control within the last year?

☐ Yes ☐ No

If yes, give date _____

(b) Do you anticipate any change of ownership or control within the year?

☐ Yes ☐ No

If yes, when? _____

(c) Do you anticipate filing for bankruptcy within the year?

☐ Yes ☐ No

If yes, when _____

Is this facility operated by a management company, or leased in whole or part by another organization?

☐ Yes ☐ No

If yes, give date of change in operations _____

V. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN) ☐ Yes ☐ No

Name EIN#

Address

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE D. C. STATE AGENCY AS APPROPRIATE.

Name of Authorized Representative	Title
Signature	Date

[redacted]

See Attached

Form **W-9**
(Rev. January 2002)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ..... ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.) | Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 2. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 2.

Note: *If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.*

Social security number
___ ___ ____

or

Employer identification number
___ _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withhholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 2.)

Sign Here | Signature of U.S. person ► | Date ►

Purpose of Form

A person who is required to file an information return with the IRS must get your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to give your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities.

Note: *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments after December 31, 2001 (29% after December 31, 2003). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part II instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions on page 2 and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name. If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first and then circle the name of the person or entity whose number you enter in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Exempt from backup withholding. If you are exempt, enter your name as described above, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. For more information on exempt payees, see the Instructions for the Requester of Form W-9.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

Note: *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

Part I—Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box.

If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see How to get a TIN below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are an LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* above), and are owned by an individual, enter your SSN (or "pre-LLC" EIN, if desired). If the owner of a disregarded LLC is a corporation, partnership, etc., enter the owner's EIN.

Note: *See the chart on this page for further clarification of name and TIN combinations.*

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office. Get Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can get Forms W-7 and SS-4 from the IRS by calling 1-800-TAX-FORM (1-800-829-3676) or from the IRS Web Site at www.irs.gov.

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: *Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.*

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II—Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 3, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt from backup withholding* above.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA or Archer MSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to give your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA or Archer MSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 30% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name, but you may also enter your business or "DBA" name. You may use either your SSN or EIN (if you have one).

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note: *If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.*

I authorize the District of Columbia Medical Assistance Administration, hereafter “agency” and its affiliates, subsidiaries or related entities to consult with hospital administrators, members of medical staffs of hospitals, malpractice carriers, licensing boards, professional organizations, and other persons to obtain and verify information and I release to the agency and its employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application; and,

I consent to the release by any person to the agency of all information that may be reasonably relevant to an evaluation of my professional competency, character, and moral and ethical qualification, including any information relating to any disciplinary action, suspension or limitation of privileges, and hereby release any such person providing such information from any and all liability for doing so.

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I further agree to notify the agency of any change to the information provided in this application within thirty (30) days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by the carrier.

_____ _____

Signature of Authorized Applicant/Provider Date

_____ _____

Printed Name of Authorized Applicant/Provider Telephone Number

_____ _____

Contact person to answer questions regarding application Telephone Number

SECTION 15 PROVIDER AGREEMENT

DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION

DEPARTMENT ON DISABILITY SERVICES (DDS) WAIVER PROVIDER AGREEMENT

Name of Provider

_____

Address

_____

Title XIX [Medicaid Provider] Provider Number _____

NPI Number_____

This Agreement made and entered into this _____ day of _____, 20 ___, by and between the District of Columbia Department of Health, hereinafter designated as the Department, and the above-named, a Provider of Services, whose address is, as stated above, hereinafter designated as the Provider.

Witnesseth:

WHEREAS, persons receiving public assistance payments from the Department of Health and other persons eligible for care and under the Medical Assistance Program operating under Title XIX of the Social Security Act, are in need of medical care;

WHEREAS, Section 1902(a) (27) of Title XIX of the Social Security Act requires the District of Columbia to enter into written agreement with every person or institution providing services under the State's Plan for Medical Assistance (Title XIX);

WHEREAS, pursuant to Commissioner's Order 70-83 and PL-90-227 which makes the DC Department of Health the agency responsible for administering the Medical Assistance Program (Title XIX) in the district of Columbia, and authorize the Department of Health to take all necessary steps for the proper and efficient administration of the District of Columbia Medical Assistance Program;

WHEREAS, to participate in the District of Columbia Medical Assistance Program, the provider when applicable, must: (1) be licensed in the jurisdiction where located and/or the District of Columbia; (2) be currently in compliance with standards for licensure; (3) services be administered by a licensed or certified practitioner; and, (4) comply with applicable Federal and District standards for participation in Title XIX of the Social Security Act, and;

WHEREAS, prospective provider has filed an application with the Department to provide medical services to persons eligible under the Medical Assistance Program operated under Title XIX of the Social Security Act and said application is incorporated by reference into this Agreement and made a part hereof the same as if it were written herein.
The Provider agrees:

I. GENERAL PROVISIONS

A. To provide to Medicaid patients, services as covered in Title XIX of the Social Security Act and the State Plan of Medical Assistance.

B. To accept as payment for supplying the services in "A" above, a reimbursement rate calculated in accordance with the District State Plan for Medical Assistance;

1. The provider's payment shall be accepted as payment in full for the care of the patient, and;

2. No additional charge shall be imposed on the patient, member of his family or to another source for any supplementation for any time except as allowed within Federal and District regulation.

C. To satisfy all requirements of the Social Security Act, as amended, and be in full compliance with the standards prescribed by Federal and State standards.

D. To accept such amendments, modifications or changes in the program made necessary by amendments, modifications or changes in the Federal or State standards for participation.

E. To comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, 42 CFR Parts 80, 84 and 90, the Americans with Disabilities Act, P.L. 101-336, any amendments thereto and the rules and regulations there under.

F. To maintain all records relevant to this Agreement at his/her cost, for a period of ten years or until all audits are completed, whichever is longer. Such records shall include all physical records originated or prepared pursuant to performance under this Agreement, including but not limited to, financial records, medical records, charts and other documents pertaining to costs, payments received and made, and services provided to cover Medicaid recipients.

G. To provide full access to these records to authorized personnel of the Department, the United States Department of Health and Human Services, the Comptroller General of the United States or any of their duly authorized representatives for audit purposes.

H. To furnish upon request to the Medical Assistance Administration (MAA), the Federal Government or their designees, information related to business transactions in accordance with 42 CFR & 455 105(b);

I. To hold harmless the District of Columbia Government, the Department and Medicaid recipients against any loss, damage, expense and liability of any kind arising out of any action of the provider or its subcontractors arising out the performance of this agreement.

J. To comply with the advance directive requirements contained in 42 CFR, Part 489, Subpart I, as appropriate.

K. To complete and sign a Provider Application to participate in the Medical Assistance Program (Title XIX), and to keep the information in the application current with the understanding that the application becomes a part of this agreement and that each succeeding change in the application constitutes an amendment to the Agreement and failure to keep the information current constitutes a breach of the Agreement.

a. To provide assurances of compliance with:

D.C. Law 12-238 which prohibits Medicaid providers from offering employment or contracting with any person who is not a licensed healthcare professional until a criminal background check has been conducted for the person and also prohibits any facility from employing or contracting with any person who has been convicted of certain criminal offenses specified in the law;

42 USC § 31306 and 49 CFR 382 which requires employers of commercial drivers to conduct pre-employment, reasonable suspicion, and post-accident testing for controlled substances; and,

The Drug-Free Work Place Act of 1988 (21 USC § 701 et seq.), which requires the implementation of an alcohol and drug-testing program.

b. That any breach of violation of any one of the above provisions shall make this entire Agreement, at the Department's option, subject to immediate cancellation or imposition of enforcement remedies in conformance with Federal and District laws and regulations.

II. REQUIRED INFORMATION:

A. A description of ownership and a list of major owners (stockholders owning or controlling five percent or more outstanding shares);

B. A list of Board members, if applicable and their affiliations;

C. A roster of key personnel, their qualifications and a copy of their position descriptions. Key personnel including: the President and Vice-President, Chief Executive Officer, Chief Medical Officer, Chief Financial Officer, Director of Nursing, Director of Quality Improvements/Quality Assurance;

D. Copies of licenses and certifications for all staff providing medical services;

E. The address of all sites at which services will be provided to Medicaid recipients;

F. Copy of the most recent audited financial statement of the organization;

G. A completed provider application;

H. A copy of the basic organizational documents of the provider, including an organizational chart and current articles of incorporation;

I. A copy of the by-laws or similar documents regulating conduct of the provider's internal affairs;

J. A copy of the business license;

K. A copy of Joint Commission on Accreditation of Health Care Organization's certification;

L. A copy of Certificate of Need approval; and,

M. The submission of any other documentation deemed necessary the Department for the approval process as a Medicaid Provider.

III. CONTRACT AND SUBCONTRACTS

A. The Department or the provider may terminate this Agreement for convenience by giving ninety (90) days written notice of intent to terminate the Agreement to the party.

B. The provider shall be legally responsible for all activities of its contractor and subcontractors, requiring that they conform to the provisions of this Agreement.

C. Sub-contractual agreement with providers who have been convicted of [felonies] certain crimes or received certain sanctions as specified in Section 1128 of the Social Security Act is prohibited. Services provided to Medicaid eligible recipients through such subcontracts shall not be eligible for reimbursement by the Department.

D. The Department reserves the right to require the Provider to furnish information relating to the ownership of the subcontractor, the subcontractor's ability to carry out the proposed obligations, assurances that the subcontractor shall comply with all applicable provisions of Federal and District law, and regulations pertaining to Title XIX of the Social Security Act and the State Plan for Medical Assistance and with all Federal and District laws and regulations applicable to the service or activity covered by the contract; the procedures to be followed by the provider in monitoring or coordinating the subcontractor's activities and such other provisions as the Department or the Federal Government may reasonably require.

E. Each subcontract shall contain a provision that the subcontractor shall look solely to the provider for payment of covered services rendered.

IV. PAYMENT TO PROVIDER

A. The Department shall reimburse providers for services to eligible Medicaid recipients in accordance with the District's State Plan of Medical Assistance.

B. The provider shall submit invoices for payment according to the Department's requirements.

C. The Department shall make payments to the provider in accordance with applicable laws, as promptly and as feasible after a proper claim is submitted and approved.

D. The Department shall notify the provider of any major changes in Title XIX rules and regulations and in the State Plan of Medical Assistance.

V. THIRD PARTY LIABILITY RECOVERY

A. The provider shall utilize and require its subcontractors to utilize, when available, covered medical and hospital services or payments from other public or private sources, including Medicare.

B. The provider shall attempt to recover, and shall require its subcontractors to attempt to recover, monies from third party liability cases involving workers' compensation, accidental injury insurance and other subrogation of benefit settlements.

C. The Department shall notify the provider of any reported third party payment sources.

D. The provider shall verify third party payment sources directly, when appropriate.

E. Payment of State and Federal funds under the District's State Plan for Medical Assistance to the provider shall be conditional upon the utilization of all benefits available from such payment sources.

F. Each third party collection by a provider for a Medicaid recipient shall be reported to the Department and all recovered monies shall be returned to the Department immediately upon recovery.

VI. SANCTIONS FOR NON-COMPLIANCE

If the Department determines that a provider has failed to comply with the applicable Federal or District law or rule, or any law or order that prohibits discrimination on the basis of race, age, sex, national origin, marital status or physical or mental handicap, the Department may do all of the following:

A. Withhold all or part of the providers' payments; and/or,

B. Terminate the Agreement within 30 days from date of notice to the provider

C. Before taking action described in VI, A & B, the Department shall provide written notice to the provider which shall include:

    1. Identification of the sanction to be applied;

    2. The basis for the Department's determination that the sanction should be taken;

    3. The effective date of the sanction; and,

    4. The timeframe and procedure for the provider to appeal the Department's determination.

D. The termination of the Agreement shall not discharge the responsibilities of either party with respect to services or items furnished prior to termination, including retention of records and verification of overpayment or underpayment.

E. Upon termination, the provider shall submit to the Department all outstanding invoices for allowable services rendered prior to the date of termination in the form prescribed by the Department. Invoices submitted not later than thirty (30) days following the termination date shall be paid.

F. The provider also shall submit to the Department all financial performance and other reports required as a condition to this Agreement within ninety (90) days of the termination date.

G. The Department reserves the right to terminate this Agreement immediately if:

    1. The United States Department of Health and Human Services withdraws Federal financing participation in all or part for the cost of covered services;

    2. District funds are unavailable for the continuation of the Agreement;

    3. The Department is notified by the appropriate District agencies, or other appropriate licensing or certifying bodies that the licenses and/or certification under which it operates have been revoked, expired and/or will not be renewed; or,

    4. The owners, officers, managers or other persons with substantial contractual relationships have been convicted of certain crimes or received certain sanctions as specified in Section 1128 of the Social Security Act.

H. The Department reserves the right to terminate this Agreement or take some other enforcement act consistent with Federal and District law and regulation in the event of default of the provider.

I. The following shall trigger use of an enforcement action against a provider:

1. Inability of the provider to provide the services described in this Agreement;

2. Insolvency of the provider;

3. Failure of the provider to maintain its licensure or accreditation;

4. Violation of any provision of applicable Federal or District law or implementing rules.

J. The provider shall be responsible for providing written notice to recipients thirty (30) days prior to the effective date of the termination in the form prescribed by the Department and shall be responsible for notifying the Department of those recipients who are undergoing treatment of an acute condition.

K. The Department may, at its sole discretion, offer to re-negotiate any provision of this Agreement if such re-negotiation would mitigate or eliminate any of the causes of termination specified.

VII. ASSIGNMENT OF RIGHTS

The rights, benefits and duties included under this Agreement shall not be assignable by the provider without receiving the written approval of the Department. The Department, as a condition of granting such approval, shall require that such assignees be subject to all conditions and provisions of this Agreement and all Federal laws and rules governing the assigned Agreement.

VIII. TERMINATION OR REDUCTION OF THE DEPARTMENT'S SOURCE OF FUNDING

The Department's obligation to pay funds for the purpose of this Agreement is limited solely to availability of Federal and District funds for such purposes. No commitment is made by the Department to continue or expand such activities.

IX. CONFIDENTIALITY OF INFORMATION

A. All information, records and data collected and maintained by the provider or its subcontractor relating to eligible Medicaid recipients shall be protected by the provider from unauthorized disclosure;

B. Except as otherwise provided in Federal law or rules, use or disclosure of information concerning recipients shall be restricted to purposes directly related with the administration of the Medicaid program;

C. Purpose directly related to the Medicaid program shall include the following:

1. Establishing eligibility;

2. Providing services; and,

3. Conducting or assisting in an investigation, prosecution, civil or criminal proceeds relating to the administration of the Medicaid program.

D. The type of information to be safeguarded shall include all information listed in 42 CFR 431.305.

X. EFFECTIVE DATE

The effective date of agreement for provider payments shall be on the date the provider attains participating status as determined by the Department under Federal and District regulations, and that such determination shall be made a part of this Agreement.

I/We agree that the receipt by the D.C. Medicaid program of the first and each succeeding claim for payment from me/us will be the Medicaid program's understanding of my/our declaration that the provisions of this Agreement and supplemental providers manuals and instructions have been understood and complied with:

_____

Provider's Signature Date

_____

Name of the Group, Institute, Medical Facility, Firm or Government
(i.e., the Provider Entity)

_____

Address Phone Number

_____

Signature of individuals responsible to enforce compliance with these conditions

_____

Chief Executive Officer (if applicable) Date

_____

Chief Medical Officer (if applicable) Date

_____

Principal Corporate Officer (if applicable) Date

Accepted by:

_____

Authorized Signature by: Date

Department of Health
Medical Assistance Administration

For Official Use Only

D.C. Medicaid Provider Number Assigned: _____

- All application packages MUST be assembled as instructed here.
- Please use attached Cover Sheets found in this Section and use to assemble your application package.
- Place your attachments behind the appropriate cover sheet.
- Application packages that are NOT assembled as instructed will NOT be reviewed and will be returned to sender.

APPLICANT PACKAGE

COVER PAGE

Fill in the name of your company below and place your completed and signed application behind this page as instructed.

DISTRICT OF COLUMBIA DDS PROVIDER APPLICATION

FOR

_____

(Insert the full legal name of your company)

APPLICATION PACKAGE

SECTION 1: NPI/MEDICAID

Place a copy of your NPI Letter and State Medicaid Enrollment Letter behind this page.

APPLICATION PACKAGE

SECTION 2: BUSINESS/CORPORATE

Place a legible copy of your business license/permits/Certificate of Need/JACO Certification/Certificate of Occupancy/Human Care Agreement behind this page.

APPLICATION PACKAGE

SECTION 3: APPLICANT

Place requested documents behind this page.

Out of State Applicant/Providers ONLY

- Please attach proof of Medicaid Provider enrollment in your State
- Copy of CMS Supplier Letter
- Please attach copy of D.C. Certificate of Authority

All Applicants/Providers

- Copies of additional information requested in Section 3c

APPLICATION PACKAGE

SECTION 4: PROOF OF INSURANCE

Place a copy of Certificate(s) of Insurance for the business address behind this page.

APPLICATION PACKAGE

SECTION 5: BACKGROUND INFORMATION

Place copies of background checks for all “unlicensed” professionals and administrators behind this page.

APPLICATION PACKAGE

SECTION 6, SECTION 7 & SECTION 8

No attachments required.

APPLICATION PACKAGE

SECTION 9: ELIGIBILITY CRITERIA FOR SERVICES

Place a copy of licenses and certifications behind this page.

APPLICATION PACKAGE

SECTION 10: BUSINESS INFORMATION

Place a copy of the following behind this page:

Quality Improvement Plan
Policies and Procedures

APPLICATION PACKAGE

SECTION 11

No Attachments.

APPLICATION PACKAGE

SECTION 12: DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Place completed and signed form behind this page.

APPLICATION PACKAGE

SECTION 13: REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

Place completed and signed form behind this page.

APPLICATION PACKAGE

SECTION 14: AUTHORIZATION TO RELEASE INFORMATION AND AFFIRMATION

Place completed and signed form behind this page.

APPLICATION PACKAGE

SECTION 15: PROVIDER AGREEMENT

Please sign the agreement and place behind this page.