STATE OF TENNESSEE
DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

NEW PROVIDER APPLICATION FOR LONG TERM SERVICES – PART 1
INITIAL SCREENING QUESTIONNAIRE

Instructions: This application must be completed by any entity (e.g., individual, group, agency, or other type of organization) seeking to be a new provider of services administered by the Department of Intellectual and Developmental Disabilities (DIDD).

All questions and correspondence regarding the New Provider Application should be directed to:
Provider Enrollment Coordinator
Department of Intellectual and Developmental Disabilities
E-mail: DIDDProvider.Application@tn.gov
Phone: (615) 532-6530

Process Overview: The process for completing a Long Term Application (LTA) includes the steps listed below. Refer to the 80.1.1 New Provider Application Policy for additional details regarding completing the application process.

- The Office of DIDD Provider Development will announce Open Enrollment and/or Targeted Enrollment on the DIDD Web Site. http://www.tn.gov/didd/
- Applicants submit a completed New Provider Initial Screening Questionnaire-Part 1, which is the first part of the Long Term Application Process.
- Upon approval of the New Provider Initial Screening Questionnaire-Part 1 by DIDD, applicants will be invited to the New Provider Pre-Application Activity.
- After attending the New Provider Pre-Application Activity, applicants will submit the completed New Provider Application for Long Term Services-Part 2 or Support Coordination-Part 2, which is the second part of the Long Term Application Process.
- Applicants who are not approved to register for **New Provider Pre-application Activity** (e.g. the New Provider Initial Screening Questionnaire-Part 1 was not approved) must wait until the next open and/or targeted enrollment period for identified services before submitting another Questionnaire/Application to DIDD.

Applicable Services: The Long Term Application (LTA) shall apply to the following services:

Community-Based Day	Facility-Based Day
Supported Employment	In-Home Day
Respite	Behavioral Respite
Intensive Behavior Residential (IBRS)*	Personal Assistance
Medical Residential	Supported Living
Residential Habilitation	Family Model Residential Support
Semi Independent Living	Individual Transportation for Respite and Personal Assistance
Support Coordination	

*See IBRS Requirements

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Medicaid Home and Community Based Services Waivers

ALL PROVIDERS MUST MEET THE REQUIREMENTS OF THE INITIAL SCREENING QUESTIONNAIRE TO BE CONSIDERED FOR FURTHER REVIEW.

1. DATE APPLICATION SUBMITTED: _____

2. ORGANIZATIONAL INFORMATION

Name of Provider Agency Business (as listed with the Tennessee Secretary of State):

_____

Doing Business As (if different from Name of Business): _____

Federal Employer Identification Number (FEIN): _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Fax Number:** _____

Contact Email Address: _____ **Web Site Address:** _____

Check One ☐ Not-for-Profit entity ☐ For Profit entity ☐ Other: _____

Type of Business
☐ Sole Proprietorship
☐ Partnership
☐ Limited Partnership
☐ Limited Liability Company
☐ Other: _____

Optional:

3. Business Ownership: (Check One Only)			Ownership Ethnicity: (Check One Only)	
☐	G	Government Owned	☐ A	Asian
☐	E	Race/Ethnic	☐ B	African American
☐	N	Non-Minority Owned	☐ H	Hispanic
☐	W	Female Owned	☐ I	Native American Indian
☐	P	Non-Profit Background (Minority Owned)	☐ C	Caucasian
			☐ O	Other

:

4. REQUESTED WAIVER SERVICE: Check the requested waiver service(s) and identify the requested region(s) for each service.

REQUESTED WAIVER SERVICES **Day, Respite Residential, Support Coordination and Individual Transportation**	**REQUESTED REGIONS**		
	W	M	E
Day: Community-Based Day (CB)			
Day: Facility-Based Day (FB)			
Day: Supported Employment (SE)			
Day: In-Home Day			
Respite (R)			
Residential: Behavioral Respite			
Residential: Intensive Behavior Residential			
Residential: Family Model Residential Support			
Residential: Medical Residential (MR)			
Residential: Personal Assistance (PA)			
Residential: Residential Habilitation (RH)			
Residential: Supported Living (SL)			
Residential: Semi Independent Living			
** Support Coordination			
Individual Transportation for Respite and Personal Assistance service			

***Support Coordination service providers may expand to other regions, but are prohibited from providing other waiver services.

5. PREVIOUS EXPERIENCE

Has any business owner, board member, or the executive director ever provided service(s) to persons with intellectual, developmental, or other types of disabilities in Tennessee or in another State using the business/individual name listed in the Questionnaire or using a different name? If yes, attach a statement specifying who provided the service, business name, details of the service(s) and evidence when the service(s) were provided. For existing agencies, provide a satisfaction survey of some type and/or the results of the most recent Quality Assurance Review.

Who provided the service	Details of the service(s), Length of Service & Location of Service	Evidence when the service(s) were provided

6. QUESTIONS: Please answer each question by checking "Yes' or 'No".

a. ☐ YES ☐ NO Is any business owner, board member, or the executive director currently employed by the State of Tennessee? If yes, attach a statement specifying the following:

- specify the person's name, title,
- State Department/Division where employed.

b. ☐ YES ☐ NO Has any business owner, board member, or the executive director been employed by the State of Tennessee within the past six (6) months? If yes, attach a statement specifying the following:

- specify the person's name, title,
- State Department/Division where employed,
- dates of employment.

c. ☐ YES ☐ NO Has any business owner, board member, or the executive director been the business owner, board member, or executive director of an entity that has had a contract to provide Medicaid Services terminated in any State within the past five (5) years? If yes, attach a statement specifying the state, business name, and providing details.

d. ☐ YES ☐ NO Has any business owner, board member, or the executive director ever had a license denied, revoked, suspended, placed on probation, or surrendered to avoid loss of license or disciplinary action in Tennessee or another State? If yes, attach a detailed explanation.

e. ☐ YES ☐ NO Does any business owner, board member, or the executive director have a license in Tennessee or in another state that is currently under investigation by the licensing body? If yes, attach a statement specifying the type of license and the State and a detailed explanation.

f. ☐ YES ☐ NO Has any business owner, board member, or the executive director ever been convicted of a felony or a misdemeanor involving physical harm to a person including but not limited to neglect or abuse or a misdemeanor involving financial harm/exploitation to a person including but not limited to theft, misappropriation of funds, fraud or breach of fiduciary duty; or during a period of less than ten years prior to employment with the Provider; a misdemeanor involving illicit drugs, drug/alcohol misuse or sexual misbehavior (e.g. indecent exposure, voyeurism)? If yes, attach a detailed explanation.

g. ☐ YES ☐ NO Is any business owner, board member, or the executive director currently the subject of pending litigation? If yes, attach a detailed explanation.

h. ☐ YES ☐ NO Has any business owner, board member, or the executive director ever filed personal or business bankruptcy? If yes, attach a detailed explanation.

7. STATE BACKGROUND CHECKS: for the purpose of the following background checks to be completed by DIDD, complete the applicable section of the table below :

- **Tennessee Felony Offender Information**
- **Tennessee Department of Health: Abuse Registry**
- **Business Entity Search – Business Services Online (Tennessee Secretary of State)**
- **Tennessee Department of Health: Health Care Facilities**
- **Tennessee Department of Health: Licensure Verification**
- **Sex Offender Search – Tennessee Bureau of Investigation Sex Offender Registry**
- **Office of Inspector General US Department of Health & Human Services (OIG)**
- **DIDD Substantiated Investigation Record**

Name of Chairperson of the Board	Date of Birth	Social Security Number

Name of all Board Members and/or Advisory Group	Date of Birth	Social Security Number
Name of Owner(s)		
Name of Executive Director	**Date of Birth**	**Social Security Number**

8. **NATIONAL CRIMINAL BACKGROUND CHECK** : At the time the initial screening application is submitted, the applicant must submit proof that a National Criminal Background check has been completed for each of the following:

    - Chairperson of the Board
    - Owner(s)
    - Executive Director

9. **RESUMES AND REQUIREMENTS:** Submit a resume for each Chairperson of the Board, Owner(s), and Executive Director.

    - **Executive Director** : The DIDD considers this position to be an individual responsible for management oversight of an Agency with one of the following qualifications:

        1. A bachelor's degree in a human service field (such as social work, psychology, education, nursing, or closely related field) and five years of experience **in service delivery to** persons with intellectual/developmental disabilities, with at least two of these years serving in a supervisory capacity; or

        2. An associate degree in nursing, education or a related field and six years of experience **in service delivery to** persons with intellectual/ developmental disabilities, with at least two of these years serving in a supervisory capacity.

    - **Support Coordination Executive Director:** see current provider manual for qualifications.

10. **REFERENCES:** For each Chairperson of the Board, Owner(s), and Executive Director provide: three current professional reference letters that are signed and on a professional letterhead who are knowledgeable about the person's professional qualifications. Include one individual who has known the person for at least five (5) years and at least one of these letters must be from an entity with which the agency has held a contract that confirms that the agency has previously delivered similar home and community based services. For an applicant providing similar HCBS services in other states or in Tennessee, submit a professional letter of reference from the State Director of Developmental Disabilities or the designated State Authority for the specific State in which you are operating. The reference dates must be within the year of the date the application is submitted.

Provide the names and contact information below for each reference:

References for Chairperson of the Board	Phone number	e-mail address
Reference for Owner(s)	**Phone number**	**e-mail address**
Reference for Executive Director	**Phone number**	**e-mail address**

11. FINANCIAL STABILITY:

- **Describe organization and owner's financial stability for <u>Existing Agency</u>: Provide independent audits, IRS tax returns or financial statements for the past two years for Owner(s) and Board Chairperson.**
- **Describe organization and owner's financial stability for <u>Start Up Agency</u>: Provide personal income IRS tax return for the past two years for Owner(s) and Board Chairperson.**

12. ORGANIZATION STRUCTURE:

- **Provide an Agency Organizational Chart of all agency participants which should include, but not limited to, the Executive Director, Developmental Disabilities Professional and a nurse (for nursing specific provider).**
- **Provide an attestation from each management position listed on the organization chart regarding their commitment of time and understanding of their obligation to the agency.**

The Department reserves the right to request any additional information deemed relevant to the qualification process.

CERTIFICATION

The New Provider Initial Screening Questionnaire must be signed and dated by the Executive Director, Chairperson of the Board, Business Owner(s), or other executive manager who is authorized by the applicant(s) to submit a New Provider Initial Screening Questionnaire and to attest to the truthfulness and accuracy of the information submitted. DIDD may terminate any potential provider from participation in the process due to material misrepresentation or falsification of information.

Certification Statement of the Person Authorized to Submit the New Provider Initial Screening Questionnaire.

State of Tennessee County: _____.

Agency Name: _____.

Name of Person and Title: _____

1. I am authorized to submit the New Provider Initial Screening Questionnaire as the sole applicant or as the authorized representative of the applicant(s);

2. The information in this questionnaire and the accompanying attachments is true and accurate; and

3. I understand that falsifying and failing to disclose any required information will result in my organization not moving forward in the DIDD provider application process.

_____ _____

Printed Name of Authorized Representative **Title**

_____ _____

Signature **Date**