TN Department of Disability & Aging

PROVIDER RECREDENTIALING APPLICATION

KATIE BECKETT,1915c HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS, EMPLOYMENT AND COMMUNITY FIRST (ECF)-CHOICES, AND CHOICES SERVICES

The Department of Disability and Aging (DDA) serves as the recredentialing authority for 1915(c) Waiver Providers, ECF CHOICES Providers, Katie Beckett Service Providers, and CHOICES providers that also provide ECF CHOICES, 1915(c), Katie Beckett services. *For a guide when completing this application, see the Instructions Page for Provider Recredentialing Application Completion located on the DDA website.*

DATE: _____

PROVIDER INFORMATION

1. Provider Legal Name:		DBA:	
2. Tax ID/FEIN:	3. NPI:	4. Medicaid ID:	5. Taxonomy:

APPLICATION TYPE:

☐ **Recredentialing**
(Existing Providers Only)

PLEASE MARK THE PROGRAM(S) YOU ARE CURRENTLY CONTRACTED TO PROVIDE:

☐ **1915c Waivers**	☐ **Katie Beckett:**	☐ **ECF CHOICES**	☐ **CHOICES**
	☐ Part A (*BlueCare*)	☐ Amerigroup	☐ Amerigroup
	☐ Part B (*DDA*)	☐ BlueCare	☐ BlueCare
		☐ United Health Care	☐ United Health Care

RECREDENTIALING APPLICATION SUBMISSION GENERAL GUIDELINES

To begin the Recredentialing process, please complete this application in its entirety and submit it with all appropriate documentation. If any changes in ownership and /or structure occurs during the Recredentialing process, the applicant is required to notify DDA for further direction via email at DDAProvider.Application@tn.gov . Completion and acceptance of this Recredentialing application by DDA is not a guarantee of MCO network participation.

SUPPORTING DOCUMENTS CHECKLIST

Place a checkmark next to each applicable document you are uploading.
Please see attachments 1-3 for requirements.

☐ **Applicable Professional Licenses/Certifications**	☐ **Employee Roster**
☐ **HCBS self-assessment: Non-Residential**	☐ **Policies (*If your agency has not been credentialed or recredentialed by DDA, please submit all required policies and/or submit any policy that has been revised since your last credentialing or recredentialing.)***
☐ **HCBS self-assessment: Residential**	

☐ **Certificate of Insurance for the following*:**

- **Automobile Coverage** (including owned, leased, hired, and non-owned vehicles coverage) with a bodily injury/property damage combined single limits not less than one million dollars ($1,000,000.00).
- **Comprehensive Commercial General Liability** (including personal injury & property damage, premises/operations, independent Provider, contractual liability and completed operations/products coverage) with bodily injury/property damage combined single limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence and one million, five hundred thousand dollars ($1,500,000.00) aggregate.
- **Professional Malpractice Liability** coverage, as may be required by DDA, with a limit of not less than seven hundred fifty thousand dollars ($750,000.00) and one million, five hundred thousand dollars ($1,500,000.00) aggregate.
- **Workers' Compensation/ Employers' Liability** (including all States' coverage) with a limit not less than seven hundred fifty thousand dollars ($750,000.00) per occurrence for employers' liability. **If an employer has less than 5 employees under TN Law Worker's Compensation is not required.*

SECTION 1: GENERAL INFORMATION

PROVIDER PRIMARY CONTACT INFORMATION		
5. Address:		
6. City:	7. State:	8. Zip Code:
9. Phone Number:	10. Fax Number:	
11. Credentialing Contact Name and Title:		
12. Email Address:	13. Provider Website URL:	

EXECUTIVE DIRECTORS		
14. Katie Beckett Executive Director Name:		☐ n/a
15. 1915(c) Executive Director Name:		☐ n/a
16. ECF CHOICES Executive Director Name:		☐ n/a
17. CHOICES Executive Director Name:		☐ n/a

PROVIDER PRIMARY MAILING ADDRESS		
18. Address:	19. ☐ Same as Primary Address	
20. City:	21. State:	22. Zip Code:
23. Phone Number:	24. Fax Number:	
25. Contact Name and Title:		

26. Email Address:	27. Provider Website URL:

ADDITIONAL LOCATION 1		ADDITIONAL LOCATION 2		ADDITIONAL LOCATION 3	
Region	Choose an item.	**Region**	Choose an item.	**Region**	Choose an item.
Address		**Address**		**Address**	
County		**County**		**County**	
Phone Number		**Phone Number**		**Phone Number**	
Fax Number		**Fax Number**		**Fax Number**	
Managing Director		**Managing Director**		**Managing Director**	

ADDITIONAL LOCATION 4		ADDITIONAL LOCATION 5		ADDITIONAL LOCATION 6	
Region	Choose an item.	**Region**	Choose an item.	**Region**	Choose an item.
Address		**Address**		**Address**	
County		**County**		**County**	
Phone Number		**Phone Number**		**Phone Number**	
Fax Number		**Fax Number**		**Fax Number**	
Managing Director		**Managing Director**		**Managing Director**	

BILLING-PAYMENT/REMIT ADDRESS

28. Address:	29. ☐ Same as Primary Address	
30. City:	31. State:	32. Zip Code:
33. Billing Phone Number:	34. Billing Fax Number:	
35. Billing Contact Name and Title:		
36. Billing Email Address:		

ELECTRONIC VISIT VERIFICATION (EVV)

**Applicable for all programs: Personal Assistance, Respite, Supportive Home Care, or Clinical Services (Nursing, Behavior services,*

Physical Therapy, Occupational Therapy, Nutrition, and Speech Language and Hearing/Pathology)	
37. EVV Contact Name and Title:	38. EVV Contact Fax Number:
39. EVV Contact Phone Number:	40.EVV Contact Email Address:

PROVIDER CONTACT INFORMATION CONTINUED

**Refer to provider's organizational chart, provider directory, or direct contact with provider*

	CONTACT NAME	CONTACT PHONE NUMBER	CONTACT EMAIL ADDRESS
Contact for Referral			
Contact for Employment Services *(If applicable)*			
Reportable Event Management Coordinator *(see REM policy)*			
Training Coordinator			

HOURS OF OPERATION							
☐ 24 Hours	☐ Mon	☐ Tues	☐ Wed	☐ Thurs	☐ Fri	☐ Sat	☐ Sun
☐ Specific Hours of Operation							

EMERGENCY CONTACT INFORMATION (AFTER HOURS OF OPERATION)	
41. Emergency Contact Name and Title:	42. Emergency Contact Phone Number:
43. Emergency Contact Email Address:	

SECTION 2: PROGRAM SERVICES

INSTRUCTION: Please select all services and regions the agency is contracted or credentialed to provide.

☐ KATIE BECKETT PART A ☐ n/a

***THE KATIE BECKETT A PROGRAM IS EXCLUSIVELY THROUGH BLUECARE**

PROGRAM SERVICES	WEST	MIDDLE	EAST
PERSONAL ASSISTANCE/ SUPPORTIVE HOME CARE - IN-HOME			
Katie Beckett Part A - Supportive Home Care (KB–A SHC)			
RESPITE SERVICE			
Katie Beckett Part A - Respite (KB–A RES)			
ANCILLARY SERVICES			
Katie Beckett Part A - Assistive Technology, Adaptive Equipment, and Supplies (KB–A ATAES)			
Katie Beckett Part A - Minor Home Modification (KB–A MHM)			
DAY SERVICES			
Katie Beckett Part A - Community Integration Support Services (KB–A CISS)			
TRANSPORTATION			
Katie Beckett Part A - Community Transportation (KB–A TRANS)			

☐ KATIE BECKETT PART B ☐ n/a

*** THE KATIE BECKETT B PROGRAM IS EXCLUSIVELY THROUGH DDA**

PROGRAM SERVICES	WEST	MIDDLE	EAST
PERSONAL ASSISTANCE /SUPPORTIVE HOME CARE-IN HOME			
Katie Beckett Part B Supportive Home Care (KB–B SHC)			
RESPITE SERVICE			
Katie Beckett Part B Respite (KB–B RES)			
SUPPORT COORDINATION SERVICE:			
Katie Beckett Part B Support Coordination (KB-B SUPP COORD)			
ANCILLARY SERVICES			
Katie Beckett Part B Assistive Technology, Adaptive Equipment, and Supplies (KB–B ATAES)			
Katie Beckett Part B Minor Home Modification (KB–B MHM)			
DAY SERVICES			
Katie Beckett Part B Community Integration Support Services (KB–B CISS)			
TRANSPORTATION			
Katie Beckett Part B Community Transportation (KB–B TRANS)			

☐ 1915c WAIVERS ☐ n/a

PROGRAM SERVICES	WEST	MIDDLE	EAST
RESIDENTIAL SERVICES			
DDA 1915c Family Model Residential Support (DDA FMRS)			
DDA 1915c Medical Residential Services* (DDA MED RES)) **Must apply for Nursing Services **and** either Residential Habilitation or Supported Living*			
DDA 1915c Residential Habilitation (DDA RES HAB))			
DDA 1915c Semi-Independent Living (DDA SIL)			
DDA 1915c Supported Living (DDA SL)			
DAY SERVICES			
DDA 1915c Community Participation Supports (DDA CP)			
DDA 1915c Intermittent Employment & Community Integration Wrap-Around Supports (DDA IECW)			
DDA 1915c Non-Residential Homebound Support Services (DDA NRHS)			
DDA 1915c Facility Based Day (DDA FBD)			
EMPLOYMENT SERVICES			
DDA 1915c Supported Employment Discovery (DDA SE IND DSC)			
DDA 1915 Supported Employment Exploration (DDA SE IND EXP)			
DDA 1915c Supported Employment Individual - Job Development (DDA SE IND JOB DEV) *[consists of Job Dev (JD) Plan or Self-Employment (SE) Plan, Job Dev (JD)Start-Up or Self-Employment (SE) Start-Up] DDA 1915c - Supported Employment Individual -Job Development*			
DDA 1915c Supported Employment Individual - Job Coaching (SE IND JC) *[consists of Job Coaching-Individualized Integrated Employment (JC IIE) and Job Coaching for Self-Employment (JC SE)]*			
DDA 1915c Supported Employment - Small Group (DDA SE SG) *(Examples include mobile crews, small enclaves and other small groups participating in integrated employment)*			
DDA 1915c Supported Employment - Benefits Counseling (DDA SE IND BC)			

THERAPY/CLINICAL SERVICES			
DDA 1915c Behavior Services (DDA BA SVS)			
DDA 1915c Nursing (DDA NURS)			
DDA 1915c Nutrition (DDA NUTR)			
DDA 1915c Occupational Therapy (DDA OT)			
DDA 1915c Orientation and Mobility* (DDA O&M)			
DDA 1915c Physical Therapy (DDA PT)			
DDA 1915c Speech, Language and Hearing (DDA SLH)			
DDA 1915c Speech, Language and Hearing Assistive Technology (DDA SLP)			
ANCILLARY SERVICES			
DDA 1915c Environmental Accessibility Modifications (DDA EAM)			
DDA 1915c Personal Emergency Response System (DDA PERS)			
ENABLING TECHNOLOGY SERVICES			
DDA 1915c Enabling Technology (DDA ETECH)			
DDA 1915c Specialized Medical Equipment Supplies and Assistive Technology (DDA SMESAT)			

PERSONAL ASSISTANCE SERVICE			
DDA 1915c Personal Assistance (DDA PA)*			
RESPITE			
DDA 1915c Respite (DDA RESP)			
DDA 1915c Behavioral Respite (DDA BA RESP)			
SUPPORT COORDINATION SERVICE			
DDA 1915c Support Coordination (DDA SC) *Providers of Support Coordination services are prohibited from providing any other 1915C Waiver service(s). However, Providers of Support Coordination services may apply to provide services under the Katie Beckett A and B, ECF CHOICES, and CHOICES.*			
TRANSPORTATION SERVICE			
DDA 1915c Individual Transportation (DDA IND TRANSP) ** The 1915c Individual Transportation service applies only if requesting the Personal Assistance service, Respite service **or** Orientation and Mobility service. The 1915c Individual Transportation service is not a **stand-alone** service.*			

☐ ECF CHOICES ☐ n/a

PROGRAM SERVICES	WEST	MIDDLE	EAST
RESIDENTIAL SERVICES			
ECF Community Living Supports 1a (ECF CLS 1a)			
ECF Community Living Supports 1b (ECF CLS 1b)			
ECF Community Living Supports 2 (ECF CLS 2)			
ECF Community Living Supports 3 (ECF CLS 3)			
ECF Community Living Supports 4 (ECF CLS 4)			
ECF Community Living Supports Family Model 1a (ECF CLS-FM 1a)			
ECF Community Living Supports Family Model 1b (ECF CLS-FM 1b)			
ECF Community Living Supports Family Model 2 (ECF CLS-FM 2)			
ECF Community Living Supports Family Model 3 (ECF CLS FM 3)			
ECF Community Living Supports Family Model 4 (ECF CLS FM 4)			
ECF Community Stabilization and Transition (ECF CLS CST) Up to 90 Days*Days* **This service is used prior to placing persons in the appropriate level for CLS services. Please select when applying to provide CLS and CLS-FM services.*			
ECF CLS Behavioral Health Community Stabilization and Transition 2a (ECF CLS BHCST 2a)			
ECF CLS Behavioral Health Community Stabilization and Transition (ECF CLS BHCST 2b)			
ECF CLS Emergency Placement (ECF CLS EPCST) **This is a temporary service used in conjunction with CLS Services. Please select when applying to provide CLS and CLS-FM services.*			
ECF Intensive Behavioral Family-Centered Treatment, Stabilization and Supports Group 7 (ECF IBFCTSS 7)			
ECF Intensive Behavioral Community Transition and Stabilization Services Group 8 (ECF IBCTSS 8)			

PROGRAM SERVICES	WEST	MIDDLE	EAST
DAY SERVICE			
ECF Community Integrated Support Services (ECF CLS CISS)			
ECF Independent Living Skills Training (ECF CLS ILST)			
EMPLOYMENT SERVICES			
ECF Co-Worker Supports (ECF CWS)			
ECF Discovery (ECF DISC)			
ECF Exploration for Wage Employment (Also known as Exploration for CIE) (ECF EXPL WE)			
ECF Exploration for Self-Employment (ECF EXPL SE)			
ECF Self-Employment Plan (ECF SEP)			
ECF Job Coaching – Integrated, Competitive Employment (ECF JCICE)			
ECF Job Coaching - Individual Self-Employment (ECF JCSE)			
ECF Job Development Plan (ECF JDSEP)			
ECF Job Development Startup (ECF JDSU)			
ECF Self-Employment Startup (ECF SESU)			
ECF Situational Observation and Assessment (ECF SOA)			
ECF Supported Employment Small Group (Max 2 People) Enclave (ECF SESGE)			
ECF Supported Employment Small Group (Max 3 People) Mobile Work Crew (ECF SE SGMWC)			
ECF Integrated Employment Path Services (Time-Limited Prevocational Training) (ECF IEPS)			
ECF Benefits Counseling *(CWIC, Self Employed or Provider Employed)* (ECF BENE) *(CWIC, Self Employed or Provider Employed)*			
ECF Career Advancement (ECF CAREER)			
ANCILLARY SERVICES			
ECF Assistive Technology/Adaptive Equipment and Supplies (ECF ATAES)			
ECF Minor Home Modifications (ECF MHM)			
THERAPY/CLINICAL SERVICES			
ECF Specialized Consultation and Training Occupational Therapy (ECF SLT OT)			
ECF Specialized Consultation and Training Physical Therapy (ECF SLT PT)			
ECF Specialized Consultation and Training Speech Language Pathology (ECF SLT SLP)			
ECF Specialized Consultation and Training Nurse Education, Training and Delegation (ECF SLT RN)			
ECF Specialized Consultation and Training Nutrition (ECF SLT NUTR)			
ECF Specialized Consultation and Training Behavioral Services (ECF SLT BEHAV SRVS)			
ECF Specialized Consultation and Training Orientation and Mobility (ECF SLT O&M)			

PERSONAL ASSISTANCE SERVICE			
ECF Personal Assistance (ECF PA)			
ECF Supportive Home Care (ECF SHC)			
RESPITE SERVICE			
ECF Respite (ECF RESP)			
ENABLING TECHNOLOGY SERVICES			
ECF Enabling Technology (ECF ETECH)			
OTHER SERVICES			
ECF Community Support, Development, Organization and Navigation (ECF CSDON) Navigation			
ECF Health Insurance Counseling and Forms Assistance (ECF HICFA)			
ECF Peer–to-Peer Support Self Direction Employment and Community Support and Navigation (ECF PPSN)			
ECF Decision Making Supports formerly known as (f.k.a.) Conservatorship and alternative to Conservatorship Counseling (ECF DMS)			
TRANSPORTATION SERVICES			
ECF Community Transportation *Non-Emergency Transportation/ Stand Alone Transportation* (ECF COM TRANSP)			

☐ CHOICES ☐ n/a

PROGRAM SERVICES	WEST	MIDDLE	EAST
RESIDENTIAL SERVICES			
CHOICES Community Living Supports 1 (CH CLS 1)			
CHOICES Community Living Supports 2 (CH CLS 2)			
CHOICES Community Living Supports 3 (CH CLS 3)			
CHOICES Community Living Supports Family Model 1 (CH CLS FM 1)			
CHOICES Community Living Supports Family Model 2 (CH CLS FM 2)			
CHOICES Community Living Supports Family Model 3 (CH CLS FM 3)			
CHOICES Adult Care Home (HCBS ACH 1)			
CHOICES Adult Care Home (HCBS ACH 2)			
CHOICES Assisted Care Living Facility (CH ACF)			
DAY SERVICE			
CHOICES Adult Day Care (HCBS ADC)			
EMPLOYMENT SERVICES			
CHOICES Exploration for Wage Employment (CHOICES EXPL)			
CHOICES Exploration for Self-Employment (CHOICES EXPL-SE)			
CHOICES Discovery (CHOICES DISC)			
CHOICES Situational Observation and Assessment (CHOICES SOA)			
CHOICES Job Dev Plan (CHOICES JDP)			
CHOICES Self-Employment Plan (CHOICES SEP)			
CHOICES Job Dev Start Up (CHOICES JDSU)			
CHOICES Self-Employment Start Up(CHOICES SESU)			
CHOICES Job Coaching – Integrated, Competitive Employment (CHOICES JCICE)			
CHOICES Job Coaching - Self-Employment (CHOICES JCSE)			

PROGRAM SERVICES	WEST	MIDDLE	EAST
CHOICES Co-Worker Supports (CHOICES CWS)			
CHOICES Integrated Employment Path Services: Pre-Vocational (CHOICES IEPS:PV)			
CHOICES Career Advancement (CHOICES CAREER)			
CHOICES Benefits Counseling (CHOICES BENE)			
PERSONAL ASSISTANCE / SUPPORTIVE HOME CARE – IN-HOME			
CHOICES Personal Care (HCBS PC)			
RESPITE SERVICE			
CHOICES Respite In-Home (HCBS IHR)			
ANCILLARY SERVICES			
CHOICES Assistive Technology (HCBS AT)			
CHOICES Minor Home Modifications (HCBS MHM)			
CHOICES Personal Emergency Response System - Monthly Fee (HCBS PERS-Mo)			
CHOICES Personal Emergency Response System- Installation (HCBS PERS-Inst)			
ENABLING TECHNOLOGY			
CHOICES Enabling Technology (HCBS ETECH)			
TRANSPORTATION			
CHOICES Community Transportation (CHOICES TRANS)			
OTHER SERVICES			
CHOICES Home-Delivered Meals (CHOICES HDM)			
CHOICES Pest Control (CHOICES PC)			

SECTION 3: COUNTIES COVERED BY PROGRAM Select the counties and program(s) the provider serves:

MIDDLE REGION: ☐ All Counties ☐ n/a

COUNTY	KB-A	KB-B	1915c	ECF	CHOICES	COUNTY	KB-A	KB-B	1915c	ECF	CHOICES
Bedford						Lewis					
Cannon						Lincoln					
Cheatham						Macon					
Clay						Marshall					
Coffee						Maury					
Cumberland						Montgomery					
Davidson						Moore					
DeKalb						Overton					
Dickson						Perry					
Fentress						Pickett					
Franklin						Putnam					
Giles						Robertson					
Hickman						Rutherford					
Houston						Smith					
Humphreys						Stewart					
Jackson						Sumner					
Lawrence						Trousdale					
Lewis						Van Buren					
Lincoln						Warren					
Houston						Wayne					
Humphreys						White					
Jackson						Williamson					
Lawrence						Wilson					

WEST REGION: ☐ All Counties ☐ n/a

COUNTY	KB-A	KB-B	1915c	ECF	CHOICES	COUNTY	KB-A	KB-B	1915c	ECF	CHOICES
Benton						Haywood					
Carroll						Henderson					
Chester						Henry					
Crockett						Lake					
Decatur						Lauderdale					
Dyer						Madison					
Fayette						McNairy					
Gibson						Obion					
Hardeman						Shelby					
Hardin						Tipton					
						Weakley					

EAST REGION: ☐ **All Counties** ☐ **n/a**

COUNTY	KB-A	KB-B	1915c	ECF	CHOICES		COUNTY	KB-A	KB-B	1915c	ECF	CHOICES
Anderson							Knox					
Bledsoe							Loudon					
Blount							Marion					
Bradley							McMinn					
Campbell							Meigs					
Carter							Monroe					
Claiborne							Morgan					
Cocke							Polk					
Grainger							Rhea					
Greene							Roane					
Grundy							Scott					
Hamblen							Sequatchie					
Hamilton							Sevier					
Hancock							Sullivan					
Hawkins							Unicoi					
Jefferson							Union					
Johnson							Washington					

PROGRAM	EXPLAIN IF NOT ALL SELECTED SERVICES DO NOT APPLY TO ALL COUNTIES SELECTED:
1915c Waivers	
Katie Beckett	
ECF	
CHOICES	

SECTION 4: EMPLOYMENT

* Providers of employment services (excluding providers who only provide Benefits Counseling) are required to have a designated Supported Employment (SE) Manager/Front Line Supervisor (FLS) on staff that is at least a 50% full-time equivalent position and that supervises Job Coaches and Job Developers.

- Attach the job description for the Supported Employment (SE) Manager/Front Line Supervisor (FLS). Verify the Supported Employment (SE) Manager/Front Line Supervisor (FLS) is a position on the organization chart.
- **For informational purposes, does the provider have CESP or ACRE (Pro)*? _____**

  If yes, what certification(s) do you have?_____

  **This is not required for credentialing or recredentialing; however is required to provide services. Provider should work with DDA Employment or MCOs regarding a plan to obtain.*

SECTION 5: GENERAL QUESTIONS

	QUESTION	ANSWER
1.	Has the provider had any professional liability claim judgements or settlements? **If yes, attach a statement with the application which specifies information regarding any professional liability claim judgements or settlements.*	**Choose an item.**
2.	Has the business ever had its professional liability coverage canceled or not renewed? **If yes, attach a statement with the application which specifies information regarding the cancelation or non-renewal of any professional liability.*	**Choose an item.**
3.	Has the business been denied participation, suspended from or denied renewal from Medicare or Medicaid? **If yes, attach a statement with the application which specifies information regarding the denied participation, suspension or denied renewal from Medicare or Medicaid.*	**Choose an item.**
4.	Has any business owner, board member, or the executive director 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 statement with the application which specifies the state, business name, details and legal disposition of such action.*	**Choose an item.**
5.	Has the license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed? * *If yes, attach a statement with the application specifying the type of license (if applicable), applicable state and a detailed explanation regarding the investigation/ litigation, why it originated and current status.*	**Choose an item.**
6.	Does any business owner, board member, or the executive director have a license in Tennessee or in another state who is currently under investigation/litigation by a licensing body or is personally under investigation/litigation by a licensing body? * *If yes, attach a statement with the application specifying information regarding the investigation/ litigation.*	**Choose an item.**
7.	Has any business owner, board member, or the executive director been the business owner, board member, or executive director of an entity who has had a contract to provide Medicaid or Medicare Services barred, suspended or terminated in any State within the past five (5) years? * *If yes, attach a statement specifying the state, business name, and provide details regarding the termination.*	**Choose an item.**
8.	Has the business owner, any board member or board chairperson, and/or executive director been found to be directly responsible for Medicaid fraud or fraudulent activities against a state or federal agency? * *If yes, attach detailed documentation including the year of occurrence, state in which itoccurred and related legal documentation.*	**Choose an item.**

9.	Has your agency provided (or is currently providing) any Medicaid funded services within Tennessee or another state? * *If yes, please supply the following with your application: For a new agency, a statement/resume attached supplying sufficient information on who provided the service, the business name, the types of service(s) and evidence of the length and location of such service(s); OR For an existing or previously approved agency, satisfaction survey results regarding the last two (2) years and/or the results of the most recent Quality Assurance Review which demonstrates good standing.*	Choose an item.
10.	Has the business owner, board member, board chairperson, and/or the executive director been determined to be directly responsible for a provider's closure or termination of a DDA provider agreement or MCO contract due to negligence in performance of duties in a similar position of administrative responsibility? **If yes, attach detailed documentation explaining such closure or termination*	Choose an item.
11.	Has any business owner, board member, or the executive director ever filed personal or business bankruptcy? **If yes, attach with the applicable a detailed explanation of the bankruptcy which includes legal documentation showing the bankruptcy was dismissed.*	Choose an item.
12.	Has any business owner, board member, or executive director ever defaultedon monies owed to DDA or the DDA/MCOs? * *If yes, attach detailed documentation explaining how the debt was resolved.*	Choose an item.

SECTION 6: CERTIFICATION STATEMENT

The Certification Statement must contain a signature which is dated by the executive director, chairperson of the board, business owner(s), or other executive manager who is both authorized by the applicant(s) to submit this Provider Recredentialing Application, and to also attest to the truthfulness and accuracy of the information submitted. DDA may terminate any potential provider from participation in the application process due to material misrepresentation or falsification of information.

I certify the information given in this application is correct and complete to the best of my knowledge. I am aware that should an investigation show any falsification, my agency will not be considered as a potential provider of 1915c Waivers, Katie Beckett-Part A, Katie Beckett-Part B, ECF CHOICES, and/or CHOICES program. I hereby authorize the State of Tennessee to make all necessary investigations concerning the applicant. I further authorize and request each former employer, educational institution, or organization (including law enforcement agencies) to provide all information which may be sought in connection with this application. The agency will carry adequate and appropriate general liability, professional liability, and workers compensation insurance for the protection of persons receiving services, staff, facilities, and the general public.

SIGNATURE SECTION

1. Agency Name	
2. Name of Authorized Representative:	3. Title:
4. Signature:	5. Date:

SECTION 7: ATTACHMENTS

- Instructions for Completing Recredentialing Application
- Recredentialing Review Checklist
- Licensure Requirements