**EXPANSION credentialing APPLICATION**

**for the following programs:**

KATIE BECKETT (Part A), KATIE BECKETT (Part B), 1915c HOME AND COMMUNITY-BASED SERVICES (HCBS) waivers, employment and community first (ECF) choices, and Choices\*

*The Department of Disability and Aging (DDA) serves as the credentialing authority for all 1915c, Employment and Community First (ECF) Waiver program, Katie Beckett (KB) Services- Part A and B (collectively “provider services”), and ECF Providers who provide CHOICES Waiver Services . Effective June 1, 2024, DDA serves as the credentialing authority for CHOICES Providers who also provide 1915c, and/ or Katie Beckett services.*

**INTRODUCTION**: The purpose of this Department of Disability and Aging (DDA) EXPANSION CRENDENTIALING APPLICATION is to add a new program(s), new service(s), and/or new region(s). This application must be completed by an entity (e.g., individual, group, agency, or other type of organization) who is currently contracted through either of the following programs: Katie Beckett- Part A, Katie Beckett- Part B, the 1915c Home and Community Based Services (HCBS) Waivers, Employment Community First (ECF) CHOICES, or CHOICES.

**If you are solely requesting to add a Managed Care Organization (MCO) contract or counties to your current contracted region(s), complete the MCO Contract and County Expansion Request Form located on the DDA website:** [Become a Credentialed Provider (tn.gov)](https://www.tn.gov/disability-and-aging/provider-information/become-a-credentialed-provider.html)

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| **DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **PROVIDER INFORMATION** | | | |
| 1. Provider Agency Legal Name: | | DBA: | |
| 1. Tax ID/FEIN: | 1. NPI: | 1. Medicaid ID: | 1. Taxonomy # |

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| **AppLICATION Type:** | | | **Program(s) Applying For:** | | | | |
| **Add Program(s)**  **Add Service(s)**  **Add Region (s)** | | | **DDA1915c Waivers**  **DDA Katie Beckett-B** | | **MCO Katie Beckett-A: (*BlueCare*)**  **MCO ECF CHOICES**  **MCO CHOICES\*\*\*** | | |
| **PLEASE MARK THE PROGRAM(S) YOU ARE CURRENTLY CONTRACTED/ CREDENTIALED TO PROVIDE SERVICES:** | | | | | | | |
| **1915c WAIVERS** (DDA) | **KATIE BECKETT (KB)**  MCO KB Part A (BlueCare)  DDA KB Part B | | | **MCO ECF CHOICES**  Wellpoint  BlueCare  United Health Care | | **MCO CHOICES**  Wellpoint  BlueCare  United Health Care | |
| **PLEASE INDICATE BELOW YOUR MOST RECENT RECREDENTIALING DATE. IF YOU HAVE NOT COMPLETED RECREDENTIALING, BECAUSE YOU ARE A NEWLY CREDENTIALED PROVIDER, GIVE THE DATE YOU WERE INITIALLY CREDENTIALED.** | | | | | | | |
| **Give your Initial Credentialing date** | |  | | **Give your most recent Recredentialing date** | | |  |

***PLEASE NOTE****:*

*\*\*\*For a new provider applicant applying for the CHOICES program, credentialing is conducted by DDA only if the provider applicant is also applying to provide any of the following Katie Beckett, 1915c, or ECF Choices .*

*\*\*\*\*Should you wish to provide CHOICES as a stand-alone program, credentialing is conducted by the Managed Care Organization (MCO). Therefore contact the MCOs,* ***(***Wellpoint***, BlueCare, and/or UnitedHealthcare)*** *for the CHOICES application and submit the completed application directly to the MCO.*

**EXPANSION CREDENTIALING APPLICATION SUBMISSION GENERAL GUIDELINES**

**Application Submission**

1. Please submit the application to [DDA.Provider.Application@tn.gov](mailto:DDA.Provider.Application@tn.gov) .
2. Type in the Subject section your organization’s name and the region ( West, or Middle, or East, or Statewide\*) you are requesting the service

\* Statewide applies If you are applying for more than one region

1. For each uploaded document label the document’s name. See Attachment 1 for the list of appropriate documents to upload according to your selected service(s). For Example :

* Credentialing Application
* TN Business State License and/or County of TN Business License, as applicable
* Disclosure Form
* *Tax Forms* (W-9 , IRS 147c and Substitute W-9)

If each uploaded document is not named this may delay the downloading process and impact credentialing of your application.Graphic files such as:  JPEG (photo) or TIFF, will not be accepted.

**Note:**Due to documentation uploading capacity limitation, you may need  to continue uploads onto  more than one submission. Remember for each submission, type in the Subject line your organization’s  name and the region ( West, Middle, or East, or Statewide\*) you are requesting the service. Also label the name of each uploaded document.

\* Statewide applies If you are applying for more than one region

**Note**: If you decide to upload a ZIP FILE. Please ensure the uploaded file states the name of your organization and the region. Also label the name of each document within the ZIP FILE.

1. DDA will email confirmation of your application within two (2) business days. It is very important you contact DDA if you do not receive this email.
2. Please allow 30 calendar days before requesting the status of your application.
3. For questions, contact the DDA Provider Enrollment Coordinator by email at [DDA.Provider.Application@tn.gov](mailto:DDA.Provider.Application@tn.gov) or phone (615) 532-6530
4. Applicants may submit the **Expansion Credentialing Application** throughout the year.
5. To begin the expansion process, applicants should complete the application in its entirety.
6. Applications that do not include all required information will not be processed.
7. The applicant must provide a signature and date where indicated. An electronic signature is acceptable, but a handwritten signature is required for the VECHS-Waiver Form and the Disclosure Form.
8. For services with multiple levels, you must select **each** level you wish to provide.

* EXAMPLE: If you would like only to provide Community Living Supports (CLS) Level 4 then you will not select the other CLS Levels.

1. If any changes in ownership and /or structure occurs during the application process, the applicant is required to notify DDA for further direction via email at [DDA.Provider.Application@tn.gov](mailto:DDA.Provider.Application@tn.gov).
2. Only one set of supporting documents should be submitted, regardless of the number of programs/services requiring the same document.
3. Graphic files such as:  JPEG (photo) or TIFF, will not be accepted.
4. Reference the [Become a Credentialed Provider (tn.gov)](https://www.tn.gov/disability-and-aging/provider-information/become-a-credentialed-provider.html) site for instructions, tools, and forms to be submitted with your application.  This includes, but is not limited to, specific supporting documents required for each application/service type.
5. Completion and acceptance of this credentialing application by DDA is not a guarantee of MCO network participation. DDA/MCO policies and procedures will govern appeals, related to network participation.

**Expansion Service license PrerequisiteS**

The following must be completed prior to submission of the **Expansion Credentialing Application**.

1. **Service/ProfessionAL licenses:** **FOR SPECIFIC DETAILS SEE ATTACHMENT 4 service definition AND ATTACHMENT 2 Licensing Requirement** 
   1. **PROFESSIONAL License(s)/CERTIFICATIONS:** For example, when applying to provide Behavioral services, Nursing, Occupational Therapy, the applicant must submit the individual’s professional license.
   2. **PROFESSIONAL SERVICES SUPPORT LICENSE (PSSL)**: This is applicable to 1915c clinical/therapy services (Nursing, Physical Therapy, Occupational Therapy, and Speech Language and Hearing) and is issued by the Tennessee Department of Health. **\*Please note:** *the PSSL is not issued until after the completion of the credentialing process and therefore a copy is not required during credentialing. However, this must be obtained and uploaded before your contract may be executed.*
   3. **SERVICE LICENSE(S)**: Applicable service licenses pertain to residential, day, personal assistance, and other services. *For example: in the Residential category, the applicant must submit the required residential license from DDA’s Office of Licensure.*

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| **Provider Primary Contact Information** | | | | |
| 6**.** Address: | | | | |
| 7. City: | 8. State: | | | 9. Zip Code: |
| 10. Phone Number: | | | 11. Fax Number: | |
| 12. Credentialing Contact Name and Title: | | | | |
| 13. Email Address: | | | 14. Provider Website URL: | |
| **15. EXECUTIVE DIRECTORS/Managing Employee Name** | | | | |
|  | | | | |
| **provider primary Mailing Address** | | | | |
| 16**.** Address | | 17. ☐ Same as Primary Address | | |
| 18. City: | 19. State: | | | 20. Zip Code: |
| 21. Phone Number: | | | 22. Fax Number: | |
| 23. Contact Name and Title: | | | | |
| 24. Email Address: | | | 25. Provider Website URL: | |
| **BIlling-Payment/remit address** | | | | |
| 26. Address: | | 27. ☐ Same as Primary Address | | |
| 28. City: | 29. State: | | | 30. Zip Code: |
| 31. Billing Phone Number: | | | 32. Billing Fax Number: | |
| 33. Billing Contact Name and Title: | | | | |
| 34. Billing Email Address: | | | | |

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| **Electronic Visit Verification (EVV*)***  *Complete the EVV section and* provide an EVV policy, if you are requesting to provide the following services: *Personal Assistance, Respite, Supportive Home Care, Nursing, Behavior services, Physical Therapy, Occupational Therapy, Speech Language and Hearing, and Nutrition.* | |
| 35. EVV Contact Name and Title: | 36. EVV Contact Fax Number: |
| 37. EVV Contact Phone Number: | 38.EVV Contact Email Address: |

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| **Hours of Operation** | | | | | | | |
| ☐ 24 Hours | ☐ Mon | ☐ Tues | ☐ Wed | ☐ Thurs | ☐ Fri | ☐ Sat | ☐ Sun |
| ☐ Specific Hours of Operation |  |  |  |  |  |  |  |

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| **Emergency Contact Information (after hours of operation)** | |
| 39. Emergency Contact Name and Title: | 40. Emergency Contact Phone Number: |
| 41. Emergency Contact Email Address: | |

# **SECTION 3: PROGRAM SERVICES**

**Scope of Services:** Applicants may apply to become a credentialed provider of Katie Beckett (KB), 1915c Waivers,

Employment and Community First CHOICES (ECF), and CHOICES Please see the Attachments 1-4 for additional

information and requirements at [Become a Credentialed Provider (tn.gov)](https://www.tn.gov/disability-and-aging/provider-information/become-a-credentialed-provider.html)

**Instruction:** Prior to selecting the program service(s) and region(s) you are applying to participate in, review the

attachments 1-4: Credentialing Standards, License Requirements Policy Requirements, and Service

Definitions. Please select each service you wish to provide under the corresponding program ( Katie Beckett: Part A

or B, 1915c Waivers, ECF Choices, and/or CHOICES). You will also mark the region(s) you wish to serve.

**NOTES**: When selecting the areas, including region(s) and or county(ies) the applicant shall note the following:

* Credentialed 1915c and Katie Part-B providers will be qualified for all counties in the selected Region(s).
* ECF CHOICES, CHOICES, Katie Part-A providers will be credentialed only under the counties and services selected.  However, the MCOs contract is based on network capacity, county and services needed.

NOTE: When selecting program services, please only select the service(s) you wish to **add** to your existing provider agreement/contract. **DO not Select services you are currently contracted to provide.**

# **Please select all services and region(s) the provider will offer for the following:**

**Katie Beckett** **Part A  N/A**

**\*CONTRACTED 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 SERVICE** | | | |
| Katie Beckett Part A - Community Integration Support Services (KB–A CISS) |  |  |  |
| **TRANSPORTATION** **SERVICE** | | | |
| Katie Beckett Part A Community Transportation (KB–A TRANS) |  |  |  |

**Katie Beckett Part B  N/A**

**\*CONTRACTED exclusively THROUGH DDA**

| **PROGRAM SERVICES** | **West** | **Middle** | **East** |
| --- | --- | --- | --- |
| **PERSONAL ASSISTANCE/SUPPORTIVE HOME CARE IN HOME SERVICE** | | | |
| Katie Beckett Part B Supportive Home Care (KB–B SHC) |  |  |  |
| **RESPITE SERVICE** | | | |
| Katie Beckett Part B Respite (KB–B RES) |  |  |  |
| **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 SERVICE** | | | |
| Katie Beckett Part B Community Integration Support Services (KB–B CISS) |  |  |  |
| **TRANSPORTATION SERVICE** | | | |
| 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 MEDRES)  *\*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 NRSHMB) |  |  |  |
| **EMPLOYMENT Services** | | | |
| DDA 1915c Supported Employment Discovery (DDA DISC) |  |  |  |
| DDA 1915 Supported Employment Exploration (DDA EXPL) |  |  |  |
| DDA 1915c Supported Employment Individual - Job Development (DDA SE JD) *[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* |  |  |  |

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| DDA 1915c Supported Employment Individual - Job Coaching (DDA JCICE)  *[consists of Job Coaching - Individualized Integrated Employment (JC IIE) and Job Coaching for Self-Employment (JC SE)]* |  |  |  |
| DDA 1915c Supported Employment - Small Group (DDA SESG)  *(Examples include mobile crews, small enclaves and other small groups participating in integrated employment)* |  |  |  |
| DDA 1915c Supported Employment - Benefits Counseling (DDA BENE) |  |  |  |

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| **THERAPY/CLINICAL Services** | | | |
| DDA 1915c Behavior Services: Behavior Analyst (DDA BA) |  |  |  |
| DDA 1915c Behavior Services; Behavior Specialist (DDA BS)  *\*Must have a Behavior Analyst to provide oversight.* |  |  |  |
| 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) |  |  |  |
| **PROGRAM ServiceS** | **West** | **Middle** | **East** |
| 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 SERVICES** | | | |
| DDA 1915c Respite (DDA RESP)\* |  |  |  |
| DDA 1915c Behavioral Respite (DDA BA RESP) |  |  |  |
| **SUPPORT COORDINATION SERVICE** | | | |
| DDA 1915c Support Coordination (DDA SUPP COORD) *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 Stabilization and Transition (ECF CLS CST) Up to 90 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 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 Behavioral Health Community Stabilization and Transition 2a  (ECF CLS BHCST 2a) |  |  |  |
| ECF Behavioral Health Community Stabilization and Transition 2b  (ECF CLS BHCST 2b) |  |  |  |
| ECF 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) |  |  |  |
| **DAY SERVICES** | | | |
| ECF Community Integrated Support Services (ECF CISS) |  |  |  |
| ECF Independent Living Skills Training (ECF 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 Job Coaching – Integrated, Competitive Employment (ECF JCICE) |  |  |  |
| ECF Job Coaching - Self-Employment (ECF JCSE) |  |  |  |
| ECF Job Development Plan (ECF JDSEP) |  |  |  |
| ECF Self-Employment Plan (ECF SEP) |  |  |  |
| 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: Prevocational Training (ECF IEPS) |  |  |  |
| ECF Benefits Counseling (ECF BENE) |  |  |  |
| 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 SCT OT) |  |  |  |
| ECF Specialized Consultation and Training Physical Therapy (ECF SCT PT) |  |  |  |
| ECF Specialized Consultation and Training Speech Language Pathology (ECF SCT SLP) |  |  |  |
| ECF Specialized Consultation and Training Nurse Education, Training and Delegation (ECF SCT RN) |  |  |  |
| ECF Specialized Consultation and Training Nutrition (ECF SCT NUTR) |  |  |  |
| ECF Specialized Consultation and Training Behavioral Services (ECF SCT BEHAV SRVS) |  |  |  |
| ECF Specialized Consultation and Training Orientation and Mobility (ECF SCT O&M) |  |  |  |
| **PERSONAL ASSISTANCE SERVICE** | | | |
| ECF Personal Assistance (ECF PA) |  |  |  |
| ECF Supportive Home Care (ECF SHC) |  |  |  |
| **RESPITE SERVICE** | | | |
| ECF Respite (ECF RESP) |  |  |  |
| **Enabling Technology SERVICE** | | | |
| ECF Enabling Technology (ECF ETECH) |  |  |  |
| **OTHER SERVICES** | | | |
| ECF Community Support, Development, Organization and Navigation (ECF CSDON) |  |  |  |
| ECF Health Insurance Counseling / 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 SERVICE** | | | |
| ECF Community Transportation *Non-Emergency Transportation/ Stand Alone Transportation* (ECF TRANS) |  |  |  |

**CHOICES**   **N/A**

##### The Expansion provider credentialing application is for CONTRACTED CHOICES PROVIDERS INTERESTED in providing services IN ANY OF THE FOLLOWING PROGRAM SERVICE: kATIE bECKETT 1915C, AND /OR ECF CHOICES.

##### Should you wish to provide CHOICES as a stand-alone program, credentialing is conducted by the MCO. Therefore, CONTACT THE MCO FOR THEIR APPLICATION AND SUBMIT IT DIRECTLY TO THE MCO.

| **PROGRAM SERVICES** | **West** | **Middle** | **East** |
| --- | --- | --- | --- |
| **RESIDENTIAL SERVICES** | | | |
| CHOICES Community Living Supports 1 (HCBS CLS 1) |  |  |  |
| CHOICES Community Living Supports 2 (HCBS CLS 2) |  |  |  |
| CHOICES Community Living Supports 3 (HCBS CLS 3) |  |  |  |
| CHOICES Community Living Supports Family Model 1 (HCBS CLS FM 1) |  |  |  |
| CHOICES Community Living Supports Family Model 2 (HCBS CLS FM 2) |  |  |  |
| CHOICES Community Living Supports Family Model 3 (HCBS CLS FM 3) |  |  |  |
| CHOICES Adult Care Home (HCBS ACH 1) |  |  |  |
| CHOICES Adult Care Home (HCBS ACH 2) |  |  |  |
| CHOICES Assisted Care Living Facility (HCBS ACLF) |  |  |  |
| **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) |  |  |  |
| 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 SERVICES** | | | |
| CHOICES Community Transportation (CHOICES TRANS) |  |  |  |
| **OTHER SERVICES** | | | |
| CHOICES Home-Delivered Meals (HCBS HDM) |  |  |  |
| CHOICES Pest Control (CHOICES PC) |  |  |  |
| CHOICES Community Transportation (CHOICES TRANS) |  |  |  |

# SECTION 6: COUNTIES COVERED BY PROGRAM

## Select the counties and program(s) the applicant has the **capacity** to serve:

## **PLEASE NOTE:**

## If you are solely requesting to add counties to your contracted Program region(s), please complete and submit THE MCO Contract and County Expansion Request Form located on the DDA website:

Select the counties and program(s) the applicant has the **capacity** to serve:

## PLEASE NOTE:

## **1915c & Katie Beckett – Part B** are credentialed and may be contracted for all counties and regions requested.

## **ECF/CHOICES/KB Part A** are credentialed for all counties requested. However, contracted counties are per MCO need.

**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** |  |  |  |  |  |

**MIDDLE REGION:  All Counties  n/a**

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

**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** |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Explain if not all selected services do not apply to all counties selected:** | | | | |
| **1915c Waivers** |  |  | **ECF** |  |
| **Katie Beckett** |  | **CHOICES** |  |

**APPLICATION TYPE INSTRUCTIONS:**

1. **Check and complete the applicable Expansion Option (A, B, or C) described below**
2. **Complete the supporting documents 1-10 for Option “ A” and Option “B” Note: The supporting documents 1-10 are the same for both Option “ A” and Option “B”.**
3. **Complete the additional supporting documents 11-15 if Option B is checked.**
4. **The Sections 7, 8, 9 , and 10 below are to be completed for Options ( A, B ,and C).**
5. **Answer Sections C and/or D below if applicable for Option A or Option B**

**option a: check the option a that applies.**

**A1.DDA contracted /CREDENTIALED provider requesting additional DDA services (1915c waivers and/OR Katie Beckett-Part B) and regions**

**a2. DDA contracted/CREDENTIALED provider requesting to Add an MC0 Program (ECF, CHOICES, and/OR Katie Beckett-Part A), service(s) and region(s)**

**a3, MCO contracted/CREDENTIALED provider requesting TO add Another MCO Program(ECF, CHOICES, and Katie Beckett-Part A), service(s) and region(s)**

**Option B: MCO CONTRACTED/CREDENTIALED PROVIDER (ecf, CHOICES,KATIE BECKETT-PART A) REQUESTING TO ADD THE DDA PROGRAM SERVICES (1915C AND /OR KATIE BECKETT-PART B)**

**Option C: Contracted/CREDENTIALED clinical/therapy & ancillary service providers requesting to provide the service CATEGORIES: Residential, Day, EMployment, PERSONAL aSsisTANCE, Respite and OTHER, MUST COMPLETE and submit the New provider credentialing application.**

**SUPPORTING DOCUMENTS FOR OPTION A and B**

* + - 1. **Reason(s) for requesting to add service(s) and/or Region(s)**: Please provide an explanation as to the reason for the request. For example: If this is being requested for a person supported, please let us know.
      2. **Submit the Required** service license (s) and/or professional license(s).
      3. **Updated Agency Supervision plan:** Please provide your updated supervision plan which demonstrates managerial oversight and monitoring of the service(s) you are requesting to add.
      4. **Updated Organizational Chart:** Please provide an updated Organizational Chart showing coverage for the requested service(s).

Hint: Please ensure on your organizational chart and job descriptions coverage is provided as needed to deliver all required services.

* + - 1. **Job Description of new service(s):** Please provide an updated job description which apply to the requested service(s) please supply job descriptions showing job duties, education requirements and experience requirements. Job Descriptions must match positions on the Organizational Chart.

**If Applying for Supported EMployment Services, See Attachment 1.**   
Hint: Please ensure on your organizational chart and job descriptions coverage is provided as needed to deliver all required services.

Hint: FOR EMPLOYMENT SERVICES: To meet initial credentialing [Applicable to Employment Service providers across all programs (1915c, ECF Choices, and CHOICES], the provider must submit a job description for the Supported Employment Manager/Front Line Supervisor and this position must display on the organizational chart

* + - 1. **PROVIDER PERFORMANCE**: As a currently contracted provider of Medicaid funded services within Tennessee, please supply your satisfaction survey results regarding the last two (2) years and/or the results of the most recent Quality Assurance Review which demonstrates good standing.
      2. **If applying for the Enabling TECHNOLOGY SERVICE complete the Additional Requirement Specific to Enabling TECHNOLOGY**, see Attachment 1.
      3. **SEE SECTION C Policies & pROCEDURES Below:** For #8, please provide any policies you do not currently have for the new services or for # 8 answer **“NOT APPLICABLE”**.
      4. **SEE BELOW SECTION D for ad**dding residential, and/or nonresidential service(s) and/or regions are required to show a plan to comply with the Centers for Medicaid and Medicare Services (CMS) at the time of credentialing

| * + - 1. **GENERAL QUESTIONS** | | Answer |
| --- | --- | --- |
|  | 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. |
|  | 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. |
|  | 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. |
|  | 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. |
|  | 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. |
|  | 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. |
|  | 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. |
|  | 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 it occurred and related legal documentation.* | Choose an item. |
|  | 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. |
|  | 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. |
|  | 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. |
|  | Has any business owner, board member, or executive director ever defaulted on monies owed to DDA or the DDA/MCOs? \* *If yes, attach detailed documentation explaining how the debt was resolved.* | Choose an item. |

**Option B: ADDITIONAL SUPPORTING DOCUMENTS items 11- 15 : MCO Contracted/CREDENTIALED provider (ECF, CHOICES, KAtie BEckett–Part A) requesting to add the DDA program services (1915c and/or Katie BEckett-Part B)**

* + - 1. **Proof of active TN Secretary of state registration and/or county busIness license** where appropriate.
      2. **DISCLOSURE FORM (for Provider entities or provider person as appropriate):** *Business information must match what is reported on the TN Secretary of State and contracted name(s).*
* Any person or entity who owns five (5) percent or more of the business should be reported as an owner.
* Complete the entire form as instructed.
* The provider Entity Federal Tax ID number
* The National Provider Identifier (NPI) number must be for an organization.
* Must have an assigned TennCare/Medicaid ID number.
* Must report the Social Security Number and Date of Birth for all owners, executive director/managing employee, and board chairperson (if applicable).
  + - 1. **National Criminal Background Check:** A national criminal background check must be complete for the:
* Chairperson of the Board
* Owner(s)
* Executive Director and/or Managing Employee.
* Please supply the following documentation for the individuals identified to fulfill these positions for your agency:
* Proof of registration for national criminal background check (copy of paid receipts)
* Volunteer and Criminal History System (VECHS) form
  + - 1. **Proof of required insurance(s):** Please submit a current valid Certificate of Insurance detailing: Coverage Description; Insurance Company & Policy Number; Exceptions and Exclusions; Policy Effective Date; Policy Expiration Date; Limit(s) of Liability; and Name and Address of Insured. For the following:

1. **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.
2. **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**.
3. **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**). The Department will accept, for Service Agreement and Credentialling purposes, $1,000,000 in Automobile Liability Insurance, combined with an Umbrella Policy that has an additional $500,000 in coverage. An Umbrella Policy cannot substitute the required $1,000,000 Automobile Liability Insurance.
4. **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**.
   * + 1. **OPTIONAL DEMOGRAPHIC INFORMATION**.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Business Ownership** *(please select all which apply)* | | |  | **Ownership Ethnicity** *(please select one)* | | | |
|  | 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 |

**Section c: Policies & Procedures**

**Policies & pROCEDURES:** Please provide any policies you do not currently have for the new services. Please see ATTACHMENT 3-Provider Credentialing Policy Requirements for policy requirements per service type.

* Providers are charged with writing policies which explain the plan of implementation and the processes to monitor its effectiveness/success.
* **Please complete and submit the Minimum Required Policies & Review Guidelines Tool**. The critical elements in each policy are provided to aid the provider in developing standards and expectations to ensure health, safety, and accessibility. The provider must clearly demonstrate in each its policy all critical elements, concepts, expectations, and outcomes.

The tool is located at [Become a Credentialed Provider (tn.gov)](https://www.tn.gov/disability-and-aging/provider-information/become-a-credentialed-provider.html)

* It is recommended you use the supplied Medication Safety Policy: Please review this policy and if you choose to use it, you may then “Save as”, insert your agency’s name, and submit.
* Please note your Succession and Back-up staffing plans may be used in conjunction with your current supervision plan.
* Please ensure on your organizational chart and job descriptions coverage is provided as needed to deliver all required services.

**Section D: Home & Community-Based Services (HCBS) Settings Rule:**

**All contracted/credentialed providers applying to add residential, and/or nonresidential service(s) and/or regions are required to show a plan to comply with the Centers for Medicaid and Medicare Services (CMS) at the time of credentialing.** *This requirement includes completing and submitting a new self-assessment on each new setting/service you are requesting to expand as prescribed by DDA to meet 100% compliance with the HCBS Settings Rule:*

1. As a **contracted/credentialed** provider applying to add services and/or region(s) you are answering questions related to future **and** current sites **and** how you plan to implement Federal guidelines.
2. In the “evidence” section of the self-assessments, please note **where** proof of your plan to comply may be found. Please verify evidence is documented where indicated. Do not provide just a statement of your plan to comply on the self-assessment. This includes, but is not limited to the following:

* Employment application
* Lease
* Picture of MapQuest/Google Maps/Google Earth showing location meets requirements
* Resident handbook
* Satisfaction survey
* Specific name of policy
* Tenant agreement

1. List of all licensed homes showing not located on the same street, etc. CBS Self-Assessments are not required for Clinical and Ancillary, or the Katie Beckett programs.
2. **TN Residential Provider Self-Assessment:** For the assessment click the link below:

[**https://www.tn.gov/content/dam/tn/disability-and-aging/documents/provider-information/become-a-credentialed-provider/TN%20Residential%20Provider%20Self-Assessment.docx**](https://www.tn.gov/content/dam/tn/disability-and-aging/documents/provider-information/become-a-credentialed-provider/TN%20Residential%20Provider%20Self-Assessment.docx)

**On**ly **one** TN Residential Provider Self-Assessment is required for **all** residential services requested.

* **1915c Waiver Services:** Family Model Residential Support, Medical Residential, Residential Habilitation, Semi-Independent Living, and Supported Living.
* **ECF CHOICES:** Community Living Supports (1a-4), Community Living Supports – Family Model (1a-4), Intensive Behavioral Community Transition and Stabilization Services, Community Stabilization and Transition, Behavioral Health Community Stabilization and Transition 2a & 2b, and Emergency Placement.
* **CHOICES:** Assisted Care Living Facility,Community Living Supports (1-3), Community Living Supports – Family Model (1-3) and Adult Care Home (1 and 2).

**B: TN Non-Residential Provider Self-Assessment:** For the assessment click the link below:

**https://www.tn.gov/content/dam/tn/disability-and-aging/documents/provider-information/become-a-credentialed-provider/TN%20Non-Residential%20Self-Assessment.docx**

Only **one** TN Non-Residential Provider Self-Assessment is required for **all** non-residential services requested.

* **1915c Waiver Services:** Community Participation Supports, Intermittent Employment & Community Integration Wrap-Around Supports, Non-Residential Homebound Support Services, and Supported Employment – Individual Job Development, Supported Employment – Individual Job Coaching, Supported Employment – Small Group, Benefits Counseling, Exploration, Discovery
* **ECF CHOICES:** Community Integrated Support Services, Independent Living Skills Training, Co-Worker Supports, Discovery, Exploration for Wage Employment, Job Development Plan, Job Development Startup, Self-Employment Startup, Situational Observation and Assessment, Job Coaching Integrated Competitive Employment, Job Coaching SelfEmployment , Supported Employment – Small Group Enclave, Supported Employment – Small Group Mobile Work Crew, Integrated Employment Path Services, Prevocational Training, Career Advancement, and Benefits Counseling
* **CHOICES:** Adult Day Care, Exploration for Wage Employment, Exploration for Self-Employment, Discovery, Situational Observation and Assessment, Job Development Plan, Self-Employment Plan, Job Development Start-up, Self-Employment Start-up, Job Coaching Integrated, Competitive Employment, Job Coaching Self-Employment, Co-Worker Supports, Integrated Employment Path Services: Pre-Vocational, Career Advancement, Benefits Counseling
* **Katie Beckett A & B:** Community Integrated Support Services

# **SECTION 7: STATEMENT OF UNDERSTANDING**

# **Are the executive director (managing employee), owner(s), and/or chairperson of the board, a fiduciary for someone the agency intends to support? \* Yes No**

*\*If* ***YES****, complete the following Statement of Understanding below. If* ***NO****, this section should be left blank.*

**The fiduciary** **will not receive payment as an employee or board member if the person is supported by the organization unless specifically permitted by court order.**

**As the fiduciary** **of a person enrolled in any of the Medicaid Waivers, I hereby acknowledge I/we are aware that under federal guidelines I/we cannot be paid as an employee or board member for services provided and funded under the Medicaid Home and Community Based Services (HCBS) Waiver program. DDA and/or the MCO’s will monitor compliance to this federal statute. Consequences for non-compliance may include recoupment of funds used to pay the noted relatives, possible investigation of Medicaid fraud, and disenrollment as a provider.**

**SIGNATURE SECTION**

|  |  |
| --- | --- |
| **1. Agency Name:** | **2. Tennessee County:** |
| **3. Name:** | **4. Relation:** |
| **5. Signature:** | **6. Date:** |
|  | |
| **7. Name:** | **8. Relation:** |
| **9. Signature:** | **10. Date:** |

# **SECTION 8: PROGRAM SERVICE DEFINITIONS AND IMPLEMENTATION**

This 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 Credential 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.

**See Attachment 4 for the Program Service Definitions: I certify I have reviewed, understand, and agree to the service definitions and implementation requirements for program(s) applicable to the service(s) selected on this application.**

Katie Beckett-Part A

Katie Beckett-Part B

1915c

ECF CHOICES

CHOICES

**SIGNATURE SECTION**

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

# **SECTION 9: ATTEStaTION**

***This 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 Credentialing or Re-credentialing Application.***

By signing this statement below, I attest to the truthfulness and accuracy of the information submitted.

* I understand DDA may terminate any potential provider from participation in the application process due to material misrepresentation or falsification of information.
* I certify that I have reviewed, understand, and agree to notify the Department of Disability and Aging and applicable contracted Managed Care Organizations should my agency/organization purchase or acquire “*any autos”* prior to the next application review/submission used for business purposes, and I will immediately acquire and submit proof the required “*any-auto” insurance* has been purchased in the required coverage amount.
* I hereby authorize the State of Tennessee to make all necessary investigations concerning the applicant (Re-Credentialing and/or Expansion Credentialing Application).
* I further authorize my insurance agency, or other organization (including law enforcement agencies) to provide all information which may be sought in connection with this attestation. 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.

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

# **SECTION 10: 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 Credential 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 B program, and/or ECF 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:** |

APPLICATION STATUS:

* 1. Your application will be credentialed when all required supporting documents are complete and accurate.
  2. DDA Credentialing will send you a Credentialing Notification Letter, it gives the status of your application.

DDA MERGERS AND ACQUISITIONS:

When a change of ownership, merger and/or acquisitions occurs, it is the provider’s responsibility to notify DDA.

DDA revocation of credentialing application

The Department reserves the right to revoke credentialing of any application(s) including but not limited to the following reasons:

1. Evidence is discovered demonstrating material misrepresentation or falsification of information on the application.
2. Additional information is received or discovered indicating the Department erroneously credentialed the application (e.g., the Department discovered the applicant is listed on the LEIE exclusion list or one of the offender registries, etc.).

additional notices

* DDA reserves the right to request any information deemed relevant to the provider credentialing process.
* Completion and acceptance of this credentialing application by DDA is not a guarantee of MCO network participation.
* DDA/MCO policies and procedures will govern appeals related to network participation *(if available).*