

NEW PROVIDER CREDENTIALING APPLICATION

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 New Provider Credentialing Application is to be completed by an entity (e.g., individual, group, agency, or other type of organization) seeking to provide 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 (for details see the Program Scope below)*. These programs are administered by the Department of Disability and Aging (DDA) and the Managed Care Organizations (MCOs): Wellpoint, BlueCare, and United Health Care.

APPLICATION TYPE: NEW PROVIDER		DATE: _____	
PROVIDER INFORMATION			
1. Provider Agency Legal Name:		DBA:	
2. Tax ID/FEIN:	3. NPI:	4. Medicaid ID:	5. Taxonomy:
*PROGRAM SCOPE			

- Providers seeking to offer only CHOICES services must complete credentialing through any of the MCOs (WellPoint, BlueCare, and/or UnitedHealthcare). Contact the MCO directly to obtain and submit their credentialing application.
Providers requesting to offer CHOICES in combination with any of the following programs—1915(c), ECF Choices, or Katie Beckett—must complete and submit this **New Provider Credentialing Application** to the DDA.
- New provider applicants requesting to offer any of the following programs—1915(c), ECF Choices or Katie Beckett—must complete and submit this **New Provider Credentialing Application** to the DDA.
- Providers currently contracted, credentialed, or recredentialed for Katie Beckett, 1915(c), ECF Choices, or CHOICES who wish to add a program, region, county, or service must complete the applicable **Expansion Application(s)**:
 - MCO Contract and County Expansion Request Form; and/or
 - Expansion Credentialing Application.
 Submit all required expansion documents to the DDA

CREDENTIALING APPLICATION SUBMISSION GENERAL GUIDELINES

Application Submission

1. Please submit the application to 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
3. 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.

4. 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.
5. Please allow 30 calendar days before requesting the status of your application.
6. For questions, contact the DDA Provider Enrollment Coordinator by email at DDA.Provider.Application@tn.gov or phone (615) 532-6530

To begin the contracting and credentialing process, please complete this application in its entirety and submit it with all appropriate documentation. Applications that do not include all requested information will not be processed. A separate application, disclosure form, tax forms, and supporting documents are required for each program operating under separate National Provider Indicator (NPI) numbers or separate tax identification numbers. If any changes in ownership and /or structure (tax identification number) occurs during the credentialing process, the applicant is required to notify DDA for further direction via email at DDA.Provider.Application@tn.gov.

Please select the program(s), service(s), and region(s) you are applying to participate in. Prior to selecting the service, review the service definition and license requirements. For services with multiple levels, you must select **each** level you wish to provide. EXAMPLE: If you would like to only provide CLS-level 4 then you will not select the other levels. Ensure all information is complete and aligns with your Tennessee Secretary of State registration.

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 Disclosure Form. Only one set of supporting documents should be submitted regardless of the number of programs/services requiring the same document. Graphic files such as: JPEG (photo) or TIFF, will not be accepted.

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.

Providers must have a valid Tennessee Medicaid ID number for credentialing purposes and to contract with DDA/TennCare Managed Care Organization(s). If you have not registered with TennCare, we cannot accept your application. To register with TennCare, please visit: [HTTP://TN.GOV/TENNCARE/Providers/Provider Registration](http://TN.GOV/TENNCARE/Providers/Provider%20Registration)

PREREQUISITES

The following must be completed prior to submission of the credentialing application. *Items 1-5 must be completed before you may proceed to the TennCare Registration Portal and obtain your Medicaid ID.*

1. **SERVICE/PROFESSIONAL LICENSES: FOR SPECIFIC DETAILS SEE EACH SERVICE DEFINITION AND ATTACHMENT 2 LICENSING REQUIREMENT**

- a. **PROFESSIONAL License(s)/CERTIFICATIONS:** *For example, when applying to provide Behavioral services, Nursing, Occupational Therapy, the applicant must submit the individual's professional license.*
- b. **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.*
- c. **PROFESSIONAL SERVICES SUPPORT LICENSE (PSSL):** *This is applicable to 1915c clinical/therapy services and is issued by the Tennessee Department of Health. *PLEASE NOTE: this license 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. To start the PSSL process, DDA will send an approval letter to you and the Tennessee Department of Health.*

2. **FEDERAL TAX ID:** This is issued by the Federal Government's Internal Revenue Service. *Please visit their website for instructions and questions.*

3. **REGISTRATION WITH THE TENNESSEE SECRETARY OF STATE (IF APPLICABLE):** *Please visit the Tennessee Secretary of State website to register your business. The business must remain in an "Active" status.*

4. **TAXONOMY:** The provider type and specialty for the services your agency offers sets the taxonomy. Please refer to the national taxonomy list set by CMS for information and questions. *For Example: If you register as a "HCBS-In Home Supportive Care (Pest Control, etc.)" provider there are certain requirements to enroll as that provider type and taxonomy which will need to be met in the TennCare Provider Portal.*

5. **NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER:** The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry

other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions. *Please visit the National Plan & Provider Enumeration System (NPPES) website for registration, instructions, and frequently asked questions.*

6. TENNCARE PROVIDER REGISTRATION PORTAL: This system is used by TennCare for each provider of services. This includes but is not limited to business and vendor information, ownership information, practice locations, sub-contracts, services authorized, licenses, and additional information.

- a. **If you have not registered with TennCare, we cannot accept your application.**
- b. To register with TennCare, please visit: [PDMS User Login - 3497154c-d926-42fd-b5eb-86c6a541fd23 \(tn.gov\)](#)
- c. **For questions and information, please visit:** <https://www.tn.gov/tenncare/providers/provider-registration.html>
- d. **Please note:** the system only allows **sixty (60) days** to complete the registration. This includes uploading copies of licenses and tax forms. Failure to meet this deadline will require you to start the registration process over.

7. MEDICAID ID NUMBER:

What is a Medicaid ID and when can I use it? Before a provider can be considered for participation in TennCare, registration with the Division of TennCare is required. TennCare issues a Medicaid ID to eligible providers who have completed the registration process. Without a valid, active Medicaid ID, providers cannot be considered for contracting with any TennCare Managed Care Organization or receive payment for services rendered to TennCare enrollees.

- a. Applicants/providers are required to obtain a valid Medicaid ID number for credentialing purposes and to contract with DDA/TennCare Managed Care Organization(s). *This is issued by the Tennessee Division of TennCare through the TennCare Provider Registration Portal.*
- b. To obtain the Medicaid ID number, the service license(s) for each service being requested must be obtained and uploaded into the applicant's TennCare Provider Portal account.
- c. See *Attachment 2 Licensure Requirement* and contact the appropriate licensure (DDA, Department of Health, etc.) to obtain the appropriate service license.

PROVIDER PRIMARY CONTACT INFORMATION		
8. Address:		
9. City:	10. State:	11. Zip Code:
12. Phone Number:		13. Fax Number:
14. Credentialing Contact Name and Title:		
15. Email Address:		16. Provider Website URL:

Please indicate the names, social security numbers, and dates of birth for the positions noted below. should a person perform more than one duty then only one set of numbers is needed. this information will be used by DDA to perform state registry checks.

17. OWNER(S) NAME For individuals having 5% or more ownership For ownership add additional pages if needed. Also place this information on the Disclosure Form

OWNER(S) NAME

Owner(s)DATE OF BIRTH

Owner(s)SOCIAL SECURITY NUMBER

OWNER(S) NAME

Owner(s)DATE OF BIRTH

Owner(s)SOCIAL SECURITY NUMBER

OWNER(S) NAME

Owner(s)DATE OF BIRTH

Owner(s)SOCIAL SECURITY NUMBER

18. EXECUTIVE DIRECTOR/MANAGING EMPLOYEE NAME. Also place this information on the Disclosure Form

*** See the Licensure Rule 0465-02-01-01 note below about the Executive Director/Managing Employee**

Executive Director/Managing Employee DATE OF BIRTH

Executive Director/Managing Employee SOCIAL SECURITY NUMBER

19. BOARD CHAIRPERSON (NOT FOR PROFIT ENTITY)NAME Also place this information on the Disclosure Form

Board Chairperson DATE OF BIRTH

Board Chairperson SOCIAL SECURITY NUMBER

NOTE: EXECUTIVE DIRECTOR/MANAGING EMPLOYEE shall mean and adhere to:

Licensure rules: 0465-02-01-.01

11) "Chief Executive Officer or Director" means the individual appointed, designated, or hired by the governing body to be responsible for the licensee's day-to-day operation.

0465-02-06-.02 (1b, c)

- (b) An organizational chart which clearly shows or describes the lines of authority between the governing body, the chief executive officer, and the staff;
- (c) Policy and procedures which ensure that someone is delegated the authority to act in the absence of the individual responsible for the operation of the facility/service

PROVIDER MAILING ADDRESS

20. Address: 21. ☐ Same as Primary Address

22. City:

23. State:

24. Zip Code:

25. Phone Number:

26. Fax Number:

27. Contact Name and Title:

28. Email Address:

29. Provider Website URL:

BILLING-PAYMENT/REMIT ADDRESS

30. Address: 31. ☐ Same as Primary Address

32. City:

33. State:

34. Zip Code:

35. Billing Phone Number:

36. Billing Fax Number:

37. Billing Contact Name and Title:

38. Billing Email Address:

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.

39. EVV Contact Name and Title:

40. EVV Contact Fax Number:

41. EVV Contact Phone Number:

42. EVV Contact Email Address:

43. WHAT ARE THE HOURS OF OPERATION?

☐ 24 hours daily

☐ State Specific Hours of Operation

☐ Monday

State hours of operation for Monday:

☐ Tuesday

State hours of operation for Tuesday:

☐ Wednesday

State hours of operation for Wednesday:

☐ Thursday

State hours of operation for Thursday:

☐ Friday

State hours of operation for Friday

☐ Saturday

State hours of operation for Saturday

☐ Sunday

State hours of operation for Sunday

EMERGENCY CONTACT INFORMATION (AFTER HOURS OF OPERATION)

44. Emergency Contact Name and Title:

45. Emergency Contact Phone Number:

46. Emergency Contact Email Address:

SECTION 2: ADDITIONAL INFORMATION & QUESTIONS

MEDICAID CERTIFIED	MINORITY BUSINESS	MINORITY BUS, CERTIFIED	VETERAN OWNED BUSINESS
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
1. List Population(s) Served:			
2. Did the provider complete Cultural competency training?			☐ Yes ☐ No
3. Is the provider an Indian Healthcare provider?			☐ Yes ☐ No
4. Does this office meet (Americans with Disabilities Act) accessibility requirement?			☐ Yes ☐ No
5. Does the provider have interpretation services? <i>If yes, please indicate what type:</i>			☐ Yes ☐ No
6. Does the provider have any other cultural or linguistic services (including ASL)? <i>If yes, please indicate what type:</i>			☐ Yes ☐ No
7. Languages Provided			

SECTION 3: OPTIONAL DEMOGRAPHICS 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
			☐	O	Other

SECTION 4: GENERAL QUESTIONS

For each question with a yes response, the applicant is required to submit details and final disposition as noted.

QUESTION	ANSWER
1. Has the provider had any professional liability claim judgments or settlements?	Choose an item.
2. Has the business ever had its professional liability coverage canceled or not renewed?	Choose an item.
3. Has the business been denied participation, suspended from, or denied renewal from Medicare or Medicaid?	Choose an item.
4. Has the business been denied accreditation by its selected accrediting body or had its accreditation status reduced, suspended, revoked or in any way revised by the accrediting body?	Choose an item.
5. 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.
6. Has the license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced, or not renewed?	Choose an item.
7. 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 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.
8. 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.
9. 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.
10. 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.

QUESTION	ANSWER
11. Does any business owner, board member, or the executive director have a history of poor performance on behalf of the applicant due to evidence of repeated poor performance within the past five (5) years, either as a current DDA/MCO provider or as another provider in Tennessee or any other state? <i>*If yes, attach a statement specifying the state, business name, dates, and provide details regarding the agency's performance.</i>	Choose an item.
12. Has the business owner, board member, board chairperson, and/or the executive director been determined to be directly responsible for a providers' 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? <i>*If yes, attach detailed documentation explaining such closure or termination</i>	Choose an item.
13. Has any business owner, board member, or the executive director ever filed personal or business bankruptcy? <i>*If yes, attach with the applicable a detailed explanation of the bankruptcy which includes legal documentation showing the bankruptcy was dismissed.</i>	Choose an item.
14. Has any business owner, board member, or executive director ever defaulted on monies owed to DDA and/or the MCOs? <i>*If yes, attach detailed documentation explaining how the debt was resolved.</i>	Choose an item.

SECTION 5: PROGRAM SERVICES: select all programs, services and region(s) the provider will offer

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/become-a-credentialed-provider)

INSTRUCTIONS: Before selecting the program ,service(s) and region(s) review Attachments 1-4: Credentialing Standards, License Requirements, Policy Requirements, and Service Definitions. After reviewing these Attachments , select the service (s) you wish to provide under the corresponding program (Katie Beckett: Part A or B, 1915c Waivers, ECF Choices, and/or CHOICES), and specify 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.

☐ **KATIE BECKETT PART A IS CONTRACTED EXCLUSIVELY THROUGH BLUECARE**

☐ **N/A**

Note: For any services selected under the **Katie Beckett-Part A** program , the provider is required also to select any service (s) from the **ECF Choices** program.

PROGRAM SERVICES	WEST	MIDDLE	EAST
☐ PERSONAL ASSISTANCE/ SUPPORTIVE HOME CARE - IN-HOME: Katie Beckett Part A - Supportive Home Care (KB-A SHC)	☐	☐	☐
☐ RESPIRE SERVICE: Katie Beckett Part A - Respite (KB-A RES)	☐	☐	☐
☐ ANCILLARY SERVICE: Katie Beckett Part A - Assistive Technology, Adaptive Equipment, and Supplies (KB-A ATAES)	☐	☐	☐
☐ ANCILLARY SERVICE: 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 IS CONTRACTED EXCLUSIVELY THROUGH DDA**☐ N/A**

PROGRAM SERVICES	WEST	MIDDLE	EAST
☐ PERSONAL ASSISTANCE /SUPPORTIVE HOME CARE-IN HOME SERVICE: Katie Beckett Part B Supportive Home Care (KB-B SHC)	☐	☐	☐
☐ RESPIRE SERVICE: Katie Beckett Part B Respite (KB-B RES)	☐	☐	☐
☐ SUPPORT COORDINATION SERVICE: DDA Katie Beckett Part B Support Coordination (DDA SUPP COORD)	☐	☐	☐
☐ ANCILLARY SERVICE: Katie Beckett Part B Assistive Technology, Adaptive Equipment, and Supplies (KB-B ATAES)	☐	☐	☐
☐ ANCILLARY SERVICE: 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 SERVICE: DDA 1915c Family Model Residential Support (DDA FMRS)	☐	☐	☐
☐ RESIDENTIAL SERVICE: DDA 1915c Medical Residential Services* (DDA MEDRES) <i>*Must apply for Nursing Services and either Residential Habilitation <u>or</u> Supported Living</i>	☐	☐	☐
☐ RESIDENTIAL SERVICE: DDA 1915c Residential Habilitation (DDA RES HAB)	☐	☐	☐
☐ RESIDENTIAL SERVICE: DDA 1915c Semi-Independent Living (DDA SIL)	☐	☐	☐
☐ RESIDENTIAL SERVICE: DDA 1915c Supported Living (DDA SL)	☐	☐	☐
☐ DAY SERVICE: DDA 1915c Community Participation Supports (DDA CP)	☐	☐	☐
☐ DAY SERVICE: DDA 1915c Intermittent Employment & Community Integration Wrap-Around Supports (DDA IECW)	☐	☐	☐
☐ DAY SERVICE: DDA 1915c Non-Residential Homebound Support Services (DDA NRSHMB)	☐	☐	☐

PROGRAM SERVICES	WEST	MIDDLE	EAST
☐ DAY SERVICE: DDA 1915c Facility Based Day Supports (DDA FBD)	☐	☐	☐
☐ EMPLOYMENT SERVICE: DDA 1915c Supported Employment Discovery (DDA DISC)	☐	☐	☐
☐ EMPLOYMENT SERVICE: DDA 1915 Supported Employment Exploration (DDA EXPL)	☐	☐	☐
☐ EMPLOYMENT SERVICE: DDA 1915c Supported Employment Individual - Job Development (DDA SE IND JD) <i>[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</i>	☐	☐	☐
☐ EMPLOYMENT SERVICE: DDA 1915c Supported Employment Individual - Job Coaching (DDA JCICE) <i>[consists of Job Coaching - Individualized Integrated Employment (JC IIE) and Job Coaching for Self-Employment (JC SE)]</i>	☐	☐	☐
☐ EMPLOYMENT SERVICE: DDA 1915c Supported Employment - Small Group (DDA SESG) <i>(Examples include mobile crews, small enclaves and other small groups participating in integrated employment)</i>	☐	☐	☐
☐ EMPLOYMENT SERVICE: DDA 1915c Supported Employment - Benefits Counseling (DDA BENE)	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: DDA 1915c Behavior Services: Behavior Analyst (DDA BA)	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: DDA 1915c Behavior Services: Behavior Specialist (DDA BS) <i>*Must have a Behavior Analyst to provide oversight.</i>	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: DDA 1915c Nursing (DDA NURS)	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: DDA 1915c Nutrition (DDA NUTR)	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: DDA 1915c Occupational Therapy (DDA OT)	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: DDA 1915c Orientation and Mobility* (DDA O&M)	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: DDA 1915c Physical Therapy (DDA PT)	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: DDA 1915c Speech, Language and Hearing (DDA SLH)	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: DDA 1915c Speech, Language and Hearing Assistive Technology (DDA SLP)	☐	☐	☐
☐ ANCILLARY SERVICE: DDA 1915c Environmental Accessibility Modifications (DDA EAM)	☐	☐	☐

☐ ANCILLARY SERVICE: DDA 1915c Specialized Medical Equipment Supplies and Assistive Technology (DDA SMESAT)	☐	☐	☐
☐ ANCILLARY SERVICE: DDA 1915c Personal Emergency Response System (DDA PERS)	☐	☐	☐
☐ ENABLING TECHNOLOGY SERVICE DDA 1915c Enabling Technology (DDA ETECH)	☐	☐	☐
☐ PERSONAL ASSISTANCE SERVICE: DDA 1915c Personal Assistance (DDA PA)*	☐	☐	☐
☐ RESPITE SERVICE: DDA 1915c Respite (DDA RESP)*	☐	☐	☐
☐ RESPITE SERVICE: DDA 1915c Behavioral Respite (DDA BA RESP)	☐	☐	☐
☐ SUPPORT COORDINATION SERVICE: DDA 1915c Support Coordination (DDA SUPP COORD) <i>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.</i>	☐	☐	☐
☐ TRANSPORTATION SERVICE: DDA 1915c Individual Transportation (DDA IND TRANSP)	☐	☐	☐

☐ ECF Choices☐ N/A

PROGRAM SERVICES	WEST	MIDDLE	EAST
☐ RESIDENTIAL SERVICE: ECF Community Stabilization and Transition (ECF CLS CST) Up to 90 Days* <i>*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.</i>	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Community Living Supports 1a (ECF CLS 1a)	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Community Living Supports 1b (ECF CLS 1b)	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Community Living Supports 2 (ECF CLS 2)	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Community Living Supports 3 (ECF CLS 3)	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Community Living Supports 4 (ECF CLS 4)	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Community Living Supports Family Model 1a (ECF CLS-FM 1a)	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Community Living Supports Family Model 1b (ECF CLS-FM 1b)	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Community Living Supports Family Model 2 (ECF CLS-FM 2)	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Community Living Supports Family Model 3 (ECF CLS FM 3)	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Community Living Supports Family Model 4 (ECF CLS FM 4)	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Behavioral Health Community Stabilization and Transition 2a (ECF CLS BHCST 2a)	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Behavioral Health Community Stabilization and Transition 2b (ECF CLS BHCST 2b)	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Emergency Placement (ECF CLS EPCST) <i>*This is a temporary service used in conjunction with CLS Services. Please select when applying to provide CLS and CLS-FM services.</i>	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Intensive Behavioral Family-Centered Treatment, Stabilization and Supports Group 7 (ECF IBFCTSS 7)	☐	☐	☐
☐ RESIDENTIAL SERVICE: ECF Intensive Behavioral Community Transition and Stabilization Services Group 8 (ECF IBCTSS 8)	☐	☐	☐
☐ DAY SERVICE: ECF Community Integrated Support Services (ECF CISS)	☐	☐	☐
☐ DAY SERVICE: ECF Independent Living Skills Training (ECF ILST)	☐	☐	☐

PROGRAM SERVICES	WEST	MIDDLE	EAST
☐ EMPLOYMENT SERVICE: ECF Co-Worker Supports (ECF CWS)	☐	☐	☐
☐ EMPLOYMENT SERVICE: ECF Discovery (ECF DISC)	☐	☐	☐
☐ EMPLOYMENT SERVICE: ECF Exploration for Wage Employment (Also known as Exploration for CIE) (ECF EXPL WE)	☐	☐	☐
☐ EMPLOYMENT SERVICE: ECF Exploration for Self-Employment (ECF EXPL SE)	☐	☐	☐
☐ EMPLOYMENT SERVICE: ECF Job Coaching – Integrated, Competitive Employment (ECF JCICE)	☐	☐	☐
☐ EMPLOYMENT SERVICE: ECF Job Coaching - Self-Employment (ECF JCSE)	☐	☐	☐
☐ EMPLOYMENT SERVICE: ECF Job Development Plan (ECF JDSEP)	☐	☐	☐
☐ EMPLOYMENT SERVICE: ECF Self-Employment Plan (ECF SEP)	☐	☐	☐
☐ EMPLOYMENT SERVICE: ECF Job Development Startup (ECF JDSU)	☐	☐	☐
☐ EMPLOYMENT SERVICE: ECF Self-Employment Startup (ECF SESU)	☐	☐	☐
☐ EMPLOYMENT SERVICE: ECF Situational Observation and Assessment (ECF SOA)	☐	☐	☐
☐ EMPLOYMENT SERVICE: ECF Supported Employment Small Group (Max 2 People) Enclave (ECF SESGE)	☐	☐	☐
☐ EMPLOYMENT SERVICE: ECF Supported Employment Small Group (Max 3 People) Mobile Work Crew (ECF SE SGMWC)	☐	☐	☐
☐ EMPLOYMENT SERVICE: ECF Integrated Employment Path Services: Prevocational Training (ECF IEPS)	☐	☐	☐
☐ EMPLOYMENT SERVICE: ECF Benefits Counseling (ECF BENE)	☐	☐	☐
☐ EMPLOYMENT SERVICE: CF Career Advancement (ECF CAREER)	☐	☐	☐
☐ ANCILLARY SERVICE: ECF Assistive Technology/Adaptive Equipment and Supplies (ECF ATAES)	☐	☐	☐
☐ ANCILLARY SERVICE: ECF Minor Home Modifications (ECF MHM)	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: ECF Specialized Consultation and Training Occupational Therapy (ECF SCT OT)	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: ECF Specialized Consultation and Training Physical Therapy (ECF SCT PT)	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: ECF Specialized Consultation and Training Speech Language Pathology (ECF SCT SLP)	☐	☐	☐

PROGRAM SERVICES	WEST	MIDDLE	EAST
☐ THERAPY/CLINICAL SERVICE: ECF Specialized Consultation and Training Nurse Education, Training and Delegation (ECF SCT RN)	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: ECF Specialized Consultation and Training Nutrition (ECF SCT NUTR)	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: ECF Specialized Consultation and Training Behavioral Services (ECF SCT BEHAV SRVS)	☐	☐	☐
☐ THERAPY/CLINICAL SERVICE: ECF Specialized Consultation and Training Orientation and Mobility (ECF SCT O&M)	☐	☐	☐
☐ PERSONAL ASSISTANCE SERVICE: ECF Personal Assistance (ECF PA)	☐	☐	☐
☐ PERSONAL ASSISTANCE SERVICE: ECF Supportive Home Care (ECF SHC)	☐	☐	☐
☐ RESPIRE SERVICE: ECF Respite (ECF RESP)	☐	☐	☐
☐ ENABLING TECHNOLOGY SERVICE: ECF Enabling Technology (ECF ETECH)	☐	☐	☐
☐ OTHER SERVICE: ECF Community Support, Development, Organization and Navigation (ECF CSDON)	☐	☐	☐
☐ OTHER SERVICE: ECF Health Insurance Counseling / Forms Assistance (ECF HICFA)	☐	☐	☐
☐ OTHER SERVICE: ECF Peer-to-Peer Support Self Direction Employment and Community Support and Navigation (ECF PPSN)	☐	☐	☐
☐ OTHER SERVICE: ECF Decision Making Supports formerly known as (f.k.a.) Conservatorship and alternative to Conservatorship Counseling (ECF DMS)	☐	☐	☐
☐ TRANSPORTATION SERVICE: ECF Community Transportation <i>Non-Emergency Transportation/ Stand Alone Transportation</i> (ECF TRANS)	☐	☐	☐

☐ CHOICES**☐ N/A**

The New Provider Credentialing Application is for CHOICES applicants interested in providing services along with any of the following program service: Katie Beckett-Part A, Katie Beckett-Part B, 1915c, and/or ECF Choices

If you intend to provide CHOICES as a stand-alone program, credentialing is conducted by the Managed Care Organization (MCO). Therefore, contact the MCO for their application and submit it directly to them.

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

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

SECTION 6: COUNTIES COVERED BY PROGRAM

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	☐	☐	☐	☐	☐
Program	Explain if not all selected services do not apply to all counties selected:										
1915c Waivers											
Katie Beckett											
ECF CHOICES											
CHOICES											

SUPPORTING DOCUMENTATION below must be submitted with the **New Provider Credentialing Application**:

- Please see the DDA Website: [BECOME A CREDENTIALLED PROVIDER \(TN.GOV\)](https://www.tn.gov/become-a-credentialed-provider) for links to requirements (ATTACHMENTS 1-4) per service type and links to the supplied documents.
- The Attachments 1-4 describe requirements for each program and service.

- 1. CERTIFICATE OF EXISTENCE/AUTHORIZATION WITH AN OUT OF STATE BUSINESS LICENSE:** This is only applicable to Enabling Technology providers outside of the State of Tennessee. Also complete and submit from the Attachment 1 the section titled **Additional Requirements Specific to Enabling Technology: Enabling Technology Credentialing Criteria**
- 2. TENNESSEE SECRETARY OF STATE REGISTRATION:** Please submit documentation showing proof of active status with the Tennessee Secretary of State (where applicable) authorizing the agency to conduct business. *This information must align with the submitted Disclosure Form and tax forms.*
- 3. INSURANCE COVERAGE QUOTES OR VALID CERTIFICATE OF INSURANCE:** Please submit a quote 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.*
 - a) The insurer's name must align with the submitted Tennessee Secretary of State, Disclosure Form, and tax forms.
 - b) Only a QUOTE is required during the credentialing process.
 - c) A valid Certificate of Insurance (COI) is **required** for each insurance type listed below before your contract may be activated.
 - d) Please note coverages must meet the expressed requirements noted below:

TYPES OF POLICIES AND COVERAGE:

- (1) 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 Credentialing purposes, \$1,000,000 in Automobile Liability Insurance. The \$1,000,000 total can contain an Umbrella Policy of \$500,000 in coverage. An Umbrella Policy cannot be used to substitute for the required \$1,000,000 Automobile Liability Insurance.
- (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 **\$750,000.00 per occurrence** and **\$1,500,000 aggregate**.
Comprehensive Commercial General Liability coverage for ECF Choices and CHOICES providers must include an automobile coverage add-on to the policy to cover transportation as a component of

service delivery within LTSS programs. ECF Choices and CHOICES providers are no longer required to have a stand-alone policy for automobile coverage.

- (3) **Professional Malpractice Liability** coverage with a limit of not less than **\$750,000** and **\$1,500,000** aggregate.
- (4) **Workers' Compensation/ Employers' Liability** (including all States' coverage) with a limit of not less than **\$750,000 per occurrence** for employers' liability.

4. TAX FORMS: Please submit the W-9 Form, Substitute W-9, and IRS 147c Form/Letter for your organization. *This information must align with the submitted Disclosure Form, the business name on the applicable Tennessee Secretary of State registration and the 147c letter that the applicant must obtain from the IRS.*

5. NATIONAL CRIMINAL BACKGROUND CHECK: See the section **Submitting a National Background Check to DDA**. A national criminal background check must be completed for the Chairperson of the Board, Owner(s), and Executive Director/Managing Employee.

- a) The National Background Check Frequently Asked Questions for instructions on how to complete the national criminal background check. Note: The applicant should obtain the National Fingerprint-based Criminal History Record Check (FCHRC) no more than 60 calendar days prior to submission of the Provider Credentialing Application. *A national FCHRC obtained more than 60 calendar days of the submission of the Provider Credentialing Application will **NOT** be accepted.*
- b) The IdentoGo Tennessee Instructions communicates step by step on how to register and complete the national criminal background check.
- c) **VECHS-Waiver (Volunteer and Criminal History System) form:** To aid in the accurate completion of this form, the qualifying entity (DDA) information/section has been completed.
 - Each of the following persons must submit the **VECHS form along with their receipt proof of completing their national background check:** owner(s), executive director, managing employee, and board chairperson (not-for-profit). The completed VECHS form and receipt proof are submitted with the New Provider Credentialing Application. The correctly completed VECHS form gives DDA permission to obtain the person's national FCHRC report and the receipt directs DDA on when the check was completed.
 - For the NONCRIMINAL JUSTICE APPLICANT'S PRIVACY RIGHTS (PRIVACY RIGHTS) document, please read prior to completion of your national criminal background check and retain a copy for agency files.

6. RESUME FOR EXECUTIVE DIRECTOR: Please submit a resume for the person slated for the Executive Director position as required, ensuring the person meets one of the following educational and experience requirements: See Attachment 1 for the service categories that require an Executive Director.

1. Bachelor's Degree in a human service field (such as social work, psychology, education, nursing, or closely related field) and five (5) years of experience in service delivery to persons with intellectual/developmental disabilities, with at least two (2) of these years serving in a supervisory capacity.
2. An Associate's Degree in nursing, education, or a related field and six (6) years of experience in service delivery to persons with intellectual/ developmental disabilities, with at least two (2) of these years serving in a supervisory capacity.

3. A Bachelor's Degree with seven (7) years of experience in service delivery to person with intellectual/developmental disabilities, with at least four (4) of these years serving in a supervisory capacity.
4. Substitute Experience for Education: Ten (10) years of experience in service delivery to persons with intellectual/developmental disabilities, with at least four (4) of these years serving in a supervisory capacity.

7. **ORGANIZATIONAL CHART:** Please submit an organizational chart which shows all agency participants (i.e., owner(s), board of directors/advisory board, executive director, management staff, human resources, direct support staff, housing manager(s), nurse(s), etc.). Ensure key operational positions and reporting structures are clearly demonstrated on your organizational chart and job descriptions coverage is provided as needed to deliver all required services.
8. **JOB DESCRIPTIONS:** Where indicated, please supply job descriptions showing job duties, education requirements and experience requirements. Job Descriptions must match title/positions on the Organizational Chart. The Job responsibilities/functions cited for specific policies on the Minimum Required Policies and Review Guidelines document must be noted in the job descriptions such as : Complaint Resolution, Reportable Event Management, Title VI, Staff Training, and Personal Funds Management (Rep Payee, if applicable).

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 be displayed on the organizational chart.

9. **PROOF OF FINANCIAL CAPACITY:** These documents describe your understanding about service implementation and overall operations as it relates to DDA and MCO(s).
 - A. **PROJECTED BUDGET:** Submit forecast income statements (*projected budget*), based on the current Service Rate structure, for the initial six (6) months of operation. Please be sure to note each month separately showing growth of agency as needed. Address direct and Indirect operating costs including, but not limited to, the following:
 - I. **EXPENSES:** employee salaries and other employee costs, facility costs, utilities, transportation, service contracts, administrative cost, workman's compensation insurance, licensure fees, other support services, etc. *For employee salaries, please be sure to reflect coverage for the services and levels of need reported in calculations.*
 - II. **INCOME:** Identify each specific service rate and level of need used. This must include each service requested. Your budget may also include other income such as SSI for residential services.
 - III. **SUMMARY OF BUDGET CALCULATIONS:** Utilize the Available Service Rates for the current Fiscal Year (FY) document(s) for the applicable program(s) you are applying for when preparing your budget. Identify each specific service rate and level of need used when calculating your budget. Provide the number of persons used to calculate each service.
 - B. **PROOF OF ELIGIBLE FUNDS:** Submit a signed letter from a bank or lending institution showing proof of access to funds equal to or exceeding the initial six (6) months of the projected expenses. This includes

operational reserves or a line of credit. This letter must show the account is in the name of the agency. Bank statements will not be accepted.

10. **DISCLOSURE FORMS FOR: PROVIDER -ENTITIES AND PROVIDER -PERSON**

- 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.
- Must have an assigned Tax ID number (TIN), National Provider Identifier (NPI), and Medicaid ID number.
- In the % of ownership section, must enter the individual's name, full social security number and DOB for the Owners ,Board chair and Executive Director/Managing employee. **please do not include the EIN in this section**), and date of birth for each owner, executive director/managing employee, and board chair.

This information is used by DDA to check the following registries: Office of Inspector General/Exclusion data base (OIG LEIE), TN Department of Health Abuse Registry, TN Department of Correction Felony Offender Information (FOIL), National Sex Offender Public Website, Substantiated Investigations Records Inquiry (SIRI), Systems For Award Management (SAM) and TennCare Terminated Provider List (TTPL).

- a. **PROVIDER ENTITIES:** The National Provider Identifier (NPI) number must be for an organization. *Business information must match the New Provider Credentialing Application, W9 Form, Substitute W9 form, IRS's147C form/letter, and Tennessee Secretary of State registration.*
- b. **PROVIDER PERSON:** The National Provider Identifier (NPI) number must be for an individual. *Business information must match the New Provider Credentialing Application, W9 Form, Substitute W9 form, IRS's147C form/letter, and if obtained your Tennessee Secretary of State registration.*

11. **HOME & COMMUNITY-BASED SERVICES (HCBS) SETTINGS RULE SELF-ASSESSMENT:**

- a) See Attachment 1 for the provider applicant is required to submit the HCBS Assessment. All applicable current and incoming providers are required to show a plan to comply with the Centers for Medicaid and Medicare Services (CMS) at the time of credentialing and ensure compliance monitoring is ongoing.
- b) As a new provider you are answering questions related to future **and** current sites **and** how you plan to implement these Federal guidelines.
- c) Please follow the instructions at the beginning and end of each tool when providing answers.
- d) In the "evidence" section of the self-assessments, please note **the specific name of the policy or document** which shows where proof of your plan to comply may be found.
- e) Please submit the following documentation to demonstrate how your agency will meet 100% compliance with the HCBS Settings Rule. This includes, but is not limited to the following:
 - Employment application
 - Lease
 - Resident handbook
 - Satisfaction survey
 - Specific name of policy
 - Tenant agreement
- f) Please verify evidence is documented where indicated.
- g) General statements in lieu of policy or document will not be accepted as proof of an intent to comply.

FOR EXAMPLE:

SAMPLE QUESTION	YES/NO	Required Evidence of Compliance with HCBS rules
Does the setting offer onsite services, such as day habilitation, medical, behavioral, therapeutic, social and or recreational services in a manner that comports with the HCBS Setting Rule?	Yes	"Rights Policy" states these services can be provided in the person's home should they desire.
Do all residents have a legally enforceable agreement with the setting landlord?	Yes	We are applying to provide supported living services and leases will be between the person and their landlord. However, we will inform them of their right to this legally enforceable agreement in the "Resident Handbook".
Does the setting offer the same responsibilities/protections from eviction for Medicaid recipients as all tenants under the Uniform Residential Landlord and Tenant Act?	Yes	Please see the "resident handbook" which states the person will not be evicted should they decide to change provider agencies.
Are cameras that are present inside the setting only utilized in direct relation to the person-centered plan of care? (Put N/A if no cameras are present in the setting)	N/A	Cameras will NOT be used, please see "HCBS policy"
Is there a curfew or other requirement for a scheduled return to the setting?	NO	The "Rights Policy" shows the person will not be required to be at home or other location at a specific or scheduled time and no curfew is present.
Are individuals receiving Medicaid HCBS facilitated in accessing amenities such as a pool or gym use by others on-site?	Yes	The "Resident Handbook" states the person has the right to use any amenities such as pool or gym available at their residence (i.e., leased apartment building).

A. TN RESIDENTIAL PROVIDER SELF-ASSESSMENT: the document go to [Become a Credentialed Provider \(tn.gov\)](https://www.tn.gov/become-a-credentialed-provider) go to the Credentialing Application section.

Only **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 document go to [Become a Credentialed Provider \(tn.gov\)](https://www.tn.gov/become-a-credentialed-provider) go to the Credentialing Application section.

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 Self Employment , 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

12. POLICIES & PROCEDURES:

- Providers are charged with writing policies which explain your plan of implementation and processes to monitor the Agency's effectiveness/success.
- Please see **ATTACHMENT 3- Provider Credentialing Policy Requirements** for policy requirements per service type.
- **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 policy all critical elements, concepts, expectations, and outcomes. The tool is located at [Become a Credentialed Provider \(tn.gov\)](https://www.tn.gov/become-a-credentialed-provider).

SECTION 7: STATEMENT OF UNDERSTANDING

Is 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 conservator will not receive payment as an employee or board member if the person is supported by the organization unless specifically permitted in the Order of Conservatorship. As the conservator 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 Waiver program. DDA and/or the DDA/MCO's will monitor compliance to this federal statute. Consequences for non-compliance will 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:
11. Name:	12. Relation:
13. Signature:	14. Date:

SECTION 8: 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 Katie Beckett, 1915c Home and Community-Based Services (HCBS) waivers, and Employment and Community First (ECF)-CHOICES and CHOICES as 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.

2. 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, CHOICES, and ECF CHOICES. 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 not move to the next step of the credentialing process until it and all required supporting documents are complete and accurate.
2. Once the application is complete, the application will be reviewed by the Provider Development Committee (PDC).
3. The applicant will be notified upon successful completion of the credentialing process.

MERGERS AND ACQUISITIONS

When a change of ownership, merger and/or acquisition 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:

- a. Evidence is discovered demonstrating material misrepresentation or falsification of information on the application.
- b. 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 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*).